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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	07/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

CONTRACT NUMBER
71163 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for the contract period January 1, 2017 through December 31, 2021. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

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AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/119 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/19/19 ml)

AMENDMENT EIGHT (8) AS ATTACHED. (03/03/20 mel)

AMENDMENT NINE (9) AS ATTACHED. (07/14/20 mel)

AMENDMENT TEN (10) AS ATTACHED. (07/14/20 mel)

AMENDMENT ELEVEN (11) AS ATTACHED. (07/14/20 mel)

DocuSigned by:
Jeremy Brunssen
42A81D4FE4D94B5...
DHHS DIVISION DIRECTOR

BUYER
MATERIEL ADMINISTRATOR
7/28/2020

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1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
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	Total Order				**1,228,166,329.00**

JS
BUYER INITIALS

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AMENDMENT ELEVEN
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the Amendment") to Contract 71163 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Glossary of Acronyms

HHA: Heritage Health Adult

B. Glossary of Terms

Basic Coverage: Provides benefits equivalent to the current state plan with the exception of dental services, vision services, and over the counter medications.

Benefit Tier: Individuals eligible in the Heritage Health Adult program will be eligible for coverage in one of two benefit tiers, the Nebraska Basic Alternative Benefit Plan, also known as the Basic benefit tier, and the Nebraska Prime Alternative Benefit Plan, also known as the Prime benefit tier.

Case Management: Case Management plan includes the Health Risk Screen which is the initial and ongoing screening to identify care needs of a beneficiary and identify any changes in health or social status.

Heritage Health Adult Expansion: Initiative 427, which expands Medicaid eligibility to able-bodied Nebraska residents, ages 19 to 64, whose income is at or below 138 percent of the federal poverty level.

Medically Frail: For an individual to be determined medically frail, he or she must have a documented medical condition attested to by a healthcare provider who is able to diagnose within the scope of his or her respective practice act and is licensed and in good standing within the state in which they practice, identified though analysis and evaluation of historical claims data performed by the MCO, or identified through information supplied by the Department, that falls into one or more of the following categories:

(i) A disabling mental disorder;
(ii) A chronic substance abuse disorder;
(iii) A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs, see 471 NAC 12 for the definition of activities of daily living for adults;
(iv) A disability determination based on Social Security criteria;
(v) A serious and complex medical condition; or

(vi) Chronically homeless as defined by the United States Department of Housing and Urban Development.

Prime coverage: Provides benefits equivalent to the current state plan including dental services, vision services, and over-the-counter medications.

C. **Section IV.A.10 – Included Populations**
m. Members eligible for Heritage Health Adult (HHA) expansion

D. **Section IV.E.6.h. – Value-Added Services**
h. HHA members in the Basic Tier are not eligible for value-added services of dental, vision, or OTC medication.

E. **Section IV.F.5.f.xxxiv. – MEMBER SERVICES AND EDUCATION**
xxxiv. HHA Benefit Tier Requirements

F. **Section IV.K.4 – SUBCONTRACTING REQUIREMENTS**
4. MCOs must be able to communicate the eligibility of Prime vs. Basic membership with their subcontractors.

G. **Section IV.I.1.n – PROVIDER NETWORK REQUIREMENTS**
n. MCO must include in its contracts with its providers the requirement that Medically Frail attestation forms must be completed by the provider.

H. **Section IV.J.3.a.xxxi – PROVIDER SERVICES**
xxxi. HHA Benefit Tier Requirements

I. **Section IV.L.2.h. – CARE MANAGEMENT**
h. MCOs are required to implement the MLTC defined Health Risk Screening questions at a minimum.

J. **Section IV.R.2.k – SYSTEMS AND TECHNICAL REQUIREMENTS**
k. Transmit and receive the HHA Inbound MCE Member Data Response File

K. **Section IV.Z. HHA - Heritage Health Adult Expansion**

Effective October 1, 2020, all eligible HHA 19 to 64 year old members will receive integrated medical, behavioral health, and pharmacy benefits through the Heritage Health managed care program.

Members who meet the criteria for the Prime benefits package will receive vision and OTC benefits through their Heritage Health plan and dental benefits through the dental prepaid ambulatory health program (PAHP). Members who do not meet the criteria for Prime benefits will receive services equivalent to the current state plan with the exception of dental services, vision services, and over the counter medications.

All members newly eligible for Medicaid under the HHA program will receive the Basic benefits package.

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HHA members will receive the Prime benefits package only if:

- They are medically frail; or
- They are age 19 or 20; or
- They are a pregnant woman eligible under expansion

A. Medically Frail

1. Any Heritage Health Adult (HHA) expansion group member may be evaluated by MLTC for medically frail status during any time of the member's enrollment.
2. MLTC is responsible for determining members as medically frail and providing final notification to the member of approval or denial of medically frail.
    a. MLTC will notify the MCO when medically frail is approved or denied.
3. The MCO may identify HHA members who may be medically frail using the following methods:
    a. The member self-identifies as medically frail to the MCO.
        i. The MCO must assist members who self-identify as medically frail with obtaining necessary documentation as required in MLTC Medically Frail Guidance policy. This also includes obtaining documentation collected by the member related to the medically frail condition.
    b. Information the MCO collects from the members Health Risk Screening which includes, but is not limited to, the MLTC defined required HRS questions.
        i. The MCO must assist members that the MCO has identified as potentially medically frail with obtaining necessary documentation as required in the MLTC Medically Frail Guidance policy. This also includes obtaining documentation collected by the member related to the medically frail condition.
    c. Performing periodic evaluation of the member's historical claims data including diagnosis information that is current and verified within a 12 month look back as defined in the medically frail guidance policy.
    d. Ongoing engagement with the member through care/case management as described in Section IV.L. Care Management.
        i. Enroll the HHA member that is determined to be medically frail in active care/case management as described in Section IV.L. Care Management
4. The MCO must submit a written notification letter to all members prior to or simultaneously with the MCO submitting a medically frail referral to MLTC. The written notification letter used by the MCO must include information members may use to contact the MCO, including telephone or e-mail specific to MCO staff responsible for medically frail referrals.
5. The MCO must provide medically frail referrals to MLTC according to the specifications included in the Medically Frail Guidance policy.
    a. The MCO must provide MLTC supporting documentation simultaneously with the submission of a medically frail referral

according to the specifications included in the Medically Frail Guidance policy.
   b. As requested by MLTC, the MCO must provide additional documentation to support a medically frail determination.
   c. MCO must use available data sources to support identification of potentially medically frail members (e.g. diagnosis retrieved from electronic health information available through NEHII).
6. MCOs must reassess members that MLTC has previously determined to be medically frail and refer members to MLTC prior to the end of the current determination according to the specifications included in the Medically Frail Guidance Document.
7. As requested by MLTC, the MCO must respond to MLTC requests for supporting documentation to support periodic audits.
8. MCO must transmit medically frail data to the Department on the HHA Inbound MCE Member Data Response file.

II. **Modifications:** The Parties hereto modify the following sections:

A. Glossary of Terms

Care Management: Care Management is the individualized beneficiary plan developed to address the physical health, behavioral health, or social determinant needs of a beneficiary. Care management is the strategies and methods utilized to stabilize and then improve the health of the beneficiary. Care management plans need to be responsive to beneficiary needs and include physical and behavioral interventions and care, along with social services supports.

Care Management Plans are:

- Ongoing and modified as needed to meet the changing needs of the patient
- Comprehensive
- Evidence-based
- Care coordination with multi-disciplinary care teams
  - At a minimum includes clinical and behavioral health services, psychosocial needs, referrals and care transition management
- Cost-effective and high-quality

Value-added services: Those services a MCO provides in addition to a service covered under this contract because the MCO has determined that the health status and quality of life for the member is expected to be the same or better using the value-added health service as it would be using the covered service. Value-added services of vision, dental, and OTC medications are not available to members in the HHA Basic Tier.

B. Section IV.E.8.a.xvi. – COVERED SERVICES AND BENEFITS

xvi. Vision Services. Vision services to the HHA Basic Tier members must be medically necessary based on a diagnosed condition or an emergency vision services.

C. Section IV.E.8.a.xxiii – COVERED SERVICES AND BENEFITS

xxxiii. Pharmacy Services. HHA members in the Basic Tier are excluded from OTC benefits, including those on the PDL.

D. Section IV.E.10. – COVERED SERVICES AND BENEFITS

10. Eye Care and Vision Services. As set forth in the Medicaid State Plan and applicable regulations, the MCO must provide to all members any medically necessary eye care, vision examinations, prescriptive lenses, frames, and treatments. Eye care and vision services are to be performed by a licensed ophthalmologist or optometrist, conforming to accepted methods of screening, and diagnosis and treatment. Vision services to the HHA Basic Tier members must be medically necessary based on a diagnosed condition or an emergency vision services.

H. Section IV.E.11.e – Pharmacy Services

e. The MCO must, at a minimum, cover the OTC drugs listed in the Medicaid State Plan, except for HHA members in the Basic Tier who are excluded from OTC benefits, including those on the PDL.

L. Attachment 38 – Revised Reporting Requirements

The Reporting requirements and timeframes have been changed. The updated requirements are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This Amendment becomes part of the Contract. Except as set forth in this Amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/28/2020

UnitedHealthcare of the Midlands, Inc.

By: _____

Printed Name: Jeffrey S. Stafford

Title: Chief Executive Officer

Date: 06/29/2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: DocuSigned by: Jeremy Brunssen
42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

Date: 7/22/2020 | 13:41:23 CDT

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Health Risk Screening Completion Report - 90 Day Eligible	Contains information related to eligible member completion of HRS within 90 days of enrollment	Monthly

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Attachment 38 – Revised Reporting Requirements

Health Risk Screening Completion Report - Annual Eligible	Contains information related to eligible member completion of HRS for annual enrollment	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Supplemental Member Care Report	Contains supplemental information related to member care and case management and member outreach.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC as follows: Dec. 15 (data from June 1-Nov 30), March 15th (data from Dec 1-Feb 28), June 15 (data from March 1-May 31)
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
Medication compliance report for Chronic Diseases and High Risk Therapeutic Classes	Medication compliance report for chronic disease medications and specific high-risk therapeutic classes as defined by MLTC Compliance measure aligns with HEDIS definition of compliance	Quarterly

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MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NEMT Quarterly Report	Data regarding non-emergency transportation.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**

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Attachment 38 – Revised Reporting Requirements

Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually

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Attachment 38 – Revised Reporting Requirements

MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

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Original/Bid Document 5151 Z1

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Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

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DocuSigned by:
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DHHS DIVISION DIRECTOR

BUYER
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3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

JS
BUYER INITIALS

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AMENDMENT TEN
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the Amendment") to Contract 71163 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Attachment 11 – Rates

Rates for October 1, 2020, through December 31, 2020, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

This Amendment becomes part of the Contract. Except as set form in this Amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Cobb

Title: Materiel Administrator

Date: 7/28/2020

UnitedHealthcare of the Midlands, Inc.

By: _____

Printed Name: Jeffrey S. Stafford

Title: CEO

Date: 06/26/2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: Jeremy Brunssen
DocuSigned by:
42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

Date: 7/22/2020 | 13:41:23 CDT

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

United HealthCare – HH Rates – 10.1.2020

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
AABD 00-20 M&F	$1,681.57	$25.03	$1,706.60
AABD 21+ M&F	$2,172.81	$20.44	$2,193.25
AABD 21+ M&F-WWC	$5,362.59	$40.04	$5,402.63
CHIP M&F	$220.93	$3.50	$224.43
Family Under 1 M&F	$856.07	$18.89	$874.96
Family 01-05 M&F	$199.82	$3.72	$203.54
Family 06-20 F	$231.21	$3.20	$234.41
Family 06-20 M	$261.38	$2.98	$264.36
Family 21+ M&F	$631.24	$5.36	$636.60
Foster Care M&F	$702.40	$7.00	$709.40
Healthy Dual	$358.27	$0.00	$358.27
Dual LTC	$190.35	$0.00	$190.35
Non-Dual LTC	$3,817.89	$28.76	$3,846.65
Dual Waiver	$306.17	$0.00	$306.17
Non-Dual Waiver	$1,727.28	$15.22	$1,742.50
Katie Beckett 00-18 M&F	$13,624.39	$28.98	$13,653.37
599 CHIP - Cohort	$555.43	$3.96	$559.39
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,037.84	$68.41	$5,106.25
Refugee Resettlement	$287.36	$0.00	$287.36

Heritage Health Adult Rates (Rating Region 1)

Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
19-44 M - Prime	$371.85	$4.28	$376.13
19-44 F - Prime	$429.43	$4.95	$434.38
45-64 M&F - Prime	$1,078.97	$12.43	$1,091.40
21-44 M - Basic	$484.22	$5.58	$489.80
21-44 F - Basic	$533.76	$6.15	$539.91
45-64 M&F - Basic	$1,069.40	$12.32	$1,081.72
Medically Frail 19-44	$1,573.98	$17.45	$1,591.43
Medically Frail 45-64	$2,109.72	$23.38	$2,133.10

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United HealthCare – HH Rates – 10.1.2020

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
AABD 00-20 M&F	$1,324.07	$29.13	$1,353.20
AABD 21+ M&F	$2,278.33	$8.68	$2,287.01
AABD 21+ M&F-WWC	$6,536.79	$88.80	$6,625.59
CHIP M&F	$225.48	$1.29	$226.77
Family Under 1 M&F	$836.62	$10.81	$847.43
Family 01-05 M&F	$206.45	$1.15	$207.60
Family 06-20 F	$253.63	$0.78	$254.41
Family 06-20 M	$239.55	$0.72	$240.27
Family 21+ M&F	$731.63	$1.36	$732.99
Foster Care M&F	$548.17	$1.85	$550.02
Healthy Dual	$311.64	$0.00	$311.64
Dual LTC	$192.93	$0.00	$192.93
Non-Dual LTC	$2,018.48	$3.56	$2,022.04
Dual Waiver	$303.35	$0.00	$303.35
Non-Dual Waiver	$1,984.21	$10.16	$1,994.37
Katie Beckett 00-18 M&F	$13,624.39	$28.98	$13,653.37
599 CHIP - Cohort	$555.43	$3.96	$559.39
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,177.93	$2.90	$5,180.83
Refugee Resettlement	$287.36	$0.00	$287.36

Heritage Health Adult Rates (Rating Region 2)

Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
19-44 M - Prime	$431.20	$1.09	$432.29
19-44 F - Prime	$505.61	$1.28	$506.89
45-64 M&F - Prime	$1,243.94	$3.14	$1,247.08
21-44 M - Basic	$562.21	$1.42	$563.63
21-44 F - Basic	$629.98	$1.59	$631.57
45-64 M&F - Basic	$1,235.97	$3.12	$1,239.09
Medically Frail 19-44	$1,573.98	$17.45	$1,591.43
Medically Frail 45-64	$2,109.72	$23.38	$2,133.10

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	07/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71163 O4

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for the contract period January 1, 2017 through December 31, 2021. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/119 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/19/19 ml)

AMENDMENT EIGHT (8) AS ATTACHED. (03/03/20 mel)

AMENDMENT NINE (9) AS ATTACHED. (07/14/20 mel)

DocuSigned by:
Jeremy Brunssen
42A61D4FE4D94B5...
DHHS DIVISION DIRECTOR

BUYER

7/28/2020
MATERIEL ADMINISTRATOR

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VENDOR NUMBER: 552562	

CONTRACT NUMBER
71163 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

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AMENDMENT NINE
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the Amendment") to Contract 71163 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Section IV.C.12.d – Audit Requirements

d. The MCO shall be subject to an audit of Managed Care Data operations and underlying security, privacy, and isolation controls, no more often than every three months, to ensure that the required controls for data isolation, access, and usage are operational. The audit will be conducted by a third party to be selected by MLTC and approved by the MCO. The MCO will provide open and complete access to the underlying systems. Any and all relevant and/or necessary documentation to support the audit must be provided by the MCO no less than ten (10) days ahead of the on-site audit. Said audit will be conducted at MCO's expense.

B. Section IV.E.3.f & g – Behavioral Health Parity

f. The MCO may not impose an annual dollar limit on mental health or substance use disorder benefits per 42 CFR 438.905 (b). Any financial, quantitative or non-qualitative limits in force, are applied consistently for medical/surgical & mental health/SUD benefits per 42 CRF 438.910.

g. MCO may not impose a nonquantitative treatment limitation for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO, PIHP, or PAHP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards.

C. Section IV.R.9.l -

l. The MCO must adhere to the following Data Protection Requirements:

i. Medicaid data must be maintained and stored solely by the servicing MCO, except as in (ii) below. The MCO may not use a subcontractor or other entity owned, controlled, and/or operated by any other MCO operating within the State of Nebraska or any other state to store, maintain, utilize, share, or access any Medicaid data.

ii. During a transition period, as defined by IV.X., resulting from a merger, reorganization and/or change of ownership as defined by IV.C.11, the MCO must submit a Data Use Agreement to MLTC no later than thirty (30) days prior to the start of the transition regarding temporary dual-retention of data during the transition.

iii. Medicaid data previously stored, maintained, utilized, shared, or accessed by a MCO must be destroyed and/or rendered completely and totally inaccessible contemporaneously upon completion of a merger, reorganization, and/or change of ownership per the terms of Section IV.C.11 (Merger, Reorganization, and Change of Ownership).

D. Section IV.V.2.j

j. Data Breach

i. Should the MCO fail to protect Medicaid data in accordance with the terms of this contract or any applicable law, MTLC may assess damages of $10,000 per calendar day for each day the MCO remains in breach.

II. MODIFICATIONS: The Parties hereto modify the following sections:

A. Section IV.X.2.a - Transition Period

a. The transition period for the contract begins on contract award and ends 90 days after the contract start date for new contracts. The transition period for a contract resulting from a merger, reorganization, or change in ownership of an existing contract begins at the date of close of said the merger, reorganization, or change of ownership, and ends 180 days thereafter, with optional 90-day extension periods available upon request in writing by the MCO no less than ten (10) days prior to the end of each period, and upon approval by MLTC. During the transition period the MCO must implement the requirements of the contract and collaborate with MLTC to facilitate a seamless transition between MCOs, providers and programs in order to prevent an interruption of services and to ensure continuity of care for members.

With the exception of transplants, for which all previous authorizations will be honored, MCOs will honor, regardless of provider participation network status, previous authorizations for the lesser of:

i. 90 days from implementation;
ii. The end date on the authorization from the previous entity; or
iv. A new decision by the plan with consultation from the provider if determined on the medical necessity of the service.

B. Section IV.C.11 - Merger, Reorganization, and Change of Ownership

a. The MCO must submit notification to MLTC of a merger, reorganization, or change of ownership prior to its proposed effective date. The MCO must also submit a detailed merger, reorganization, or transition plan to MLTC for review prior to the effective date of the proposed merger, reorganization, or change of ownership. The purpose of the transition plan's review is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, and ensure that services to members are not diminished. In addition, the MCO must provide adequate assurances to MLTC that the major components of its organization and programs are not adversely affected by such merger, reorganization, or change in ownership. This plan must be approved by MLTC prior to any merger, reorganization, or change of ownership. MLTC will not permit one organization to own or manage more than one contract within the same program.

b. Upon a merger, reorganization, or change of ownership of any MCO, MLTC may offer open enrollment period of no more than ninety (90) calendar days to all Medicaid members. During this period of open enrollment, each member may change to another MCO for any reason. Each MCO must notify its respective members of the open enrollment period and their rights therein.

C. Section IV.C.8 – Participation in the Nebraska Health Information Initiative

The MCO is required to enter into a participation agreement with the Nebraska Health Information Initiative (NeHII). NeHII is a non-profit organization that includes health care providers, payers, and the State. NeHII's purpose is to achieve health care transformation through the creation of a secure, web-based health information exchange to serve the State. More information on NeHII can be found at: www.nehii.org.

III. **MODIFICATIONS:** The Parties hereto modify the following sections, effective sixty (60) days after execution of this amendment:

A. Section IV.B.3.f.iii – Auto-Assignment Algorithm

iii. MLTC reserves the right to remove the MCO from the auto-assignment round robin process for any quarter, beginning with the 4th Quarter, 2020, but members can continue to pro-actively select that plan.

This Amendment becomes part of the contract. Except as set form in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Contract or any earlier Amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/28/2020

UnitedHealthcare of the Midlands, Inc.

By: _____

Printed Name: Jeffrey S. Stafford

Title: CEO

Date: 06/26/2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: DocuSigned by: Jeremy Brunssen 42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

Date: 7/22/2020 | 13:41:23 CDT

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

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PAGE	ORDER DATE
1 of 2	03/03/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

CONTRACT NUMBER
71163 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for the contract period January 1, 2017 through December 31, 2021. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/119 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/19/19 ml)

AMENDMENT EIGHT (8) AS ATTACHED. (03/03/20 mel)

3/4/20 3-4-20

BUYER

3-4-2020

DHHS DIVISION DIRECTOR

MATERIEL ADMINISTRATOR

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VENDOR NUMBER: 552562

CONTRACT NUMBER
71163 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
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3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT EIGHT
Contract 71163 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the Amendment") to Contract 71163 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. IV.N.9.c; i; ii; iii; and iv

c. Per section 1004 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)* consistent with section 1902(oo)(1)(A)(ii) of the Social Security Act, MCO is required to operate a DUR program and implement provisions in the DUR program, effective October 1, 2019. The MCO DUR program must have in place:

i. prospective safety edits and a claims review automated process for subsequent opioid fills (refills) when in excess of any limitation (duplicate fills, early fills, and drug quantity limitations) that may be specified by the State and retrospective safety edits and a claims review automated process for any fills in excess of the maximum MME dose limitation identified by the state.

ii. process for retrospective automated claims review (as specified by the state) that monitors concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. Permitted exclusions from the above safety edits and claims review requirements to not apply to beneficiaries receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; or other individuals the state elects to treat as exempted from such requirements

iii. program to monitor and manage appropriate use of antipsychotic medications by children not more than the age of 18 and children in foster care.

iv. process as defined by the state that identifies potential fraud or abuse of controlled substances by individuals, health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

Process may include lock in programs and prescription drug monitoring programs.

B. Section IV.P.14; i; ii; a; i; ii; and iii; b and c – Reinvestment Accounts

Pursuant to Neb. Rev. Stat. §71-831, reinvestment of profits in excess of the contracted amount, performance contingencies imposed by the department, and any unearned (forfeited) hold-back funds must be reinvested. To this end, the MCO must establish and manage two accounts:

i. A hold-back account, for the purpose of holding funds listed in the QPP. Funds in this account include both the Federal and State share of cost in the State's Medicaid program.

ii. A reinvestment account, for the purpose of holding funds pursuant to Neb. Rev. Stat. §71-831 subject to reinvestment.

a. Both the holding and reinvestment distribution accounts must:

i. Be separate from other accounts required by the contract, or that may be required by State or Federal law.

ii. Have no risk-bearing investments.

iii. Be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. §30-3801 to 30-38110).

b. The MCO must distribute funds in the reinvestment distribution account in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

c. The MCO will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the reinvestment holding and reinvestment distribution accounts. Oversight of the financial accounting will be in accordance with the financial management reporting requirements outlined in Section IV.T Reporting and Deliverables of this RFP.

C. Attachment 42 - High Risk Drug Pool Risk Corridor

The high cost drug pool risk corridors are set forth in Attachment 42 attached hereto and made a part hereof.

II. **Modifications:** The Parties hereto modify the following sections:

A. Section IV.P.2.e.xvii

xvii. Refugee Medical Assistance Program (RMAP)

B. Section IV.P.2.i – Capitation Rate Determination Process

i. Any adjusted rates will be actuarially sound and consistent with requirements set forth in 42 CFR 438.6(c), and 42 CFR 457.1203(a). Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

C. Section IV.P.9.c

c. This calculation must be completed within eleven (11) months of the end of the contract year. The risk corridor will be calculated first, and any payments/receipt under the risk corridor will be incorporated in the MLR calculation. This methodology is consistent with the Final Rule published by CMS.

D. Section IV.P.12.d

d. To ensure compliance with state law, MLTC will calculate the administrative expense rate within eleven (11) months of the end of each contract year.

E. Section IV.P.17 – High Cost Drug Pool Risk Corridor

Beginning with the CY19 contract period MLTC implemented a high cost drug pool as part of the Heritage Health program. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs should there be a disproportionate share of high-cost drug experience for any MCO(s). The CY19 high-cost drug pool was considered budget-neutral from the State and CMS' perspective. However, as a result of continued uncertainty regarding emerging high cost drugs coming into the market, MLTC is implementing a risk corridor around the high-cost drug pool effective January 1, 2020, as set forth in Attachment 42 – High Cost Drug Pool Risk Corridor.

F. Attachment 11 – Rates

Rates for January 1, 2020, through December 31, 2020, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

G. Attachment 14 – Quality Performance Program Measures-Contract Year Four

The Quality Performance Program measures have been revised for the time period January 1, 2020, through December 31, 2020, and are set forth in the Amended Attachment 14 attached hereto and made a part hereof.

H. Attachment 38 – Revised Reporting Requirements

The Reporting requirements and timeframes have been changed. The updated requirements are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 3-4-2020

UnitedHealthcare of the Midlands, Inc.

By: K G Mallatt

Printed Name: Kathleen A. Mallatt

Title: CEO

Date: 2/27/2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew Van Patton

Title: Director

Date: March 4, 2020

Attachment 42
High Cost Drug Pool Risk Corridor

Beginning with the CY19 contract period the State has implemented a high cost drug pool as part of the Heritage Health program. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs should there be a disproportionate share of high-cost drug experience for any MCO(s). The CY19 high-cost drug pool was considered budget-neutral from the State and CMS' perspective. However, as a result of continued uncertainty regarding emerging high cost drugs coming into the market, the State has decided to include a risk corridor around the high-cost drug pool in CY20. Detail surrounding the high-cost drug risk corridor below.

Drug Identification Criteria
High-cost drug experience has been identified within the CY18 base data using a cost-based approach. Ten digit Generic Product Indicators (GPIs), and injectable codes on the CY18 fee schedule that have an average cost of $10,000 PMPM have been classified as high-cost. This high-cost drug pool will only be applicable to the non-dual populations. The following Heritage Health rating cohorts will be exempt: Healthy Dual, Dual LTC, and Dual Waiver.

The following steps have been taken to identify the GPIs or injectables that meet the high-cost criteria:
1. Utilizers of each GPI or injectable were identified, along with all associated member months for these utilizers.
2. The total dollars paid, and total member months for drug utilizers were summarized to determine an average "utilizer" PMPM for each GPI and injectable within the CY18 data.
3. Each GPI or injectable with an average "utilizer" PMPM of $10,000 or greater meet the criteria for the high cost pharmacy risk pool within the base data.

For example: there are 10 members who utilize a particular GPI in CY18. These 10 members have a combined 90 member months through CY18. The total expenditures for this GPI are $900,000, resulting in an average PMPM of $10,000. All expenditures associated with this GPI would now be included in the development of the high-cost drug pool.

Establish Benchmarks
Upon identification of the relevant GPIs and injectables, the total spend associated with these drugs are summarized to arrive at a specific high cost drug PMPM by COA and Rating Region. These amounts are then projected forward to the CY20 contract period. A sample of the high-cost drug pool cost projection is show below:

COA	Total COA MMs	High Cost GPI PMPM	High Cost Injectable Code PMPM	Total High Cost PMPM (GPI+J Code)	Illustrative Projection Factor	Projected to CY20
1	50,000	*$0.00*	*$0.00*	$0.00	-	$0.00
2	150,000	*$8.00*	*$2.00*	$10.00	1.15	$11.50
3	250,000	*$15.00*	*$5.00*	$20.00	1.15	$23.00

Once COA and Regional PMPM projections are established, these PMPMs are converted to MCO-specific PMPMs. MCO-specific PMPMs are calculated using the CDPS+Rx prospective risk score applicable to the CY20 Heritage Health capitation rates.

		MCO A		MCO B	
COA	**Statewide Projected to CY20**	**Risk Score**	**MCO-Specific PMPM**	**Risk Score**	**MCO-Specific PMPM**
1	$0.00	1.00	$0.00	1.00	$0.00
2	$11.50	1.10	$12.65	0.90	$10.35
3	$23.00	0.95	$21.85	1.05	$24.15

Experience Period Reconciliation

Once the CY20 contract period ends, a reconciliation will occur between MCOs to the extent that the distribution of high cost drugs between MCOs is different than the distribution projected by the rate development process.

A total pool of dollars will be calculated after the end of the CY20 contract period. This pool will be calculated based on the total CY20 member months and the MCO-specific PMPMs described in the "Establish Benchmarks" section above. Once this pool is established, dollars may be added to or subtracted from the pool, as a result of the risk corridor that is in place for CY20.

In order to determine the CY20 actual expenditures that will be compared to the high-cost drug pool, high cost GPIs and injectables relevant to CY20 will be determined. Due to the nature of new drugs coming onto the market over time, it is possible that drugs that exist in CY20 were not present in the CY18 base data period. Therefore, a separate identification of drugs with an average PMPM of $10,000 in the CY20 contract period will be completed. This will be completed in a manner consistent with the approach described in the "High Cost Drug Identification Criteria" section above, with the exception being that the membership and claims data will be based on CY20 experience, and a standardized unit cost will be applied to NDCs underlying each GPI identified. Once this identification process is completed, the total experience for the GPIs and injectables that meet the criteria in CY20 will comprise the experience to be compared to the high-cost drug pool.

Prior to determining dollar transfers between MCOs, the CY20 experience for drugs that meet the high cost criteria will be evaluated against the risk corridor. The risk corridor bands are noted below:

Corridor Bands		**State/Fed and MCO Share**	
Low	**High**	**State/Fed Share**	**MCO Share**
<=85%	85%	100%	0%
85%	90%	75%	25%
90%	95%	50%	50%
95%	100%	0%	100%
100%	105%	0%	100%
105%	110%	50%	50%

110%	115%	75%	25%
115%	>=115%	100%	0%

If the program-wide experience for high cost drugs exceeds the original pool enough to warrant a State/Fed share of the excess expenditures, new dollars will be added to the pool in addition to the capitation rates. Likewise, if the experience is far enough below the original pool to warrant State/Fed savings, then dollars will be removed and MCOs will collectively pay dollars back to the State/Fed.

Once the risk corridor is calculated, any additions or reductions to the pool are made as necessary. A dollar transfer will then occur to the extent that an MCO's total contribution to the statewide pool is proportionally different than its actual CY20 experience as compared to the statewide CY20 actual experience. For example: an MCO's CY20 member months multiplied by its MCO-Specific PMPMs contributes 30% of the high cost drug pool but its CY20 expenditures for high cost drugs reflects 35% of the statewide CY20 expenditures. In this scenario, the MCO would receive a payment of 5% (35% - 30%) of the total high-cost drug pool. Conversely, either one or two of the other MCOs would have to pay out the equivalent of the 5%.

United HealthCare – HH Rates – 1.1.2020

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,510.05	$25.03	$1,535.08
AABD 21+ M&F	$1,951.19	$20.44	$1,971.63
AABD 21+ M&F-WWC	$4,815.60	$40.04	$4,855.64
CHIP M&F	$198.40	$3.50	$201.90
Family Under 1 M&F	$768.75	$18.89	$787.64
Family 01-05 M&F	$179.44	$3.72	$183.16
Family 06-20 F	$207.63	$3.20	$210.83
Family 06-20 M	$234.72	$2.98	$237.70
Family 21+ M&F	$566.86	$5.36	$572.22
Foster Care M&F	$630.75	$7.00	$637.75
Healthy Dual	$321.73	$0.00	$321.73
Dual LTC	$170.94	$0.00	$170.94
Non-Dual LTC	$3,428.47	$28.76	$3,457.23
Dual Waiver	$274.94	$0.00	$274.94
Non-Dual Waiver	$1,551.10	$15.22	$1,566.32
Katie Beckett 00-18 M&F	$12,234.70	$28.98	$12,263.68
599 CHIP - Cohort	$498.77	$3.96	$502.73
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,037.84	$68.41	$5,106.25
Refugee Resettlement	$287.36	$0.00	$287.36

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,189.01	$29.13	$1,218.14
AABD 21+ M&F	$2,045.94	$8.68	$2,054.62
AABD 21+ M&F-WWC	$5,870.04	$88.80	$5,958.84
CHIP M&F	$202.48	$1.29	$203.77
Family Under 1 M&F	$751.28	$10.81	$762.09
Family 01-05 M&F	$185.39	$1.15	$186.54
Family 06-20 F	$227.76	$0.78	$228.54
Family 06-20 M	$215.12	$0.72	$215.84
Family 21+ M&F	$657.00	$1.36	$658.36
Foster Care M&F	$492.26	$1.85	$494.11
Healthy Dual	$279.85	$0.00	$279.85
Dual LTC	$173.25	$0.00	$173.25
Non-Dual LTC	$1,812.59	$3.56	$1,816.15
Dual Waiver	$272.41	$0.00	$272.41
Non-Dual Waiver	$1,781.82	$10.16	$1,791.98
Katie Beckett 00-18 M&F	$12,234.70	$28.98	$12,263.68
599 CHIP - Cohort	$498.77	$3.96	$502.73
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,177.93	$2.90	$5,180.83
Refugee Resettlement	$287.36	$0.00	$287.36

Attachment 14
Quality Performance Program Measures – Contract Year Four

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	5%
Encounter Acceptance Rate: Submitted encounters must be accepted 95% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	15%
Appeal Resolution Timeliness: MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	5%
Lead Screening in Children (LSC): Percentage of children two (2) years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	69%	10%
Well-Child Visits in the First 15 Months of Life (W15): Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits. • One (1) well-child visit. • Two (2) well-child visits. • Three (3) well-child visits. • Four (4) well-child visits. • Five (5) well-child visits. • Six (6) or more well-child visits.	69%	10%
Adolescent Well-Care Visits (AWC): Percentage of enrolled members 12-21 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	57%	10%

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34): Percentage of members three (3) to six (6) years of age who had one (1) or more well-child visits with a PCP during the measurement year.	71%	10%
Childhood Immunization Status (CIS): Percentage of children two (2) years of age who had four (4) diphtheria, tetanus and acellular pertussis (DtaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) haemophilus influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday. Measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 34% Combination #10 23%	Combination #2 - 5% Combination #10 - 5%
Immunization for Adolescents (IMA): Percentage of adolescents 13 years of age who had one (1) dose of meningococcal vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. Measure calculates a rate for each vaccine and two (2) combination rates.	Combo #1 – 84% HPV- 25%	Combo #1 – 7% HPV—3%
Follow-up After Hospitalization for Mental Illness (FUH): Percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. Percentage of discharges for which the member received follow-up within 30 days after discharge. Percentage of discharges for which the member received follow-up within 7 days after discharge.	30 day – 65% 7 day – 45%	30 day 5% 7 day 5%
MEASURE AMB-CH: AMBULATORY CARE: EMERGENCY DEPARTMENTY (ED) VISITS Rate of Emergency Department (ED) visits per 1,000 beneficiary months among children up to age 19.	43	5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD): Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three (3) follow-up visits within a 10 month period,	Monitoring Metric Only Note: State pharmacy file format change may impact validation	NA

one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: • *Initiation Phase.* Percentage of members six (6) to 12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one (1) follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *Continuation and Maintenance (C&M) Phase*. Percentage of members six (6) to 12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two (2) follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.		
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH): Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/CHIP.	Monitoring Metric Only 2018 CMS Median 80.6%	NA
Antidepressant Medication Management (AMM): Percentage of members 18 years of age and older treated with antidepressant medication, had a diagnosis of major depression and remained on antidepressant medication treatment. Two rates are reported: 1. *Effective Acute Phase Treatment*. Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. *Effective Continuation Phase Treatment*. Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	Monitoring Metric Only Note: State pharmacy file format change may impact validation	NA

Plans may use whichever reporting methodology that they wish but must notify the state on submission. State may request supporting documentation for metrics, including but not limited to, claims extracts, denominator member list, supplemental information used in calculation, etc. If the plan does not supply the requested documentation, the measure target will be held to have not been met.

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	Description	Due Date
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly

Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC as follows: Dec. 15 (data from June 1-Nov 30), March 15th (data from Dec 1-Feb 28), June 15 (data from March 1-May 31)
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NEMT Quarterly Report	Data regarding non-emergency transportation.	Quarterly

NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31

MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually by November 1
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually by November 1
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually by November 1
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually

Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	07/19/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

CONTRACT NUMBER
71163 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from the date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/119 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/19/19 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00

DHHS DIVISION DIRECTOR

7/24/19 7/25/19
BUYER
7/29/19
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	07/19/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 552562

CONTRACT NUMBER
71163 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT SEVEN
Contract 71163 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the Amendment") to Contract 71163 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **REMOVALS:** The following section is hereby removed:

A. Attachment 7 – Performance Measures

B. IV.I.14.i

II. **ADDITIONS:** The following sections are hereby added effective November 1, 2019:

A. Section IV.S.4.a.vi – Drug Claims Processing

vi. MLTC prohibits "spread pricing" defined as any amount charged or claimed by a PBM to an MCO that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.

C. Section IV.E.22.f.ix – Medical Services for Special Populations

x. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly.

III. **Modifications:** The Parties hereto modify the following sections:

A. Section IV.B.6.b – MCO Changes

b. After the initial 90 calendar day period, Medicaid members will be locked in to their MCO selection until the next annual open enrollment period. The annual open enrollment period will take place November 1 through December 31 each year of the contract.

B. Section IV.D.3.k – Additional Required Staff

k. Non-Emergency Medical Transportation (NEMT) Network Coordinator. Responsible for receiving and processing provider inquiries and complaints, investigating provider complaints, and referring complaints to the Public Service Commission (PSC) for transportation providers governed by the PSC. The NEMT Network Coordinator is also responsible for resolving provider issues to include but not limited to payment delays. This position must be available to meet personally with transportation providers but is not required to be located in Nebraska.

C. Section IV.E.6.a – Value Added Services

a. As permitted under 42 CFR 438.3(e), and to the extent consistent with provisions of State law, the MCO may, in its discretion, offer expanded services and benefits to enrollees in addition to those benefits and services specified in this section of the RFP.

D. Attachment 11 – Rates

July 1, 2019, through December 31, 2019, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

E. Attachment 38 – Revised Reporting Requirements

The Reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carter

Title: Materiel Administrator

Date: 7/29/19

UnitedHealthcare of the Midlands, Inc.

By: _____

Printed Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: July 10, 2019

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew Van Patton

Title: Director

Date: 24 July 19

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,363.01	$26.78	$1,389.79
AABD 21+ M&F	$1,919.06	$26.14	$1,945.20
AABD 21+ M&F-WWC	$3,385.08	$153.92	$3,539.01
CHIP M&F	$194.06	$2.04	$196.10
Family Under 1 M&F	$758.35	$12.03	$770.38
Family 01-05 M&F	$169.15	$2.45	$171.60
Family 06-20 F	$203.02	$2.41	$205.43
Family 06-20 M	$221.64	$2.09	$223.72
Family 21+ M&F	$523.42	$8.37	$531.79
Foster Care M&F	$625.55	$6.25	$631.79
Healthy Dual	$310.82	$2.60	$313.42
Dual LTC	$202.11	$0.53	$202.64
Non-Dual LTC	$3,373.90	$32.44	$3,406.34
Dual Waiver	$256.05	$1.25	$257.30
Non-Dual Waiver	$1,480.84	$16.11	$1,496.95
Katie Beckett 00-18 M&F	$11,549.17	$35.95	$11,585.11
599 CHIP - Cohort	$438.11	$6.60	$444.71
599 CHIP - Supplemental	$4,754.16	$50.30	$4,804.46
Maternity	$5,036.12	$44.13	$5,080.24
Refugee Resettlement	$263.16	$0.00	$263.16

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,428.93	$7.52	$1,436.45
AABD 21+ M&F	$1,947.38	$8.96	$1,956.34
AABD 21+ M&F-WWC	$3,588.88	$61.20	$3,650.08
CHIP M&F	$187.27	$0.92	$188.18
Family Under 1 M&F	$747.73	$7.69	$755.42
Family 01-05 M&F	$162.48	$0.74	$163.21
Family 06-20 F	$218.48	$0.75	$219.23
Family 06-20 M	$224.88	$0.55	$225.43
Family 21+ M&F	$583.49	$2.64	$586.13
Foster Care M&F	$609.61	$2.59	$612.21
Healthy Dual	$263.52	$0.33	$263.85
Dual LTC	$173.77	$0.09	$173.86
Non-Dual LTC	$2,075.10	$1.40	$2,076.50
Dual Waiver	$263.50	$0.12	$263.62
Non-Dual Waiver	$1,508.23	$5.10	$1,513.33
Katie Beckett 00-18 M&F	$11,549.17	$35.95	$11,585.11
599 CHIP - Cohort	$438.11	$6.60	$444.71
599 CHIP - Supplemental	$4,754.16	$50.30	$4,804.46
Maternity	$5,092.04	$8.69	$5,100.73
Refugee Resettlement	$263.16	$0.00	$263.16

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	Description	Due Date
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly

Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature by MLTC on Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit the data for these reports to MLTC as follows: Dec 15 (data from July 1 – Nov 30), March 15th (data from Dec 1 –Feb 28), June 15 (data from March 1 – May 31).
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly

MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be	June 30 and December 31

	submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1

Attachment 38 – Revised Reporting Requirements

PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	01/09/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71163 O4

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/119 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE	409,151,871.0000	$	1.0000	409,151,871.00

DHHS DIVISION DIRECTOR

2/26/19 PK

BUYER 2-25-19

MATERIEL ADMINISTRATOR 2/26/19

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
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PAGE	ORDER DATE
2 of 2	01/09/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 552562

CONTRACT NUMBER
71163 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT TERM YEAR 2				
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT SIX
Contract 71163 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the Amendment") to Contract 71163 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **REMOVALS:** The following section is hereby removed effective January 1, 2019:

A. **Glossary of Term:**
Reinvestment Account.

II. **REMOVALS:** The following sections are hereby removed effective July 1, 2019:

Section IV.E.29.h

Section IV.P.14

III. **ADDITIONS:** The following sections are hereby added effective July 1, 2019:

A. **Glossary of Terms**

Accompanying Adults: A legally responsible adult/guardian, or an adult selected by the legally responsible adult, to accompany a minor to a Medicaid coverable service.

Common Carrier: Any commercial provider who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).

Consecutive Appointments: Appointments beginning, or scheduled to begin, within thirty (30) minutes of the last completed appointment.

Escort/Attendant Provider: A paid or unpaid individual or caregiver accompanying a program eligible member who is physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision to receive a Nebraska Medicaid coverable service. The escort/attendant provider may drive or utilize transportation services with the program eligible member.

Exempt Provider: An individual or entity providing transportation services exempted from Public Service Commission licensure by law (Neb. Rev. Stat. § 75-303).

Individual Provider: A person who is not in the business of providing transportation for hire; for example, a friend, neighbor, or non-legally responsible

relative, exempted from Public Service Commission (PSC) licensure by law (Neb. Rev. Stat. § 75-303.01).

Public Transportation: A fixed or non-fixed route public transit system regulated as such with the Nebraska Department of Transportation (NDOT) (See Neb. Rev. Stat. § 13-1203).

B. Section IV.A.10 – Included Populations

j. Members eligible for the Refugee Medical Assistance Program (RMAP).

k. Members eligible for the State Disability Program-Medical (SDP Medical).

l. Members with continuous eligibility that have a share of cost.

C. Section IV.D.3 – Additional Required Staff

k. Non-Emergency Medical Transportation (NMET) Network Coordinator. Responsible for receiving and processing provider inquiries and complaints, investigating provider complaints, and referring complaints to the Public Service Commission (PSC) for transportation providers governed by the PSC. The NEMT Network Coordinator is also responsible for resolving provider issues to include but not limited to payment delays. This position must be available to meet personally with transportation providers but is not required to be located in Nebraska.

IV. Modifications: The Parties hereto modify the following sections effective January 1, 2019:

A. Glossary of Terms

Hold-back account: The portion of the MCO's revenue that the MCO must reserve in the holding account and may potentially earn based upon MLTC's determination of the MCO's results on identified performance measures.

B. Section IV.J

3. Provider Handbook

xix. Paper and electronic claims submission protocols and standards, including instructions and all information necessary for a claim, in accordance with 42 CFR 447.45, along with samples of claims.

C. Section IV.M

6. Quality Performance Measurement and Evaluation

a. The MCO must report on CMS Adult Core, Child Core, CAHPS, and HEDIS measures, as well as additional performance measures as determined by MLTC. Measures may be removed or added at will by

MLTC, and MCOs will be given a 60 day period in which to implement additional measure requirements. MCOs will report using the most current version, specification, or manual that is available prior to required reporting deadlines, as is related to the given measure set. MCOs may request exemption from reporting specific measures within respective sets due to inability to report, subject to MLTC approval, within a MLTC designated schedule.

D. Section IV.P

5. Supplemental Delivery Payments

g. Supplemental payment for deliveries will be to reimburse the MCO for the expenses incurred between the date of admission and the date of discharge of a delivery event.

9. Risk Corridor

d. If the calculation produces a profit above the indicated amount, the MCO must ensure that the surplus is returned to MLTC, within 30 days of written notification of the final surplus amount from MLTC.

e. The MCO must provide a full financial statement and additional data, as requested to MLTC and its actuary to support the calculation. MLTC will reimburse the Federal share of the forfeited funds to CMS and retain the state share for reinvestment pursuant to Neb. Rev. Stat. §71-831.

10. MLTC Quality Performance Program

g. The MCO must return unearned (forfeited) hold-back funds to MLTC.

E. Section IV.Q

9. Reimbursement to FQHCs and RHCs

g. The MCO may stipulate that reimbursement is contingent on receiving a claim, in accordance with 42 CFR 447.45, and all medical information required to update the member's medical record.

F. Section IV.S

3. Claims Processing

ii. In accordance with 42 CFR 447.45, process and pay or deny, as appropriate, a minimum of 90% of all claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the claim.

iii. In accordance with 42 CFR 447.45, process and pay or deny, as appropriate, a minimum of 99% of all claims for medical services provided to members within 60 calendar days of the date of receipt.

b. For Pharmacy providers, in accordance with 42 CFR 447.45, the MCO must establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all claims from pharmacy providers for covered services are paid within seven calendar days of receipt and 99% of all claims are paid within 14 calendar days of receipt, except to the extent providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC within three business days of their implementation.

d. Pended Claims
In accordance with 42 CFR 447.45, if a claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

5. Payments to Providers

e. The MCO must pay providers interest at an annualized rate of 12%, calculated daily for the full period in which a payable claim, in accordance with 42 CFR 447.45, remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

7. Paid Claims Sampling

b. The MCO must stratify the sample group by dollar figure amounts in a representative manner. To the extent that the MCO or MLTC considers a particular pool to warrant closer scrutiny, the MCO may oversample this group. The paid claims sample should be a minimum of 2% of claims per month. The results must be reported to MLTC on a quarterly basis, per the requirements in Attachment 38 - Revised Reporting Requirements. Stratifications of groups should be done by the following dollar amounts: $0 – $999.99, $1,000 - $9,999.99, $10,000 - $49,999.99, $50,000 or greater.

10. Encounter Data

c. The MCO must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MLTC data quality standards as originally defined or subsequently amended. The MCO must comply with industry-accepted claim standards, in accordance with 42 CFR 447.45, for all encounter data,

including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

u. Encounter data must be submitted a minimum of monthly on a date designated by MLTC and include all claims, in accordance with 42 CFR 447.45, adjudicated and/or adjusted by the MCO.

G. Attachment 11 – Rates

January 1, 2019, through December 31, 2019, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

H. Attachment 14 – Quality Performance Program Measures-Contract Year Two

The Quality Performance Program measures have been revised for the time period January 1, 2019, through December 31, 2019, and are set forth in the Amended Attachment 14 attached hereto and made a part hereof.

V. Modifications: The Parties hereto modify the following sections effective July 1, 2019:

A. Section IV. A.11 – Excluded Populations

b. Beneficiaries who have excess income or are required to pay a premium, and are intermittently eligible.

B. Section IV.E. – Covered Services and Benefits

8. Core Benefits and Services

The following services represent a minimum benefit package that the MCO must provide to its members:

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.

ii. Outpatient hospital services.

iii. Ambulatory surgical center (ASC) services.

iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia

services including those provided by a certified registered nurse anesthetist.

v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

vi. Services provided in Indian Health Service (IHS) facilities.

vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.

viii. Radiology services.

ix. Health Check (EPSDT) services.

x. Home health services.

xi. Private duty nursing services.

xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).

xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.

xiv. Podiatry services.

xv. Chiropractic services.

xvi. Vision services.

xvii. Free standing birth center services.

xviii. Hospice services, except when provided in a nursing facility.

xix. Skilled/rehabilitative and transitional nursing facility services.

xx. Ambulance services.

xxi. Non-emergency medical transportation.

xxii. Transplant services.

xxiii. Pharmacy services.

xxiv. Nutrition Services.

b. Behavioral Health Services

Services for individuals age 20 and under, unless otherwise indicated:

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

- a) Partial hospitalization.
- b) Day treatment.
- c) Intensive outpatient.
- d) Medication management.
- e) Outpatient therapy (individual, family, or group).
- f) Injectable psychotropic medications.
- g) Substance use disorder treatment.
- h) Psychological evaluation and testing.
- i) Initial diagnostic interviews.
- j) Sex offender risk assessment.
- k) Community treatment aide (CTA) services.
- l) Hospital observation room services (up to 23 hours and 59 minutes in duration).
- m) Parent child interaction therapy.
- n) Child-parent psychotherapy.
- o) Applied behavioral analysis.
- p) Multi-systemic therapy.
- q) Functional family therapy.
- r) Peer support.

v. Rehabilitation services

- a) Day treatment/intensive outpatient.
- b) CTA services.
- c) Professional resource family care.
- d) Therapeutic group home.
- e) Community Support.
- f) Day rehabilitation.

28. Medical Transportation

a. The MCO must provide emergency and non-emergency medical transportation (NMET) for its members.

b. The MCO must establish policies for emergency transportation and NEMT services that ensures members' access to care and is compliant with Nebraska Medicaid guidelines for emergency transportation and NEMT.

c. The MCO must establish a broker to ensure NEMT access for its members. The broker must be responsible for and perform all administrative functions including, but not limited to:

i. Establishing a transportation network;

ii. Receiving NEMT services requests;

iii. Verifying member program eligibility and MCO enrollment;

iv. Screening members for mobility status and existing transportation resources;

v. Verifying coverage of program services, authorizing and arranging for transport; and

vi. Validating claims for provider payments

d. The direct provision of services shall be performed by transportation providers with active service provider agreements with the Department.

e. Customer Call Center

The MCO must ensure its broker maintains a toll-free telephone number, with access to oral interpretation services free of charge, and other toll-free voice and telecommunications devices for deaf clients. Toll-free telephone access for approving NEMT requests is required as follows:

i. Maintain sufficient personnel to perform the functions required herein for at least ten (10) consecutive hours during the hours of 8:00 a.m. through 7:00 p.m. Central Time, Monday through Friday;

ii. Maintain voice mail routing and response procedures;

iii. Provide twenty-four (24) hour toll-free access in order to provide information on how to access transportation for an urgent medical condition;

iv. Accept NEMT services requests by telephone and secure online ordering; and

v. Call performance standards per **Section IV.F.2.c** apply to the MCO's broker and must be included in the Member/Provider Call Center monthly report.

f. Service Approval

i. The MCO must ensure its broker is responsible for determining appropriateness for NEMT for members enrolled in the MCO per 471 NAC Chapter 27;

ii. The MCO must ensure its broker receives requests for NEMT, screen each request and, if approved, assign the trip to the most appropriate NEMT providers;

iii. The MCO must ensure that its broker requires no more than three (3) business days advance notice from the member, with the exception of urgent care or the availability of an Individual NEMT provider;

iv. The MCO must ensure that its broker establishes procedures regarding NEMT for standing orders so that members are not required to continually make arrangements for repetitive program appointments or services. Standing orders must include, but are not limited to outpatient therapy services, chemotherapy, dialysis, high-risk pregnancy prenatal care, and outpatient behavioral health services;

v. The MCO must ensure that its broker make a decision and arrange NEMT and provide notice to the member within one (1) business day of the request or as expeditiously as the member's health requires for urgent care;

vi. The MCO must ensure its broker arranges the most appropriate and lowest cost available mode of transportation based on each member's mobility status and personal capabilities;

vii. The MCO must ensure its broker maintain documentation supporting medical necessity for approval of a personal attendant/escort;

viii. The MCO must ensure its broker arrange NEMT for hospital discharges (acute, psychiatric, and state hospitals) when such requests are verified by hospital staff;

ix. The MCO must ensure its broker approve NEMT for one legally responsible adult to accompany children under the age of nineteen (19), if requested, or an adult selected by the legally responsible adult. The MCO's broker must ensure children age twelve (12) and under are not transported by a public or commercial NEMT provider without adult supervision; and

x. The MCO shall ensure consistent application of criteria for approval decisions and consultation with the member's medical service provider when appropriate.

g. NEMT Provider Service Delivery

The MCO must ensure that its broker ensures that NEMT network providers deliver service that allows members to arrive promptly for appointments, so that there is not an excessive wait for their transportations. The pick-up and wait times should align with the following requirements:

i. The wait time for a pick-up to a scheduled appointment should not exceed sixty (60) minutes prior to the scheduled appointment time;

ii. The member should not wait more than thirty (30) minutes from drop off time to their scheduled appointment time;

iii. The wait time for a scheduled return trip, after an appointment, will not exceed sixty (60) minutes;

iv. Member's may be picked up on a "will call" basis, which will also not exceed sixty (60) minutes wait time after the NEMT provider is contacted for the return trip;

v. For multiple passenger trips, which are only allowed for commercial providers when the first member approves multi-loading, members should not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for transport, for an individual client using that mode, from the point of pick-up to the destination;

vi. Exceptions to service delivery times specified herein may be made for trips with pick-up or destinations outside the client's local area, or verified scheduled consecutive trips;

vii. Exceptions may also be made due to unusual situations such as exceptional distances in rural areas or other situations out of the control of the NEMT provider; and

viii. During periods of inclement weather conditions, the MCO's broker shall have written procedures in place that at a minimum includes notifying the members of the delay, the alternative schedule, and of any alternate pick-up arrangements.

h. The MCO must ensure its broker authorizes and reimburses a personal attendant/escort when medically necessary.

i. Record of Service Documentation

The MCO must ensure its broker require NEMT providers maintain a daily drivers' log. The daily drivers' log is excluded for fixed-route public transit systems, and commercial air. The NEMT providers'/escort's daily logs shall contain, at a minimum, the following information per transportation leg:

i. Driver/Escort's full name;

ii. Driver/Escort's signature or approved electronic signature;

iii. Vehicle Identification;

iv. Actual pick up time (clearly designate time using either a.m. or p.m. designation or military time) for each approved member;

v. Actual pick up address;

vi. Name of member transported, and, if applicable, the name of the accompanying adult or escort; and

vii. Member or parent/guardian signature or approved electronic signature and date.

j. The MCO must ensure its broker have an internal system of monitoring, analysis, evaluation, and improvement of the delivery of the NEMT service that:

i. Provides for regular utilization management and quality assessment reporting to the MCO and the Department, including profiling of NEMT provider utilization patterns;

ii. Provides for systematic data collection, analysis, and evaluation of performance; and

iii. Provides for timeliness for correction, and assignment of specific personnel to be responsible for ensuring compliance and follow up.

k. NEMT Information Technology Requirements

i. The MCO must ensure its broker has information technology systems that include unique or innovative features including a web-based system that allows remote notification of and access to errors or demonstration of benefits in a live system environment;

ii. The MCO must ensure its broker has information technology systems that accommodates screening, services approval, submission of claims for adjudication, payment, and any other information necessary to ensure that appropriate NEMT is approved and provided;

iii. The MCO must ensure its broker has information technology systems that includes a member and provider portal so that members may schedule trips and providers may accept/decline trips, schedule, and dispatch trips in the portal;

iv. The MCO must ensure its broker information system is designed to automate trip assignment to providers based first on lowest

cost, appropriate mode of transportation and second on provider performance. The MCO's broker is prohibited from excluding trip assignments to NEMT providers that do not use tablet technology;

v. The MCO must ensure its broker information system is able to interface with tablet technology already in use by commercial carriers and/or NDOR supplied technology;

vi. The MCO must ensure its broker's information system has claims clearing practices with real-time access to client signature logs and GPS tagged trip verifications;

vii. The MCO must ensure its broker's information system allows for claims to be submitted electronically; and

viii. The MCO must ensure that its broker follow all other provisions of **Section IV. R** and **Section IV.S**.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas DCarlson

Title: Materiel Administrator

Date: 2/26/19

UnitedHealthcare of the Midlands, Inc.

By: _____

Printed Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: 2-21-2019

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew Van Patton

Title: Director

Date: 25 Feb 2019

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$ 1,342.98	$ 26.78	$ 1,369.77
AABD 21+ M&F	$ 1,876.29	$ 26.14	$ 1,902.43
AABD 21+ M&F-WWC	$ 3,332.07	$ 153.92	$ 3,485.99
CHIP M&F	$ 191.89	$ 2.04	$ 193.93
Family Under 1 M&F	$ 746.83	$ 12.03	$ 758.86
Family 01-05 M&F	$ 167.16	$ 2.45	$ 169.61
Family 06-20 F	$ 200.33	$ 2.41	$ 202.73
Family 06-20 M	$ 218.64	$ 2.09	$ 220.73
Family 21+ M&F	$ 517.79	$ 8.37	$ 526.16
Foster Care M&F	$ 614.36	$ 6.25	$ 620.60
Healthy Dual	$ 279.33	$ 2.60	$ 281.93
Dual LTC	$ 198.15	$ 0.53	$ 198.68
Non-Dual LTC	$ 3,330.52	$ 32.44	$ 3,362.96
Dual Waiver	$ 237.45	$ 1.25	$ 238.71
Non-Dual Waiver	$ 1,458.85	$ 16.11	$ 1,474.96
Katie Beckett 00-18 M&F	$ 11,328.47	$ 35.95	$ 11,364.41
599 CHIP - Cohort	$ 437.50	$ 6.60	$ 444.10
599 CHIP - Supplemental	$ 4,667.30	$ 50.30	$ 4,717.60
Maternity	$ 4,935.35	$ 44.13	$ 4,979.48

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$ 1,412.15	$ 7.52	$ 1,419.68
AABD 21+ M&F	$ 1,911.58	$ 8.96	$ 1,920.54
AABD 21+ M&F-WWC	$ 3,539.94	$ 61.20	$ 3,601.15
CHIP M&F	$ 185.37	$ 0.92	$ 186.29
Family Under 1 M&F	$ 736.76	$ 7.69	$ 744.45
Family 01-05 M&F	$ 160.96	$ 0.74	$ 161.70
Family 06-20 F	$ 215.90	$ 0.75	$ 216.65
Family 06-20 M	$ 222.24	$ 0.55	$ 222.79
Family 21+ M&F	$ 577.91	$ 2.64	$ 580.55
Foster Care M&F	$ 600.47	$ 2.59	$ 603.07
Healthy Dual	$ 246.05	$ 0.33	$ 246.38
Dual LTC	$ 171.13	$ 0.09	$ 171.22
Non-Dual LTC	$ 2,057.60	$ 1.40	$ 2,059.00
Dual Waiver	$ 241.68	$ 0.12	$ 241.80
Non-Dual Waiver	$ 1,486.72	$ 5.10	$ 1,491.82
Katie Beckett 00-18 M&F	$ 11,328.47	$ 35.95	$ 11,364.41
599 CHIP - Cohort	$ 437.50	$ 6.60	$ 444.10
599 CHIP - Supplemental	$ 4,667.30	$ 50.30	$ 4,717.60
Maternity	$ 4,996.83	$ 8.69	$ 5,005.53

Attachment 14
Quality Performance Program Measures – Contract Year Three

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	15%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	5%
Lead Screening in Children: The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	68%[1]	10%
Well-Child Visits in the First 15 Months of Life: The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	66%[2]	10%
Childhood Immunization Status: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 29%[3] Combination #10 - 19%[3]	Combination #2 - 5% Combination #10 - 5%
Immunization for Adolescents: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Meningococcal – 77%[1] Tdap –85 %[1] HPV – 21%[1]	Meningococcal –3% Tdap – 3% HPV—4%

Cancer Screening: ***Breast Cancer Screening*** **–** The percentage of woman 50-74 years of age who had a mammogram to screen for breast cancer. ***Cervical Cancer Screening*** **–** The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: 1) Women age 21-64 who had cervical cytology performed every 3 years, OR 2) Women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	BCS – 59%[1] CCS – 59%[1]	BCS—5% CCS--5%
Antidepressant Medication Management: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported: ***Effective Acute Phase Treatment*** – The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ***Effective Continuation Phase Treatment*** – The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	EAPT –76%[3] ECPT – 66%[3]	5%
Follow Up Care for Children Prescribed Meds for ADHD-ADD: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: ***Initiation Phase*** **–** The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *Continuation and Maintenance (C&M) Phase* – The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	IP – 46%[1] C&MP – 55%[1]	10%
Medication Management for People with Asthma: The percentage of Members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. For therapeutic purposes, the percentage of Members who remained on an asthma controller medication for at least 75% of their treatment period were monitored.	75% Med-adherent – 35%[1]	5%

Note: [1] NCQA Hedis 2016 Medicaid HMO Mean Reference Group; https://www.ncqa.org/hedis/measures. [2] Medicaid Health Care Quality Measures Adult/Child Chart Pack Top Quartile Reference Group

https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-chart-pack.pdf. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html. (Well-Child Visits in the First 15 Months of Life: All MCOs met or exceeded mean NCQA Reference Group)

[3] MCO Aggregate Highest Performer + 5% (All MCOs met or exceeded both NCQA and Core Adult Set Reference Group Baseline)

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	11/06/18
BUSINESS UNIT	BUYER
25710178	VACANT (AS)

CONTRACT NUMBER
71163 O4

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00

11/9/18
DHHS DIVISION DIRECTOR

11/9/18 11/6/18
BUYER
11/9/18
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	11/06/18
BUSINESS UNIT	BUYER
25710178	VACANT (AS)

VENDOR NUMBER: 552562

CONTRACT NUMBER
71163 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT FIVE
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands Inc. make this Amendment (the "amendment") to Contract 71163 04 (the "contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

Amend the Contract End date from December 31, 2022 to December 31, 2021, with an option to be renewed for two (2) additional one (1) year periods as mutually agreed upon by both parties.

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: David Zwart

Title: Materiel Administrator

Date: 11/9/18

UnitedHealthcare of Midlands

By: _____

Printed Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: 10-31-18

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew VanPatton

Title: Director

Date: 11/8/18

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 1	05/17/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

CONTRACT NUMBER
71163 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

3/22/18

BUYER

8/29/18

MATERIEL ADMINISTRATOR

R43500|NIS10003,NISH0003 20160901

AMENDMENT FOUR
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the "amendment") to Contract 71163 04 (the "contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **MODIFICATIONS:** The Parties hereto modify the following sections:

Section IV.E – COVERED SERVICES AND BENEFITS

25. Durable Medical Equipment

c. For in-network and out-of network providers, air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to:
i) Nursing facility, or
ii) Intermediate care facility for individuals with developmental disabilities

Section IV.P - MCO REIMBURSEMENT

10. MLTC Quality Performance Program

e. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess the MCO's performance based on the measures annually and notify the MCO of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC will make this determination within eleven (11) months after the end of each contract year.

II. **REMOVAL:** The following sections are hereby removed upon execution by the parties hereto:

Section IV.Z – FFS CLAIMS MANAGEMENT AND PROCESSING

III. **Attachment 11 – RATES has been updated.**
Rates for July 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set forth in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.
IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

United Healthcare of Midlands

By: _____

Printed Name: David D Zwisler

Title: Materiel Administrator

Date: 8/24/18

By: _____

Printed Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: 7-25-18

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew VanPatton

Title: Director

Date: 27 Aug 2018

AMENDMENT FOUR
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and UnitedHealthcare of the Midlands, Inc.

The State of Nebraska and UnitedHealthcare of the Midlands, Inc. make this Amendment (the "amendment") to Contract 71163 04 (the "contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **MODIFICATIONS:** The Parties hereto modify the following sections:

Section IV.E – COVERED SERVICES AND BENEFITS

25. Durable Medical Equipment

c. For in-network and out-of network providers, air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to:
i) Nursing facility, or
ii) Intermediate care facility for individuals with developmental disabilities

Section IV.P - MCO REIMBURSEMENT

10. MLTC Quality Performance Program

e. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess the MCO's performance based on the measures annually and notify the MCO of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC will make this determination within eleven (11) months after the end of each contract year.

II. **REMOVAL:** The following sections are hereby removed upon execution by the parties hereto:

Section IV.Z – FFS CLAIMS MANAGEMENT AND PROCESSING

III. **Attachment 11 – RATES has been updated.**
Rates for July 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set forth in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.
IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

United Healthcare of Midlands

By: _____

Printed Name: David Jurset 8/29/18

Title: Materiel Administrator

Date: _____

By: _____

Printed Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: 7-25-18

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew VanPatton

Title: Director

Date: 27 Aug 18

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,265.42	$14.69	$1,280.12
AABD 21+ M&F	$1,960.55	$16.49	$1,977.04
AABD 21+ M&F-WWC	$3,484.74	$49.60	$3,534.34
CHIP M&F	$194.36	$1.06	$195.42
Family Under 1 M&F	$761.32	$14.40	$775.72
Family 01-05 M&F	$175.59	$1.24	$176.82
Family 06-20 F	$191.37	$1.02	$192.39
Family 06-20 M	$208.22	$0.83	$209.05
Family 21+ M&F	$453.84	$3.44	$457.27
Foster Care M&F	$533.26	$3.83	$537.09
Healthy Dual	$277.84	$4.04	$281.88
Dual LTC	$233.79	$2.86	$236.65
Non-Dual LTC	$3,606.37	$52.66	$3,659.02
Dual Waiver	$285.59	$3.71	$289.30
Non-Dual Waiver	$1,758.14	$28.48	$1,786.62
Katie Beckett 00-18 M&F	$13,988.06	$13.55	$14,001.61
599 CHIP - Cohort	$419.68	$10.35	$430.03
599 CHIP - Supplemental	$4,714.41	$74.83	$4,789.24
Maternity	$8,111.44	$134.69	$8,246.12

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,279.06	$10.17	$1,289.23
AABD 21+ M&F	$1,960.91	$6.63	$1,967.54
AABD 21+ M&F-WWC	$4,522.93	$3.61	$4,526.54
CHIP M&F	$195.66	$0.76	$196.42
Family Under 1 M&F	$693.27	$12.22	$705.49
Family 01-05 M&F	$168.08	$0.54	$168.62
Family 06-20 F	$197.51	$0.61	$198.12
Family 06-20 M	$234.92	$0.50	$235.42
Family 21+ M&F	$518.81	$1.28	$520.09
Foster Care M&F	$538.06	$1.59	$539.65
Healthy Dual	$231.19	$1.75	$232.95
Dual LTC	$196.25	$1.04	$197.29
Non-Dual LTC	$2,272.93	$11.94	$2,284.86
Dual Waiver	$254.53	$1.85	$256.38
Non-Dual Waiver	$1,628.62	$12.76	$1,641.38
Katie Beckett 00-18 M&F	$13,988.06	$13.55	$14,001.61
599 CHIP - Cohort	$419.68	$10.35	$430.03
599 CHIP - Supplemental	$4,714.41	$74.83	$4,789.24
Maternity	$8,119.13	$19.62	$8,138.76

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	11/14/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
71163 O4

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/14/17 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

11/21/17 Michelle Thompson 11.16.17
BUYER

Douglas Wilken 21 NOV 17
MATERIEL ADMINISTRATOR

R43501|NISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	04/12/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 552562

CONTRACT NUMBER
71163 O4

MT 11.16.17
BUYER INITIALS

AMENDMENT THREE
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and United Healthcare of Midlands

The State of Nebraska and United Healthcare of Midlands make this Amendment (the Amendment") to Contract 71163 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **MODIFICATIONS:** The Parties hereto modify the following sections effective January 1, 2018:

A. Section IV.Q. – Provider Reimbursement

16. Pharmacy Reimbursement

d. The MCO's dispensing fee reimbursement must be, at a minimum, the Medicaid FFS rate at the time of contract start for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider.

B. Attachment 11 – Rates

January 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

C. Attachment 14 – Quality Performance Program Measures-Contract Year Two

The Quality Performance Program measures have been revised for the time period January 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 14 attached hereto and made a part hereof.

D. Attachment 38 – Revised Reporting Requirements

The reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: Douglas Wilken

Printed Name: Doug Wilken

Title: Materiel Administrator

Date: 21 NOV 17

United Healthcare of Midlands

By: K.L. Mallatt

Printed Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: November 13, 2017

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By:

Name: Thomas "Rocky" Thompson

Title: Interim Director

Date: 11/15/2017

UHC – HH Risk Adjusted Rates – 1.1.2018

Attachment 11 – Rates

Rating Region 1			
Category of Aid	Non-UNMC Portion of the Rate	UNMC Pass-through	Payment Rate
AABD 00-20 M&F	$ 1,191.88	$ 20.77	$ 1,212.65
AABD 21+ M&F	$ 1,805.77	$ 23.32	$ 1,829.09
AABD 21+ M&F-WWC	$ 3,311.18	$ 70.12	$ 3,381.30
CHIP M&F	$ 182.53	$ 1.50	$ 184.03
Family Under 1 M&F	$ 718.19	$ 20.36	$ 738.55
Family 01-05 M&F	$ 166.59	$ 1.75	$ 168.34
Family 06-20 F	$ 177.86	$ 1.44	$ 179.30
Family 06-20 M	$ 194.48	$ 1.17	$ 195.65
Family 21+ M&F	$ 425.00	$ 4.86	$ 429.86
Foster Care M&F	$ 507.07	$ 5.41	$ 512.48
Healthy Dual	$ 264.32	$ 5.71	$ 270.03
Dual LTC	$ 222.35	$ 4.04	$ 226.39
Non-Dual LTC	$ 3,436.52	$ 74.44	$ 3,510.96
Dual Waiver	$ 271.66	$ 5.25	$ 276.91
Non-Dual Waiver	$ 1,673.38	$ 40.26	$ 1,713.64
Katie Beckett 00-18 M&F	$ 13,305.61	$ 19.15	$ 13,324.76
599 CHIP - Cohort	$ 399.04	$ 14.63	$ 413.67
599 CHIP - Supplemental	$4,586.72	$105.79	$4,692.51
Maternity	$ 8,002.22	$ 190.41	$ 8,192.63

Rating Region 2			
Category of Aid	Non-UNMC Portion of the Rate	UNMC Pass-through	Payment Rate
AABD 00-20 M&F	$ 1,237.05	$ 14.37	$ 1,251.42
AABD 21+ M&F	$ 1,849.96	$ 9.37	$ 1,859.33
AABD 21+ M&F-WWC	$ 4,304.25	$ 5.11	$ 4,309.36
CHIP M&F	$ 184.83	$ 1.08	$ 185.91
Family Under 1 M&F	$ 654.31	$ 17.28	$ 671.59
Family 01-05 M&F	$ 162.50	$ 0.77	$ 163.27
Family 06-20 F	$ 186.04	$ 0.86	$ 186.90
Family 06-20 M	$ 219.07	$ 0.71	$ 219.78
Family 21+ M&F	$ 489.37	$ 1.81	$ 491.18
Foster Care M&F	$ 512.34	$ 2.25	$ 514.59
Healthy Dual	$ 219.99	$ 2.48	$ 222.47
Dual LTC	$ 186.61	$ 1.47	$ 188.08
Non-Dual LTC	$ 2,172.50	$ 16.87	$ 2,189.37
Dual Waiver	$ 242.14	$ 2.62	$ 244.76
Non-Dual Waiver	$ 1,549.27	$ 18.04	$ 1,567.31
Katie Beckett 00-18 M&F	$ 13,305.61	$ 19.15	$ 13,324.76
599 CHIP - Cohort	$ 399.04	$ 14.63	$ 413.67
599 CHIP - Supplemental	$4,586.72	$105.79	$4,692.51
Maternity	$ 8,033.16	$ 27.74	$ 8,060.90

Attachment 14
Quality Performance Program Measures – Contract Year Two

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<2%	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%
Lead Screening in Children - The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	65%	10%
Well-Child Visits in the First 15 Months of Life - The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	52% with 6 Visits or more	10%
Childhood Immunization Status - The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 19% Combination #10 - 8%	Combination #2 - 5% Combination #10 - 5%

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Behavioral Health Children in Residential Treatment	Summary data, by member, on children in residential treatment including information on: wait list, discharges, children currently in treatment, and restraints and seclusions.	Monthly
Behavioral Health Critical Incident	Summary data on the number of critical incident reports by behavioral health facility and location.	Monthly
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly

Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Hospice Monthly Report	Data summarizing hospice authorizations, admissions, and discharges.	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
PDL Load Report	Data documenting that the MCO received and loaded the PDL file per contract requirements.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Restricted Services Report	Summary data related to members on restricted services.	Monthly
Third Party Resource	Summary data of all instances in which an MCO identified a TPR.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Eligible and Number of BH Services Recipients	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	Quarterly
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC December 15, March 15, June 15 and September 15 for the previous calendar quarter.

Attachment 38 – Revised Reporting Requirements

MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Admit and Re-Admit to Psych Inpatient	Data of inpatient or residential admissions and re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
PDL Compliance Report	Data documenting accuracy in dispensing medications in PDL categories.	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly

Attachment 38 – Revised Reporting Requirements

Quality Oversight Committee Report	Committee activity summary as described in Section IV.M - Quality Management	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly IHS Tracking	Data and metrics summarizing Indian Health Service delivery.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Subrogation	Data summarizing new and ongoing instances of subrogation.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually

Attachment 38 – Revised Reporting Requirements

HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from September 1 to August 31 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
Medication Therapy Management Report	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	Annually
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Utilization Management	Data and analysis summarizing the MCO's annual evaluation of its UM program.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 1	06/23/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
71163 O4

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

7/3/17 PK
BUYER
7-3-17
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

AMENDMENT TWO
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services
for the State of Nebraska
Between the State of Nebraska and United Healthcare of Midlands

The State of Nebraska and United Healthcare of Midlands make this Amendment (the Amendment") to Contract 71163 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. MODIFICATIONS: The Parties hereto modify the following sections upon execution of this Amendment:

A. Glossary of Terms

Adverse Benefit Determination (formerly referred to as "Action"):
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of the MCO to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments and other enrollee financial liabilities.

B. Section IV.B.7.c.iv

If the member's request for disenrollment is denied, the member can file a grievance to the enrollment broker or appeal the decision through the State's fair hearing process.

C. Section IV.E. – Covered Services and Benefits

8. Core Benefits and Services

The following services represent a minimum benefit package that the MCO must provide to its members:

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.

ii. Outpatient hospital services.
iii. Ambulatory surgical center (ASC) services.
iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.
v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).
vi. Services provided in Indian Health Service (IHS) facilities.
vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.
viii. Radiology services.
ix. Health Check (EPSDT) services.
x. Home health services.
xi. Private duty nursing services.
xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).
xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.
xiv. Podiatry services.
xv. Chiropractic services.
xvi. Vision services.
xvii. Free standing birth center services.
xviii. Hospice services, except when provided in a nursing facility.
xix. Skilled/rehabilitative and transitional nursing facility services.
xx. Ambulance services.
xxi. Non-emergency ambulance transportation.
xxii. Transplant services.
xxiii. Pharmacy services.
xxiv. Nutrition Services

b. Behavioral Health Services

<u>Services for individuals age 20 and under, unless otherwise indicated:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

a) Partial hospitalization.
b) Day treatment.
c) Intensive outpatient.
d) Medication management.
e) Outpatient therapy (individual, family, or group).
f) Injectable psychotropic medications.
g) Substance use disorder treatment.
h) Psychological evaluation and testing.
i) Initial diagnostic interviews.
j) Sex offender risk assessment.
k) Community treatment aide (CTA) services.
l) Comprehensive child and adolescent assessment (CCAA).
m) CCAA addendum.
n) Hospital observation room services (up to 23 hours and 59 minutes in duration).
o) Parent child interaction therapy.
p) Child-parent psychotherapy.
q) Applied behavioral analysis.
r) Multi-systemic therapy.
s) Functional family therapy.
t) Peer support.

v. Rehabilitation services

a) Day treatment/intensive outpatient.
b) CTA services.
c) Professional resource family care.
d) Therapeutic group home.

<u>Services for adults age 21 and over:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital services (acute and sub-acute).

iii. Outpatient assessment and treatment:

a) Partial hospitalization.
b) Social detoxification.
c) Day treatment.
d) Intensive outpatient.
e) Medication management.

f) Outpatient therapy (individual, family, or group).
g) Injectable psychotropic medications.
h) Substance use disorder treatment.
i) Psychological evaluation and testing.
j) Electroconvulsive therapy.
k) Initial diagnostic interviews.
~~l) Ambulatory detoxification.~~
l) In-home psychiatric nursing.
m) Peer Support

iv. Rehabilitation services

a) Dual-disorder residential.
b) Intermediate residential (SUD).
c) Short-term residential.
d) Halfway house.
e) Therapeutic community (SUD only).
f) Community support.
g) Psychiatric residential rehabilitation.
h) Secure residential rehabilitation.
i) Assertive community treatment (ACT) and Alternative (Alt) ACT.
j) Community support.
k) Day rehabilitation.

11. Pharmacy Services

c. Nebraska Medicaid Preferred Drug List

i. The MCO must follow the Nebraska Medicaid PDL. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis. Refer to the following link for additional information: http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx
ii. The MLTC PDL vendor will provide to the MCO a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC.
iii. The MCO must begin updating the pharmacy claim system within twenty-four (24) hours of file receipt of the PDL file and loading must be complete within five (5) business days.
iv. The MCO must, at the direction of MLTC, begin to perform off-cycle PDL file updates within twenty-four (24) hours of file receipt of the PDL file and loading must be complete within five (5) business days.
v. The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes.

vi. The MCO is not authorized to and must not negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. MLTC or its designee will negotiate rebate agreements. Regardless if the MCO or its PBM has an existing rebate agreement with a manufacturer, all Nebraska Medicaid outpatient drug claims, including provider-administered drugs, must be rebateable exclusively to Nebraska Medicaid.

vii. The MCO must nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. Written final approval of nominees is made by MLTC.

D. Section IV.H. – Grievances and Appeals

4. Appeal Process

b. Following receipt of a notification of an adverse benefit determination by the MCO, the member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.

e. The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must:

I. Make reasonable efforts to give the member prompt verbal notice of the delay.

II. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision.

III. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

6. Continuation of Benefits

a. The MCO must continue a member's benefits if all of the following occur:

i. The member files the request for an appeal timely;

ii. The appeal involves the termination, suspension, or reduction of previously authorized services;

iii. The services were ordered by an authorized provider;

iv. The period covered by the original authorization has not expired; and

v. The member timely files for continuation of benefits, timely files means on or before the later of the following:

i. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination.

ii. The intended effective date of the MCO's proposed adverse benefit determination.

b. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

vi. The member withdraws the appeal or request for state fair hearing.
vii. The member fails to request a state fair and continuation of benefits within 10 calendar days after the MCO send the notice of an adverse resolution to the member's appeal.
viii. The state fair hearing office issues a hearing decision adverse to the member.
ix. The authorization expires or authorization service limits are met.

c. The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action to the extent that the services were furnished solely because of the requirements of this section.

7. Access to State Fair Hearings

c. The member or the member's representative (if any) may request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.

E. Section IV.P. – MCO Reimbursement

5. Supplemental Delivery Payments

l. The MCO must not bill for a supplemental maternity payment until the delivery is paid by the MCO. The MCO must submit encounter data evidence of the delivery to be eligible to receive a supplemental delivery payment.

16. Medicare Crossover Methodology

a. The MCO must use the methodology for reconciling Medicare crossover claim experience for the period of July 1, 2017, through December 31, 2017, as set forth in Attachment 41 – Medicare Crossover Methodology.

F. Section IV.Q. – Provider Reimbursement

4. Indian Health Protections

a. Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the MCO must:
   i. Provide I/T/U providers, whether participating in the network or not, payment for covered services provided to Indian

members who are eligible to receive services from these providers either:

i. At the all-inclusive encounter rate that the Unites States Department of Health and Human Services establishes.

ii. Make prompt payment to all I/T/U providers in its network in compliance with Federal regulations regarding payments to practitioners in individual or group practices, per 42 CFR 447.45 and 447.46.

b. Additional required Indian health protections are included in Section IV.F Member Services and Education.

G. Section IV.S. – Claims Management

4. Drug Claims Processing

j. The MCO will send its pharmacy encounter claims to Magellan via the FTP process. The MCO will send the encounter claims in the current State of Nebraska proprietary format and must send files from the preceding month no later than the eighth (8th) day of the following month.

H. Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative

The MCO must utilize prior authorization and additional edits for psychotropic drugs prescribed to youth, at a minimum, following the current DHHS guidelines.

I. Attachment 14 – Quality Performance Program Measures – Contract Year One

The updated Attachment 14 is attached hereto and made a part hereof.

J. Attachment 38 – Revised Reporting Requirements

The reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

K. Attachment 11 – Rates

The capitation rates for the Contractor have been adjusted for the time period of July 1, 2017, through December 31, 2017, and are set forth in the amended Attachment 11 attached hereto and made a part hereof.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: ~~Bo Botelho~~ Doug Wilken

Title: Materiel Administrator

Date: 6 July 17

United Healthcare of Midlands

By: _____

Name: Kathleen A. Mallatt

Title: CEO

Date: June 19, 2017

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Thomas M Thompson

Title: Interim Director

Date: June 29, 2017

ATTACHMENT 11 - RATES Effective July 1, 2017			
CATEGORY OF AID	NON-UNMC PORTION OF THE RATE	UNMC PASS-THROUGH	PAYMENT RATE
AABD 00-20 M&F	$ 1,216.27	$ 21.85	$ 1,238.12
AABD 21+M&F	$ 1,763.79	$ 24.33	$ 1,788.12
AABD 21+M&F-WWC	$ 3,076.40	$ 70.82	$ 3,147.22
CHIP M&F	$ 179.27	$ 1.33	$ 180.60
Family Under 1 M&F	$ 710.56	$ 20.25	$ 730.81
Family 01-05 M&F	$ 158.35	$ 1.73	$ 160.08
Family 06-20 F	$ 174.79	$ 1.40	$ 176.19
Family 06-20 M	$ 191.75	$ 1.10	$ 192.85
Family 21+ M&F	$ 417.76	$ 4.96	$ 422.72
Foster Care M&F	$ 513.33	$ 5.55	$ 518.88
Healthy Dual	$ 257.06	$ 6.40	$ 263.46
Dual LTC	$ 221.47	$ 4.43	$ 225.90
Non-Dual LTC	$ 3,419.62	$ 72.91	$ 3,492.53
Dual Waiver	$ 265.57	$ 5.65	$ 271.22
Non-Dual Waiver	$ 1,689.23	$ 41.37	$ 1,730.60
Katie Beckett 00-18 M&F	$ 13,552.65	$ 35.65	$ 13,588.30
599 CHIP - Cohort	$ 385.19	$ 16.05	$ 401.24
599 CHIP - Supplemental	$ 5,012.09	$ 134.95	$ 5,147.04
Maternity	$ 8,093.98	$ 212.79	$ 8,306.77

Rating Region 2			
CATEGORY OF AID	NON-UNMC PORTION OF THE RATE	UNMC PASS-THROUGH	PAYMENT RATE
AABD 00-20 M&F	$ 1,198.92	$ 13.91	$ 1,212.83
AABD 21+ M&F	$ 1,827.85	$ 8.79	$ 1,836.64
AABD 21+ M&F-WWC	$ 3,884.51	$ 4.26	$ 3,888.77
CHIP M&F	$ 177.43	$ 0.88	$ 178.31
Family Under 1 M&F	$ 651.15	$ 18.64	$ 669.79
Family 01-05 M&F	$ 155.09	$ 0.68	$ 155.77
Familly 06-20 F	$ 179.88	$ 0.60	$ 180.48
Family 06-20 M	$ 212.55	$ 0.80	$ 213.35
Family 21+ M&F	$ 487.61	$ 1.49	$ 489.10
Foster Care M&F	$ 515.25	$ 3.46	$ 518.71
Healthy Dual	$ 213.38	$ 2.35	$ 215.73
Dual LTC	$ 186.89	$ 1.37	$ 188.26
Non-Dual LTC	$ 2,212.90	$ 24.75	$ 2,237.65
Dual Waiver	$ 231.96	$ 2.77	$ 234.73
Non-Dual Waiver	$ 1,574.71	$ 22.56	$ 1,597.27
Katie Beckett 00-18 M&F	$ 13,552.65	$ 35.65	$ 13,588.30
599 CHIP - Cohort	$ 385.19	$ 16.05	$ 401.24
599 CHIP - Supplemental	$ 5,012.09	$ 134.95	$ 5,147.04
Maternity	$ 8,139.57	$ 35.34	$ 8,174.91

Attachment 14
Quality Performance Program Measures – Contract Year One

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 15 business days	20%
Pharmacy Claims Processing Timeliness - 7 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims from pharmacy providers for covered services within seven calendar days of receipt. The date of receipt is the date the MCO receives the claim.	95% within 7 calendar days	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 30 days	10%
Grievance Resolution Timeliness: The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance.	95% within 60 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Behavioral Health Wait and Wards in Residential Treatment	Summary data, by member, of the number of days before a member is accepted into a program and, by member, the number of days before the member is admitted to the program.	Monthly
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Eligible and Number of BH Services Recipients	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	Monthly
Hospice Monthly Report	Data summarizing hospice authorizations, admissions, and discharges.	Monthly

Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	15th day of the following calendar month for each of the first 6 months, then Quarterly
MLTC Reporting Database: Out of State Placement Table	Summary data on admissions and discharges of members placed in out of state residential treatment.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
PDL Load Report	Data documenting that the MCO received and loaded the PDL file per contract requirements.	Monthly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Call Center Quality	MCO's report of its measurement and monitoring of the accuracy of responses by the provider call center staff.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Monthly
Restricted Services Report	Summary data related to members on restricted services.	Monthly
Third Party Resource	Summary data of all instances in which an MCO identified a TPR.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
BH Residential Beds and Critical Incident	Summary data on the number of behavioral health-related residential beds available statewide and the number of critical incident reports by behavioral health facility and location.	Quarterly
GEO Access	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements.	Quarterly
IHS Pharmacy Report	Summary data related to IHS pharmacy services.	Quarterly

Attachment 38 – Revised Reporting Requirements

LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC December 15, March 15, June 15 and September 15 for the previous calendar quarter.
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Summary data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Summary data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Admit and Re-Admit to Psych Inpatient	Summary data of inpatient or residential admissions and re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Summary data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly, after the first 6 months of the contract. Monthly for the first 6 months of the contract.
MLTC Reporting Database: Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	Quarterly
MLTC Reporting Database: Restraint and Seclusion	Data summarized, by behavioral health provider, on the number of incidents of restraint or seclusion by program type and location.	Quarterly
Network Adequacy and Cultural Competency Report	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 2 - Access Standards; including data and metrics on cultural competency access as determined by MLTC.	Quarterly
PDL Compliance Report	Data documenting accuracy in dispensing medications in PDL categories.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly

Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Network and PCP Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 2 - Access Standards.	Quarterly
Quality Oversight Committee Report	Committee activity summary as described in Section IV.M - Quality Management.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly IHS Tracking	Data and metrics summarizing Indian Health Service delivery.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Subrogation	Data summarizing new and ongoing instances of subrogation.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually

Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually
Medication Therapy Management Report	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	Annually
MLTC Reporting Database: CAHPS – Adult	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data and analysis summarizing results of the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Utilization Management	Data and analysis summarizing the MCO's annual evaluation of its UM program.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	**Annually; Upon request of MLTC, no later than June 1**
IRS Form 8963	Copy of form	**Annually; By Sept. 5**

Attachment 41 --
Medicare Crossover Methodology

The State of Nebraska is implementing a change in its methodology for reimbursing providers for crossover claims, effective July 1, 2017. The new approach will consist of Medicaid being responsible for the lesser of the Medicaid allowed amount, and the Medicare cost-sharing remaining to be paid for each claim. For example, if the Medicare allowed amount for a claim is $100, the Medicaid allowed amount is $75, and Medicare has already paid $80 (assuming 20% coinsurance), then Medicaid would pay $0. If the Medicaid allowed amount were instead $85, then Medicaid would pay $5 ($85 Medicaid allowed - $80 Medicare paid).

Due to the significant impact this adjustment has on the dually eligible populations, the State and MCOs have agreed to the conduct a risk corridor surrounding crossover claim payments for the July – December 2017 period, which provides protection against misestimating, but still provides limited risk transfer between the parties.

The process for the risk corridor reconciliation will consist of a comparison of the actual PMPM experienced for crossover claims during the July – December 2017 contract period, and the assumed crossover PMPM within the capitation rates. The initial calculation will be done by MCO, Rating Region (1 and 2), and Dual COA (Healthy Dual, Dual LTC, and Dual Waiver). However, after calculating the comparison at the detailed level, the aggregate difference between the assumed and actual PMPM amounts for an individual MCO (across all Rating Regions and COAs) will be subject to the reconciliation.

The reconciliation process will be handled as a +/- 3% risk corridor, with no transfer of funds between 97-103% of the assumed PMPM amount, and 100% reconciliation outside of that threshold. In other words, this will be handled in a manner such that experience within 3% of the assumed crossover claims PMPM within the capitation rate (converted to dollars based on actual contract period membership) for an MCO will be at full risk (no payments or recoupments from the State). Any difference in excess of +/-3% will be fully reconciled. For example, if an MCO experiences $95 in claims, and the crossover claim amount assumed within the rates was $100, the State would recoup $2 from the MCO, and vice versa if the actual experience were higher than $103. If the MCO experiences between $97-$103, no recoupments or payments will be necessary. These thresholds mirror the percentages currently in place for the Heritage Health program-wide risk corridor.

The calculation will occur with six months of claims run out (paid through June 30, 2018), with an estimate for IBNR.

Given that the State has other risk-mitigation strategies in place for the Heritage Health program, which must be conducted within nine months of the end of CY17, the outcome of the crossover claims risk corridor will be incorporated as an adjustment to MCO revenue, prior to the calculation of the program-wide risk corridor and MLR.

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
71163 O4

PAGE	ORDER DATE
1 of 1	11/18/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-Mail: kmallatt@uhc.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/18/16 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

11/21/16 Michelle Thompson 11-21-16
BUYER
11/21/16
MATERIEL ADMINISTRATOR

R4350d|NISH0003|NISH0003 20150901

AMENDMENT ONE
Contract 71163 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services
for the State of Nebraska
Between
The State of Nebraska and UnitedHealthcare of the Midlands, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and UnitedHealthcare of the Midlands, Inc. parties to Contract 71163 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITION:** The following section is hereby added upon execution by the parties hereto:

A. Section IV.B.4.e Retroactive Enrollment

i. For members who are enrolled with retroactive enrollment dates, the plan must establish processes for: appropriate payment of providers for services provided.
ii. Providers to request retroactive determination of medical necessity for services.
    a. Plans may only deny the retroactive request after consultation with the provider and if the plan determines that the service was not medically necessary.
iii. Reimbursement of out-of-network Medicaid providers for services provided prior to the plan selection.
iv. The plan must establish a method for waiving the claim timely filing limit if the provider submitted the claim within the State's established timely filing limit from the date of member plan selection.

B. Section IV.E.31 Continuity of Care Post Implementation

a. The plans must establish processes for continuity of care for members newly enrolled in the plan after the implementation period.

b. The plans must establish an automated process for sharing of previously approved authorizations and care management plans in which a member was enrolled. The previous plan, must respond to the request of the new plan for this information within three (3) business days.

c. The plans shall provide active assistance to members when transitioning to another Heritage Health MCO or to Medicaid FFS.

d. The receiving Heritage Health MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

e. With the exception of transplants, for which all previous authorizations will be honored, plans will honor, regardless of provider participation network status, previous authorizations for the lesser of:

   i. 30 days from the transition between Heritage Health Plans;

   ii. The end date on the authorization from the previous entity; or

   iii. A new decision by the plan with consultation from the provider is reached on the medical necessity of the service.

C. Section IV.N.11.e.v.
The MCO's must establish processes for identification of new and transferred members who have existing restricted services.

II. **REMOVAL:** The following sections are hereby removed upon execution by the parties hereto:

A. Section IV.B.2.d.
B. Section IV.P.11. State Performance Penalties

III. **MODIFICATIONS:** The following sections are hereby modified effective upon execution by the parties hereto:

A. Glossary of Terms.

Administrative cap: The upper limit a MCO may spend on non-quality improvement administrative expenses. The calculation of the administrative cap is conducted by dividing an MCO's administrative spend by the MCO's revenue. The revenue used for this calculation will be the original premium developed by the MLTC actuary net of HIPF but gross of hold-back funds (i.e. HIPF load will be subtracted but the premium will include both earned and forfeited hold-back funds). The HIPF load is the only component removed from the premium when calculating the administrative cap.

Health care professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed mental health practitioner or licensed independent mental health practitioner, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse(including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Risk Corridor payment: Payment made by MLTC to a MCO to compensate the MCO for losses greater than the contracted amount for year one, as determined by the risk corridor calculation.

State Fair Hearing: A request by a member or any provider to appeal a decision made by a MCO, addressed to the State.

B. Section IV.B.2. Member Enrollment/Assignment

a. The MCO must comply with all enrollment and disenrollment procedures described in this section of the RFP.

b. The MCO and all its staff and subcontractors must have an understanding of the Medicaid population and the enrollment process. The MCO must work cooperatively with MLTC to resolve issues relating to enrollee participation and the enrollment process.

c. The State maintains responsibility for the enrollment of members into MCOs through a contractual arrangement with its enrollment broker. The State or its enrollment broker provides enrollees with access to a member guidebook, plan matrix, and provider directory to assist each enrollee in choosing a MCO plan and a PCP. The enrollment broker provides impartial choice counseling to assist each enrollee in choosing an MCO.

d. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of an MCO. The enrollment broker is responsible for notifying all managed care enrollees and MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section.

e. Potential enrollees determined mandatory for managed care will be immediately enrolled in a Heritage Health Plan, retroactive to the first day of the member's eligibility for Medicaid. Retroactive enrollment into a Heritage Health Plan will not exceed three (3) months prior to month of plan selection, but in no instance shall be prior to January 1, 2017.

f. The MCO must have the technological capability and resources to interface with the State's and the enrollment broker's systems as necessary to support all aspects of the enrollment and disenrollment processes.

g. The MCO's eligibility system must show the member's effective date with the MCO as the first day of the month in which the member is determined Medicaid eligible, not to exceed three (3) months prior to the month of plan selection, but in no instance shall be prior to January 1, 2017. For example, if the State's eligibility file indicates the member was determined eligible on March 15, 2017 with a retroactive eligibility date of January 1, 2017, the MCO's eligibility system must reflect an enrollment date of January 1, 2017.

h. For current Heritage Health members at the time of the effective date of this contract, the annual enrollment choice period will be aligned with the contract start date.

i. MLTC and it enrollment broker shall make every effort to ensure that Medicaid eligible individuals who are excluded from managed care are not enrolled in a MCO. To ensure that such individuals are not assigned to a MCO, the MCO must work with MLTC or its enrollment broker to identify these individuals. The MCO must also notify MLTC if it learns that a member is no longer Medicaid eligible.

j. The enrollment broker will automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility,

when the loss of eligibility does not exceed two (2) months, into the same MCO.

C. Section IV.B.4.b. ii.

Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in a MCO is the effective date of eligibility, not to exceed three (3) months, the effective date of enrollment may occur prior to the MCO being notified of the individual's enrollment.

D. Section IV.B.7.c.iv.

If the member's request for disenrollment is denied, the member can make a grievance or appeal to the enrollment broker.

E. Section IV.C.2.a.

All contracts must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Section 1557 of the Affordable Care Act; and the Americans with Disabilities Act. The MCO must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

F. Section IV.E.25 Durable Medical Equipment

a. The MCO must provide coverage and be financially responsible for medically necessary durable medical equipment (DME), prosthetics, orthotics, medical supplies, and assistive devices including, but not limited to, hearing aids.

b. The MCO must, at a minimum, provide coverage for DME-related covered services as listed in Chapters 7 and 8 of Title 471 of the Nebraska Administrative Code.

c. For in-network and out-of network providers, air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to the nursing facility or intermediate care facility for intellectual and developmental disabled according to the maximum allowable rate on the durable medical equipment and supplies fee schedule.

G. Section IV.L.6.e.

The MCO must educate staff members and providers of the DHHS Division of Behavioral Health Women's Set Aside program. The MCO must educate staff of the Priority Populations which include; pregnant and injecting drug users, pregnant substance abusers, injecting drug users, and women with dependent children. This may include collaboration with the Division of Behavioral Health (DBH) as appropriate.

H. Section IV.P.9. Risk Corridor

a. Annual MCO profits must not exceed 3% in the first contract year. Annual MCO profits must not exceed 2.5% in the second contract year, and annual MCO profits in subsequent contract years must not exceed 2%. MCO losses for the first contract year must not exceed 3%. In subsequent contract years, there is no limit on MCO losses.

b. Profits and losses are calculated by MLTC's actuary as a percentage of the aggregate of all qualifying revenue by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.

c. This calculation must be completed within nine months of the end of the contract year. The risk corridor will be calculated first, and any payments/receipts under the risk corridor will be incorporated in the MLR calculation. This methodology is consistent with the Final Rule published by CMS.

d. If the calculation produces a profit above the indicated amount, the MCO must ensure that the surplus is deposited in the reinvestment account, as described in this section, within nine months of the end of each contract year.

e. The MCO must provide a full financial statement and additional data as requested to MLTC and its actuary to support the calculation. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited funds will be returned to the MCO for deposit back into the reinvestment account.

f. If the calculation for the first contract year produces a loss of more than 3%, MLTC will make a payment to the MCO an amount equal to the loss above that amount.

g. There will be no payment under this calculation by either party for the first contract year if the calculation produces an amount between a 3% profit and a 3% loss. There will be no payment by the MCO under this calculation for the second contract year if the calculation produces an amount that does not exceed a 2.5% profit. There will be no payment by the MCO under this calculation for any subsequent contract year if the calculation produces an amount that does not exceed a 2% profit.

I. Section IV.P.10.a

The MCO must participate in the MLTC quality performance program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

J. Section IV.P.10.d

The MCO must report its performance measures that affect the MCO's eligibility to earn holdback funds monthly, quarterly, annually, and upon the request of MLTC.

K. Section IV.P.12 Administrative Cap

a. Per Neb. Rev. Stat. §71-831, the MCO's administrative spending must not exceed 12%.

b. Administrative expenditures do not include profit.

c. With its quarterly financial report, the MCO must provide to MLTC an accounting of administrative expenses.

d. To ensure compliance with state law, MLTC will calculate the administrative expense rate within nine months of the end of each contract year.

e. Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation.

L. Section IV.S.11.d

The MCO must ensure that its claims adjudication process only allows claims from providers with 340B Health Resources and Service Administration (HRSA) designation to carve-in Nebraska Medicaid. The MCO must have a system in place to properly identify at the claim level and transmit these claims to MLTC or its designee.

The MCO must ensure that its claims adjudication process recognizes and denies payment on 340B claims submitted by any contract pharmacy in addition to, any provider that does not have a HRSA designation carving-in Nebraska Medicaid.

M. Section IV.V.2.d. Network Performance Requirement

Between the contract award date and the contract start date, the MCO must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required sufficiency must be submitted to MLTC a minimum of forty-five (45) calendar days prior to contract start date. MLTC may assess a penalty of $1,000 per calendar day for each day that the provider network is not adequate to meet the service needs of its members.

N. Section IV.X.2 Transition Period

a. The transition period for the contract begins on contract award and ends 90 calendar days after the contract start date. During the transition period the MCO must implement the requirements of the contract and collaborate with MLTC to facilitate a seamless transition between MCOs, providers, and programs in order to prevent an interruption of services and to ensure continuity of care for members.

With the exception of transplants, for which all previous authorizations will be honored, MCOs will honor regardless of provider participation network status previous authorizations for the lesser of:

i. 90 days from implementation;

ii. The end date on the authorization from the previous entity; or

iii. A new decision by the plan with consultation from the provider is determined on the medical necessity of the service.

O. Attachment 11- Rates

The capitation rates for the Contractor have been adjusted for the time period of January 1, 2017 through December 31, 2017, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

P. Vendor Contact change

Vendor Contact: Kathleen A. Mallatt
Phone: 402-445-5591
E-mail: kmallatt@uhc.com

This amendment becomes part of the contract. Except as set forth in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska
Administrative Services

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 11/21/16

UnitedHealthcare of the Midlands, Inc.

By: K C Mallatt

Name: Kathleen A. Mallatt

Title: Chief Executive Officer

Date: 11-15-16

State of Nebraska
Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Calder Lynch

Title: Director

Date: 11/21/16

Amended Attachment 11 Rates

Rating Region 1			
Category Of Aid	Non-UNMC Portion of the Rate	UNMC Supplemental	Payment Rate
AABD 00-20 M&F	$ 1,217.94	$ 28.18	$ 1,246.12
AABD 21+ M&F	$ 1,712.27	$ 31.43	$ 1,743.70
AABD 21+ M&F-WWC	$ 2,840.54	$ 113.34	$ 2,953.88
CHIP M&F	$ 189.25	$ 2.17	$ 191.42
Family Under 1 M&F	$ 703.82	$ 20.98	$ 724.80
Family 01-05 M&F	$ 155.03	$ 2.83	$ 157.86
Family 06-20 F	$ 180.20	$ 2.41	$ 182.61
Family 06-20 M	$ 197.24	$ 1.92	$ 199.16
Family 21+ M&F	$ 423.08	$ 5.84	$ 428.92
Foster Care M&F	$ 519.52	$ 7.91	$ 527.43
Katie Beckett 00-18 M&F	$ 13,208.51	$ 100.00	$ 13,308.51
599 CHIP - Cohort	$ 398.99	$ 23.12	$ 422.11
599 CHIP - Supplemental	$ 5,280.32	$ 169.84	$ 5,450.16
Maternity	$ 8,108.55	$ 201.41	$ 8,309.96
Healthy Dual	$ 333.60	$ 10.79	$ 344.39
Dual LTC	$ 275.65	$ 7.45	$ 283.10
Non-Dual LTC	$ 3,163.51	$ 72.77	$ 3,236.28
Dual Waiver	$ 324.04	$ 9.36	$ 333.40
Non-Dual Waiver	$ 1,637.27	$ 45.52	$ 1,682.79

Rating Region 2			
Category of Aid	Non-UNMC Portion of the Rate	UNMC Supplemental	Payment Rate
AABD 00-20 M&F	$ 1,251.17	$ 18.54	$ 1,269.71
AABD 21+ M&F	$ 1,820.84	$ 10.10	$ 1,830.94
AABD 21+ M&F-WWC	$ 3,280.01	$ 0.47	$ 3,280.48
CHIP M&F	$ 188.17	$ 1.16	$ 189.33
Family Under 1 M&F	$ 683.16	$ 16.73	$ 699.89
Family 01-05 M&F	$ 163.69	$ 0.88	$ 164.57
Family 06-20 F	$ 187.70	$ 0.92	$ 188.62
Family 06-20 M	$ 224.63	$ 1.02	$ 225.65
Family 21+ M&F	$ 512.11	$ 1.88	$ 513.99
Foster Care M&F	$ 535.16	$ 4.11	$ 539.27
Katie Beckett 00-18 M&F	$ 13,208.51	$ 100.00	$ 13,308.51
599 CHIP - Cohort	$ 398.99	$ 23.12	$ 422.11
599 CHIP - Supplemental	$ 5,280.32	$ 169.84	$ 5,450.16
Maternity	$ 8,164.11	$ 42.87	$ 8,206.98
Healthy Dual	$ 289.47	$ 2.81	$ 292.28
Dual LTC	$ 239.30	$ 1.82	$ 241.12
Non-Dual LTC	$ 2,363.84	$ 31.55	$ 2,395.39
Dual Waiver	$ 299.89	$ 3.09	$ 302.98
Non-Dual Waiver	$ 1,622.05	$ 30.33	$ 1,652.38

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
71163 O4

PAGE	ORDER DATE
1 of 1	04/12/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 552562

VENDOR ADDRESS:

UNITED HEALTHCARE OF MIDLANDS
2717 N 118TH CIR
OMAHA NE 68164-9688

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Eileen Fisher
Phone: 952-931-4574
Cellular: 612-965-0713
Fax: 952-931-5262
E-Mail: eileen_m_fisher@uhc.com

(djo 04/12/16)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS DIVISION DIRECTOR

PK Michelle Thompson 4.14.16
BUYER

4/14/16
MATERIEL ADMINISTRATOR

For public information purposes only; not part of contract.

Request for Proposal Number 5151 Z1
Contract Number 71163 O4
Proposal Opening: January 6, 2016

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

UnitedHealthcare of the Midlands, Inc.

1. Resumes
- Attachment 5-1 Kathleen Mallatt
- Attachment 5-2 Michael Horn, MD
- Attachment 5-3 Charles Freed
- Attachment 5-4 Von Grubbs
- Attachment 5-5 Sean Jones
- Attachment 5-6 Jim Elliston
- Attachment 5-7 Tim Langdon
- Attachment 5-8 Lori Caldwell
- Attachment 5-9 Cyndi Margritz
- Attachment 5-10 Patricia Jones
- Attachment 5-11 Tim Mergens, MD
- Attachment 5-12 Jeremy Sand
- Attachment 5-13 Lisa Reynolds
- Attachment 5-14 Diane Knutson
- Attachment 5-15 Candace White
- Attachment 5-16 Barbara Palmer
- Attachment 5-17 Cybele Kanin
- Attachment 5-18 Robert J. Steffens
- Attachment 5-19 Kim Manning
- Attachment 5-20 Jeanne Cavanaugh
- Attachment 5-21 Heather A Johnson

2. Attachment 19 Q106 Business Continuity Disaster Recovery Plan

3. Attachment 19 Q115-1 Member Grievance Systems Report

4. Attachment 19 Q115-2 PIP Report – Improving Screening and Follow-up for Adolescent Depression

5. Attachment 19 Q115-3 PIP Report – Reducing Non-Emergent Emergency Department Visits

6. Attachment 19 Q115-4 Care Management Report

7. Attachment 5-1 Provider Contract Template – Medical Group Participation Agreement

8. Attachment 5-2 Provider Contract Template – Sample Facility Participation Agreement

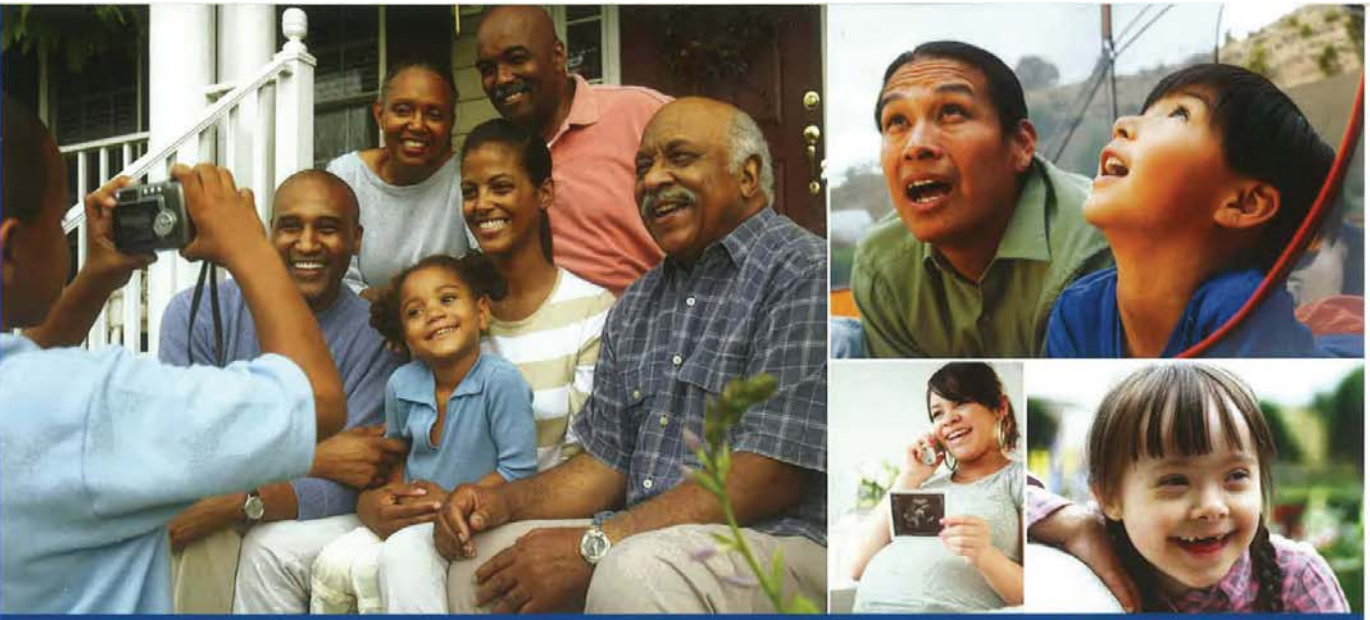
9. Attachment 5-4 Provider Contract Template – NE Medicaid Regulatory Appendix (Provider)

10. Attachment 5-5 Provider Contract Template - Pharmacy

In accordance with Federal U.S. Copyright Law Title 17 U.S.C. Section 101 et seq., Title 18 U.S.C. 2319, the following material(s) has not been included due to them being copyrighted.

UnitedHealthcare of the Midlands, Inc.

1. Baby Blocks Brochure
2. Personal Empowerment Program
3. Asthma Mailer
4. Asthma Mailer – Spanish
5. Diabetes Mailer
6. Diabetes Mailer – Spanish
7. KidsHealth Flyer
8. Attachment 19 Q47-1 NE Provider Handbook
9. Attachment 19 Q47-4 NE 2015 Provider Welcome Kit
10. Attachment 19 Q47-6 2015 BH Provider Example
11. Attachment 19 Q49-1 NE Practice Matters
12. Attachment 19 Q49-4 Provider Portal Quick Reference Guides
13. Attachment 19 Q49-5 OptumRx PA QRG
14. Attachment 19 Q49-6 Link Eligibility – Benefits Referral Status
15. Attachment 19 Q49-7 Fee Schedule QRC
16. Attachment 19 Q49-8 Electronic Payments and Statement QRC
17. Attachment 19 Q77-3 NE HIPR Utilization Summary Report Template
18. Attachment 5 Member Handbook



STATE OF NEBRASKA

Request for Proposal for

Nebraska State Purchasing Bureau
Heritage Health

Medicaid Managed Care for Physical Health, Behavioral Health, and Pharmacy Services

Request for Proposal Form and Corporate Overview

Binder 1 of 3

RFP #5151 Z1

ORIGINAL

UnitedHealthcare®
Community Plan

UnitedHealthcare®
Community Plan

December 29, 2015

Michelle Thompson / Teresa Fleming
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508

Re: RFP 5151 Z1

Dear Ms. Thompson and Ms. Fleming,

UnitedHealthcare of the Midlands, Inc., d/b/a UnitedHealthcare Community Plan is pleased to submit our response to the Division of Medicaid and Long Term Care (MLTC)'s request for proposal (RFP) 5151 Z1 to provide health care services statewide to Medicaid enrollees participating in the Heritage Health program. We have served Nebraska citizens since 1984, and began serving Nebraska Medicaid members in three counties in 1996. Overall, we serve more than 425,000 Nebraskans enrolled in our Medicaid, Medicare and commercial programs, 60,000 of which are Medicaid members. Nationally, we offer support to low-income consumers in 24 states and the District of Columbia, serving more than 5.3 million people. We operate health plans that meet the unique needs of local populations while leveraging the national resources and practical innovations, medical knowledge and efficiencies of UnitedHealth Group.

We are pleased to highlight our experience and commitment to continuing to serve and enhance the lives of members in the Heritage Health program. Our commitment supports MLTC's focus on integrated physical and behavioral health in achieving these important outcomes:

- Improved health outcomes
- Enhanced integration of services and quality of care
- Emphasis on person-centered care, including enhanced preventive and care management (CM) services
- Reduced rate of costly and avoidable care
- Improved financially sustainable system

As required by the RFP we are providing one original hard copy of our proposal.

If you have questions or require clarification of the content of our response, please contact Eileen Fisher at 952-931-4574 or eileen_m_fisher@uhc.com. Should Ms. Fisher be unavailable, please contact me at 402.445.5591 or kmallatt@uhc.com. UnitedHealthcare Community plan looks forward to continuing our work in serving Nebraska's Heritage Health members.

Sincerely,

K A Mallatt

Kathleen A. Mallatt
Chief Executive Officer

REQUEST FOR PROPOSAL FORM AND CORPORATE OVERVIEW

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1. REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat §73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

__X__ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. §73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: UnitedHealthcare of the Midlands, Inc.

COMPLETE ADDRESS: 2717 N. 118th Street, Suite 300 Omaha, Nebraska 68164

TELEPHONE NUMBER: (402) 445-5591 FAX NUMBER: (402) 445-5730

SIGNATURE: KAMallatt DATE: December 29, 2015

TYPED NAME & TITLE OF SIGNER: Kathleen A. Mallatt, Chief Executive Officer

FORM A - BIDDER
CONTACT SHEET

Form A
Bidder Contact Sheet
Request for Proposal Number 5151 Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	UnitedHealthcare of the Midlands, Inc.
Bidder Address:	2717 N. 118th Street, Suite 300 Omaha, Nebraska 68164
Contact Person & Title:	Kathleen A. Mallatt, Chief Executive Officer
E-mail Address:	kmallatt@uhc.com
Telephone Number (Office):	(402) 445-5591
Telephone Number (Cellular):	(402) 490-7855
Fax Number:	(402) 445-5730

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	UnitedHealthcare of the Midlands, Inc.
Bidder Address:	2717 N. 118th Street, Suite 300 Omaha, Nebraska 68164
Contact Person & Title:	Eileen Fisher, Proposal Director
E-mail Address:	eileen_m_fisher@uhc.com
Telephone Number (Office):	(952) 931-4574
Telephone Number (Cellular):	(612) 965-0713
Fax Number:	(952) 931-5262

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response**.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to

award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. **COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Sub-Contractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all sub-contracts for services to be covered by any contract resulting from this Request for Proposal.

D. **PERMITS, REGULATIONS, LAWS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. **OWNERSHIP OF INFORMATION AND DATA**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Sub-Contractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Sub-Contractor(s). The Contractor is also responsible for ensuring Sub-Contractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Sub-Contractor to commence work on any Sub-Contract until all similar insurance required of the Sub-Contractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Sub-Contractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Sub-Contractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Sub-Contractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Sub-Contractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. **REINSURANCE**

a. The MCO must file all contracts of reinsurance, or a summary of the plan of self-insurance.

b. All reinsurance agreements or summaries of plans of self-insurance must be filed with MLTC and must remain in full force and effect for a minimum of 30 calendar days following written notice by registered mail of cancellation by either party. Pursuant to the Health Maintenance Organization Act, Neb. Rev. Stat. §44-3292 et seq. and other relevant laws.

c. The MCO must maintain reinsurance agreements throughout the contract period, including any extension(s) or renewal(s). The MCO must provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for any members enrolled in the MCO.

d. The MCO must provide to MLTC the risk analyses, assumptions, cost estimates, and rationales supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related-party relationship must be specifically disclosed.

4. **INSURANCE COVERAGE AMOUNTS REQUIRED**

a. **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY**

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. **COMMERCIAL GENERAL LIABILITY**

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. **COMMERCIAL AUTOMOBILE LIABILITY**

Bodily Injury/Property Damage $1,000,000 combined single limit

d. **UMBRELLA/EXCESS LIABILITY**

Over Primary Insurance $5,000,000 per occurrence

e. **ERRORS AND OMISSIONS** $10,000,000, per occurrence

f. **CYBER LIABILITY**

Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties
$10,000,000 each occurrence / aggregate

g. **SUBROGRATION WAIVER**

"Waiver of Subrogation on the Worker's Compensation in favor of the State of Nebraska."

h. **LIABILITY WAIVER**

"The State of Nebraska, Certificate holder, is an additionally insured, primary & noncontributory on the General Liability."

5. **EVIDENCE OF COVERAGE**

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

9. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
10. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Sub-Contractor's services, the Sub-Contractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Sub-Contractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KL			

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Sub-Contractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Sub-Contractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Sub-Contractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

9. any and all employment taxes and/or other payroll withholding;
10. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
11. damages incurred by Contractor's employees within the scope of their duties under the contract;
12. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
13. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KL			

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project for a period of two years after the contract implementation date.

L. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

N. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

O. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

P. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

Q. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

S. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

T. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KL			

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

U. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KL			

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

V. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KL			

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KL			

The Contractor shall use its best efforts to ensure that its employees, agents, and Sub-Contractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

X. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor.

3. Pursuant to 42 CFR §438.708 the State may enroll that Contractor's members in other MCOs or provide their benefits through other options included in the Medicaid State Plan if the State, at its sole discretion, determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

4. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

5. The State will provide the Contractor with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

6. The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

7. In accordance with 42 CFR §438.710, the State will conduct a pre-termination hearing upon the request of the MCO as outlined in the Notice to provide MCO the opportunity to contest the nature and basis of the sanction.

   a. The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.

   b. The MCO shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

8. The State will notify Medicaid members enrolled in the MCO in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.

9. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;

   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;

   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;

   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;

   e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for a minimum of sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;

   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

   g. Contractor intentionally discloses confidential information;

   h. Contractor has or announces it will discontinue support of the deliverable;

   i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

   j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

AA. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

BB. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

DD. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State has the option to invoke penalties as described in Section IV Project Description and Scope of Work.

EE. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a performance bond in an amount equal to $50,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

   a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to

nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;

b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;

c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;

d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and

e. The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

FF. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

GG. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not

limited to those kept by the Contractor, its employees, agents, assigns, successors, and Sub-Contractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of ten (10) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Sub-Contractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Sub-Contractors to the extent that those sub-contracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

II. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KV			

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

JJ. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KV			

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Sub-Contractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

KK. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, that this RFP must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to this RFP that are required to bring Nebraska in compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

LL. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

MM. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

NN. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

OO. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

PP. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

QQ. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

Price information is provided under Section IV.P MCO Reimbursement.

RR. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Sub-Contractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Sub-Contractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
KW			

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. §81-15,159.

ZZ. POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all sub-contracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

EEE. LICENSE/SERVICE OR OTHER AGREEMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Any License/Service or other such agreements which the bidder may want the State to consider must be submitted with the bid. Any License/Service or other such agreements submitted to the State post bid opening may result in

the bid being rejected in its entirety. Any such agreement, if agreed to by the State, will be considered an addendum to the contract. Any terms and conditions contained in any such accepted agreement (addendum) must not conflict with or alter the State's Terms and Conditions (Terms and Conditions) as contained in the RFP and finalized in the contract. In the event of any conflict between the Terms and Conditions and any addendum the Terms and Conditions will prevail.

The State reserves the right to reject any submitted addendum and considers the submission of any such addendum to be a proposed alteration of the Terms and Conditions.

This clause does not apply to any third party license or service agreements.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/30/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH USA INC.
333 SOUTH 7TH STREET, SUITE 1400
MINNEAPOLIS, MN 55402-2427
Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307

401115-5M--GAWX5-15-16

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Old Republic Insurance Company	24147
INSURER B : American Guarantee & Liability Ins Co	26247
INSURER C : Travelers Property Casualty Company of America	25674
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
UNITEDHEALTHCARE OF THE MIDLANDS, INC.
2717 N. 118TH STREET, SUITE 300
OMAHA, NE 68164

COVERAGES **CERTIFICATE NUMBER:** CHI-006382252-01 **REVISION NUMBER:** 6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			MWZY302189	05/01/2014	05/01/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ $	1,000,000 1,000,000 2,500 1,000,000 3,000,000 2,000,000
	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			MWTB301263	05/01/2014	05/01/2016	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $	2,000,000
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			AUC596527907	05/01/2015	05/01/2016	EACH OCCURRENCE AGGREGATE	$ $	5,000,000 5,000,000
C C C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		HC2JUB472M475515 (AOS) HRJUB472M476715 (MA & WI) HWXJUB472M477915 (XWC OH)	05/01/2015 05/01/2015 05/01/2015	05/01/2016 05/01/2016 05/01/2016	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $	1,000,000 1,000,000 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: STATE OF NEBRASKA, DEPARTMENT OF HEALTH & HUMAN SERVICES - DIVISION OF MEDICAID AND LONG-TERM CARE / CONTRACT/RFP

THE GENERAL LIABILITY AND AUTOMOBILE LIABILITY POLICIES INCLUDE A BLANKET ADDITIONAL INSURED ENDORSEMENT FOR PERSONS OR ORGANIZATIONS WHERE UNITEDHEALTH GROUP IS OBLIGATED TO PROVIDE SUCH STATUS BY WRITTEN CONTRACT OR AGREEMENT, ONLY TO THE MINIMUM EXTENT REQUIRED AND SUBJECT TO POLICY TERMS AND CONDITIONS. THE GENERAL LIABILITY, AUTOMOBILE, UMBRELLA LIABILITY AND WORKERS' COMPENSATION POLICIES INCLUDE WAIVER OF SUBROGATION ON A BLANKET BASIS WHERE REQUIRED BY WRITTEN CONTRACT WITH UNITEDHEALTH GROUP, EXECUTED PRIOR TO LOSS.

CERTIFICATE HOLDER

STATE OF NEBRASKA
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF MEDICAID AND LONG-TERM CARE
P.O. BOX 95026
LINCOLN, NE 68509

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

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CERTIFICATE
OF GOOD STANDING

STATE OF NEBRASKA

United States of America, } ss.
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, John A. Gale, Secretary of State of the State of Nebraska, do hereby certify that

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

incorporated on April 16, 1984 and is duly incorporated under the law of Nebraska;

that no occupation taxes due from and assessable against the Corporation are unpaid and have become delinquent;

that no annual or biennial report required to be forwarded by the Corporation to the Secretary of State has become delinquent;

that Articles of Dissolution have not been filed.

This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's financial condition or business activities and practices.

In Testimony Whereof,

I have hereunto set my hand and affixed the Great Seal of the State of Nebraska on this date of
November 10, 2015

John A. Gale

Secretary of State

Item deemed proprietary/confidential	Supporting documentation
Resumes	
Attachment 5-1 Kathleen Mallatt	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-2 Michael Horn, MD	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-3 Charles Freed	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-4 Von Grubbs	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-5 Sean Jones	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-6 Jim Elliston	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-7 Tim Langdon	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-8 Lori Caldwell	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-9 Cyndi Margritz	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-10 Patricia Jones	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-11 Tim Mergens, MD	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-12 Jeremy Sand	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.

Item deemed proprietary/confidential	Supporting documentation
Attachment 5-13 Lisa Reynolds	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-14 Diane Knutson	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-15 Candace White	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-16 Barbara Palmer	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-17 Cybele Kanin	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-18 Robert J. Steffens	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-19 Kim Manning	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-20 Jeanne Cavanaugh	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachment 5-21 Heather A Johnson	Please see Neb. Rev. Stat. § 84-712.05 (2015). The vitae of our staff provide UnitedHealthcare with significant strengths, and awareness of those strengths would provide an advantage to our competitors and serve no public purpose.
Attachments	
Attachment 19 Q106 Sample Business Continuity Disaster Recovery Plan	Please see Neb. Rev. Stat. § 84-712.05 (2015). UnitedHealthcare's plan to continue its business in the event of significant events is a critical component of its ability to deliver services. If released a competitor would give an advantage and serve no public purpose.
Attachment 19 Q115-2 PIP Report - Improving Screening and Follow-up for Adolescent Depression	UnitedHealthcare has maintained that this report format remain protected under its current contract. Releasing the format and results would give an advantage to competitors and serve no public purpose. Please see Neb. Rev. Stat. § 84-12.05 (2015).
Attachment 19 Q115-3 PIP Report - Reducing Non-Emergent Emergency Department Visits	UnitedHealthcare has maintained that this report format remain protected under its current contract. Releasing the format and results would give an advantage to competitors and serve no public purpose. Please see Neb. Rev. Stat. § 84-12.05 (2015).

Item deemed proprietary/confidential	Supporting documentation
Attachment 19 Q115-1 Member Grievance Systems Report	UnitedHealthcare has maintained that this report format remain protected under its current contract. Releasing the format and results would give an advantage to competitors and serve no public purpose. Please see Neb. Rev. Stat. § 84-12.05 (2015).
Attachment 19 Q115-4 Care Management Report	UnitedHealthcare has maintained that this report format remain protected under its current contract. Releasing the format and results would give an advantage to competitors and serve no public purpose. Please see Neb. Rev. Stat. § 84-12.05 (2015).

ADDENDA
ACKNOWLEDGMENT

ADDENDA ACKNOWLEDGMENT

The list below represents the Addenda received for RFP 5151 Z1:

Addenda	Date Posted
5151 Z1 Addendum 1 – Questions and Answers	10/23/15
5151 Z1 Addendum 2 – Revised Schedule of Events	11/09/15
5151 Z1 Addendum 3 – Revisions to RFP	11/10/15
5151 Z1 Addendum 4 – Revised Schedule of Events	11/17/15
5151 Z1 Addendum 5 – Revised Schedule of Events	11/18/15
5151 Z1 Addendum 6 – Questions and Answers 1-220	11/18/15
5151 Z1 Addendum 7 – Questions and Answers 221-382	11/19/15
5151 Z1 Addendum 8 – Revised Schedule of Events	11/20/15
5151 Z1 Addendum 9 – Questions and Answers, 2nd Round	12/17/15
5151 Z1 Addendum 10 – Additional Revisions to RFP	12/17/15
5151 Z1 Addendum 11 – Additional Revisions to RFP	12/22/15
5151 Z1 Addendum 12	12/30/15

a. Bidder Identification and Information

a. Bidder Identification and Information

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

UnitedHealthcare of the Midlands, Inc.
2717 North 118th St., Suite 300
Omaha, NE 68164

The company was incorporated as a for-profit corporation in Nebraska on April 16, 1984, under the name of Share Health Plan of Nebraska, Inc. (NAIC #95591) Effective Sept. 2, 1994, the company changed its name to UnitedHealthcare of the Midlands, Inc. The original corporate form of the organization has remained unchanged since 1984.

We will hereinafter refer to ourselves in this proposal as "UnitedHealthcare."

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b. Financial Statements

The bidder must provide three years of independently audited financial statements, prepared under U.S. generally accepted accounting principles, and associated enrollment figures applicable to the firm. The bidder must also provide the last three years rating from AM Best Company; verification of any contributions made to the bidder to improve its financial position after its most recent audit (e.g. copies of bank statements and deposit slips), if applicable; and, a statement of whether the bidder or predecessor company has filed or had filed against it any bankruptcy or insolvency proceeding, and if so, relevant details. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization in the form of a letter, indicating that the bidder's business relationship with the financial institution is in positive standing.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

UnitedHealthcare of the Midlands, Inc., is licensed and in good standing as a health maintenance organization (HMO) in Nebraska, and we comply with all applicable insurance regulations, including submitting filings in a timely manner. We are in compliance with both the current minimum capital and minimum deposit requirements per Nebraska Admin. Code 191 Chapter 40.12(514B) and reporting requirements per 191 Chapter 40.14(514B). We will copy the State of Nebraska at the Division of Health and Human Services (DHHS) on all required filings with the Nebraska Insurance Division.

Audited Financial Statements and Enrollment Figures

As requested, we included the following financial statements for UnitedHealthcare of the Midlands, Inc., as attachments:

- 2. Corporate Overview b-1 2012 UnitedHealthcare of the Midlands Annual AFS and ICL
- 2. Corporate Overview b-2 2013 UnitedHealthcare of the Midlands AFS and ICL
- 2. Corporate Overview b-3 2014 UnitedHealthcare of the Midlands AFS and ICL
- 2. Corporate Overview b-4 2012 Enrollment by Product
- 2. Corporate Overview b-5 2013 Enrollment by Product
- 2. Corporate Overview b-6 2014 Enrollment by Product
- 2. Corporate Overview b-7 2014 UnitedHealth Group Annual Statement

UnitedHealthcare of the Midlands, Inc., is a wholly owned subsidiary of UnitedHealth Group, which is a publicly traded company. Attached is the UnitedHealth Group 10K Report for 2014 (2b-7).

Ratings

As requested, the table below provides the UnitedHealthcare of the Midlands, Inc., requested A.M. Best rating for the last three-year rating years and the current 2015 rating.

UnitedHealthcare of the Midlands, Inc.	A.M. Best
March 31, 2015	A
December 11, 2014	A
December 11, 2013	A
December 12, 2012	A

Bankruptcy

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

Insolvency

UnitedHealthcare is dedicated to the highest standards of fiscal and program integrity and continually strives to work in partnership with our state customers to be good stewards of the public resources entrusted to us. We operate in accordance with generally accepted accounting principles and sound financial practices that demonstrate economic viability, regulatory compliance, and prompt and accurate payments to providers. Our accounting system verifies that costs applicable to the program are clearly identifiable and records related to all services and expenditures made under this contract will be maintained. Chief financial officer (CFO) Jim Elliston will verify we fully meet the requirements of this section regarding the disclosure of financial records and the preparation and submission of all required financial reports.

Fiscal Responsibility

The financial strength of UnitedHealthcare, through our parent corporation UnitedHealth Group, enables us to be a dependable partner to Nebraska to serve the State's most vulnerable citizens. *Fortune* magazine distributed its annual issue listing of the top 500 companies in the United States. UnitedHealth Group is ranked No. 14 in 2015, increasing revenue by 6 percent to $130.5 billion. We will be using these financial resources to fund the required surplus in the specified timeframe.

UnitedHealthcare monitors its compliance with minimum capital and surplus requirements per both state regulations and risk-based capital. State regulations require us to maintain a minimum surplus in an amount that is the greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of annualized premium. Risk-based capital (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.

UnitedHealthcare is part of UnitedHealth Group, which has the financial resources for UnitedHealthcare to meet all financial obligations. In the event of an immediate and material cash demand, a surplus infusion in the form of cash would be executed to address cash requirements. In the case of a short-term and immaterial cash demand, we may use revolving credit with our parent, UnitedHealth Group. Attachment 2. Corporate Overview b-8 Bank Reference Letter is the UnitedHealthcare letter from Wells Fargo that the business relationship with the financial institution is in positive standing.

Also, Attachment 2. Corporate Overview b-9 UnitedHealthcare of the Midlands Credit Reference Letter is a fiscal responsibility letter from J.P. Morgan indicating UnitedHealthcare of the Midlands, Inc., business relationship is in positive standing.

Table X. below outlines UnitedHealthcare's proof of fiscal soundness over the reporting periods before the most recent reporting period.

Proof of Fiscal Soundness				
	4Q14	1Q15	2Q15	3Q15
Equity Requirements and Solvency Protection: Highest Requirement Under Three-Part Test	$4,117,916	$4,353,503	$4,320,041	$4,350,208
Risk-Based Capital Ratio	393.8%	367.0%	401.5%	403.7%
Statutory Equity	$32,649,948	$30,428,897	$33,288,429	$33,469,420

In the unlikely event UnitedHealthcare became insolvent, our cash reserves, capital and surplus requirements would be divided among plan providers. We maintain insolvency insurance under a reinsurance contract with our affiliated company, UnitedHealthcare Insurance Company. We would access coverage under that policy to the extent necessary to satisfy remaining appropriate provider claims. We will cover continuation of services to members during insolvency for the duration of the period for which payment has been made by Nebraska as well as for inpatient admissions up until discharge. In no event will a member be held liable for UnitedHealthcare's debts or for the cost of covered services provided to the member. Further, as required by Nebraska, all provider contracts will include a "hold harmless" provision prohibiting providers from seeking financial recovery for services from members.

Judgments and Litigation

UnitedHealthcare of the Midlands, Inc., has no judgments, pending or expected litigation or other real or potential financial reversals that might materially affect the viability or stability of the organization.

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UnitedHealthcare of the Midlands, Inc.

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2012 and 2011,
Supplemental Schedules as of and for the
Year Ended December 31, 2012,
Independent Auditors' Report, Qualification Letter,
and Internal Control Letter

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

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Deloitte

Deloitte & Touche LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA
Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of the Midlands, Inc.
Omaha, Nebraska

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of the Midlands, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2012 and 2011, 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 accounting practices as prescribed or permitted by the Nebraska 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 the Company as of December 31, 2012 and 2011, 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 Nebraska 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 the Company using accounting practices prescribed or permitted by the Nebraska 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 Nebraska Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2012 audit was conducted for the purpose of forming an opinion on the 2012 statutory basis financial statements as a whole. The supplemental schedule of investment risk interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2012 are presented for purposes of additional analysis and are not a required part of the 2012 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 2012 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 2012 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the board of directors 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 17, 2013

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2012 AND 2011

(In thousands, except common capital stock share data)

	2012	2011
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$28,462	$31,273
Cash overdrafts ($754) and ($6,939), cash equivalents $8,949 and $5,000, and short-term investments $9,201 and $11,351 in 2012 and 2011, respectively	17,396	9,412
Subtotal cash and invested assets	45,858	40,685
OTHER ASSETS:		
Investment income due and accrued	221	300
Uncollected premiums	5,212	5,144
Amounts receivable relating to uninsured plans	137	172
Current federal income taxes recoverable	961	-
Net deferred tax asset	566	1,875
Health care receivables	782	418
Other assets	43	-
Subtotal other assets	7,922	7,909
TOTAL ADMITTED ASSETS	$53,780	$48,594
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$28,152	$21,294
Accrued medical incentive pool and bonus amounts	3,109	3,031
Unpaid claims adjustment expenses	528	415
Aggregate health policy reserves	542	205
Aggregate health claim reserves	177	212
Premiums received in advance	6	138
General expenses due or accrued	54	62
Current federal income taxes payable	-	217
Ceded reinsurance premiums payable	62	58
Remittances and items not allocated	-	1
Amounts due to parent, subsidiaries, and affiliates, net	433	773
Liability for amounts held under uninsured plans	383	547
Other liabilities	3	5
Total liabilities	33,449	26,958
CAPITAL AND SURPLUS:		
Common capital stock, $1.00 par value — 100,000 shares authorized; 100,000 shares issued and outstanding	100	100
Gross paid-in and contributed surplus	1,100	1,100
Unassigned surplus	19,131	20,436
Total capital and surplus	20,331	21,636
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$53,780	$48,594

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011
(In thousands)

	2012	2011
REVENUES:		
Net premium income	$ 187,221	$ 173,808
Change in reserve for rate credits	(336)	(58)
Total revenues	186,885	173,750
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	138,873	129,450
Other professional services	1,498	2,844
Prescription drugs	4,218	4,406
Medicaid University of Nebraska Medical Center capitation	4,524	4,218
Incentive pool, withhold adjustments, and bonus amounts	2,992	3,654
Other expenses	7	-
Total hospital and medical	152,112	144,572
Claims adjustment expenses	8,901	7,481
General administrative expenses	14,013	12,582
Total underwriting deductions	175,026	164,635
NET UNDERWRITING GAIN	11,859	9,115
NET INVESTMENT GAINS:		
Net investment income earned	1,013	1,162
Net realized capital gains less capital gains tax of $59 and $105, in 2012 and 2011, respectively	219	217
Total net investment gains	1,232	1,379
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(4)	-
OTHER LOSSES	(25)	-
NET INCOME BEFORE FEDERAL INCOME TAXES	13,062	10,494
FEDERAL INCOME TAXES INCURRED	4,346	3,552
NET INCOME	$ 8,716	$ 6,942

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011
(In thousands, except common capital stock share data)

	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
	Shares	Amount			
BALANCE — January 1, 2011	100,000	$ 100	$ 1,100	$ 20,843	$ 22,043
Net income	-	-	-	6,942	6,942
Change in net deferred income taxes	-	-	-	1,631	1,631
Change in nonadmitted assets	-	-	-	(4,480)	(4,480)
Dividend paid	-	-	-	(4,500)	(4,500)
BALANCE — December 31, 2011	100,000	100	1,100	20,436	21,636
Net income	-	-	-	8,716	8,716
Change in net deferred income taxes	-	-	-	(1,309)	(1,309)
Change in nonadmitted assets	-	-	-	3,688	3,688
Dividends paid	-	-	-	(12,400)	(12,400)
BALANCE — December 31, 2012	100,000	$ 100	$ 1,100	$ 19,131	$ 20,331

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011
(In thousands)

	2012	2011
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 187,026	$ 175,903
Net investment income	1,267	1,343
Benefit and loss related payments	(141,736)	(146,572)
Operating expenses paid	(22,982)	(19,892)
Federal income taxes paid — net	(5,584)	(4,094)
Net cash provided by operations	17,991	6,688
CASH FLOWS FROM INVESTMENTS:		
Proceeds from bonds sold, matured, or repaid	12,611	8,747
Cost of bonds acquired	(9,701)	(9,595)
Net cash provided by (used in) investments	2,910	(848)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Dividends paid	(12,400)	(4,500)
Cash (used) provided through net transfer (to) from affiliates	(340)	390
Other cash applied	(177)	(29)
Net cash used in financing and miscellaneous activities	(12,917)	(4,139)
NET CHANGE IN CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	7,984	1,701
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — Beginning of year	9,412	7,711
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — End of year	$ 17,396	$ 9,412

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization and Operation

UnitedHealthcare of the Midlands, 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), an HMO management corporation that provides services to the Company under the terms of a management 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 April 16, 1984, as a HMO and operations commenced in August 1984. The Company is certified as a HMO by the Nebraska Department of Insurance (the Department) and the Iowa Insurance Division. The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage (Medicare Part D program) under a contract with the Centers for Medicare and Medicaid Services (CMS). Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year; these payment elements are CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share and the CMS coverage gap discount program.

The Company has a contract with the State of Nebraska, Department of Health and Human Services (DHHS), Division of Medicaid and Long Term Care, to provide health care services to Medicaid eligible beneficiaries in Nebraska. The current contract is effective through June 30, 2013, and is renewed through June 30, 2014, and has provision for an additional one-year extension renewal (through June 30, 2015) under the current contract. The additional provision year is subject to mutual agreement between parties. The contract 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 Nebraska, for determining and reporting the financial condition and results of operations of a HMO, for determining its solvency under Nebraska 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 statement.

(1–8) No significant differences exist between the practices prescribed or permitted by the State of Nebraska and those prescribed or permitted by the NAIC SAP which materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

	State of Domicile	2012	2011
Net Income			
(1) Nebraska basis	Nebraska	$ 8,716	$ 6,942
(2) State prescribed practices that increase/(decrease) NAIC SAP — Not applicable	Nebraska	-	-
(3) State permitted practices that increase/(decrease) NAIC SAP — Not applicable	Nebraska	-	-
(4) NAIC SAP	Nebraska	$ 8,716	$ 6,942
Surplus			
(5) Nebraska basis	Nebraska	$20,331	$21,636
(6) State prescribed practices that increase/(decrease) NAIC SAP — Not applicable	Nebraska	-	-
(7) State permitted practices that increase/(decrease) NAIC SAP — Not applicable	Nebraska	-	-
(8) NAIC SAP	Nebraska	$20,331	$21,636

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, and aggregate health policy reserves and aggregate health claim reserves (collectively known as "aggregate health reserves"). 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

(1–13) 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).

The more significant differences are as follows:

- Cash overdrafts, cash equivalents, and short-term investments 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, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date;

- 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;

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

- Under statutory accounting, the change to deferred tax assets and liabilities is recorded directly to unassigned surplus and deferred tax assets are subject to limitations regarding the realization and admissibility of the assets in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets and liabilities 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 statutory accounting, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheets;

- Certain assets, including certain aged premium, health care receivables, and other assets are considered nonadmitted assets for statutory purposes and are excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus. Nonadmitted assets are excluded from the statutory basis financial statements and are charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheet;

- Comprehensive income and its components are not presented in the statutory basis financial statements;

- Cash overdrafts, cash equivalents, and short-term investments in the statutory basis statements of cash flows represent cash balances and investments with original maturities of one year or less from the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and cash equivalents with maturities of three months or less. The corresponding caption of short-term investments under GAAP represents securities with a final maturity of one year or less from the balance sheet date. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Cash and Invested Assets —

- Cash overdrafts and cash equivalents represent cash held by the Company in disbursement accounts and agency discount notes. Claims and other payments are made from the disbursement accounts daily. Cash overdrafts are a result of timing differences in funding disbursement accounts for claims payments. Cash equivalents have original maturity dates of three months or less from the date of acquisition and are reported at cost or amortized cost depending on the nature of the underlying security, which approximates fair value.

- Short-term investments represent money market instruments with a maturity of greater than three months but less than one year at the time of purchase. Short-term investments also consist of the Company's share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than

one year, with the average life of the individual investments being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company has executed a custodial agreement whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or amortized cost. Interest income from the pool accrues daily to participating members based upon ownership percentage.

- Bonds include corporate debt securities, government and state and state agency obligations and municipal securities with a maturity of greater than one year at the time of purchase.

- Bonds and short-term investments are stated at amortized cost if they meet NAIC designation of one or two and stated at the lower of amortized cost or fair value if they meet an NAIC designation of three or higher. Amortization of bond premium or discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the Securities Valuation Office of the NAIC (SVO) in accordance with the NAIC Valuations of Securities manual prepared by the SVO or an external pricing service.

- The Company holds no mortgage loans on real estate.

- Corporate bonds and government obligations include mortgage-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of mortgage-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 non-agency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets and total investments in mortgage-backed securities to 30% of total cash and invested assets.

- The Company holds no common or preferred stock.

- The Company holds no investments in subsidiaries, controlled, or affiliated entities.

- The Company has no investment interests with respect to joint ventures, partnerships or limited liability companies.

- The Company holds no derivatives.

- 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 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 gains less capital gains tax in the statutory basis statements of operations. The new cost basis is not changed for subsequent recoveries in

fair value. The prospective adjustment method is utilized for mortgage-backed securities for periods subsequent to the loss recognition. The Company has not recorded any other-than-temporary impairments for the years ended December 31, 2012 and 2011.

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 are 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 amounts determined to be uncollectible are written off in the period in which the determination is made.

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).

Amounts Due to Parent, Subsidiaries, and Affiliates — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts due to parent, subsidiaries, and affiliates in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

Medicaid University of Nebraska Medical Capitation Program — The State of Nebraska, DHHS, and the Company have a contract for the purposes of increasing reimbursement for Medicaid eligible services to the Company, which in turn is required to be passed through to the University of Nebraska Medical Center (UNMC). The program was approved by the CMS pursuant to Nebraska Medicaid Reform to develop a physician upper limit program that provides higher reimbursement to designated physician groups. The Company will pass-through 100% of the UNMC supplemental capitation payment received from the State of Nebraska, DHHS.

In 2012 and 2011, the Company recorded $4,524 and $4,218, respectively, as net premium income for these payment with a corresponding offset of $4,524 and $4,218, respectively, reflected as Medicaid UNMC capitation as a component of total hospital and medical in the accompanying statutory basis statements of operations. The Company did not realize any underwriting gains or losses resulting from the arrangement. The Company also recorded a liability in claims unpaid of $2,487 and $1,040 as a result of this arrangement in the accompanying statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2012 and 2011, respectively.

Properties Occupied by the Company, Properties Held for the Production of Income, Properties Held for Sale, Furniture and Equipment and Electronic Data Processing Equipment and Software — The Company does not carry any fixed assets on the statutory basis financial statements.

Hospital and Medical Expenses, Claims Unpaid, and Aggregate Health Reserves — Hospital and medical expenses and corresponding liabilities 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.

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 2012 and 2011. Management believes the amount of claims unpaid and aggregate health reserves is adequate to cover the Company's liability for unpaid claims and aggregate health reserves as of December 31, 2012; however, actual payments may differ from those established estimates. Adjustments to claims unpaid estimates and aggregate health reserves are reflected in statutory statement of operations in the period in which the change in estimate is identified.

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.

Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held under Uninsured Plans — Receivables and liabilities for amounts held under uninsured plans represent the cost reimbursement under the Medicare Part D program for the catastrophic reinsurance subsidy and the low-income member cost-sharing subsidy. The Company is fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. The Patient Protection and Affordable Care Act and its related reconciliation act "Health Reform Legislation" mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap (Coverage Gap Discount Program or CGDP). These discounts are pre-funded by CMS, and ultimately reimbursed by pharmaceutical manufacturers, and the Company solely administers the application of these funds and has no insurance risk. If the Company incurs costs either in excess of or less than these subsidies, a corresponding receivable or payable is recorded in amounts receivable relating to uninsured plans or liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Related cash flows are presented within operating expenses paid within cash provided by operations in the statutory basis statements of cash flows.

Net Deferred Tax Asset and Federal Income Taxes Incurred — Statutory accounting provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets and liabilities, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 35% to net income before federal income taxes plus capital gains tax subject to certain adjustments (see Note 9).

Claims Adjustment Expense — Claims adjustment expenses (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 management agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. A detailed review of UHS' and the Company's administrative expenses is performed to determine the allocation between CAE and general administrative expenses. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid claims adjustment expenses associated with incurred but unpaid claims, which is included in unpaid claims adjustment expenses in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid claims adjustment expenses as of December 31, 2012 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 claims adjustment expenses are reflected in operating results in the period in which the change in estimate is identified.

Remittances and Items Not Allocated — Remittances and items not allocated generally represent monies received from policyholders for monthly premium billings that have not been entered into the billing system. The majority is from monies received in the lockbox account on the last day of the year.

General Administrative Expenses — Pursuant to the terms of the management 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 management agreement are directly expensed as incurred. State income taxes are also a component of general administrative expenses. A detailed review of UHS' and the Company's administrative expenses is performed to determine the allocation between claims adjustment expenses and general administrative expenses to be reported in the statutory basis statements of operations.

Revenues — 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. Premiums received in full during the current period which are not due until future periods are recorded as premiums received in advance in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

Net premium income includes the Medicare Advantage CMS premium, and the premium under the Medicare Part D program, which includes CMS premium, member premium, and 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 estimates retrospective premium adjustments based on guidelines determined by CMS (see Note 24).

CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. 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. The estimated risk-adjusted payments due to the Company at December 31, 2012 and 2011, were $321 and $786, respectively, and are recorded as uncollected premiums in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recognized $228 and ($23) for changes in prior year Medicare risk factor estimates during the years ended December 31, 2012 and 2011, respectively, which is recorded as an increase and reduction to net premium income within the statutory basis statements of operations.

Net premium income also includes amounts paid by state and federal governments per member in exchange for the provision and administration of medical benefits under the Medicaid 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, home nursing risk-sharing payments, high dollar risk pool 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. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

The Company reports uncollected premium balances from its insured members as uncollected premiums 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.

Reinsurance Ceded — The Company has an insolvency-only reinsurance agreement with United Healthcare Insurance Company (UHIC). Reinsurance premiums paid and incurred are deducted from net premium income in the accompanying statutory basis financial statements.

Ceded Reinsurance Premiums Payable — The Company has an insolvency-only reinsurance agreement whereby 0.4% of net premium income is ceded to UHIC. The ceded reinsurance premiums payable balance represents amounts due to the reinsurer for coverage which will be paid based on the contract terms.

Incentive Pool — 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 or deficits 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, and the corresponding expense or reduction to expense is included in incentive pool, withhold adjustments, and bonus amounts in the statutory basis statements of operations.

Medical Risk Share — Medicare Part D — The Company has settlements with CMS based on whether the ultimate per member per month benefit costs of any Medicare Part D program regional plan varies more than 5% above or below the level estimated in the original bid submitted by the Company and approved by CMS in 2012 and 2011. The estimated risk share adjustment of $542 and $225 in 2012 and 2011, respectively, is recorded as a decrease to change in reserve for rate credits in the statutory basis statements of operations and aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

Health Care Receivables — Health care receivables consist of pharmacy rebate receivables estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's unaffiliated pharmaceutical benefit manager and affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include receivables for amounts due to the Company for claim overpayments to providers, hospitals and other health care provider organizations and provider advance. Health care receivables are considered nonadmitted assets for statutory purposes 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).

Premium Deficiency Reserves — Premium deficiency reserves and the related expenses are recognized when it is probable that expected future health care expenses, claim adjustment expenses, 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, claim adjustment expenses and direct administration costs are considered. The methods for making such estimates and for establishing the resulting reserves are periodically reviewed and updated, and any adjustments are reflected in increase reserves for accident and health contracts in the accompanying statutory basis statements of operations in the period in which the change in estimate is identified. The Company anticipates investment income as a factor in the premium deficiency calculation (see Note 30).

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.

Direct premium income from members and CMS related to Medicare Advantage and the Medicare Part D program as a percentage of direct premium income are 26% and 24% for the years ended December 31, 2012 and 2011, respectively. Uncollected premium from CMS accounted for 6.6% and 14.7% of uncollected premiums as of December 31, 2012 and 2011, respectively.

Direct premium income from the State of Nebraska, DHHS, as a percentage of direct premium income are 74% and 76% for the years ending December 31, 2012 and 2011, respectively. Uncollected premium from the State of Nebraska, DHHS accounted for approximately 93.3% and 85.3% of uncollected premiums as of December 31, 2012 and 2011, respectively.

Restricted Cash Reserves — The Department requires the Company to maintain a minimum regulatory deposit (currently $300). The Company is in compliance with this requirement as of December 31, 2012 and 2011. This restricted cash reserve consists principally of government obligations and is stated at amortized cost, which approximates fair value. This reserve is included in bonds in the accompanying statutory basis statements of admitted assets, liabilities, and capital surplus. Interest earned on this reserve accrues to the Company. The Iowa Department of Insurance has waived the requirement to maintain restricted cash reserves since 2003.

Minimum Capital and Surplus — Under the laws of the state of Nebraska, the Department requires the Company to maintain a minimum capital and surplus equal to the greatest of $1,000 or 2% of the first $150,000 of annual premium revenue and 1% of annual premium revenue over $150,000. The minimum capital and surplus requirement based on total revenue is $3,369 and $3,238, for December 31, 2012 and 2011, respectively. The Company has $20,331 and $21,636 in total statutory basis capital and surplus as of December 31, 2012 and 2011, respectively, which is in compliance with the required amount.

Risk-based capital (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.

Recently Issued Accounting Standards — In November 2011, the NAIC adopted SSAP No. 101, *Income Taxes — A Replacement of SSAP No. 10R and SSAP No. 10*, effective for 2012 interim and annual financial statements and beyond. The new standard includes revised guidance for tax contingencies, non-elective deferred tax asset admissibility test along with significant modifications to the deferred tax asset admissibility test, and disclosure modifications. A change resulting from the adoption of this revised statement shall be accounted for prospectively. The Company adopted SSAP No. 101 in 2012 and determined there is no material impact to the statutory basis financial statements.

2. ACCOUNTING CHANGES AND CORRECTIONS OF ERRORS

No changes in accounting principles have been recorded during the years ended December 31, 2012 and 2011.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2012 and 2011, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

(1–5) The Company did not discontinue any operations during 2012 and 2011.

5. INVESTMENTS AND OTHER INVESTED ASSETS

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 investments for bonds were $287 and ($9), respectively, for 2012 and $329 and ($7), respectively, for 2011. The Company has not recorded any gains or losses on the sale of investments for short-term investments for 2012 and 2011. The net realized gain is included in net realized capital gains less capital gains tax in the accompanying statutory basis statements of operations.

As of December 31, 2012 and 2011, the amortized cost, fair value, and gross unrealized holding gains and losses of the Company's investments, excluding cash overdrafts, net of cash equivalents of $8,195 and ($1,939), respectively, are as follows:

	2012				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 year	Gross Unrealized Holding Losses > 1 year	Fair Value
US Govt and agency securities	$ 9,599	$ 282	$ -	$ -	$ 9,881
State and agency Muni's	6,361	487	-	-	6,848
City/county Muni's	2,302	244	-	-	2,546
Corporate debt securities	10,200	458	(3)	-	10,655
Money-market funds	9,201	-	-	-	9,201
Total bonds and short-term investments	$37,663	$1,471	$ (3)	$ -	$39,131

	2012				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 year	Gross Unrealized Holding Losses > 1 year	Fair Value
Less than one year	$10,794	$ 14	$ -	$ -	$10,808
One to five years	11,632	420	-	-	12,052
Five to ten years	10,363	844	(3)	-	11,204
Over ten years	4,874	193	-	-	5,067
Total bonds and short-term investments	$37,663	$1,471	$ (3)	$ -	$39,131

	2011				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 year	Gross Unrealized Holding Losses > 1 year	Fair Value
US Govt and agency securities	$ 9,376	$ 279	$ -	$ -	$ 9,655
State and agency Muni's	8,901	695	-	-	9,596
City/county Muni's	3,370	286	-	-	3,656
Corporate debt securities	9,626	387	(50)	-	9,963
Money-market funds	11,351	-	-	-	11,351
Total bonds and short-term investments	$42,624	$1,647	$(50)	$ -	$44,221

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-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 an amortized cost of $6,268 and fair value of $6,587.

The following table illustrates the fair value and gross unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrealized loss position as of December 31, 2012 and 2011:

	2012					
	< 1 year		> 1 year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
Corporate debt securities	$ 296	$ (3)	$ -	$ -	$ 296	$ (3)
Total bond and short-term investments	$ 296	$ (3)	$ -	$ -	$ 296	$ (3)

	2011					
	< 1 year		> 1 year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
Corporate debt securities	$1,048	$(50)	$ -	$ -	$1,048	$(50)
Total bonds and short-term investments	$1,048	$(50)	$ -	$ -	$1,048	$(50)

The unrealized losses on investments in corporate debt securities at December 31, 2012 and 2011 were mainly caused by interest rate increases 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 amortized cost. The contractual cash flows of the U.S. government and agency obligations are either guaranteed 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 evaluated the credit ratings of the municipalities and local agency obligations and corporate obligations, noting whether a significant deterioration since purchase or other factors which may indicate an other–than-temporary impairment, 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 mortgage-backed securities for a period of time sufficient to recover the amortized cost. As a result of this review, no other-than-temporary impairment were recorded by the Company as of December 31, 2012 and 2011, respectively.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, reverse mortgages or investments in low-income housing tax credits. 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. Total proceeds on the sale of investments for bonds were $5,125 and $4,837 and for short-term investments were $202,692 and $185,205 in 2012 and 2011, respectively.

D. Loan-Backed Securities

(1) Corporate bonds and government obligations include mortgage-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for

the determination of the amortized cost of mortgage-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 other-than-temporary impairments on mortgage-backed securities as of December 31, 2012 and 2011.

(3) The Company did not have mortgage-backed securities with an other-than-temporary impairment to report by CUSIP as of December 31, 2012 or 2011.

(4) The Company does not have any mortgage-backed securities in a continuous unrealized loss position at December 31, 2012 and 2011.

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

F. **Real Estate** — Not applicable.

G. **Low-Income Housing Tax Credits** — 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 has admitted all investment income due and accrued in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

The components of net investment income earned at December 31, 2012 and 2011 are as follows:

	2012	2011
Bonds	$ 991	$ 1,150
Cash overdrafts, cash equivalents, and short-term investments	54	42
Total investment income earned	1,045	1,192
Expenses — investment management fees	(32)	(30)
Net investment income earned	$ 1,013	$ 1,162

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

8. DERIVATIVE INSTRUMENTS

A–F. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset for the years ended December 31, are as follows:

(2012 Information is Computed under SSAP No. 101. 2011 Information was Computed under SSAP No. 10R)

	2012			2011			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
(a) Gross deferred tax assets	$577	$ 3	$580	$1,899	$ 71	$1,970	$(1,322)	$ (68)	$(1,390)
(b) Statutory valuation allowance adjustments	-	3	3	-	71	71	-	(68)	(68)
(c) Adjusted gross deferred tax assets (1a - 1b)	577	-	577	1,899	-	1,899	(1,322)	-	(1,322)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	577	-	577	1,899	-	1,899	(1,322)	-	(1,322)
(f) Deferred tax liabilities	11	-	11	24	-	24	(13)	-	(13)
(g) Net admitted deferred tax asset/(net deferred tax liability)	$566	$ -	$566	$1,875	$ -	$1,875	$(1,309)	$ -	$(1,309)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, *Income Taxes — A Replacement of SSAP No. 10R and SSAP No. 10*, are as follows (in thousands):

(2012 Information is Computed under SSAP No. 101. 2011 Infomration was Computed under SSAP No. 10R.)

Admission Calculation Components SSAP No. 101	2012			2011			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$577	$ -	$ 577	$1,899	$ -	$1,899	$(1,322)	$ -	$(1,322)
(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	2,965	XXX	XXX	2,165	XXX	XXX	800
(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 and SSAP No. 10R, respectively for 2012 and 2011 Total (2(a) + 2(b) + 2(c))	$577	$ -	$ 577	$1,899	$ -	$1,899	$(1,322)	$ -	$(1,322)

SSAP No. 101, *Income Taxes — A Replacement of SSAP No. 10R and SSAP No. 10*, is effective for 2012 interim and annual financial statements and beyond. The new standard includes revised guidance for tax contingencies, a non-elective deferred tax asset admissibility test along with significant modifications to the deferred tax assets admissibility test, and disclosure modifications. A change resulting from this adoption would be accounted for prospectively and reflected as a change in accounting principle in accordance with SSAP No. 3 — *Accounting Changes and Corrections of Errors*. The adoption of this pronouncement did not have an impact on the statutory basis financial statements.

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

	2012	2011
(a) Ratio percentage used to determine recovery period and threshold limitation amount	326 %	n/a
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2 (b) (2) above	$ 19,765	n/a

(4) There was no impact to the deferred tax assets as a result of tax-planning strategies.

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities.

C. Significant Components of Income Taxes

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

	2012	2011	Change
1. Current income tax:			
(a) Federal	$4,346	$3,552	$794
(b) Foreign	-	-	-
(c) Subtotal	4,346	3,552	794
(d) Federal income tax on net capital gains	59	105	(46)
(e) Utilization of capital loss carry-forwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$4,405	$3,657	$748

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities at December 31, 2012 and 2011, are as follows:

(2012 Information is Computed under SSAP No. 101. 2011 Information was Computed under SSAP No. 10R.)

	2012	2011	Change
2. Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$158	$ 147	$ 11
(2) Unearned premium reserve	1	10	(9)
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	418	1,695	(1,277)
(11) Net operating loss carry-forward	-	-	-
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	-	47	(47)
(99) Subtotal	577	1,899	(1,322)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	577	1,899	(1,322)
(e) Capital:			
(1) Investments	3	71	(68)
(2) Net capital loss carry-forward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	3	71	(68)
(f) Statutory valuation allowance adjustment	3	71	(68)
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	577	1,899	(1,322)
3. Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	11	24	(13)
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(99) Subtotal	11	24	(13)
(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)	11	24	(13)
4. Net deferred tax assets/liabilities (2i - 3c)	$566	$1,875	$(1,309)

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance of $3 and $71 to reduce the gross deferred tax asset to $577 and $1,899 as of December 31, 2012 and 2011, respectively which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses and/or expectations for future taxable income.

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 35% to net income before federal income taxes plus capital gains tax. The significant items causing this difference are as follows:

	2012	2011
Tax provision at the federal statutory rate	$ 4,593	$ 3,710
Tax-exempt interest	(110)	(128)
Change in statutory valuation allowance	(68)	(20)
Other	8	32
Tax effect of nonadmitted assets	1,291	(1,568)
Total	$ 5,714	$ 2,026
Federal income taxes incurred	$ 4,346	$ 3,552
Capital gains tax	59	105
Change in net deferred income tax	1,309	(1,631)
Total statutory income taxes	$ 5,714	$ 2,026

E. At December 31, 2012, the Company had no net operating loss carryforwards.

Current federal income taxes (recoverable) payable of ($961) and $217 as of December 31, 2012 and 2011, respectively, are included in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds was $5,584 and $4,094 in 2012 and 2011, respectively.

Federal income taxes incurred of $4,405 and $3,625 for 2012 and 2011, respectively, is 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 Code.

F. The Company is included in a consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in 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. Internal Revenue Service (IRS) has completed exams on UnitedHealth Group's consolidated income tax returns for fiscal years 2011 and prior. UnitedHealth Group's 2012 tax return is under advance review by the IRS under its Compliance Assurance Program (CAP). With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to 2007 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–L. Material Related Party Transactions

Effective January 1, 2011, the Company entered into a revised Management Agreement (Agreement) with UHS. This agreement has been approved by the Department. UHS will continue to provide management services to the Company under a revised fee structure that is changing from a percentage of net premium income and change reserve for rate credits to a direct charge based on UHS' expenses for services or use of assets provided to the Company. Management fees under this arrangement total $19,049 and $17,110 in 2012 and 2011, respectively, and are included in general administrative expenses and claims adjustment expenses in the accompanying statutory basis statements of operations. In addition, UHS pays certain direct expenses, such as broker commissions, DOI exam fees, premium taxes on the behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

Management believes that its 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.

The Company expensed as hospital and medical expenses, general administrative expenses, and claims adjustment expenses $1,467 and $940 in capitation fees to related parties during 2012 and 2011, respectively. Under the Agreement effective for January 2011, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a Per Member Per Month (PMPM) basis (where the charge incurred by UHS is on a PMPM basis) or using another allocation methodology consistent with the Agreement. These services include, but are not limited to, integrated personal health management solutions, such as disease management, treatment decision support and wellness services, including a 24-hour call-in service, access to a network of transplant providers and discount program services. OptumHealth Care Solutions, Inc. provides chiropractic and physical therapy services. Spectera, Inc. provides administrative services related to vision benefit management and claims processing. Dental Benefit Providers, Inc. provides dental care assistance. United Behavioral Health provides mental health and substance abuse services.

The capitation expenses, administrative services, and access fees paid to related parties, that are included as hospital and medical expenses, general administrative expenses, and claims adjustment expenses in the accompanying statutory basis statements of operations for the years ended December 31, 2012 and 2011, are shown below:

	2012	2011
UHS	$ 979	$ 529
United Behavioral Health	263	243
OptumHealth Care Solutions, Inc.	70	67
Dental Benefit Providers, Inc.	68	35
Spectera, Inc.	87	66
Total	$ 1,467	$ 940

The Company contracts with affiliates (UHS and OptumRx) to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees. Fees related to these agreements, which are calculated on a per-claim basis, of $262 and $245 in 2012 and 2011, respectively, are included in general administrative expenses and claims adjustment expenses in the accompanying statutory basis statements of operations.

The Company has an agreement with OptumInsight, Inc., a wholly owned subsidiary of UnitedHealth Group, for services that lead up to and include the prevention and recovery of medical expense overpayments. Service fees are either percentages of every recovery which are retained by OptumInsight, Inc. based on the services performed and recoveries, net of fees, are returned to the Company on a monthly basis and/or, all recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis and a capitated service fee is charged to the Company as a PMPM. Service fees of $527 and $321 are included in hospital and medical expenses, claims adjustment expenses and general administrative expenses in the accompanying statutory basis statements of operations for the years ended December 31, 2012 and 2011, respectively.

The Company has premium payments that are received and claim payments that are processed by an affiliated UnitedHealth Group entity. Both 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 amounts due to parent, subsidiaries, and affiliates in the accompanying statutory basis statements of admitted assets, liabilities and capital and surplus.

The Company has an insolvency-only reinsurance agreement with UHIC, a wholly owned subsidiary of UHIC Holdings, Inc. which is a wholly owned subsidiary of UHS, to provide insolvency protection for its enrollees. Reinsurance premiums, which are calculated on a percentage of member premium income, of $732 in 2012 and $681 in 2011 are netted against net premium income in the accompanying statutory basis statements of operations.

The Company holds a $10,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of LIBOR 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 aggregate principal amount that may be outstanding at any time shall not exceed $10,000. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was amended and restated effective June 1, 2012. No amounts were outstanding under the line of credit as of December 31, 2012 and 2011.

At December 31, 2012 and 2011, the Company reported $433 and $773, respectively, as amounts due to parent, subsidiaries, and affiliates, 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.

In addition to the agreements above, UHS maintains a private short-term money market investment pool in which affiliated companies may participate (see Note 1). At December 31, 2012 and 2011, the Company's portion was $6,509 and $8,895, respectively, and is included in cash overdrafts, cash equivalents, and short-term investments in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has entered into a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $12,400 and $4,500 in 2012 and 2011, respectively, to its parent (see Note 13).

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

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

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

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

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party, it does not have any investments in a foreign insurance subsidiary and it does not hold any investments in a downstream noninsurance holding company.

11. DEBT

A–B. The Company had no outstanding debt with third parties or outstanding federal home loan bank agreements during 2012 and 2011.

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

A–F. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits and 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 a management agreement (see Note 10).

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

(1–2) The Company has 100,000 shares authorized and 100,000 shares issued and outstanding of $1 par value common capital stock. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

(3) Payment of dividends may be restricted by the Department and Nebraska law, which generally require that dividends be paid out of earned surplus.

(4) The Company paid an ordinary cash dividend to UHC of $6,400 on September 11, 2012 and $4,500 on September 7, 2011, which required no approval and is recorded as a reduction to unassigned surplus in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company paid an extraordinary cash dividend to UHC of $6,000 on December 12, 2012, which was approved by the Department and is recorded as a reduction to unassigned surplus in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

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

(6) There are no restrictions placed on the Company's unassigned surplus.

(7) Not applicable as the Company is not a mutual reciprocal or a similarly organized entity.

(8) 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.

(9) The Company does not have any special surplus funds.

(10) The portion of unassigned surplus represented or (reduced by) each item below is as follows:

	2012	2011
Net deferred income taxes	$ 566	$ 1,875
Nonadmitted assets	(1,212)	(4,900)
	$ (646)	$ (3,025)

(11–13) The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. CONTINGENCIES

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any assessments, 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 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. All Other Contingences

Because of the nature of the business, the Company is routinely made party to a variety of legal actions related to the design and management of its service offerings. The Company records liabilities for estimates of probable costs resulting from these matters where appropriate. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes, and claims related to certain other business practices. 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 accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

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 and 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 Inspector General (OIG), the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor, the Federal Deposit Insurance Corporation and other governmental authorities. Examples of audits include the risk adjustment data validation (RADV) audits discussed below and a review by the U.S. Department of Labor of the Company's administration of applicable customer employee benefit plans with respect to ERISA compliance.

Government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs and could have a material adverse impact on the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

Risk Adjustment Data Validation Audit CMS adjusts 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 as well as, for Medicare Part D plans only, based on comparing costs predicted in the Company's annual bids to actual prescription drug costs. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

In February 2012, CMS announced a final RADV audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented. Any potential payment

adjustments could have a material adverse effect on the Company's statutory basis financial statements.

During the first quarter of 2010, the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (collectively known as Health Reform Legislation), were signed into law, after being challenged, were substantially upheld in a U.S. Supreme Court decision in the second quarter of 2012. The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, Children's Health Insurance Program, and other aspects of the health care system. Certain provisions of the Health Reform Legislation have already taken effect, and other provisions become effective at various dates over the next several years. The Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury Department have issued regulations or proposed regulations on a number of aspects of Health Reform Legislation, but final rules and interim guidance on the other key aspects of the legislation remain pending.

The Health Reform Legislation and the related federal and state regulations will impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put the Company at risk for loss of business. In addition, the Company's results of operations, financial condition, and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

There are no assets that the Company considers to be impaired at December 31, 2012 and 2011.

15. LEASES

A–B. According to the management 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 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. The Company has no operations from Administrative Services only Contracts.

B. The Company has no operations from Administrative Services Contracts.

C. **Medicare or Other Similarly Structured Cost Based Reimbursement Contract**

The Medicare Part D program is a partially insured plan. The Company recorded a payable of $159 and $231 at December 31, 2012 and 2011, respectively, for cost reimbursements under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies as described in Note 1 *Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans*. The Company also recorded a receivable of $137 and $172 and also a payable of $224 and $312 at December 31, 2012 and 2011, respectively, for the Medicare Part D Coverage Gap Discount Program as described in Note 1, *Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans*. These amounts are recorded as amounts receivable relating to uninsured plans and liability for amounts held under uninsured plans in the accompanying statutory basis statements of admitted assets, liabilities, and capital 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.

20. FAIR VALUE MEASUREMENT

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 short-term investments 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, 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 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. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services, the Company has not historically adjusted 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) The Company does not have any financial assets that are measured and reported at fair value on the statutory basis statements of admitted assets, liabilities, and capital and surplus at December 31, 2012 and 2011.

(2) The Company does not have any financial assets with a fair value hierarchy of level 3.

B. Fair Value Combination — Not applicable

C. The aggregate fair value by hierarchy of all financial instruments as of December 31, 2012 and 2011 is presented in the table below:

	2012					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practical Carrying Value
Bonds	$39,131	$37,663	$14,243	$24,888	$ -	$ -
Common stock	-	-	-	-	-	-
Perpetual preferred stock	-	-	-	-	-	-
Mortgage loans	-	-	-	-	-	-

	2011					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practical Carrying Value
Bonds	$44,221	$42,624	$14,840	$29,381	$ -	$ -
Common stock	-	-	-	-	-	-
Perpetual preferred stock	-	-	-	-	-	-
Mortgage loans	-	-	-	-	-	-

Included as Level 1 in Bonds in the fair value hierarchy table above are money market instruments of $9,202 and $11,351 as of December 31, 2012 and 2011 respectively. Money market instruments are reflected in cash overdrafts, cash equivalents and short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

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

21. OTHER ITEMS

The Company's business is regulated at federal, state and local levels, and the Company must obtain and maintain regulatory approvals to market and sell many of its products. 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. State legislatures and Congress continue to focus on health care issues.

The Company elected to use rounding in reporting amounts in the notes to statutory basis financial statements.

A. The Company did not encounter any extraordinary items for the years ended December 31, 2012 or 2011.

B. The Company has no troubled debt restructurings as of December 31, 2012 or 2011.

C. 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.

D. The Company routinely evaluates the collectability of all receivable amounts included within 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 financial condition.

E. The Company has not received any business interruption insurance recoveries during 2012 and 2011.

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

G. (1) **Sub-Prime Mortgage Related Risk Exposure** — The investment policy for the Company limits investments in asset-backed securities, which includes the 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 are rated NAIC rating of 1 or 2. The Company has no direct exposure through investments in sub-prime mortgage loans. The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

(2) Direct exposure through investments in subprime mortgage loans — Not applicable.

(3) Direct exposure through other investments:

	2012			
	Actual Cost	Book/Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$ 196	$ 206	$ 274	$ -
b. Commercial mortgage-backed securitie	1,340	1,350	1,409	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$1,536	$1,556	$1,683	$ -

	2011			
	Actual Cost	Book/Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$ 229	$ 239	$ 259	$ -
b. Commercial mortgage-backed securitie	2,570	2,577	2,673	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$2,799	$2,816	$2,932	$ -

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

I. The Company, as the Principal, entered into a performance bond on March 2, 2010, with Fidelity Deposit Company of Maryland, as the Surety, and the State of Nebraska, as the Obligee, in an amount not to exceed $10,000. The term of the contract began on March 2, 2010, and expires on June 30, 2013. The nature of the bond is to ensure against any losses the state may incur as a result of the Company's failure to comply with the terms of the Medicaid Managed Care Physician Health Service contract for the State of Nebraska. The premium for the bond is $125, which will be amortized over the contract period. The unamortized premium balance is considered a nonadmitted asset in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

22. EVENTS SUBSEQUENT

TYPE I — Recognized Subsequent Events:

Subsequent events have been evaluated through April 17, 2013, which is the date these statutory basis financial statements were available for issuance.

There are no events subsequent to December 31, 2012, that require disclosure.

TYPE II — Non-Recognized Subsequent Events:

Subsequent events have been evaluated through April 17, 2013, which is the date these statutory basis financial statements were available for issuance.

The Company has entered into a pharmaceutical benefits management agreement with an affiliated entity, OptumRx, with services to commence effective January 1, 2013. The agreement has been approved by the Department and will replace the previous agreement with Medco Health Solutions, Inc. The Company does not anticipate this change will have a significant impact on the statutory basis financial statements.

23. REINSURANCE

The Company does not have any unaffiliated reinsurance agreements (external reinsurance) in place as of December 31, 2012 or 2011.

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, 2012.

(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 2012 and 2011, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2012 or 2011.

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 from the Company are recorded in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserves for rate credits or net premium income in the statutory basis statements of operations.

C. The Company has Medicare Part D program business which is subject to a retrospective rating 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 Part D earned premiums subject to retrospective rating was $3,652 and $3,024 representing 2.0% and 1.7% of total net premium income for 2012 and 2011, respectively.

D. The Company does not have any business subject to specific minimum loss ratio requirements as of December 31, 2012 and 2011 pursuant to the Health Reform Legislation (See Note 14).

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the accompanying statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in the claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves and health care receivables for 2012 and 2011:

	2012		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (24,537)	$ (24,537)
Paid claims, net of health care receivables	127,083	14,653	141,736
End of year claim reserve	30,611	827	31,438
Incurred claims excluding the change in health care receivables	157,694	(9,057)	148,637
Beginning of year health care receivables	-	5,251	5,251
End of year health care receivables, excluding provider advance of $175	(938)	(838)	(1,776)
Total incurred claims	$ 156,756	$ (4,644)	$ 152,112

	2011		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (22,051)	$ (22,051)
Paid claims, net of health care receivables	126,028	20,722	146,750
End of year claim reserve	22,970	1,567	24,537
Incurred claims excluding the change in health care receivables	148,998	238	149,236
Beginning of year health care receivables	-	587	587
End of year health care receivables	(461)	(4,790)	(5,251)
Total incurred claims	$ 148,537	$ (3,965)	$ 144,572

The liabilities for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves and health care receivables as of December 31, 2011 were $19,286. As of December 31, 2012, $14,653 has been paid for incurred claims attributable to insured events of prior years. Receivables, net of reserves, remaining for prior years are now ($11) as a result of re-estimation of unpaid claims. Therefore, there has been $4,644 favorable prior year development since December 31, 2011 to December 31, 2012. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $1,523 and favorable development of $3,194 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. At December 31, 2011, the Company recorded $3,965 of favorable development since December 31, 2010 to December 31,

2011. The primary drivers consist of $4,825 in claim overpayments recoverable retroactivity along with ($622) of medical incentive pool retroactivity, and ($193) of capitation. Original estimates are increased or decreased, as additional information becomes known regarding individual claims. Included in this favorable development is the impact related to retrospectively rated policies. 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 unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

The Company incurred claims adjustment expenses of $8,901 and $7,481 in 2012 and 2011, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of its management agreement (see Note 10). The following tables disclose paid CAE, incurred CAE, and the balance in the unpaid claim adjustment expenses reserve for 2012 and 2011:

	2012	2011
Total claims adjustment expenses incurred	$ 8,901	$ 7,481
Less current year unpaid claims adjustment expenses	(528)	(415)
Add prior year unpaid claims adjustment expenses	415	421
Total claims adjustment expenses paid	$ 8,788	$ 7,487

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2012 or 2011.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2012 or 2011.

28. HEALTH CARE RECEIVABLES

A. Pharmaceutical 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 has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The collection history of pharmacy rebates is summarized as:

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
12/31/2012	$ 384	$ -	$ -	$ -	$ -
9/30/2012	374	365	245	-	-
6/30/2012	352	352	308	31	-
3/31/2012	352	352	317	28	6
12/31/2011	297	307	267	36	2
9/30/2011	311	311	279	27	7
6/30/2011	307	304	280	21	4
3/31/2011	295	300	281	14	4
12/31/2010	343	308	286	8	4
9/30/2010	370	334	277	63	3
6/30/2010	306	311	238	73	1
3/31/2010	307	310	259	42	9

Of the amount reported as admitted health care receivables, $504 and $418 relates to pharmaceutical rebate receivables, $266 and $0 relates to claims overpayments, and $12 and $0 relates to provider receivable as of December 31, 2012 and 2011, respectively.

The Company nonadmitted $983 and $4,825 related to claims overpayments receivable, and $163 and $0 related to provider advance as of December 31, 2012 and 2011, respectively.

B. The Company does not have any risk sharing receivables.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2012 or 2011.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any premium deficiency reserves as of December 31, 2012 or 2011. This analysis of the premium deficiency reserve was completed as of December 31, 2012 and 2011. The Company did consider anticipated investment income when calculating the premium deficiency reserve.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2012 and 2011, 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 SCHEDULE OF INVESTMENT RISKS INTERROGATORIES — STATUTORY BASIS

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2012
(To Be Filed by April 1)

Of The UnitedHealthcare of the Midlands, Inc.

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

NAIC Group Code 0707 NAIC Company Code 95591 Federal Employer's Identification Number (FEIN) 47-0676824

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. $ 53,780,088

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	Mortgage-backed securities	$ 8,121,085	15.1 %
2.02	UHC Liquidity Pool	Short term		$ 6,508,970	12.1 %
2.03	FHLB	Bonds	Mortgage-backed securities	$ 3,949,771	7.3 %
2.04	Northern Inst Govt MMKT	Short term		$ 1,743,994	3.2 %
2.05	FHLMC	Bonds		$ 1,522,406	2.8 %
2.06	WI St	Bonds		$ 824,879	1.5 %
2.07	Southern MN Mun Pwr Agy	Bonds		$ 743,780	1.4 %
2.08	CO Dept of Trans	Bonds		$ 721,673	1.3 %
2.09	OK St Turnpike Auth	Bonds		$ 677,721	1.3 %
2.10	CNH Equip Tr	Bonds		$ 639,965	1.2 %

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

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 45,653,498	84.9 %	3.07	P/RP-1	$	0.0 %
3.02	NAIC-2	$ 959,094	1.8 %	3.08	P/RP-2	$	0.0 %
3.03	NAIC-3	$	0.0 %	3.09	P/RP-3	$	0.0 %
3.04	NAIC-4	$	0.0 %	3.10	P/RP-4	$	0.0 %
3.05	NAIC-5	$	0.0 %	3.11	P/RP-5	$	0.0 %
3.06	NAIC-6	$	0.0 %	3.12	P/RP-6	$	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 [ ] No [X]

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	$ 2,207,321	4.1 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$	0.0 %

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

		1	2
5.01	Countries rated NAIC-1	$ 2,207,321	4.1 %
5.02	Countries rated NAIC-2	$	0.0 %
5.03	Countries rated NAIC-3 or below	$	0.0 %

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

		1	2
	Countries rated NAIC - 1:		
6.01	Country 1: France	$ 675,695	1.3 %
6.02	Country 2: United Kingdom	$ 604,167	1.1 %
	Countries rated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries rated 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 rating:

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

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

		1	2
	Countries rated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries rated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries rated 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 Rating	3	4
10.01	KFW	1	$ 499,269	0.9 %
10.02	Glaxosmithkline	1	$ 284,431	0.5 %
10.03	Sanofi Aventis	1	$ 249,153	0.5 %
10.04	BNP Paribas	1	$ 204,691	0.4 %
10.05	Astrazeneca PLC	1	$ 149,821	0.3 %
10.06	Fin for Danish ind	1	$ 129,951	0.2 %
10.07	France Telecom	1	$ 122,081	0.2 %
10.08	Barclays	1	$ 99,998	0.2 %
10.09	BRFKREDIT AS	1	$ 99,989	0.2 %
10.10	Nat! AU Bank	1	$ 99,978	0.2 %

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 %
11.03	Canadian-currency-denominated investments	$	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.0 %
11.05	Unhedged Canadian currency exposure	$	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 %
	Largest three investments with contractual sales restrictions:		
12.03		$	0.0 %
12.04		$	0.0 %
12.05		$	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 %
13.03		$	0.0 %
13.04		$	0.0 %
13.05		$	0.0 %
13.06		$	0.0 %
13.07		$	0.0 %
13.08		$	0.0 %
13.09		$	0.0 %
13.10		$	0.0 %
13.11		$	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 the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$	0.0 %
14.04		$	0.0 %
14.05		$	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 %
	Largest three investments in general partnership interests:		
15.03		$	0.0 %
15.04		$	0.0 %
15.05		$	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 %
16.03		$	0.0 %
16.04		$	0.0 %
16.05		$	0.0 %
16.06		$	0.0 %
16.07		$	0.0 %
16.08		$	0.0 %
16.09		$	0.0 %
16.10		$	0.0 %
16.11		$	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 %
16.13	Mortgage loans over 90 days past due	$	0.0 %
16.14	Mortgage loans in the process of foreclosure	$	0.0 %
16.15	Mortgage loans foreclosed	$	0.0 %
16.16	Restructured mortgage loans	$	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 %
17.02	91 to 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.03	81 to 90%	$	0.0 %	$	0.0 %	$	0.0 %
17.04	71 to 80%	$	0.0 %	$	0.0 %	$	0.0 %
17.05	below 70%	$	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 %
18.03		$	0.0 %
18.04		$	0.0 %
18.05		$	0.0 %
18.06		$	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 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$	0.0 %
19.04		$	0.0 %
19.05		$	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 %	$	$	$
20.02	Repurchase agreements	$	0.0 %	$	$	$
20.03	Reverse repurchase agreements	$	0.0 %	$	$	$
20.04	Dollar repurchase agreements	$	0.0 %	$	$	$
20.05	Dollar reverse repurchase agreements	$	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 %
21.02	Income generation	$	0.0 %	$	0.0 %
21.03	Other	$	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 %	$	$	$
22.02	Income generation	$ 0	0.0 %	$	$	$
22.03	Replications	$ 0	0.0 %	$	$	$
22.04	Other	$ 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 %	$	$	$
23.02	Income generation	$	0.0 %	$	$	$
23.03	Replications	$	0.0 %	$	$	$
23.04	Other	$	0.0 %	$	$	$

EXHIBIT II: SUMMARY
INVESTMENT SCHEDULE — STATUTORY BASIS

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1	Bonds:						
	1.1 U.S. treasury securities	4,947,407	10.789	4,947,407		4,947,407	10.789
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	37,852	0.083	37,852		37,852	0.083
	1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
	1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	79,865	0.174	79,865		79,865	0.174
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
	1.41 States, territories and possessions general obligations	2,340,169	5.103	2,340,169		2,340,169	5.103
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	1,783,664	3.890	1,783,664		1,783,664	3.890
	1.43 Revenue and assessment obligations	4,538,956	9.898	4,538,956		4,538,956	9.898
	1.44 Industrial development and similar obligations		0.000			0	0.000
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or guaranteed by GNMA	7,639	0.017	7,639		7,639	0.017
	1.512 Issued or guaranteed by FNMA and FHLMC	3,794,645	8.275	3,794,645		3,794,645	8.275
	1.513 All other		0.000			0	0.000
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	849,157	1.852	849,157		849,157	1.852
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	1,616,789	3.526	1,616,789		1,616,789	3.526
	1.523 All other		0.000			0	0.000
2.	Other debt and other fixed income securities (excluding short-term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	5,694,152	12.417	5,694,152		5,694,152	12.417
	2.2 Unaffiliated non-U.S. securities (including Canada)	2,771,262	6.043	2,771,262		2,771,262	6.043
	2.3 Affiliated securities		0.000			0	0.000
3	Equity interests:						
	3.1 Investments in mutual funds		0.000			0	0.000
	3.2 Preferred stocks:						
	3.21 Affiliated		0.000			0	0.000
	3.22 Unaffiliated		0.000			0	0.000
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated		0.000			0	0.000
	3.32 Unaffiliated		0.000			0	0.000
	3.4 Other equity securities:						
	3.41 Affiliated		0.000			0	0.000
	3.42 Unaffiliated		0.000			0	0.000
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated		0.000			0	0.000
	3.52 Unaffiliated		0.000			0	0.000
4.	Mortgage loans:						
	4.1 Construction and land development		0.000			0	0.000
	4.2 Agricultural		0.000			0	0.000
	4.3 Single family residential properties		0.000			0	0.000
	4.4 Multifamily residential properties		0.000			0	0.000
	4.5 Commercial loans		0.000			0	0.000
	4.6 Mezzanine real estate loans		0.000			0	0.000
5.	Real estate investments:						
	5.1 Property occupied by company		0.000	0		0	0.000
	5.2 Property held for production of income (including $ of property acquired in satisfaction of debt)		0.000	0		0	0.000
	5.3 Property held for sale (including $ property acquired in satisfaction of debt)		0.000	0		0	0.000
6.	Contract loans		0.000	0		0	0.000
7.	Derivatives		0.000	0		0	0.000
8.	Receivables for securities		0.000	0		0	0.000
9.	Securities Lending (Line 10, Asset Page reinvested collateral)		0.000	0	XXX	XXX	XXX
10.	Cash, cash equivalents and short-term investments	17,396,258	37.935	17,396,259		17,396,259	37.935
11	Other invested assets		0.000			0	0.000
12.	Total invested assets	45,857,815	100.000	45,857,816	0	45,857,816	100.000

OTHER ATTACHMENTS

Deloitte

Deloitte & Touche LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA
Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

April 17, 2013

To the Audit Committee of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

The Management of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

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 Midlands, Inc. (the "Company") for the years ended December 31, 2012, and 2011, and have issued our report thereon dated April 17, 2013.In connection therewith, we advise you as follows:

a. 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, and the Rules of Professional Conduct of the Connecticut State Board of Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have fifteen years and eight 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 53 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Nebraska 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 conformity with accounting practices prescribed or permitted by the Nebraska 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 about whether the statutory basis financial statements are free of material misstatement, whether caused by 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 over financial reporting as a basis for designing 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 statutory basis 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 statutory basis financial statements in conformity with accounting practices prescribed or permitted by the Nebraska 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.

d. We will retain the working papers prepared in the conduct of our audit until the Nebraska Department of Insurance has filed a Report of Examination covering 2012, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Nebraska Department of Insurance at the offices of the insurer, at our offices, at the Nebraska 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 Nebraska 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 Nebraska Department Insurance.

e. The engagement partner has served in this capacity with respect to the Company since 2010, is licensed by the Connecticut State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. 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 Midlands Inc. and for filing with the Nebraska 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

Deloitte

Deloitte & Touche LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA
Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

April 17, 2013

The Audit Committee of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

The Management of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

Dear Members of the Audit Committee and Management:

In planning and performing our audit of the statutory basis financial statements of UnitedHealthcare of the Midlands, Inc. (the "Company") as of and for the year ended December 31, 2012 (on which we have issued our report dated April 17, 2013), in accordance with auditing standards generally accepted in the United States of America, we considered the Company's internal control over financial reporting ("internal control") as a basis for designing 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 over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We did not identify any deficiencies in internal control over financial reporting that we consider to be unremediated material weaknesses as of December 31, 2012.

The definitions of a deficiency and a material weakness are set forth in the attached Appendix I.

A description of the responsibility of management for establishing and maintaining internal control over financial reporting and of the objectives of and inherent limitations of internal control over financial reporting, is set forth in the attached Appendix II and should be read in conjunction with this report.

This report is intended solely for the information and use of management, the Audit Committee, others within the organization, and 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.

Yours truly,

Deloitte & Touche LLP

DEFINITIONS

The definitions of a deficiency and a material weakness are as follows:

A deficiency in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when (a) a properly designed control does not operate as designed, or (b) the person performing the control does not possess the necessary authority or competence to perform the control effectively.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's statutory basis financial statements will not be prevented, or detected and corrected on a timely basis.

MANAGEMENT'S RESPONSIBILITY FOR, AND THE OBJECTIVES AND LIMITATIONS OF, INTERNAL CONTROL OVER FINANCIAL REPORTING

The following comments concerning management's responsibility for internal control over financial reporting and the objectives and inherent limitations of internal control over financial reporting are adapted from auditing standards generally accepted in the United States of America.

Management's Responsibility

The Company's management is responsible for the overall accuracy of the statutory basis financial statements and their conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance. In this regard, management is also responsible for establishing and maintaining effective internal control over financial reporting.

Objectives of Internal Control over Financial Reporting

Internal control over financial reporting is a process effected by those charged with governance, management, and other personnel and designed to provide reasonable assurance about the achievement of the entity's objectives with regard to reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control over the safeguarding of assets against unauthorized acquisition, use, or disposition may include controls related to financial reporting and operations objectives. Generally, controls that are relevant to an audit of statutory basis financial statements are those that pertain to the entity's objective of reliable financial reporting (i.e., the preparation of reliable statutory basis financial statements that are fairly presented in conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance).

Inherent Limitations of Internal Control over Financial Reporting

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected and corrected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

* * * * * *

UnitedHealthcare of the Midlands, Inc.

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2013 and 2012,
Supplemental Schedules as of and for the
Year Ended December 31, 2013,
Independent Auditors' Report, Qualification Letter,
and Internal Control Report

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

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Deloitte

Deloitte & Touche LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Audit Committee of UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of the Midlands, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2013 and 2012, 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 Nebraska 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 Midlands, Inc. as of December 31, 2013 and 2012, 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 Nebraska 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 Midlands, Inc. using accounting practices prescribed or permitted by the Nebraska 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 Nebraska Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2013 audit was conducted for the purpose of forming an opinion on the 2013 statutory basis financial statements as a whole. The supplemental schedule of investment risk interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2013 are presented for purposes of additional analysis and are not a required part of the 2013 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 2013 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 2013 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 Midlands, 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 22, 2014

UNITEDHEALTHCARE PLAN OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2013 AND 2012

(In thousands, except capital stock share data)

	2013	2012
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$40,550	$28,462
Cash overdrafts of ($764) and ($754), cash equivalents of $9,299 and $8,949, and short-term investments of $8,923 and $9,201 in 2013 and 2012, respectively	17,458	17,396
Subtotal cash and invested assets	58,008	45,858
OTHER ASSETS:		
Investment income due and accrued	263	221
Uncollected premiums	5,818	5,212
Amounts receivable relating to uninsured plans	185	137
Current federal income taxes recoverable	-	961
Net deferred tax asset	567	566
Health care receivable	991	782
Other assets	-	43
Subtotal other assets	7,824	7,922
TOTAL ADMITTED ASSETS	$65,832	$53,780
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$27,272	$28,152
Accrued medical incentive pool and bonus amounts	4,054	3,109
Unpaid claims adjustment expenses	380	528
Aggregate health policy reserves	318	542
Aggregate health claim reserves	151	177
Premiums received in advance	4	6
General expenses due or accrued	608	54
Current federal income taxes payable	1,223	-
Ceded reinsurance premiums payable	69	62
Remittances and items not allocated	1	-
Amounts due to parent, subsidiaries, and affiliates, net	1,181	433
Payable for securities	259	-
Liability for amounts held under uninsured plans	311	383
Other liabilities	6	3
Total liabilities	35,837	33,449
CAPITAL AND SURPLUS:		
Common capital stock, $1.00 par value — 100,000 shares authorized; 100,000 shares issued and outstanding	100	100
Gross paid-in and contributed surplus	1,100	1,100
Unassigned surplus	28,795	19,131
Total capital and surplus	29,995	20,331
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$65,832	$53,780

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012
(In thousands)

	2013	2012
REVENUES:		
Net premium income	$ 206,742	$ 187,221
Change in reserve for rate credits	225	(336)
Total revenues	206,967	186,885
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	153,105	138,873
Other professional services	1,871	1,498
Prescription drugs	4,727	4,218
University of Nebraska Medical Center Medicaid capitation	4,946	4,524
Incentive pool, withhold adjustments, and bonus amounts	3,050	2,992
Other expenses	-	7
Total hospital and medical	167,699	152,112
Claims adjustment expenses	9,620	8,901
General administrative expenses	15,978	14,013
Total underwriting deductions	193,297	175,026
NET UNDERWRITING GAIN	13,670	11,859
NET INVESTMENT GAINS:		
Net investment income earned	828	1,013
Net realized capital gains less capital gains tax of $113 and $59 in 2013 and 2012, respectively	200	219
Total net investment gains	1,028	1,232
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(3)	(4)
OTHER LOSSES	-	(25)
NET INCOME BEFORE FEDERAL INCOME TAXES	14,695	13,062
FEDERAL INCOME TAXES INCURRED	4,942	4,346
NET INCOME	$ 9,753	$ 8,716

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012
(In thousands, except capital stock share data)

	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
	Shares	Amount			
BALANCE — January 1, 2012	100,000	$ 100	$ 1,100	$ 20,436	$ 21,636
Net income	-	-	-	8,716	8,716
Change in net deferred income taxes	-	-	-	(1,309)	(1,309)
Change in nonadmitted assets	-	-	-	3,688	3,688
Dividends paid	-	-	-	(12,400)	(12,400)
BALANCE — December 31, 2012	100,000	100	1,100	19,131	20,331
Net income	-	-	-	9,753	9,753
Change in net deferred income taxes	-	-	-	1	1
Change in nonadmitted assets	-	-	-	(90)	(90)
BALANCE — December 31, 2013	100,000	$ 100	$ 1,100	$ 28,795	$ 29,995

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012
(In thousands)

	2013	2012
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 206,133	$ 187,026
Net investment income	974	1,267
Benefit and loss related payments	(168,128)	(141,736)
Operating expenses paid	(25,240)	(22,982)
Federal income taxes paid — net	(2,871)	(5,584)
Net cash provided by operations	10,868	17,991
CASH FLOWS FROM INVESTMENTS:		
Proceeds from bonds sold, matured, or repaid	8,617	12,611
Cost of bonds acquired	(20,320)	(9,701)
Net cash (used in) provided by investments	(11,703)	2,910
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Dividends paid	-	(12,400)
Cash provided (used) through net transfers from (to) affiliates	748	(340)
Other cash provided (applied)	149	(177)
Net cash provided by (used in) financing and miscellaneous activities	897	(12,917)
RECONCILIATION OF CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	62	7,984
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — Beginning of year	17,396	9,412
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — End of year	$ 17,458	$ 17,396

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization and Operation

UnitedHealthcare of the Midlands, 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"), an HMO management corporation that provides services to the Company under the terms of a management 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 April 16, 1984, as an HMO and operations commenced in August 1984. The Company is certified as an HMO by the Nebraska Department of Insurance ("the Department") and the Iowa Insurance Division. The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage ("Medicare Part D program") under a contract with the Centers for Medicare and Medicaid Services ("CMS"). Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year; these payment elements are CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share, and the CMS Coverage Gap Discount Program. Each component of the Medicare Part D program is further defined throughout Note 1.

The Company has a contract with the State of Nebraska, Department of Health and Human Services ("DHHS"), Division of Medicaid and Long Term Care, to provide health care services to Medicaid eligible beneficiaries in Nebraska. The current contract is effective through June 30, 2014, and has provision for an additional one-year extension renewal (through June 30, 2015) under the current contactual terms. The contract 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 Nebraska, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Nebraska 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.

(1–8) No significant differences exist between the practices prescribed or permitted by the State of Nebraska and those prescribed or permitted by the NAIC SAP that materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

	State of Domicile	2013	2012
Net Income			
(1) Company state basis	Nebraska	$ 9,753	$ 8,716
(2) State prescribed practices that increase (decrease) NAIC SAP: Not applicable	Nebraska	-	-
(3) State permitted practices that increase (decrease) NAIC SAP: Not applicable	Nebraska	-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	Nebraska	$ 9,753	$ 8,716
Surplus			
(5) Company state basis	Nebraska	$29,995	$20,331
(6) State prescribed practices that increase (decrease) NAIC SAP: Not applicable	Nebraska	-	-
(7) State permitted practices that increase (decrease) NAIC SAP: Not applicable	Nebraska	-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	Nebraska	$29,995	$20,331

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 includes 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, and aggregate health policy reserves and aggregate health claim reserves (collectively known as "aggregate health reserves"). 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

(1–13) 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").

The more significant differences are as follows:

- Cash overdrafts, cash equivalents, and short-term investments 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, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date;

- 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;

- Certain debt investments categorized as available for sale or held to maturity are presented at the lower of amortized cost 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 amortized cost, respectively;

- Under statutory accounting, the change to deferred tax assets and liabilities is recorded directly to unassigned surplus and deferred tax assets are subject to a valuation allowance and admissibility limitations of the assets in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets and liabilities 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 statutory accounting, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheets;

- Certain assets, including certain aged premium receivables, certain health care receivable, and prepaid expenses are considered nonadmitted assets for statutory purposes 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 sheets;

- 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;

- Cash overdrafts, cash equivalents, and short-term investments in the statutory basis statements of cash flows represent cash balances and investments with original maturities of one year or less from the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and cash equivalents with maturities of three months or less. The corresponding caption of short-term investments under GAAP represents securities with a final maturity of one year or less from the balance sheet date. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Cash and Invested Assets —

- Cash overdrafts and cash equivalents represent cash held by the Company in disbursement accounts and treasury bills. Claims and other payments are made from the disbursement accounts daily. Cash overdrafts are a result of timing differences in funding disbursement accounts for claims payments. Cash equivalents have original maturity dates of three months or less from the date of acquisition and are reported at cost or amortized cost depending on the nature of the underlying security, which approximates fair value;

- Short-term investments represent money market instruments, with a maturity of greater than three months but less than one year at the time of purchase. Short-term investments also consist of the Company's share of an investment pool sponsored and administered by

UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or amortized cost. Interest income from the pool accrues daily to participating members based upon ownership percentage;

- Bonds include corporate debt securities, U.S. government and state agency obligations, and municipal securities with a maturity of greater than one year at the time of purchase;

- Bonds and short-term investments are stated at amortized cost if they meet NAIC designation of one or two and stated at the lower of amortized cost or fair value if they meet an NAIC designation of three or higher. Amortization of bond premium or discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the Securities Valuation Office of the NAIC ("SVO") in accordance with the NAIC Valuations of Securities manual prepared by the SVO or an external pricing service;

- The Company holds no mortgage loans on real estate;

- Corporate bonds and government obligations include mortgage-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of mortgage-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 and total investments in mortgage-backed securities to 30% of total cash and invested assets;

- The Company holds no common or preferred stock;

- The Company holds no investments in subsidiaries, controlled, or affiliated entities;

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

- The Company holds no derivatives;

- 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 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 gains less capital gains tax in the statutory basis statements of operations. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for mortgage-backed securities for periods subsequent to the loss recognition. The Company has not recorded any other-than-temporary impairments for the years ended December 31, 2013 and 2012.

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 amounts determined to be uncollectible are written off in the period in which the determination is made.

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).

Properties Occupied by the Company, Properties Held for the Production of Income, Properties Held for Sale, Furniture and Equipment, and Electronic Data Processing Equipment and Software — The Company does not carry any fixed assets on the statutory basis financial statements.

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 as due to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

University of Nebraska Medical Medicaid Capitation Program — The State of Nebraska DHHS, and the Company have a contract for the purposes of increasing reimbursement for Medicaid eligible services to the Company, which in turn is required to be passed through to the University of Nebraska Medical Center ("UNMC"). The program was approved by the CMS pursuant to Nebraska Medicaid Reform to develop a physician upper limit program that provides higher reimbursement to designated physician groups. The Company will pass-through 100% of the UNMC supplemental capitation payment received from the State of Nebraska DHHS.

In 2013 and 2012, the Company recorded $4,946 and $4,524, respectively, as net premium income for these payments with a corresponding offset of $4,946 and $4,524, respectively, reflected as Medicaid UNMC capitation as a component of total hospital and medical in the accompanying statutory basis statements of operations. The Company did not realize any underwriting gains or losses resulting from the arrangement. The Company also recorded a liability in claims unpaid of $2,453 and $2,487 as a result of this arrangement in the accompanying statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2013 and 2012, respectively.

Hospital and Medical Expenses, Claims Unpaid, and Aggregate Health Reserves — Hospital and medical expenses and corresponding liabilities 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.

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 2013 and 2012. Management believes the amount of claims unpaid and aggregate health reserves is adequate to cover the Company's liability for unpaid claims and aggregate health reserves as of December 31, 2013; however, actual payments may differ from those established estimates. Adjustments to claims unpaid estimates and aggregate health reserves are reflected in the statutory basis statement of operations in the period in which the change in estimate is identified.

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.

Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held under Uninsured Plans — Receivables and liabilities for amounts held under uninsured plans represent the cost reimbursement under the Medicare Part D program for the catastrophic reinsurance subsidy and the low-income member cost-sharing subsidy. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. The Patient Protection and Affordable Care Act and its related reconciliation act ("Health Reform Legislation") mandate consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap ("Coverage Gap Discount Program" or "CGDP"). These discounts are pre-funded by CMS, and ultimately reimbursed by pharmaceutical manufacturers. The Company solely administers the application of these funds and has no insurance risk. If the Company incurs costs either in excess of or less than these subsidies, a corresponding receivable or payable is recorded in amounts receivable relating to uninsured plans or liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Related cash flows are presented within operating expenses paid within cash provided by operations in the statutory basis statements of cash flows.

Net Deferred Tax Asset and Federal Income Taxes Incurred — Statutory accounting provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets and liabilities, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 35% to net income before federal income taxes plus capital gains tax subject to certain adjustments (see Note 9).

Remittances and Items Not Allocated — Remittances and items not allocated generally represent monies received from policyholders for monthly premium billings that have not been entered into the billing system. The majority is from monies received in the lockbox account on the last day of the year.

Claims Adjustment Expenses — Claims adjustment expenses ("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 management agreement (see Note 10), the Company pays a management fee to 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 claims adjustment expenses

and general administrative expenses to be reported in the statutory basis statement 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 claims adjustment expenses associated with incurred but unpaid claims, which is included in unpaid claims adjustment expenses in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid claims adjustment expenses as of December 31, 2013 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 claims adjustment expenses are reflected in operating results in the period in which the change in estimate is identified.

General Administrative Expenses — Pursuant to the terms of the management 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 management agreement are directly expensed as incurred. State income taxes are also a component of general administrative expenses. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between claims adjustment expenses and general administrative expenses to be reported in the statutory basis statements of operations.

Revenues, Premiums Received in Advance, Uncollected Premiums — 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. Premiums received in full during the current period that are not due until future periods are recorded as premiums received in advance in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

Net premium income includes the Medicare Advantage CMS premium, and the premium under the Medicare Part D program, which includes, CMS premium, member premium, and 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 estimates retrospective premium adjustments based on guidelines determined by CMS (see Note 24).

CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. 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. The estimated risk-adjusted payments due to the Company at December 31, 2013 and 2012, were $664 and $321, respectively, and are recorded as uncollected premiums in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recognized ($344) and $228 for changes in prior year Medicare risk factor estimates during the years ended December 31, 2013 and 2012, respectively, which is recorded as an (increase) reduction to net premium income within the statutory basis statements of operations.

Net premium income also includes amounts paid by state and federal governments per member in exchange for the provision and administration of medical benefits under the Medicaid and/or Comprehensive Health Insurance Pool 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, home nursing risk-sharing payments, high dollar risk pool 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. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

The Company reports uncollected premium balances from its insured members as uncollected premiums 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.

Reinsurance Ceded — The Company has an insolvency-only reinsurance agreement. Reinsurance premiums paid and incurred are deducted from net premium income in the accompanying statutory basis financial statements.

Ceded Reinsurance Premiums Payable — The Company has an insolvency-only reinsurance agreement whereby 0.4% of net premium income is ceded to UnitedHealthcare Insurance Company ("UHIC"). The ceded reinsurance premiums payable balance represents amounts due to the reinsurer for coverage which will be paid based on the contract terms.

Incentive Pool — 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 or deficits 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, and the corresponding expense or reduction to expense is included in incentive pool, withhold adjustments, and bonus amounts in the statutory basis statements of operations.

Medical Risk Share — Medicare Part D — The Company has settlements with CMS based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare Part D program regional plan varies more than 5% above or below the level estimated in the original bid submitted by the Company and approved by CMS in 2013 and 2012. The estimated risk share adjustment of $318 and $542 in 2013 and 2012, respectively, is recorded as a decrease to change in reserve for rate credits in the statutory basis statements of operations and aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

Health Care Receivable — Health care receivable consists of pharmacy rebate receivables estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's unaffiliated pharmaceutical benefit manager and affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivable also includes receivables for amounts due to the Company for claim overpayments to providers, hospitals and other health care provider organizations and provider advance. Health care receivables are considered nonadmitted assets for statutory purposes 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).

Premium Deficiency Reserves — Premium deficiency reserves and the related expenses are recognized when it is probable that expected future health care expenses, claim adjustment expenses, 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 methods for making such estimates and for establishing the resulting reserves are periodically reviewed and updated, and any adjustments are reflected in increase in reserves for accident and health contracts in the accompanying statutory basis statements of operations in the period in which the change in estimate is identified. The Company anticipates investment income as a factor in the premium deficiency calculation (see Note 30).

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.

Direct premiums written and uncollected premiums from members and CMS related to Medicare Advantage and the Medicare Part D program as a percentage of total direct premiums written and total uncollected premiums are 27% and 12% as of December 31, 2013 and 26% and 7% as of December 31, 2012, respectively.

Direct premiums written and uncollected premiums from the State of Nebraska, DHHS, as a percentage of total direct premiums written and total uncollected premiums are 73% and 88% as of December 31, 2013 and 74% and 93% as of December 31, 2012, respectively.

Restricted Cash Reserves — The Department requires the Company to maintain a minimum regulatory deposit (currently $300). The Company is in compliance with this requirement as of December 31, 2013 and 2012. This restricted cash reserve consists principally of government obligations and is stated at amortized cost, which approximates fair value. This reserve is included in bonds in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus. Interest earned on this reserve accrues to the Company. The Iowa Department of Insurance has waived the requirement to maintain restricted cash reserves since 2003.

Minimum Capital and Surplus — Under the laws of the State of Nebraska, the Department requires the Company to maintain a minimum capital and surplus equal to the greatest of $1,000 or 2% of the first $150,000 of annual premium revenue and 1% of annual premium revenue over $150,000. The minimum capital and surplus requirement based on total revenue is $3,570 and $3,369, for December 31, 2013 and 2012, respectively. The Company has $29,995 and $20,331 in total statutory basis capital and surplus as of December 31, 2013 and 2012, respectively, which is in compliance with the required amount.

Risk-based capital ("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.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2012 and 2013 that has been adopted for 2013 or subsequent year's implementation and has determined that none of the items would have a significant impact to the statutory basis financial statements.

2. ACCOUNTING CHANGES AND CORRECTION OF ERRORS

No changes in accounting principles have been recorded during the years ended December 31, 2013 and 2012.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2013 and 2012, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

(1–5) The Company did not discontinue any operations during 2013 and 2012.

5. INVESTMENTS AND OTHER INVESTED ASSETS

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 investments for bonds were $330 and ($17), respectively, for 2013 and $287 and ($9), respectively, for 2012. The Company has not recorded any gains or losses on the sale of investments for short-term investments for 2013 and 2012. The net realized gain is included in net realized capital gains less capital gains tax in the accompanying statutory basis statements of operations. Total proceeds on the sale of investments for bonds were $4,131 and $5,125 and for short-term investments were $236,113 and $202,692 in 2013 and 2012, respectively.

As of December 31, 2013 and 2012, the amortized cost, fair value, and gross unrealized holding gains and losses of the Company's investments, excluding cash overdrafts and cash equivalents of $8,535 and $8,195, respectively, are as follows:

	2013				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 year	Gross Unrealized Holding Losses > 1 year	Fair Value
U.S. government and agency securities	$17,193	$ 76	$(255)	$ -	$17,014
State and agency municipalities	6,776	161	(150)	-	6,787
City and county municipalities	4,027	128	(51)	-	4,104
Corporate debt securities (includes commercial paper)	12,554	197	(80)	(26)	12,645
Money-market funds	8,923	-	-	-	8,923
Total bonds and short-term investments	$49,473	$562	$(536)	$(26)	$49,473

	2013				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 year	Gross Unrealized Holding Losses > 1 year	Fair Value
Less than one year	$11,312	$ 13	$ -	$ -	$11,325
One to five years	20,112	212	(95)	-	20,229
Five to ten years	8,413	210	(213)	(26)	8,384
Over ten years	9,636	127	(228)	-	9,535
Total bonds and short-term investments	$49,473	$562	$(536)	$(26)	$49,473

	2012				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 year	Gross Unrealized Holding Losses > 1 year	Fair Value
U.S. government and agency securities	$ 9,599	$ 282	$ -	$ -	$ 9,881
State and agency municipalities	6,361	487	-	-	6,848
City and county municipalities	2,302	244	-	-	2,546
Corporate debt securities (includes commercial paper)	10,200	458	(3)	-	10,655
Money-market funds	9,201	-	-	-	9,201
Total bonds and short-term investments	$37,663	$1,471	$ (3)	$ -	$39,131

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-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 an amortized cost of $6,523 and fair value of $6,573.

The following table illustrates the fair value and gross unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrealized loss position as of December 31, 2013 and 2012:

	2013					
	< 1 year		> 1 year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
U.S. government and agency securities	$ 13,432	$(255)	$ -	$ -	$ 13,432	$(255)
State and agency municipalities	1,345	(150)	-	-	1,345	(150)
City and county municipalities	1,953	(51)	-	-	1,953	(51)
Corporate debt securities (includes commercial paper)	5,487	(80)	273	(26)	5,760	(106)
Total bonds and short-term investments	$ 22,217	$(536)	$273	$ (26)	$ 22,490	$(562)

	2012					
	< 1 year		> 1 year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
Corporate debt securities (includes commercial paper)	$ 296	$ (3)	$ -	$ -	$ 296	$ (3)
Total bonds and short-term investments	$ 296	$ (3)	$ -	$ -	$ 296	$ (3)

The unrealized losses on investments in U.S. government and agency securities, state and agency municipalities, city and county municipalities, and corporate debt securities at December 31, 2013 and 2012, were mainly caused by interest rate increases 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 amortized cost. The contractual cash flows of the U.S. government and agency obligations are either guaranteed 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 evaluated the credit ratings of the municipalities and local agency obligations and corporate obligations, 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 mortgage-backed securities for a period of time sufficient to recover the amortized cost. As a result of this review, no other-than-temporary impairments were recorded by the company as of December 31, 2013 and 2012.

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) Corporate bonds and government obligations include mortgage-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of mortgage-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 mortgage-backed securities as of December 31, 2013 and 2012.

(3) The Company did not have mortgage-backed securities with an OTTI to report by CUSIP as of December 31, 2013 or 2012.

(4) The Company does not have any mortgage-backed securities in a continuous unrealized loss position at December 31, 2012. The following table illustrates the fair value, gross unrealized losses, and length of time that the mortgage-backed securities have been in a continuous unrealized loss position as of December 31, 2013:

	2013
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ (97)
2. 12 months or longer	-
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	4,969
2. 12 months or longer	-

(5) The Company believes that it will collect all principal and interest due on all investments that have an amortized cost in excess of fair value. The unrealized losses as of December 31, 2013 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities.

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

F. **Real Estate** — Not applicable.

G. **Low-Income Housing Tax Credits** — Not applicable.

H. Restricted Assets

(1) Restricted assets — including pledged as of December 31, 2013 and 2012:

Restricted Asset Category	1 Total Gross Restricted from Current Year	2 Total Gross Restricted from Prior Year	3 Increase (Decrease) (1 minus 2)	4 Total Current Year Admitted Restricted	5 Percentage Gross Restricted to Total Assets	6 Percentage Admitted Restricted to Total Admitted Assets
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	-	-	-	-	-	-
i. On deposit with state	333	344	(11)	333	1	1
j. On deposit with other regulatory bodies	-	-	-	-	-	-
k. Pledged as collateral not captured in other categories	-	-	-	-	-	-
l. Other restricted assets	-	-	-	-	-	-
m. Total restricted assets	$333	$344	$(11)	$333	1 %	1 %

(2–3) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2013 or 2012.

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 has admitted all investment income due and accrued in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

The components of net investment income earned as of December 31, 2013 and 2012 are as follows:

	2013	2012
Bonds	$ 824	$ 991
Cash overdrafts, cash equivalents, and short-term investments	38	54
Total investment income earned	862	1,045
Expenses — investment management fees	(34)	(32)
Net investment income earned	$ 828	$ 1,013

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

8. DERIVATIVE INSTRUMENTS

A–F. 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, 2013 and 2012, are as follows:

	2013			2012			Change		
	1	2	3	4	5	6	7	8	9
	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) Gross deferred tax assets	$575	$ -	$575	$577	$ 3	$580	$ (2)	$ (3)	$ (5)
(b) Statutory valuation allowance adjustments	-	-	-	-	3	3	-	(3)	(3)
(c) Adjusted gross deferred tax assets (1a - 1b)	575	-	575	577	-	577	(2)	-	(2)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	575	-	575	577	-	577	(2)	-	(2)
(f) Deferred tax liabilities	8	-	8	11	-	11	(3)	-	(3)
(g) Net admitted deferred tax asset (net deferred tax liability) (1e - 1f)	$567	$ -	$567	$566	$ -	$566	$ 1	$ -	$ 1

(2) The components of the adjusted gross deferred tax assets admissibility calculation under Statement of Statutory Accounting Principles ("SSAP") No. 101, *Income Taxes — A Replacement of SSAP No. 10R and SSAP No. 10*, are as follows:

	2013			2012			Change		
	1	2	3	4	5	6			
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	$575	$ -	$ 575	$577	$ -	$ 577	$ (2)	$ -	$ (2)
(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	4,414	XXX	XXX	2,965	XXX	XXX	1,449
(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))	$575	$ -	$ 575	$577	$ -	$ 577	$ (2)	$ -	$ (2)

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

	2013	2012
(a) Ratio percentage used to determine recovery period and threshold limitation amount	438 %	326 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above (in thousands)	$29,428	$19,765

(4) There was no impact to the deferred tax assets as a result of tax-planning strategies.

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred for the years ended December 31, 2013 and 2012 are as follows:

	1 2013	2 2012	3 (Col 1 - 2) Change
1. Current income tax:			
(a) Federal	$4,942	$4,346	$596
(b) Foreign	-	-	-
(c) Subtotal	4,942	4,346	596
(d) Federal income tax on net capital gains	113	59	54
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$5,055	$4,405	$650

(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, 2013 and 2012, are as follows:

	1 2013	2 2012	3 (Col 1 - 2) Change
2. Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$119	$158	$(39)
(2) Unearned premium reserve	-	1	(1)
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	456	418	38
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	-	-	-
(99) Subtotal	575	577	(2)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	575	577	(2)
(e) Capital:			
(1) Investments	-	3	(3)
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	-	3	(3)
(f) Statutory valuation allowance adjustment	-	3	(3)
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	575	577	(2)
3. Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	8	11	(3)
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities	-	-	-
(99) Subtotal	8	11	(3)
(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)	8	11	(3)
4. Net deferred tax assets/liabilities (2i - 3c)	$567	$566	$ 1

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance of $0 and $3 to reduce the gross deferred tax asset to $575 and $577 as of December 31, 2013 and 2012, respectively, which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses and/or expectations for future taxable income.

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 35% to net income before federal income taxes. The significant items causing this difference are as follows:

	2013	2012
Tax provision at the federal statutory rate	$5,183	$4,593
Tax-exempt interest	(94)	(110)
Change in statutory valuation allowance	(3)	(68)
IRS exam interest	-	-
Other	-	8
Tax effect of nonadmitted assets	(32)	1,291
Total statutory income taxes	$5,054	$5,714
Federal income taxes incurred	$4,942	$4,346
Capital gains tax	113	59
Change in net deferred income tax	(1)	1,309
Total statutory income taxes	$5,054	$5,714

E. At December 31, 2013, the Company had no net operating loss carryforwards.

Current federal income taxes payable (recoverable) of $1,223 and ($961) as of December 31, 2013 and 2012, respectively, are included in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $2,871 and $5,584 in 2013 and 2012, respectively.

Federal income taxes incurred of $5,055 and $4,405 for 2013 and 2012, 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 Code ("IRS").

F. The Company is included in a consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in 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 IRS has completed exams on UnitedHealth Group's consolidated income tax returns for fiscal years 2012 and prior. UnitedHealth Group's 2013 tax return is under advance 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 2008 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

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

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–L. Material Related Party Transactions

Pursuant to the terms of a Management Agreement (the "Agreement") UHS will provide management services to the Company under a fee structure, which is based on a direct charge representing UHS' expenses for services or use of assets provided to the Company. Management fees under this arrangement totaled $20,701 and $19,049 in 2013 and 2012, respectively, and are included in general administrative expenses and claims adjustment expenses in the accompanying statutory basis statements of operations. Direct expenses not included in the management agreement, such as broker commissions, Department of Insurance ("DOI") exam fees, and premium taxes, are paid by UHS on behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

Management believes that its 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.

The Company expensed as hospital and medical expenses, general administrative expenses, and claims adjustment expenses $2,077 and $1,467 in capitation fees to related parties during 2013 and 2012, respectively. Under the Agreement effective for January 2011, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a per member per month ("PMPM") basis (where the charge incurred by UHS is on a PMPM basis) or using another allocation methodology consistent with the Agreement. These services include, but are not limited to, integrated personal health management solutions, such as disease management, treatment decision support, and wellness services, including a 24-hour call-in service, access to a network of transplant providers, and discount program services. OptumHealth Care Solutions, Inc. provides chiropractic and physical therapy services. Spectera, Inc. provides administrative services related to vision benefit management and claims processing. Dental Benefit Providers, Inc., provides dental care assistance. United Behavioral Health provides mental health and substance abuse services.

The capitation expenses, administrative services, and access fees paid to related parties, that are included as hospital and medical expenses, general administrative expenses, and claims adjustment expenses in the accompanying statutory basis statements of operations for the years ended December 31, 2013 and 2012, are shown below:

	2013	2012
UHS	$1,320	$ 979
United Behavioral Health	452	263
OptumHealth Care Solutions, Inc.	71	70
Dental Benefit Providers, Inc.	125	68
Spectera, Inc.	109	87
Total	$2,077	$1,467

The Company contracts with affiliates (UHS and OptumRx) to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees. Fees related to these agreements, which are calculated on a per-claim basis, of ($59) and $262 in 2013 and 2012, respectively, are included in general administrative expenses and claims adjustment expenses in the accompanying statutory basis statements of operations.

The Company has an agreement with OptumInsight, Inc., an affiliate of the Company, for services that lead up to and include the prevention and recovery of medical expense overpayments. Service fees are either percentages of every recovery that are retained by OptumInsight, Inc. based on the services performed and recoveries, net of fees, are returned to the Company on a monthly basis and/or all recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis and a capitated service fee is charged to the Company as a PMPM. Service fees of $1,044 and $527 are included in hospital and medical expenses, claims adjustment expenses, and general administrative expenses in the accompanying statutory basis statements of operations for the years ended December 31, 2013 and 2012, respectively.

The Company has premium payments that are received and claim payments that are processed by an affiliated UnitedHealth Group entity. Both 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 amounts due to parent, subsidiaries, and affiliates, net, in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has an insolvency-only reinsurance agreement with UHIC, an affiliate of the Company, to provide insolvency protection for its enrollees. Reinsurance premiums, which are calculated on a percentage of member premium income, of $811 and $732 in 2013 and 2012, respectively, are netted against net premium income in the accompanying statutory basis statements of operations.

The Company holds a $10,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of LIBOR 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 aggregate principal amount that may be outstanding at any time shall not exceed $10,000. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective June 1, 2013. No amounts were outstanding under the line of credit as of December 31, 2013 and 2012.

At December 31, 2013 and 2012, the Company reported $1,181 and $433, respectively, as amounts due to parent, subsidiaries, and affiliates, net, 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.

In addition to the agreements above, UHS maintains a private short-term money market investment pool in which affiliated companies may participate (see Note 1). At December 31, 2013 and 2012, the Company's portion was $7,323 and $6,509, respectively, and is included in cash overdrafts, cash equivalents, and short-term investments in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has entered into a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $0 and $12,400 in 2013 and 2012, respectively, to its parent (see Note 13).

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

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

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

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

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

11. DEBT

A–B. The Company had no outstanding debt with third parties or outstanding federal home loan bank agreements during 2013 and 2012.

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, and 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 a management agreement (see Note 10).

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

(1–2) The Company has 100,000 shares authorized and 100,000 shares 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.

(3) Payment of dividends may be restricted by the Department and Nebraska law, which generally requires that dividends be paid out of unassigned surplus.

(4) The Company paid no dividends or received any infusions during 2013. The Company paid an ordinary cash dividend to UHC of $6,400 on September 11, 2012, which required no approval and was recorded as a reduction to unassigned surplus in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company paid an extraordinary cash dividend of $6,000 on December 12, 2012, to UHC, which was approved by the Department and recorded as a reduction to unassigned surplus in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus.

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

(6) There are no restrictions placed on the Company's unassigned surplus.

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

(8) 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.

(9) The Company does not have any special surplus funds.

(10) The portion of unassigned surplus represented or (reduced by) each item below is as follows:

	2013	2012	Change
Net deferred income taxes	$ 567	$ 566	$ 1
Nonadmitted assets	(1,302)	(1,212)	(90)
Total	$ (735)	$ (646)	$ (89)

(11–13) The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. CONTINGENCIES

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any assessments, 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. **All Other Contingences**

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 accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

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, and 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. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

RADV Audit — CMS adjusts 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. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

CMS and the Office of Inspector General for Health and Human Services periodically perform RADV audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to the Company, fines, corrective action plans or other adverse action by CMS.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

Health Reform Legislation and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's statutory basis results of operations, financial condition, and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

There are no assets that the Company considers to be impaired at December 31, 2013 and 2012, except as disclosed in Note 5 and Note 20.

F. The Company routinely evaluates the collectability of all receivable amounts included within 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.

15. LEASES

A–B. According to the management 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 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 Contract in 2013 and 2012.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a payable of $238 and $159 at December 31, 2013 and 2012, respectively, for cost reimbursements under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies as described in Note 1, *Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans*. The Company also recorded a receivable of $185 and $137 and also a payable of $73 and $224 at December 31, 2013 and 2012, respectively, for the Medicare Part D Coverage Gap Discount Program as described in Note 1, *Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans*.

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.

20. FAIR VALUE MEASUREMENT

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 short-term investments 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

(1–5) The Company does not have any financial assets that are measured and reported at fair value on the statutory basis statements of admitted assets, liabilities, and capital and surplus at December 31, 2013 and 2012.

B. Fair Value Combination — Not applicable.

C. The aggregate fair value by hierarchy of all financial instruments as of December 31, 2013 and 2012 is presented in the table below:

	2013					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practical Carrying Value
U.S. government and agency securities	$17,014	$17,193	$11,614	$ 5,400	$ -	$ -
State and agency municipalities	6,787	6,776	-	6,787	-	-
City and county municipalities	4,104	4,027	-	4,104	-	-
Corporate debt securities	12,645	12,554	-	12,645	-	-
Money-market funds	8,923	8,923	8,923	-	-	-
Total bonds and short-term investments	$49,473	$49,473	$20,537	$28,936	$ -	$ -

	2012					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practical Carrying Value
U.S. government and agency securities	$ 9,882	$ 9,599	$ 5,042	$ 4,840	$ -	$ -
State and agency municipalities	6,848	6,361	-	6,848	-	-
City and county municipalities	2,545	2,302	-	2,545	-	-
Corporate debt securities	10,655	10,200	-	10,655	-	-
Money-market funds	9,201	9,201	9,201	-	-	-
Total bonds and short-term investments	$39,131	$37,663	$14,243	$24,888	$ -	$ -

Included as Level 1 in U.S. government and agency securities in the fair value hierarchy table above are U.S. Treasury securities of $11,614 and $5,042 as of December 31, 2013 and 2012, respectively. These instruments are reflected in short-term investments and bonds in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

There is no commercial paper included in corporate debt securities in the fair value hierarchy table as of December 31, 2013 and 2012.

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

21. OTHER ITEMS

The Company elected to use rounding in reporting amounts in the notes to statutory basis financial statements.

Effective for calendar years 2013 and 2014 the Patient Protection and Affordable Care Act (ACA) has mandated that certain practicing primary care physicians ("PCPs") are eligible to receive increased payments for specified primary care services provided to Medicaid eligible individuals. This is to encourage PCPs to serve the Medicaid population in advance of the Medicaid expansion in 2014.

ACA requires that the managed care organizations ("MCO's") reimburse PCPs at a rate of no less than 100 percent of Medicare fee schedule rates for specified services. The federal government will finance the difference between the state Medicaid fee schedule rate and the corresponding Medicare fee schedule rate (enhanced rate payment) during calendar years 2013 and 2014. The state will in turn fund the enhanced rate payments to the MCO's as part of an enhanced Medicaid capitation monthly premium or as a lump sum payment of the rate differential, depending on the model selected by each state and approved by CMS.

A. The Company did not encounter any extraordinary items for the years ended December 31, 2013 or 2012.

B. The Company has no troubled debt restructurings as of December 31, 2013 or 2012.

C. 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.

D. The Company has not received any business interruption insurance recoveries during 2013 and 2012.

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

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in asset-backed securities, which includes the 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 are rated NAIC rating of 1 or 2.

(2) The Company has no direct exposure through investments in subprime mortgage loans.

(3) Direct exposure through other investments is as follows:

	2013			
	Actual Cost	Book/Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$170	$181	$229	$ -
b. Commercial mortgage-backed securities	-	-	-	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$170	$181	$229	$ -

	2012			
	Actual Cost	Book/Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$ 196	$ 206	$ 274	$ -
b. Commercial mortgage-backed securities	1,340	1,350	1,409	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$1,536	$1,556	$1,683	$ -

The Company changed its presentation in 2013 to only include securities that have sub-prime risk exposure. In 2012, the Company also included modeled commercial mortgaged-backed securities.

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

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

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

22. SUBSEQUENT EVENTS

TYPE I — Recognized Subsequent Events:

Subsequent events have been evaluated through April 22, 2014, which is the date these statutory basis financial statements were available for issuance.

There are no events subsequent to December 31, 2013, that require disclosure.

TYPE II — Nonrecognized Subsequent Events:

Subsequent events have been evaluated through April 22, 2014, which is the date these statutory basis financial statements were available for issuance.

On January 1, 2014, the Company will be subject to an annual fee under section 9010 of the Affordable Care Act ("ACA"). This annual fee will be 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, 2014. As of December 31, 2013, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2014, and estimates their portion of the annual health insurance industry fee to payable on September 30, 2014 to be $3,029. The Company's Authorized Control Level RBC ("ACL RBC") ratio was 446% as of December 31, 2013. If the ACA assessment was recognized as a liability as of December 31, 2013, the ACL RBC ratio would have been 401%.

There are no other events subsequent to December 31, 2013 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 reinsurers (see Note 10). The Company remains primarily liable as the direct insurer on all risks reinsured.

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, 2013.

(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 2013 and 2012, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2013 or 2012.

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

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 from the Company are recorded in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserves for rate credits or net premium income in the statutory basis statements of operations.

C. The Company has Medicare Part D program business which is subject to a retrospective rating 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 Part D direct premiums written subject to retrospective rating was $3,898 and $3,652 representing 2.0% and 2.0% of total direct premiums written for 2013 and 2012, respectively.

D. Pursuant to the Health Reform Legislation, the Company does not have any business subject to specific minimum loss ratio requirements as of December 31, 2013 and December 31, 2012 (see Note 14).

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the accompanying statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in the claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, and health care receivable for 2013 and 2012:

	2013		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (31,438)	$ (31,438)
Paid claims, net of health care receivable*	142,720	25,408	168,128
End of year claim reserve	29,717	1,760	31,477
Incurred claims excluding the change in health care receivable	172,437	(4,270)	168,167
Beginning of year health care receivable, excluding provider advances	-	1,776	1,776
End of year health care receivable, excluding provider advances	(1,768)	(476)	(2,244)
Total incurred claims	$ 170,669	$ (2,970)	$ 167,699

*Health care receivable excludes advances to providers of $31

	2012		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (24,537)	$ (24,537)
Paid claims, net of health care receivable*	127,083	14,653	141,736
End of year claim reserve	30,611	827	31,438
Incurred claims excluding the change in health care receivable	157,694	(9,057)	148,637
Beginning of year health care receivable, excluding provider advances	-	5,251	5,251
End of year health care receivable, excluding provider advances	(938)	(838)	(1,776)
Total incurred claims	$ 156,756	$ (4,644)	$ 152,112

*Health care receivable excludes advances to providers of $175

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, and health care receivable as of December 31, 2012 were $29,662. As of December 31, 2013, $25,408 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of healthcare receivable, excluding provider loans and advances are $1,284 as a result of re-estimation of unpaid claims. Therefore, there has been $2,970 favorable prior year development since December 31, 2012 to December 31, 2013. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $2,184 and by favorable development of $1,450 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, offset by unfavorable retroactivity of $434 for increase in provider settlement reserves. At December 31, 2012, the Company recorded $4,644 of favorable development as a result of a change in the provision for adverse deviations in experience of $1,523 and favorable development of $3,194 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. Original estimates are increased or decreased, as additional information becomes known regarding individual claims. Included in this favorable development is the impact related to retrospectively rated policies. 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 unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

The Company incurred claims adjustment expenses of $9,620 and $8,901 in 2013 and 2012, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of its management agreement (see Note 10). The following tables disclose paid CAE, incurred CAE, and the balance in the unpaid claim adjustment expenses reserve for 2013 and 2012:

	2013	2012
Total claims adjustment expenses incurred	$9,620	$8,901
Less current year unpaid claims adjustment expenses	(380)	(528)
Add prior year unpaid claims adjustment expenses	528	415
Total claims adjustment expenses paid	$9,768	$8,788

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2013 or 2012.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2013 or 2012.

28. HEALTH CARE AND OTHER AMOUNTS RECEIVABLE

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the pharmaceutical benefit manager in accordance with pharmacy 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 non-admitted all pharmacy rebate receivables that do not meet the admissibility criteria 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, the 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
12/31/2013	$ 591	$ -	$ -	$ -	$ -
9/30/2013	556	483	296	-	-
6/30/2013	460	455	375	66	-
3/31/2013	428	429	341	77	12
12/31/2012	384	379	327	40	11
9/30/2012	374	372	332	38	2
6/30/2012	352	356	308	31	16
3/31/2012	352	355	317	28	10
12/31/2011	297	307	267	36	3
9/30/2011	311	311	279	27	6
6/30/2011	307	304	280	21	4
3/31/2011	295	298	281	14	4

Of the amount reported as health care receivable, $812 and $504 relates to pharmaceutical rebate receivables, $149 and $266 related to claim overpayment receivables, and $29 and $12 relates to provider advance receivables as of December 31, 2013 and 2012, respectively. The increase in pharmaceutical rebate receivables is primarily due to increased membership along with the change in generic/name brand mix.

The Company nonadmitted $36 and $23 related to pharmaceutical rebate receivables, $1,246 and $983 related to claim overpayment receivables, and $2 and $163 related to provider advance receivables as of December 31, 2013 and 2012, respectively.

B. The Company does not have any risk-sharing receivables.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2013 or 2012.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any premium deficiency reserves as of December 31, 2013 or 2012. This analysis of the premium deficiency reserve was completed as of December 31, 2013 and 2012. The Company did consider anticipated investment income when calculating the premium deficiency reserve.

The following table summarizes the Company's premium deficiency reserves as of December 31, 2013 and 2012:

	2013
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2013
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2012
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2012
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2013 and 2012, 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, 2013
(To Be Filed by April 1)

Of The UnitedHealthcare of the Midlands, Inc.

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

NAIC Group Code 0707 NAIC Company Code 95591 Federal Employer's Identification Number (FEIN) 47-0676824

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. $ 65,832,302.00

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	UHC Liquidity Pool	Bonds	$	7,322,812.00	11.1 %
2.02	FNMA	Bonds	$	3,762,473.00	5.7 %
2.03	FHLMC	Bonds	$	1,478,706.00	2.2 %
2.04	VIRGINIA ST PUBL	Bonds	$	965,362.00	1.5 %
2.05	LA CA Cnty Colg	Bonds	$	920,137.00	1.4 %
2.06	WI St	Bonds	$	802,447.00	1.2 %
2.07	Southern MN Mun Pwr Agy	Bonds	$	734,571.00	1.1 %
2.08	CO Dept of Trans	Bonds	$	706,867.00	1.1 %
2.09	OK St Turnpike Auth	Bonds	$	658,764.00	1.0 %
2.10	MI St Bldg Auth	Bonds	$	583,234.00	0.9 %

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	$	56,863,516.00	86.4 %	3.07	P/RP-1	$	0.00	0.0 %
3.02	NAIC-2	$	1,908,217.00	2.9 %	3.08	P/RP-2	$	0.00	0.0 %
3.03	NAIC-3	$	0.00	0.0 %	3.09	P/RP-3	$	0.00	0.0 %
3.04	NAIC-4	$	0.00	0.0 %	3.10	P/RP-4	$	0.00	0.0 %
3.05	NAIC-5	$	0.00	0.0 %	3.11	P/RP-5	$	0.00	0.0 %
3.06	NAIC-6	$	0.00	0.0 %	3.12	P/RP-6	$	0.00	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	$	2,225,514.00	3.4 %
4.03	Foreign-currency-denominated investments	$	0.00	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$	0.00	0.0 %

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

			1	2
5.01	Countries designated NAIC-1	$	2,225,514.00	3.4 %
5.02	Countries designated NAIC-2	$	0.00	0.0 %
5.03	Countries designated NAIC-3 or below	$	0.00	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: United Kingdom	$	604,464.00	0.9 %
6.02	Country 2: Japan	$	532,980.00	0.8 %
	Countries designated NAIC - 2:			
6.03	Country 1:	$	0.00	0.0 %
6.04	Country 2:	$	0.00	0.0 %
	Countries designated NAIC - 3 or below:			
6.05	Country 1:	$	0.00	0.0 %
6.06	Country 2:	$	0.00	0.0 %

			1	2
7.	Aggregate unhedged foreign currency exposure	$	0.00	0.0 %

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

			1	2
8.01	Countries designated NAIC-1	$	0.00	0.0 %
8.02	Countries designated NAIC-2	$	0.00	0.0 %
8.03	Countries designated NAIC-3 or below	$	0.00	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:	$	0.00	0.0 %
9.02	Country 2:	$	0.00	0.0 %
	Countries designated NAIC - 2:			
9.03	Country 1:	$	0.00	0.0 %
9.04	Country 2:	$	0.00	0.0 %
	Countries designated NAIC - 3 or below:			
9.05	Country 1:	$	0.00	0.0 %
9.06	Country 2:	$	0.00	0.0 %

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

	1 Issuer	2 NAIC Designation		3	4
10.01	INT BK RECON&DEV	Bonds	$	532,980.00	0.8 %
10.02	KFW	Bonds	$	499,627.00	0.8 %
10.03	Glaxo SmithKline Cap Inc	Bonds	$	284,672.00	0.4 %
10.04	SANOFI	Bonds	$	268,983.00	0.4 %
10.05	Astrazeneca PLC	Bonds	$	149,846.00	0.2 %
10.06	France Telecom	Bonds	$	120,722.00	0.2 %
10.07	Barclays Bank	Bonds	$	99,999.00	0.2 %
10.08	Credit Agricole London	Bonds	$	99,869.00	0.2 %
10.09	RIO TINTO FINANC	Bonds	$	98,869.00	0.2 %
10.10	Royal Bank of Scotland	Bonds	$	69,947.00	0.1 %

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	$	0.00	0.0 %
11.03	Canadian-currency-denominated investments	$	0.00	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.00	0.0 %
11.05	Unhedged Canadian currency exposure	$	0.00	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	$	0.00	0.0 %
	Largest three investments with contractual sales restrictions:			
12.03		$	0.00	0.0 %
12.04		$	0.00	0.0 %
12.05		$	0.00	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		$	0.00	0.0 %
13.03		$	0.00	0.0 %
13.04		$	0.00	0.0 %
13.05		$	0.00	0.0 %
13.06		$	0.00	0.0 %
13.07		$	0.00	0.0 %
13.08		$	0.00	0.0 %
13.09		$	0.00	0.0 %
13.10		$	0.00	0.0 %
13.11		$	0.00	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 the remainder of Interrogatory 14.

	1		2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$	0.00	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:			
14.03		$	0.00	0.0 %
14.04		$	0.00	0.0 %
14.05		$	0.00	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	$	0.00	0.0 %
	Largest three investments in general partnership interests:			
15.03		$	0.00	0.0 %
15.04		$	0.00	0.0 %
15.05		$	0.00	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		$	0.00	0.0 %
16.03		$	0.00	0.0 %
16.04		$	0.00	0.0 %
16.05		$	0.00	0.0 %
16.06		$	0.00	0.0 %
16.07		$	0.00	0.0 %
16.08		$	0.00	0.0 %
16.09		$	0.00	0.0 %
16.10		$	0.00	0.0 %
16.11		$	0.00	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	$ 0.00	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0.00	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0.00	0.0 %
16.15	Mortgage loans foreclosed	$ 0.00	0.0 %
16.16	Restructured mortgage loans	$ 0.00	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%	$ 0.00	0.0 %	$ 0.00	0.0 %	$ 0.00	0.0 %		
17.02	91 to 95%	$ 0.00	0.0 %	$ 0.00	0.0 %	$ 0.00	0.0 %		
17.03	81 to 90%	$ 0.00	0.0 %	$ 0.00	0.0 %	$ 0.00	0.0 %		
17.04	71 to 80%	$ 0.00	0.0 %	$ 0.00	0.0 %	$ 0.00	0.0 %		
17.05	below 70%	$ 0.00	0.0 %	$ 0.00	0.0 %	$ 0.00	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		$ 0.00	0.0 %
18.03		$ 0.00	0.0 %
18.04		$ 0.00	0.0 %
18.05		$ 0.00	0.0 %
18.06		$ 0.00	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:	$ 0.00	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0.00	0.0 %
19.04		$ 0.00	0.0 %
19.05		$ 0.00	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)	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
20.02	Repurchase agreements	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
20.03	Reverse repurchase agreements	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
20.04	Dollar repurchase agreements	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
20.05	Dollar reverse repurchase agreements	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00

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	$ 0.00	0.0 %	$ 0.00	0.0 %
21.02	Income generation	$ 0.00	0.0 %	$ 0.00	0.0 %
21.03	Other	$ 0.00	0.0 %	$ 0.00	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	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
22.02	Income generation	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
22.03	Replications	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
22.04	Other	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00

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	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
23.02	Income generation	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
23.03	Replications	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00
23.04	Other	$ 0.00	0.0 %	$ 0.00	$ 0.00	$ 0.00

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1	Bonds:						
	1.1 U.S. treasury securities	11,777,508	20.303	11,777,508	0	11,777,508	20.303
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	16,647	0.029	16,647	0	16,647	0.029
	1.22 Issued by U.S. government sponsored agencies	114,480	0.197	114,480	0	114,480	0.197
	1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	79,896	0.138	79,896	0	79,896	0.138
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.						
	1.41 States, territories and possessions general obligations	1,362,789	2.349	1,362,789	0	1,362,789	2.349
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	3,093,110	5.332	3,093,110	0	3,093,110	5.332
	1.43 Revenue and assessment obligations	6,346,926	10.941	6,346,926	0	6,346,926	10.941
	1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or guaranteed by GNMA	1,882	0.003	1,882	0	1,882	0.003
	1.512 Issued or guaranteed by FNMA and FHLMC	4,261,447	7.346	4,261,447	0	4,261,447	7.346
	1.513 All other	0	0.000	0	0	0	0.000
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	979,731	1.689	979,731	0	979,731	1.689
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	1,280,211	2.207	1,280,211	0	1,280,211	2.207
	1.523 All other	0	0.000	0	0	0	0.000
2	Other debt and other fixed income securities (excluding short-term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	8,245,570	14.215	8,245,570	0	8,245,570	14.215
	2.2 Unaffiliated non-U.S. securities (including Canada)	2,989,670	5.154	2,989,670	0	2,989,670	5.154
	2.3 Affiliated securities	0	0.000	0	0	0	0.000
3	Equity interests:						
	3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
	3.2 Preferred stocks:						
	3.21 Affiliated	0	0.000	0	0	0	0.000
	3.22 Unaffiliated	0	0.000	0	0	0	0.000
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated	0	0.000	0	0	0	0.000
	3.32 Unaffiliated	0	0.000	0	0	0	0.000
	3.4 Other equity securities:						
	3.41 Affiliated	0	0.000	0	0	0	0.000
	3.42 Unaffiliated	0	0.000	0	0	0	0.000
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated	0	0.000	0	0	0	0.000
	3.52 Unaffiliated	0	0.000	0	0	0	0.000
4.	Mortgage loans:						
	4.1 Construction and land development	0	0.000	0	0	0	0.000
	4.2 Agricultural	0	0.000	0	0	0	0.000
	4.3 Single family residential properties	0	0.000	0	0	0	0.000
	4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
	4.5 Commercial loans	0	0.000	0	0	0	0.000
	4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5.	Real estate investments:						
	5.1 Property occupied by company	0	0.000	0	0	0	0.000
	5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
	5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6.	Contract loans	0	0.000	0	0	0	0.000
7.	Derivatives	0	0.000	0	0	0	0.000
8.	Receivables for securities	0	0.000	0	0	0	0.000
9.	Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10.	Cash, cash equivalents and short-term investments	17,457,981	30.096	17,457,981	0	17,457,981	30.096
11.	Other invested assets	0	0.000	0	0	0	0.000
12.	Total invested assets	58,007,848	100.000	58,007,848	0	58,007,848	100.000

OTHER ATTACHMENTS

Deloitte

Deloitte & Touche LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA
Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

To the Audit Committee of UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

The Management of UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

Dear Members of 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 Midlands, Inc. (the "Company") for the years ended December 31, 2013, and 2012, and have issued our report thereon dated April 22, 2014. In connection therewith, we advise you as follows:

a. 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 Nebraska Department of Insurance, and the *Rules of Professional Conduct* of the Michigan Board of Public Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have 20 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 49 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Nebraska 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 Nebraska 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 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 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 statutory basis 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 statutory basis financial statements in conformity with accounting practices prescribed or permitted by the Nebraska 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.

d. We will retain the working papers prepared in the conduct of our audit until the Nebraska Department of Insurance has filed a Report of Examination covering 2013, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Nebraska Department of Insurance at the offices of the insurer, at our offices, at the Nebraska 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 Nebraska 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 Nebraska Department of Insurance.

e. The engagement partner has served in this capacity with respect to the Company since 2009, is licensed by the Michigan Board of Public Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. 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 Midlands, Inc. and for filing with the Nebraska 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 22, 2014

Deloitte

Deloitte & Touche LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA
Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

April 22, 2014

The Audit Committee of UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

The Management of UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, NE 68164-9672

Dear Members of the Audit Committee and Management:

In planning and performing our audit of the statutory basis financial statements of UnitedHealthcare of the Midlands, Inc. (the "Company") as of and for the year ended December 31, 2013 (on which we have issued our report dated April 22, 2014), in accordance with auditing standards generally accepted in the United States of America, we considered the Company's internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses as of December 31, 2013.

The definitions of a deficiency and a material weakness are set forth in the attached Appendix I.

A description of the responsibility of management for establishing and maintaining internal control over financial reporting and of the objectives of and inherent limitations of internal control over financial reporting, is set forth in the attached Appendix II and should be read in conjunction with this report.

This report is intended solely for the information and use of the Audit Committee, management, others within the organization, and 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.

Yours truly,

Deloitte + Touche LLP

DEFINITIONS

The definitions of a deficiency and a material weakness are as follows:

A *deficiency* in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when (a) a properly designed control does not operate as designed, or (b) the person performing the control does not possess the necessary authority or competence to perform the control effectively.

A *material weakness* is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's statutory basis financial statements will not be prevented, or detected and corrected on a timely basis.

MANAGEMENT'S RESPONSIBILITY FOR, AND THE OBJECTIVES AND LIMITATIONS OF, INTERNAL CONTROL OVER FINANCIAL REPORTING

The following comments concerning management's responsibility for internal control over financial reporting and the objectives and inherent limitations of internal control over financial reporting are adapted from auditing standards generally accepted in the United States of America.

Management's Responsibility

The Company's management is responsible for the overall accuracy of the statutory basis financial statements and their conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance. In this regard, management is also responsible for establishing and maintaining effective internal control over financial reporting.

Objectives of Internal Control over Financial Reporting

Internal control over financial reporting is a process effected by those charged with governance, management, and other personnel and designed to provide reasonable assurance about the achievement of the entity's objectives with regard to reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control over the safeguarding of assets against unauthorized acquisition, use, or disposition may include controls related to financial reporting and operations objectives. Generally, controls that are relevant to an audit of statutory basis financial statements are those that pertain to the entity's objective of reliable financial reporting (i.e., the preparation of reliable statutory basis financial statements that are fairly presented in conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance.

Inherent Limitations of Internal Control over Financial Reporting

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented, or detected and corrected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

UnitedHealthcare of the Midlands, Inc.

Statutory Basis Financial Statements as of and for the
Years Ended December 31, 2014 and 2013,
Supplemental Schedules as of and for the
Year Ended December 31, 2014,
Independent Auditors' Report, Qualification Letter,
and Internal Control Report

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

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Internal Control Report	

Deloitte

Deloitte & Touche LLP
City Place I/185 Asylum Street
32nd Floor
Hartford, CT 06103-3402
Tel: +1 860 725 3000
Fax: +1 860 725 3500
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, Nebraska 68164-9672

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of the Midlands, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2014 and 2013, 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 Nebraska 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 Midlands, Inc. as of December 31, 2014 and 2013, 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 Nebraska 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 Midlands, Inc. using accounting practices prescribed or permitted by the Nebraska 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 Nebraska Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2014 audit was conducted for the purpose of forming an opinion on the 2014 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2014 are presented for purposes of additional analysis and are not a required part of the 2014 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 2014 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 2014 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 Midlands, 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 22, 2015

UNITEDHEALTHCARE OF THE MIDLANDS INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2014 AND 2013

	2014	2013
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$43,834,896	$40,549,867
Cash overdrafts of ($505,899) and ($763,886), cash equivalents of $0 and $9,299,065, and short-term investments of $6,095,962 and $8,922,802 in 2014 and 2013, respectively	5,590,063	17,457,981
Subtotal cash and invested assets	49,424,959	58,007,848
OTHER ASSETS:		
Investment income due and accrued	293,732	263,384
Uncollected premiums	14,543,339	5,818,608
Amounts receivable relating to uninsured plans	3,156,328	185,032
Net deferred tax asset	516,742	566,416
Health care receivable	1,932,688	991,014
Subtotal other assets	20,442,829	7,824,454
TOTAL ADMITTED ASSETS	$69,867,788	$65,832,302
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$27,456,324	$27,272,298
Accrued medical incentive pool and bonus amounts	4,226,860	4,053,784
Unpaid claims adjustment expenses	300,998	380,136
Aggregate health policy reserves	42,740	317,482
Aggregate health claim reserves	252,499	151,290
Premiums received in advance	3,304	3,509
General expenses due or accrued	1,201,198	608,411
Current federal income taxes payable	1,697,024	1,223,288
Ceded reinsurance premiums payable	86,467	68,530
Remittances and items not allocated	397	1,397
Amounts due to parent, subsidiaries, and affiliates—net	1,694,245	1,181,193
Payable for securities	-	258,537
Liability for amounts held under uninsured plans	247,776	311,240
Other liabilities	8,008	6,311
Total liabilities	37,217,840	35,837,406
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	4,945,220	-
Common capital stock, $1.00 par value—100,000 shares authorized; 100,000 shares issued and outstanding	100,000	100,000
Gross paid-in and contributed surplus	1,100,000	1,100,000
Unassigned surplus	26,504,728	28,794,896
Total capital and surplus	32,649,948	29,994,896
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$69,867,788	$65,832,302

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014	2013
REVENUES:		
Net premium income	$261,516,891	$206,742,289
Change in reserve for rate credits	274,741	224,761
Total revenues	261,791,632	206,967,050
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	188,464,546	153,104,988
Other professional services	1,764,374	1,870,655
Prescription drugs	6,698,134	4,726,932
Medicaid University of Nebraska Medical Center capitation	4,732,158	4,945,943
Incentive pool, withhold adjustments, and bonus amounts	4,125,343	3,050,361
Total hospital and medical	205,784,555	167,698,879
Claims adjustment expenses	13,192,949	9,619,502
General administrative expenses	23,660,046	15,977,616
Total underwriting deductions	242,637,550	193,295,997
NET UNDERWRITING GAIN	19,154,082	13,671,053
NET INVESTMENT GAINS:		
Net investment income earned	1,016,757	827,825
Net realized capital (losses) gains less capital gains (benefit) tax of ($11,954) and $113,581 in 2014 and 2013, respectively	(33,939)	199,648
Total net investment gains	982,818	1,027,473
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(9,668)	(3,183)
NET INCOME BEFORE FEDERAL INCOME TAXES	20,127,232	14,695,343
FEDERAL INCOME TAXES INCURRED	8,002,978	4,941,709
NET INCOME	$ 12,124,254	$ 9,753,634

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
		Shares	Amount			
BALANCE—January 1, 2013	$ -	100,000	$ 100,000	$ 1,100,000	$ 19,130,664	$ 20,330,664
Net income	-	-	-	-	9,753,634	9,753,634
Change in net deferred income taxes	-	-	-	-	722	722
Change in nonadmitted assets	-	-	-	-	(90,124)	(90,124)
BALANCE—December 31, 2013	-	100,000	100,000	1,100,000	28,794,896	29,994,896
Net income	-	-	-	-	12,124,254	12,124,254
Change in net deferred income taxes	-	-	-	-	(49,674)	(49,674)
Change in nonadmitted assets	-	-	-	-	80,472	80,472
Section 9010 ACA subsequent fee year assessment	4,945,220	-	-	-	(4,945,220)	-
Dividend paid	-	-	-	-	(9,500,000)	(9,500,000)
BALANCE—December 31, 2014	$ 4,945,220	100,000	$ 100,000	$ 1,100,000	$ 26,504,728	$ 32,649,948

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014	2013
CASH FLOWS FROM OPERATIONS:		
Premiums collected—net of reinsurance	$ 252,820,688	$ 206,132,974
Net investment income	1,194,369	973,535
Benefit and loss related payments	(206,224,169)	(168,128,237)
Operating expenses paid	(39,388,421)	(25,239,524)
Federal income taxes paid—net	(7,517,288)	(2,870,583)
Net cash provided by operations	885,179	10,868,165
CASH FLOWS FROM INVESTMENTS:		
Proceeds from bonds sold, matured, or repaid	14,668,634	8,617,268
Cost of bonds acquired	(18,466,290)	(20,320,663)
Net cash used in investments	(3,797,656)	(11,703,395)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash provided through net transfers from affiliates	513,052	747,816
Dividend paid	(9,500,000)	-
Other cash provided	31,507	149,136
Net cash (used in) provided by financing and miscellaneous activities	(8,955,441)	896,952
RECONCILIATION OF CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	(11,867,918)	61,722
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS—Beginning of year	17,457,981	17,396,259
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS—End of year	$ 5,590,063	$ 17,457,981

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization and Operation

UnitedHealthcare of the Midlands, 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"), an HMO management corporation that provides services to the Company under the terms of a management 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 April 16, 1984, as an HMO and operations commenced in August 1984. The Company is certified as an HMO by the Nebraska Department of Insurance ("the Department") and the Iowa Insurance Division. The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage ("Medicare Part D program") under a contract with the Centers for Medicare and Medicaid Services ("CMS"). Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year; these payment elements are CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share, and the CMS Coverage Gap Discount Program. Each component of the Medicare Part D program is further defined throughout Note 1.

The Company has a contract with the State of Nebraska, Department of Health and Human Services ("DHHS"), Division of Medicaid and Long Term Care, to provide health care services to Medicaid eligible beneficiaries in Nebraska. The current contract is effective through June 30, 2015 and has a provision for an additional one-year extension renewal (through June 30, 2016). The contract 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 Nebraska, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Nebraska 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.

No significant differences exist between the practices prescribed or permitted by the State of Nebraska and those prescribed or permitted by the NAIC SAP that materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

	State of Domicile	2014	2013
Net Income			
(1) Company state basis	Nebraska	$12,124,254	$ 9,753,634
(2) State prescribed practices that increase/(decrease) NAIC SAP—None	Nebraska	-	-
(3) State permitted practices that increase/(decrease) NAIC SAP—None	Nebraska	-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	Nebraska	$12,124,254	$ 9,753,634
Surplus			
(5) Company state basis	Nebraska	$32,649,948	$29,994,896
(6) State prescribed practices that increase/(decrease) NAIC SAP—None	Nebraska	-	-
(7) State permitted practices that increase/(decrease) NAIC SAP—None	Nebraska	-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	Nebraska	$32,649,948	$29,994,896

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, and aggregate health policy reserves and aggregate health claim reserves (collectively known as "aggregate health reserves"). 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 and short-term investments are stated at amortized cost if they meet NAIC designation of one or two and stated at the lower of amortized cost or fair value if they meet an NAIC designation of three or higher. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the Securities Valuation Office of the NAIC ("SVO") in accordance with the NAIC Valuations 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 mortgage-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of mortgage-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 and total investments in mortgage-backed securities to 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) Premium deficiency reserves and the related expenses are recognized when it is probable that expected future health care expenses, claim 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 methods for making such estimates and for establishing the resulting reserves are periodically reviewed and updated, and any adjustments are reflected as an increase in reserves for accident and health contracts in the accompanying statutory basis statements of operations in the period in which the change in estimate is identified. The Company anticipates investment income as a factor in the premium deficiency 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 management agreement (see Note 10), the Company pays a management fee to 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 claims adjustment expenses and general administrative expenses to be reported in the statutory basis statement 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 claims adjustment expenses associated with incurred but unpaid claims, which is included in unpaid claims adjustment expenses in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid claims adjustment expenses as of December 31, 2014 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 claims adjustment expenses 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 on the statutory basis financial statements;

(13) Health care receivable 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 receivable also includes risk share receivables and receivables for amounts due to the Company for provider advances and claim overpayments to providers, hospitals and other health care organizations. Health care receivable are considered nonadmitted assets for statutory purposes 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 differences between statutory practices and GAAP:

Assets

Cash and Invested Assets

- Bonds include U.S. government and agency securities, state and agency municipalities, city and county municipalities, 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 are presented at the lower of amortized cost 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 amortized cost, respectively;

- Cash overdrafts, cash equivalents, and short-term investments 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, cash equivalents, and short-term investments 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 daily. Cash overdrafts are a result of timing differences in funding disbursement accounts for claims payments;

- 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 represent U.S. treasury bills. Cash equivalents have original maturity dates of three months or less from the date of acquisition and are reported at cost or amortized cost depending on the nature of the underlying security, which approximates fair value;

- Short-term investments represent money-market funds, with a maturity of greater than three months but less than one year at the time of purchase. Short-term investments also consist of the Company's share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or amortized cost. Interest income from the pool accrues daily to participating members based upon ownership percentage;

- 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 (benefit) tax 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) gains less capital gains (benefit) tax in the statutory basis statements of operations. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for mortgage-backed securities for periods subsequent to the loss recognition. The Company has not recorded any other-than-temporary impairments ("OTTI") for the years ended December 31, 2014 and 2013;

- The statutory basis statements of cash flows reconciles cash overdrafts, cash equivalents, and short-term investments with original maturities of one year or less from the time of acquisition; whereas under GAAP, cash flows reconcile the corresponding captions of cash and cash equivalents 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. 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 amounts determined to be uncollectible are written off in the period in which the determination is made.

- *Uncollected Premiums*—The Company reports uncollected premium balances from its insured members as uncollected premium balances 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.

- *Amounts Receivable Relating to Uninsured Plans*—Receivables for amounts held under uninsured plans represent the cost reimbursement under the Medicare Part D program for the catastrophic reinsurance subsidy and the low-income member cost-sharing subsidy. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. The Patient Protection and Affordable Care Act and its related reconciliation act ("Health Reform Legislation") mandate consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap ("Coverage Gap Discount Program" or "CGDP"). These discounts are pre-funded by CMS, and ultimately reimbursed by pharmaceutical manufacturers. The Company solely administers the application of these funds and has no insurance risk. If the Company incurs costs in excess of these subsidies, a corresponding receivable is recorded in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Related cash flows are presented within operating expenses paid within cash provided by operations in the statutory basis statements of cash flows.

- *Net Deferred Tax Asset*—Statutory accounting provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets and liabilities, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under statutory accounting, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus and deferred tax assets are subject to a valuation allowance and admissibility limitations of the assets in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets and liabilities 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 statutory accounting, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheets.

Liabilities

- *Claims Unpaid and Aggregate Health Reserves*—Claims unpaid and aggregate health 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 2014 and 2013. Management believes the amount of claims unpaid and aggregate health reserves is a best estimate for the Company's liability for unpaid claims and aggregate health reserves as of December 31, 2014; however, actual payments may differ from those established estimates. Adjustments to claims unpaid estimates and aggregate health reserves are reflected in the statutory basis statement of operations in the period in which the change in estimate is identified.

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.

- *Incentive Pool*—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 or deficits 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, and the corresponding expense or reduction to expense is included in incentive pool, withhold adjustments, and bonus amounts in the statutory basis statements of operations.

- *Reserve for Experience Rated Refunds*—A liability is established for estimated premium refunds on experience rated contracts based on actuarial methods and assumptions and minimum loss ratio requirements. In addition, the Company is subject to minimum medical loss ratios on its Medicare product as calculated under the Health Reform Legislation. Estimated accrued retrospective premiums due to the Company are recorded in aggregate health policy reserves on the statutory basis statements of admitted assets, liabilities, and capital and surplus and as a change in reserve for rate credits in the statutory basis statements of operations.

- *Medical Risk Share—Medicare Part D*—The Company has settlements with CMS based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare Part D program regional plan varies more than 5% above or below the level estimated in the original bid submitted by the Company and approved by CMS in 2014 and 2013. The estimated risk share adjustment of $42,740 and $317,482 in 2014 and 2013, respectively, is recorded as aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus with the corresponding change in the balance reflected as a change in reserve for rate credits in the statutory basis statements of operations.

- *Premiums Received in Advance*—Premiums received in full during the current period that are not due until future periods 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.

- *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 due to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- *Payable for Securities*—The Company reports payable for securities when investments are traded at the end of an accounting period and the settlement does not occur until the following month in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- *Liability for Amounts Held under Uninsured Plans*—Liabilities for amounts held under uninsured plans represent the cost reimbursement under the Medicare Part D program for the catastrophic reinsurance subsidy and the low-income member cost-sharing subsidy. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. Health Reform Legislation mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the CGDP. These discounts are pre-funded by CMS, and ultimately reimbursed by pharmaceutical manufacturers. The Company solely administers the application of these funds and has no insurance risk. If the Company incurs costs less than these subsidies, a corresponding payable is recorded in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Related cash flows are presented within operating expenses paid within cash provided by operations in the statutory basis statements of cash flows.

Capital and Surplus and Minimum Statutory Requirements

- *Nonadmitted Assets*—Certain assets, including certain aged premium receivables, certain amounts receivable relating to uninsured plans, and certain health care receivables, are considered nonadmitted assets for statutory purposes 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 sheets.

- *Restricted Cash Reserves*—The Company held regulatory deposits in the amount of $321,412 and $332,939 as of December 31, 2014 and 2013, respectively, in compliance with the state of Nebraska requirements for qualification purposes as a domestic insurer and foreign insurer. These restricted cash reserves consist principally of government obligations and are stated at amortized cost, which approximates fair value. These reserves 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. The Iowa Department of Insurance has waived the requirement to maintain restricted cash reserves since 2003.

- *Minimum Capital and Surplus*—Under the laws of the State of Nebraska, the Department requires the Company to maintain a minimum capital and surplus equal to the greater of $1,000,000, 2% of the first $150 million of annual premium revenue and 1% of annual premium revenue over $150 million. The minimum capital and surplus requirement is $4,117,916 and $3,569,671, for December 31, 2014 and 2013, respectively, which was based on annual premium revenue, as that produced the highest minimum requirement. The Company is in compliance with the required amount.

  Risk-based capital ("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.

- *Section 9010 ACA Subsequent Fee Year Assessment*—The Company is subject to an annual fee under section 9010 of the Patient Protection and Affordable Care Act ("ACA"). Under statutory accounting, an amount equal to the estimated subsequent year fee must be apportioned out of unassigned surplus and reported as Section 9010 ACA subsequent year assessment, whereas under GAAP, no such special surplus designation is required.

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 incurred.

  Net premium income includes the Medicare Advantage CMS premium, and the premium under the Medicare Part D program, which includes CMS premium, member premium, and 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 estimates retrospective premium adjustments based on guidelines determined by CMS (see Note 24).

  Effective January 1, 2014, Medicare Advantage plans and Part D prescription drug plans are subject to MLR requirements under Health Reform Legislation. 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.

  CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. 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. The estimated risk-adjusted payments due to the Company at December 31, 2014 and 2013, were $2,070,105 and $663,763, respectively, and are recorded as uncollected premiums in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recognized $903,499 and ($343,848) for changes in prior year Medicare risk factor estimates during the years ended December 31, 2014 and 2013, respectively, which is recorded as net premium income and as a reduction to net premium income, respectively, within 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 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, home nursing risk-sharing payments, high dollar risk pool 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. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

- *University of Nebraska Medical Medicaid Capitation Program*—The State of Nebraska, DHHS, and the Company have a contract for the purposes of increasing reimbursement for Medicaid eligible services to the Company, which in turn is required to be passed through to the University of Nebraska Medical Center ("UNMC"). The program was approved by the CMS pursuant to Nebraska Medicaid Reform to develop a physician upper limit program that provides higher reimbursement to designated physician groups. The Company will pass-through 100% of the UNMC supplemental capitation payment received from the State of Nebraska, DHHS.

  In 2014 and 2013, the Company recorded $4,732,158 and $4,945,943 respectively, as net premium income for these payments with a corresponding offset of $4,732,158 and $4,946,943 respectively, reflected as Medicaid UNMC capitation as a component of total hospital and medical in the accompanying statutory basis statements of operations. The Company did not realize any underwriting gains or losses resulting from the arrangement. The Company also recorded a liability in claims unpaid of $2,500,141 and $2,453,500 as a result of this arrangement in the accompanying statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2014 and 2013, respectively.

- *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.

- *General Administrative Expenses*—Pursuant to the terms of the management 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 management agreement are directly expensed as incurred. State income taxes and premium taxes are also a component of general administrative expenses. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between claims adjustment expenses and general administrative expenses 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 for each calendar year beginning on or after January 1, 2014. Under statutory accounting, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in general administrative expenses 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.

- *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).

  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 statutory basis financial statements.

Reinsurance

- *Reinsurance Ceded*—The Company has an insolvency-only reinsurance agreement.

- *Ceded Reinsurance Premiums Payable*—The Company has an insolvency-only reinsurance agreement whereby 0.4% of net premium income is ceded to UnitedHealthcare Insurance Company ("UHIC"). The ceded reinsurance premiums payable balance represents amounts due to the reinsurer for 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.

  Direct premiums written and uncollected premiums from members and CMS related to Medicare Advantage and the Medicare Part D program as a percentage of total direct premiums written and gross uncollected premiums are 37% and 16% as of December 31, 2014 and 27% and 12% as of December 31, 2013, respectively.

  Direct written premiums and uncollected premiums from the State of Nebraska, DHHS, as a percentage of total direct premiums written and gross uncollected premiums are 63% and 84% as of December 31, 2014 and 73% and 88% as of December 31, 2013, respectively.

Recently Issued Accounting Standards—In June 2014, the NAIC adopted Statement of Statutory Accounting Principles ("SSAP") No. 106, *Affordable Care Acts Assessments*, effective January 1, 2014. The new standard incorporates guidance previously included in SSAP No. 35R, *Guaranty Fund and Other Assessments* for the accounting and disclosure requirements of the ACA Section 9010 assessment. The Company adopted SSAP No. 106 in 2014 and the impact is disclosed in Note 22.

2. ACCOUNTING CHANGES AND CORRECTION OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2014 and 2013.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2014 and 2013, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

(1–5) The Company did not discontinue any operations during 2014 and 2013.

5. INVESTMENTS AND OTHER INVESTED ASSETS

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 $52,937 and ($98,887), respectively, for 2014 and $329,974 and ($16,850), respectively, for 2013. The

Company has not recorded any gains or losses on the sale of investments for short-term investments in 2014 and 2013. The net realized gain or loss is included in net realized capital (loss) gains less capital gains (benefit) tax in the statutory basis statements of operations. Total proceeds on the sale of investments for bonds were $9,868,526 and $4,131,344 and for short-term investments were $288,919,970 and $236,112,587 in 2014 and 2013, respectively.

As of December 31, 2014 and 2013, the amortized cost, fair value, and gross unrealized holding gains and losses of the Company's investments, excluding cash (overdrafts) and cash equivalents of ($505,899) and $8,535,179 respectively, are as follow:

	2014				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value
U.S. government and agency securities	$13,736,981	$165,761	$ (1,392)	$(11,463)	$13,889,887
State and agency municipalities	5,851,883	233,448	-	(9,035)	6,076,296
City and county municipalities	4,720,353	328,704	-	-	5,049,057
Corporate debt securities	19,525,679	231,311	(30,003)	(14,246)	19,712,741
Money-market funds	6,095,962	-	-	-	6,095,962
Total bonds and short-term investments	$49,930,858	$959,224	$(31,395)	$(34,744)	$50,823,943

	2014				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value
Less than one year	$ 8,936,305	$ 10,275	$ -	$ -	$ 8,946,580
One to five years	20,442,859	190,686	(22,863)	(6,151)	20,604,531
Five to ten years	8,221,634	306,724	(8,049)	(9,012)	8,511,297
Over ten years	12,330,060	451,539	(483)	(19,581)	12,761,535
Total bonds and short-term investments	$49,930,858	$959,224	$(31,395)	$(34,744)	$50,823,943

	2013				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value
U.S. government and agency securities	$17,192,662	$ 75,849	$(254,806)	$ -	$17,013,705
State and agency municipalities	6,775,634	162,306	(149,923)	-	6,788,017
City and county municipalities	4,027,191	128,434	(51,235)	-	4,104,390
Corporate debt securities	12,554,380	196,736	(79,994)	(25,863)	12,645,259
Money-market funds	8,922,802	-	-	-	8,922,802
Total bonds and short-term investments	$49,472,669	$563,325	$(535,958)	$(25,863)	$49,474,173

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-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 an amortized cost of $8,477,377 and fair value of $8,689,460.

The following table illustrates the fair value and gross unrealized holding losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrealized loss position as of December 31, 2014 and 2013:

	2014					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
U.S. government and agency securities	$ 681,822	$ (1,392)	$ 829,028	$(11,463)	$ 1,510,850	$ (12,855)
State and agency municipalities	-	-	938,238	(9,035)	938,238	(9,035)
Corporate debt securities	6,598,077	(30,003)	1,174,421	(14,246)	7,772,498	(44,249)
Total bonds and short-term investments	$ 7,279,899	$ (31,395)	$2,941,687	$(34,744)	$10,221,586	$ (66,139)

	2013					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
U.S. government and agency securities	$13,432,066	$(254,806)	$ -	$ -	$13,432,066	$(254,806)
State and agency municipalities	1,345,262	(149,923)	-	-	1,345,262	(149,923)
City and county municipalities	1,953,353	(51,235)	-	-	1,953,353	(51,235)
Corporate debt securities	5,486,383	(79,994)	273,300	(25,863)	5,759,683	(105,857)
Total bonds and short-term investments	$22,217,064	$(535,958)	$ 273,300	$(25,863)	$22,490,364	$(561,821)

The unrealized losses on investments in U.S. government and agency securities, state and agency municipalities, city and county municipalities, and corporate debt securities at December 31, 2014 and 2013, were mainly caused by interest rate increases 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 amortized cost. The contractual cash flows of the U.S. government and agency obligations are either guaranteed 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 evaluated the credit ratings of the municipalities and local agency obligations and corporate obligations, 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 mortgage-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, no OTTI were recorded as of December 31, 2014 and 2013.

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 mortgage-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of mortgage-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 mortgage-backed securities as of December 31, 2014 and 2013.

(3) The Company did not have any mortgage-backed securities with an OTTI to report by CUSIP as of December 31, 2014 or 2013.

(4) The following table illustrates the fair value, gross unrealized losses, and length of time that the mortgage-backed securities have been in a continuous unrealized loss position as of December 31, 2014 and 2013:

	2014
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ (8,031)
2. 12 months or longer	(11,800)
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	2,410,638
2. 12 months or longer	890,212

	2013
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ (97,202)
2. 12 months or longer	-
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	4,969,059
2. 12 months or longer	-

(5) The Company believes that it will collect all principal and interest due on all investments that have an amortized cost in excess of fair value. The unrealized losses as of December 31, 2014 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities.

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

F. **Real Estate**—Not applicable.

G. **Low-Income Housing Tax Credits**—Not applicable.

H. Restricted Assets—

(1) Restricted assets—including pledged as of December 31, 2014 and 2013:

Restricted Asset Category	1 Total Gross Restricted from Current Year	2 Total Gross Restricted from Prior Year	3 Increase/ (Decrease) (1 minus 2)	4 Total Current Year Admitted Restricted	5 Percentage Gross Restricted to Total Assets	6 Percentage Admitted Restricted to Total Admitted Assets
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 state	321,412	332,939	(11,527)	321,412	-	-
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	$321,412	$332,939	$(11,527)	$321,412	- %	- %

(2–3) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2014 or 2013.

I. Working Capital Finance Investments—Not applicable.

J. 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.

K. Structured Notes

The Company does not have any structured notes.

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 has admitted all investment income due and accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The components of net investment income earned as of December 31, 2014 and 2013 are as follows:

	2014	2013
Bonds	$1,032,135	$824,390
Cash overdrafts, cash equivalents, and short-term investments	21,046	37,672
Total investment income earned	1,053,181	862,062
Expenses—investment management fees	(36,424)	(34,237)
Net investment income earned	$1,016,757	$827,825

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

8. DERIVATIVE INSTRUMENTS

A–F. 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, 2014 and 2013, are as follows:

	2014			2013			Change		
	1	2	3	4	5	6	7	8	9
	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) Gross deferred tax assets	$528,060	$ -	$528,060	$574,540	$ -	$574,540	$(46,480)	$ -	$(46,480)
(b) Statutory valuation allowance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	528,060	-	528,060	574,540	-	574,540	(46,480)	-	(46,480)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	528,060	-	528,060	574,540	-	574,540	(46,480)	-	(46,480)
(f) Deferred tax liabilities	10,430	888	11,318	7,663	461	8,124	2,767	427	3,194
(g) Net admitted deferred tax asset/ (net deferred tax liability) (1e - 1f)	$517,630	$(888)	$516,742	$566,877	$(461)	$566,416	$(49,247)	$(427)	$(49,674)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, *Income Taxes—A Replacement of SSAP No. 10R and SSAP No. 10*, are as follows:

	2014			2013			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	$528,060	$ -	$ 528,060	$574,540	$ -	$ 574,540	$(46,480)	$ -	$ (46,480)
(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	4,819,981	XXX	XXX	4,414,272	XXX	XXX	405,709
(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))	$528,060	$ -	$ 528,060	$574,540	$ -	$ 574,540	$(46,480)	$ -	$ (46,480)

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

	2014	2013
(a) Ratio percentage used to determine recovery period and threshold limitation amount	388 %	438 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$32,133,206	$29,428,480

(4) There was no impact to the gross deferred tax assets as a result of tax-planning strategies.

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred for the years ended December 31, 2014 and 2013 are as follows:

	1 2014	2 2013	3 (Col 1 - 2) Change
1. Current income tax:			
(a) Federal	$8,002,978	$4,941,709	$3,061,269
(b) Foreign	-	-	-
(c) Subtotal	8,002,978	4,941,709	3,061,269
(d) Federal income tax on net capital (losses) gains	(11,954)	113,581	(125,535)
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$7,991,024	$5,055,290	$2,935,734

(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, 2014 and 2013, are as follows:

	1 2014	2 2013	3 (Col 1 - 2) Change
2. Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 99,650	$118,503	$(18,853)
(2) Unearned premium reserve	226	239	(13)
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables—nonadmitted	427,633	455,798	(28,165)
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	551	-	551
(99) Subtotal	528,060	574,540	(46,480)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	528,060	574,540	(46,480)
(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)	528,060	574,540	(46,480)
3. Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	10,430	7,663	2,767
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(99) Subtotal	10,430	7,663	2,767
(b) Capital:			
(1) Investments	888	461	427
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	888	461	427
(c) Deferred tax liabilities (3a99 + 3b99)	11,318	8,124	3,194
4. Net deferred tax assets/liabilities (2i - 3c)	$516,742	$566,416	$(49,674)

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, 2014 and 2013.

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 35% to net income before federal income taxes, less capital gains (benefit)/plus capital gains tax. A summarization of the significant items causing this difference as of December 31, 2014 and 2013 are as follows:

	2014	2013
Tax provision at the federal statutory rate	$7,040,347	$5,183,121
Tax-exempt interest	(99,294)	(93,527)
Change in statutory valuation allowance	-	(3,486)
Health insurer fee	1,071,480	-
Tax effect of nonadmitted assets	28,165	(31,542)
Total statutory income taxes	$8,040,698	$5,054,566
Federal income taxes incurred	$8,002,978	$4,941,709
Capital gains (benefit) tax	(11,954)	113,581
Change in net deferred income tax	49,674	(724)
Total statutory income taxes	$8,040,698	$5,054,566

E. At December 31, 2014, the Company had no net operating loss carryforwards.

Current federal income taxes payable of $1,697,024 and $1,223,288 as of December 31, 2014 and 2013, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $7,517,288 and $2,870,583 in 2014 and 2013, respectively.

Federal income taxes incurred of $7,991,023 and $5,055,288 for 2014 and 2013, 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 Code ("IRS").

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 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 IRS has completed exams on UnitedHealth Group's consolidated income tax returns for fiscal years 2013 and prior. UnitedHealth Group's 2014 tax return is under advance 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 2007 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

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

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–L. Material Related Party Transactions

Pursuant to the terms of a Management Agreement (the "Agreement"), UHS will provide management services to the Company under a fee structure, which is based on a percentage of premium charge representing UHS' expenses for services or use of assets provided to the Company. In addition, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a PMPM basis or using another allocation methodology consistent with the Agreement. These services may include, but are not limited to, integrated personal health management solutions, such as disease management, treatment decision support, and wellness services, including a 24-hour call-in service, access to a network of transplant providers, and discount program services. The amount and types of services provided pursuant to the pass-through provision of the Agreement can change year over year as UHS becomes the contracting entity for services provided to the Company's members. Total administrative services, capitation, and access fees under this arrangement totaled $29,011,019 and $22,021,564 in 2014 and 2013, respectively, and are included in total hospital and medical expenses, general administrative expenses, and claims adjustment expenses in the statutory basis statements of operations. Direct expenses not covered under the Agreement, such as broker commissions, Department of Exam ("DOI") exam fees, ACA assessments, state taxes, and premium taxes, are paid by UHS on behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

The Company also directly contracts with related parties to provide services to its members. The Company expensed as hospital and medical expenses, general administrative expenses, and claims adjustment expenses $935,580 and $756,498 in capitation fees to related parties during 2014 and 2013, respectively. United Behavioral Health provides mental health and substance abuse services. OptumHealth Care Solutions, Inc. provides chiropractic, physical therapy and complex medical conditions services. Dental Benefit Providers, Inc., provides dental care assistance. Spectera, Inc. provides administrative services related to vision benefit management and claims processing. The capitation expenses, administrative services, and access fees paid to related parties, that are included as hospital and medical expenses, general administrative expenses, and claims adjustment expenses in the statutory basis statements of operations for the years ended December 31, 2014 and 2013, are shown below:

	2014	2013
United Behavioral Health	$ 861,207	$ 452,007
OptumHealth Care Solutions, Inc.	74,341	70,695
Dental Benefit Providers, Inc.	-	124,694
Spectera, Inc.	32	109,102
Total	$ 935,580	$ 756,498

Management believes that its 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.

The Company contracts with affiliate OptumRx to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees. Fees related to these agreements, which are calculated on a per- script basis, of $1,206,974 and ($58,580) in 2014 and 2013, respectively, are included in general administrative expenses and claims adjustment expenses in the statutory basis statements of operations.

The Company contracts with OptumRx to provide personal health products catalogues showing the healthcare products and benefit credits needed to redeem the respective products. OptumRx will mail the appropriate personal health products' catalogues to the Company's members and manage the personal health products credit balance. OptumRx also distributes personal health products to individual members based upon the terms of the agreement. Fees related to this agreement in 2014 and 2013, which are calculated on a PMPM basis of $290 and $4,300 are included in hospital and medical expenses in the statutory basis statements of operations.

The Company has an agreement with OptumInsight, Inc., an affiliate of the Company, for claim analytics, 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 and a capitated service fee is charged to the Company as a PMPM. Service fees of $984,245 and $1,044,005 are included in hospital and medical expenses, claims adjustment expenses, and general administrative expenses in the statutory basis statements of operations for the years ended December 31, 2014 and 2013, respectively.

The Company has premium payments that are received and claim payments that are processed by an affiliated UnitedHealth Group entity. Both 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 or amounts due to parent, subsidiaries, and affiliates in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has an insolvency-only reinsurance agreement with UHIC, an affiliate of the Company, to provide insolvency protection for its enrollees. Reinsurance premiums, which are calculated on a percentage of member premium income, of $1,032,367 and $811,330 in 2014 and 2013, respectively, are netted against net premium income in the statutory basis statement of operations.

The Company holds a $10,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate ("LIBOR") 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 aggregate principal amount that may be outstanding at any time shall not exceed $10,000,000. The credit agreement is effective until terminated. The credit agreement may be terminated without penalty by either party or will terminate immediately if the Company is no longer under common ownership of UnitedHealth Group. No amounts were outstanding under the line of credit as of December 31, 2014 and 2013.

At December 31, 2014 and 2013, the Company reported $1,694,245 and $1,181,193, respectively, as amounts due to parent, subsidiaries, and affiliates, 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.

In addition to the agreements above, UHS maintains a private short-term money market investment pool in which affiliated companies may participate (see Note 1). At December 31, 2014 and 2013, the Company's portion was $3,735,534 and $7,322,812, respectively, and is included in cash overdrafts, cash equivalents, and short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has entered into a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $9,500,000 and $0 in 2014 and 2013, respectively, to its parent (see Note 13).

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.

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

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

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

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

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

11. DEBT

A–B. The Company had no outstanding debt with third parties or outstanding federal home loan bank agreements during 2014 and 2013.

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 a management agreement (see Note 10).

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

(1–2) The Company has 100,000 shares authorized and 100,000 shares 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.

(3) Payment of dividends may be restricted by the Department and Nebraska law, which generally requires that dividends be paid out of unassigned surplus.

(4) The Company paid an ordinary cash dividend to UHC of $9,500,000 on September 26, 2014, which complied with the provisions set forth in the statutes of Nebraska and recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company paid no dividends and no infusions were received during 2013.

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

(6) There are no restrictions placed on the Company's unassigned surplus.

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

(8) 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.

(9) As discussed in Note 1, an amount equal to the estimated subsequent year ACA fee must be apportioned out of unassigned surplus and reported as Section 9010 ACA subsequent fee year assessment. For the year ending December 31, 2014, the amount was $4,945,220.

(10) The portion of unassigned funds, excluding the apportionment of estimated subsequent year Section 9010 ACA fee, net income, and dividends, represented (or reduced) by each item below is as follows:

	2014	2013	Change
Net deferred income taxes	$ 516,742	$ 566,416	$ (49,674)
Nonadmitted assets	(1,221,809)	(1,302,281)	80,472
Total	$ (705,067)	$ (735,865)	$ 30,798

(11–13) 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 assessments, 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 Contingences**

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'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. Certain of the Company's businesses have been reviewed or are currently under review. Certain of the Company's businesses have been reviewed or are currently under review, for reasons including compliance with coding and other requirements under the Medicare risk-adjustment model.

Risk Adjustment Data Validation Audit ("RADV")—CMS adjusts 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. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

CMS and the Office of Inspector General for Health and Human Services periodically perform RADV audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Such audits have in the past resulted and in

the future could result in retrospective adjustments to payments made to the Company, fines, corrective action plans or other adverse action by CMS.

In February 2012, CMS announced a final RADV and payment adjustment methodology audit and that it will conduct the RADV beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

Health Reform Legislation and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing the Company's liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's statutory basis results of operations, financial condition, and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the long term impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

The Company routinely evaluates the collectability of all receivable amounts included within 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, 2014 and 2013, except as disclosed in Note 5 and Note 20.

15. LEASES

A–B. According to the management 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 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 2014 and 2013.

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 $2,628,118 and a payable $238,323 at December 31, 2014 and 2013, respectively, for cost reimbursements under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies as described in Note 1, *Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans*. The Company also recorded a receivable of $528,210 and $185,032 and also a payable of $247,776 and $72,917 at December 31, 2014 and 2013, respectively, for the Medicare Part D Coverage Gap Discount Program as described in Note 1, *Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans*.

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 2014 and 2013.

20. FAIR VALUE MEASUREMENT

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 short-term investments 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

(1–5) The Company does not have any financial assets that are measured and reported at fair value on the statutory basis statements of admitted assets, liabilities, and capital and surplus at December 31, 2014 and 2013.

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, 2014 and 2013 is presented in the table below:

	2014					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practical Carrying Value
U.S. government and agency securities	$13,889,887	$13,736,981	$ 6,887,254	$ 7,002,633	$ -	$ -
State and agency municipalities	6,076,296	5,851,883	-	6,076,296	-	-
City and county municipalities	5,049,057	4,720,353	-	5,049,057	-	-
Corporate debt securities	19,712,741	19,525,679	-	19,712,741	-	-
Money-market funds	6,095,962	6,095,962	6,095,962	-	-	-
Total bonds and short-term investments	$50,823,943	$49,930,858	$12,983,216	$37,840,727	$ -	$ -

	2013					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practical Carrying Value
U.S. government and agency securities	$17,013,705	$17,192,662	$11,613,397	$ 5,400,308	$ -	$ -
State and agency municipalities	6,788,017	6,775,634	-	6,788,017	-	-
City and county municipalities	4,104,390	4,027,191	-	4,104,390	-	-
Corporate debt securities	12,645,259	12,554,380	-	12,645,259	-	-
Money-market funds	8,922,802	8,922,802	8,922,802	-	-	-
Total bonds and short-term investments	$49,474,173	$49,472,669	$20,536,199	$28,937,974	$ -	$ -

Included as Level 1 in U.S. government and agency securities in the fair value hierarchy table above are U.S. Treasury securities of $6,887,254 and $11,613,397 as of December 31, 2014 and December 31, 2013, respectively.

There are no commercial paper investments included in corporate debt securities in the fair value hierarchy table as of December 31, 2014 and 2013.

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

21. OTHER ITEMS

Effective for calendar years 2014 and 2013 the ACA has mandated that certain practicing primary care physicians ("PCPs") are eligible to receive increased payments for specified primary care services provided to Medicaid eligible individuals. This is to encourage PCPs to serve the Medicaid population in advance of the Medicaid expansion in 2014. This government mandate expired at December 31, 2014.

ACA requires that the managed care organizations ("MCO's") reimburse PCPs at a rate of no less than 100 percent of Medicare fee schedule rates for specified services. The federal government will finance the difference between the state Medicaid fee schedule rate and the corresponding Medicare fee schedule rate ("enhanced rate payment") during calendar years 2014 and 2013. The state will in turn fund the enhanced rate payments to the MCO's as part of an enhanced Medicaid capitation monthly

premium or as a lump sum payment of the rate differential, depending on the model selected by each state and approved by CMS.

The state of Nebraska has elected to continue the enhanced rate payments to PCPs beyond the government mandated period.

A. The Company did not encounter any extraordinary items for the years ended December 31, 2014 or 2013.

B. The Company has no troubled debt restructurings as of December 31, 2014 or 2013.

C. 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.

D. The Company has not received any business interruption insurance recoveries during 2014 and 2013.

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

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in asset-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 are rated NAIC rating of 1 or 2.

(2) The Company has no direct exposure through investments in subprime mortgage loans.

(3) Direct exposure through other investments is as follows:

	2014			
	Actual Cost	Book/Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$147,389	$158,313	$205,989	$-
b. Commercial mortgage-backed securities	-	-	-	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$147,389	$158,313	$205,989	$-

	2013			
	Actual Cost	Book/Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$170,458	$181,121	$228,658	$ -
b. Commercial mortgage-backed securities	-	-	-	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$170,458	$181,121	$228,658	$ -

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

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

22. SUBSEQUENT EVENTS

TYPE I—Recognized Subsequent Events

Subsequent events have been evaluated through April 22, 2015, which is the date these statutory basis financial statements were available for issuance.

There are no events subsequent to December 31, 2014, that require disclosure.

TYPE II—Nonrecognized Subsequent Events

Subsequent events have been evaluated through April 22, 2015, which is the date these statutory basis financial statements were available for issuance.

The Company is subject to the annual fee under section 9010 of the ACA. This annual 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. As of December 31, 2014, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2015, and estimates its portion of the annual health insurance industry fee payable on September 30, 2015 to be $4,945,220. This amount is reflected in Section 9010 ACA subsequent fee year assessment. The Company's Authorized Control Level RBC ("ACL RBC") ratio was 394% as of December 31, 2014. Reporting the ACA assessment as of December 31, 2014 would not have triggered an RBC action level.

		Current Year	Prior Year
A.	ACA fee assessment payable for the upcoming year	$ 4,945,220	$ 3,029,484
B.	ACA fee assessment paid	3,061,370	-
C.	Premium written subject to ACA 9010 assessment	258,173,714	208,086,797
D.	Total adjusted capital before surplus adjustment	32,649,948	-
E.	Authorized control level before surplus adjustment	8,290,134	-
F.	Total adjusted capital after surplus adjustment	27,704,728	-
G.	Authorized control level after surplus adjustment	8,290,134	-
H.	Would reporting the ACA assessment as of December 31, 2014, have triggered an RBC action level (YES/NO/Not Applicable)?	NO	

There are no other events subsequent to December 31, 2014 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 reinsurers (see Note 10). The Company remains primarily liable as the direct insurer on all risks reinsured.

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, 2014.

(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 2014 and 2013, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance**—There was no commutation of reinsurance in 2014 or 2013.

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

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 from the Company are recorded in 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. The Company has Medicare Part D program business which is subject to a retrospective rating 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 Part D direct premiums written subject to retrospective rating was $6,408,335 and $3,897,921 representing 2.5% and 2.0% of total direct premiums written for 2014 and 2013, respectively.

D. The Company does not have any comprehensive major medical business subject to specific minimum loss ratio requirements as of December 31, 2014 and December 31, 2013.

Pursuant to Health Care Reform changes effective for contract years beginning in 2014, the Company is required to maintain a specific minimum medical loss ratio on its Medicare contracts. The Company's actual medical loss ratios were in excess of the minimum requirements and, as a result, no minimum medical loss ratio liability for Medicare was required to be established as of December 31, 2014.

E. **Risk-Sharing Provisions of the Affordable Care Act**

(1–3) The Company did not write Accident and Health premiums in 2014 subject to the risk-sharing provisions of the ACA on assets, liabilities, and revenue.

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

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 the claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, and health care receivable (excluding provider loans and advances) for 2014 and 2013:

	2014		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (31,477,373)	$ (31,477,373)
Paid claims—net of health care receivable	180,414,043	25,810,126	206,224,169
End of year claim reserve	31,105,775	829,908	31,935,683
Incurred claims, (excluding the change in health care receivable)	211,519,818	(4,837,339)	206,682,479
Beginning of year health care receivable, (excluding provider loans and advances)	-	2,243,785	2,243,785
End of year health care receivable	(2,493,171)	(648,538)	(3,141,709)
Total incurred claims	$209,026,647	$ (3,242,092)	$205,784,555

	2013		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (31,438,505)	$ (31,438,505)
Paid claims—net of health care receivable*	142,720,145	25,408,092	168,128,237
End of year claim reserve	29,717,035	1,760,338	31,477,373
Incurred claims, (excluding the change in health care receivable)	172,437,180	(4,270,075)	168,167,105
Beginning of year health care receivable, (excluding provider loans and advances)	-	1,775,559	1,775,559
End of year health care receivable, (excluding provider loans and advances)	(1,767,830)	(475,955)	(2,243,785)
Total incurred claims	$170,669,350	$ (2,970,471)	$ 167,698,879

*Health care receivable excludes provider loans and advances of $30,809

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, and health care receivable (excluding provider loans and advances) as of December 31, 2013 were $29,233,588. As of December 31, 2014, $25,810,126 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivable are $181,370, as a result of re-estimation of unpaid claims. Therefore, there has been $3,242,092 favorable prior year development since December 31, 2013 to December 31, 2014. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $2,112,664, favorable development in capitation reserves of $891,880, and favorable development in retroactivity for inpatient, outpatient, physician, and pharmacy claims of $349,395. At December 31, 2013, the Company recorded $2,970,471 of favorable development as a result of a change in the provision for adverse deviations in experience of $2,184,346 and by favorable development in retroactivity for inpatient, outpatient, physician, and pharmacy claims of $1,449,817, offset by unfavorable retroactivity for increase in provider settlement reserves of $433,877. Original estimates are increased or decreased, as additional information becomes known regarding individual claims. Included in this favorable development is the impact related to retrospectively rated policies. 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 claims adjustment expenses of $13,192,949 and $9,619,502 in 2014 and 2013, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of its management agreement (see Note 10). The following tables disclose paid CAE, incurred CAE, and the balance in the unpaid claim adjustment expenses reserve for 2014 and 2013:

	2014	2013
Total claims adjustment expenses	$13,192,949	$9,619,502
Less current year unpaid claims adjustment expenses	(300,998)	(380,136)
Add prior year unpaid claims adjustment expenses	380,136	527,676
Total claims adjustment expenses paid	$13,272,087	$9,767,042

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2014 or 2013.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2014 or 2013.

28. HEALTH CARE RECEIVABLE

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the pharmaceutical benefit manager in accordance with pharmacy 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 all pharmacy rebates receivable that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

For each pharmacy management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria, the 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
12/31/2014	$ 1,187,221	$ -	$ -	$ -	$ -
9/30/2014	1,132,367	1,102,146	676,792	-	-
6/30/2014	1,028,709	1,020,887	797,172	164,155	-
3/31/2014	952,694	979,269	732,369	162,617	66,571
12/31/2013	591,308	523,823	459,579	44,053	11,198
9/30/2013	556,363	499,191	404,092	78,496	12,950
6/30/2013	459,825	455,196	375,393	65,889	11,058
3/31/2013	427,688	427,782	341,122	77,038	6,202
12/31/2012	384,485	378,795	326,635	39,593	11,376
9/30/2012	374,497	371,570	331,880	38,164	1,746
6/30/2012	352,461	355,620	307,917	31,429	15,985
3/31/2012	351,598	355,095	316,859	28,036	10,190

Of the amount reported as health care receivable, $1,602,672 and $813,009 relates to pharmacy rebates receivable as of December 31, 2014 and 2013, respectively. This increase is primarily due to increased membership along with the change in generic/name brand mix.

B. The Company nonadmitted all risk-sharing receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company admitted $330,016 and $148,861 related to claims overpayment receivables, and $0 and $29,144 related to provider advance receivables as of December 31, 2014 and 2013, respectively.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2014 or 2013.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any premium deficiency reserves as of December 31, 2014 or 2013. The analysis of premium deficiency reserves was completed as of December 31, 2014 and 2013. The Company did consider anticipated investment income when calculating the premium deficiency reserves.

The following table summarizes the Company's premium deficiency reserves as of December 31, 2014 and 2013:

	2014
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2014
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2013
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2013
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2014 and 2013, 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, 2014
(To Be Filed by April 1)

Of The UnitedHealthcare of the Midlands, Inc.

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

NAIC Group Code 0707 NAIC Company Code 95591 Federal Employer's Identification Number (FEIN) 47-0676824

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. $ 69,867,788

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	$ 4,572,521	6.5 %
2.02	UHC Liquidity Pool	Bonds	$ 3,735,534	5.3 %
2.03	FHLMC	Bonds	$ 1,719,409	2.5 %
2.04	VIRGINIA ST PUBL	Bonds	$ 947,273	1.4 %
2.05	LA CA Cnty Colg	Bonds	$ 909,226	1.3 %
2.06	WISCONSIN ST	Bonds	$ 779,670	1.1 %
2.07	Southern MN Mun Pwr Agy	Bonds	$ 725,000	1.0 %
2.08	OK St Turnpike Auth	Bonds	$ 639,496	0.9 %
2.09	MI St Bldg Auth	Bonds	$ 579,989	0.8 %
2.10	MARYLAND ST	Bonds	$ 549,340	0.8 %

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	$ 46,597,715	66.7 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 3,333,142	4.8 %	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 [ ] No [X]

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	$ 2,775,042	4.0 %
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	$ 2,775,042	4.0 %
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: United Kingdom	$ 764,764	1.1 %
6.02	Country 2: Japan	$ 532,991	0.8 %
	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	INT BK RECON&DEV	1FE	$ 532,991	0.8 %
10.02	LCM LTD PARTNERS 15A	1FE	$ 510,000	0.7 %
10.03	KFW	1FE	$ 498,621	0.7 %
10.04	Glaxo SmithKline Cap Inc	1FE	$ 284,914	0.4 %
10.05	GENZYME CORP	1FE	$ 269,216	0.4 %
10.06	BP CAPITAL PLC	1FE	$ 160,000	0.2 %
10.07	Astrazeneca PLC	1FE	$ 149,872	0.2 %
10.08	Barclays Bank	1FE	$ 100,000	0.1 %
10.09	Credit Agricole Bank	1FE	$ 99,971	0.1 %
10.10	RIO TINTO FINANC	1FE	$ 99,479	0.1 %

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 the remainder of Interrogatory 14.

	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 %

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	2	3	4	5	6
		Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1.	Bonds:						
	1.1 U.S. treasury securities	6,848,453	13.856	6,848,453	0	6,848,453	13.856
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	3,565	0.007	3,565	0	3,565	0.007
	1.22 Issued by U.S. government sponsored agencies	314,371	0.636	314,371	0	314,371	0.636
	1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	79,927	0.162	79,927	0	79,927	0.162
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
	1.41 States, territories and possessions general obligations	1,446,264	2.926	1,446,264	0	1,446,264	2.926
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	3,055,228	6.182	3,055,228	0	3,055,228	6.182
	1.43 Revenue and assessment obligations	6,070,744	12.283	6,070,744	0	6,070,744	12.283
	1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or guaranteed by GNMA	0	0.000	0	0	0	0.000
	1.512 Issued or guaranteed by FNMA and FHLMC	5,823,343	11.782	5,823,343	0	5,823,343	11.782
	1.513 All other	0	0.000	0	0	0	0.000
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	697,725	1.412	697,725	0	697,725	1.412
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	1,956,310	3.958	1,956,310	0	1,956,310	3.958
	1.523 All other	0	0.000	0	0	0	0.000
2.	Other debt and other fixed income securities (excluding short-term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	14,004,502	28.335	14,004,502	0	14,004,502	28.335
	2.2 Unaffiliated non-U.S. securities (including Canada)	3,534,464	7.151	3,534,464	0	3,534,464	7.151
	2.3 Affiliated securities	0	0.000	0	0	0	0.000
3.	Equity interests:						
	3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
	3.2 Preferred stocks:						
	3.21 Affiliated	0	0.000	0	0	0	0.000
	3.22 Unaffiliated	0	0.000	0	0	0	0.000
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated	0	0.000	0	0	0	0.000
	3.32 Unaffiliated	0	0.000	0	0	0	0.000
	3.4 Other equity securities:						
	3.41 Affiliated	0	0.000	0	0	0	0.000
	3.42 Unaffiliated	0	0.000	0	0	0	0.000
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated	0	0.000	0	0	0	0.000
	3.52 Unaffiliated	0	0.000	0	0	0	0.000
4.	Mortgage loans:						
	4.1 Construction and land development	0	0.000	0	0	0	0.000
	4.2 Agricultural	0	0.000	0	0	0	0.000
	4.3 Single family residential properties	0	0.000	0	0	0	0.000
	4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
	4.5 Commercial loans	0	0.000	0	0	0	0.000
	4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5.	Real estate investments:						
	5.1 Property occupied by company	0	0.000	0	0	0	0.000
	5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
	5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6.	Contract loans	0	0.000	0	0	0	0.000
7.	Derivatives	0	0.000	0	0	0	0.000
8.	Receivables for securities	0	0.000	0	0	0	0.000
9.	Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10.	Cash, cash equivalents and short-term investments	5,590,063	11.310	5,590,063	0	5,590,063	11.310
11.	Other invested assets	0	0.000	0	0	0	0.000
12.	Total invested assets	49,424,959	100.000	49,424,959	0	49,424,959	100.000

OTHER ATTACHMENTS

Deloitte

Deloitte & Touche LLP
City Place I/185 Asylum Street
32nd Floor
Hartford, CT 06103-3402
Tel: +1 860 725 3000
Fax: +1 860 725 3500
www.deloitte.com

To the Audit Committee of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, Nebraska 68164-9672

The Management of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, Nebraska 68164-9672

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 Midlands, Inc. (the "Company") for the years ended December 31, 2014, and 2013, and have issued our report thereon dated April 22, 2015. In connection therewith, we advise you as follows:

a. 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 Nebraska Department of Insurance, and the *Rules of Professional Conduct* of the Connecticut State Board of Accountancy.

b. The engagement director and engagement manager, who are certified public accountants, have 15 years and 5 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 55% percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Nebraska 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 Nebraska 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 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 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 statutory basis 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 statutory basis financial statements in conformity with accounting practices prescribed or permitted by the Nebraska 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.

d. We will retain the working papers prepared in the conduct of our audit until the Nebraska Department of Insurance has filed a Report of Examination covering 2014, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Nebraska Department of Insurance, at the offices of the insurer, at our offices, at the Nebraska 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 Nebraska 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 Nebraska Department of Insurance.

e. The engagement director has served in this capacity with respect to the Company since 2014, is licensed by the Connecticut State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. 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 Midlands, Inc. and for filing with the Nebraska 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 22, 2015

Deloitte

Deloitte & Touche LLP
City Place I/185 Asylum Street
32nd Floor
Hartford, CT 06103-3402

Tel: +1 860 725 3000
Fax: +1 860 725 3500
www.deloitte.com

April 22, 2015

The Audit Committee of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, Nebraska 68164-9672

The Management of
UnitedHealthcare of the Midlands, Inc.
2717 North 118th Circle
Omaha, Nebraska 68164-9672

Dear Members of the Audit Committee and Management:

In planning and performing our audit of the statutory basis financial statements of UnitedHealthcare of the Midlands, Inc. (the "Company") as of and for the year ended December 31, 2014 (on which we have issued our report dated April 22, 2015), in accordance with auditing standards generally accepted in the United States of America, we considered the Company's internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses as of December 31, 2014.

The definitions of a deficiency and a material weakness are set forth in the attached Appendix I.

A description of the responsibility of management for establishing and maintaining internal control over financial reporting and of the objectives of and inherent limitations of internal control over financial reporting, is set forth in the attached Appendix II and should be read in conjunction with this report.

This report is intended solely for the information and use of the Audit Committee, management, others within the organization, and 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.

Yours truly,

Deloitte & Touche LLP

APPENDIX I

DEFINITIONS

The definitions of a deficiency and a material weakness are as follows:

A *deficiency* in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when (a) a properly designed control does not operate as designed, or (b) the person performing the control does not possess the necessary authority or competence to perform the control effectively.

A *material weakness* is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's statutory basis financial statements will not be prevented, or detected and corrected on a timely basis.

MANAGEMENT'S RESPONSIBILITY FOR, AND THE OBJECTIVES AND LIMITATIONS OF, INTERNAL CONTROL OVER FINANCIAL REPORTING

The following comments concerning management's responsibility for internal control over financial reporting and the objectives and inherent limitations of internal control over financial reporting are adapted from auditing standards generally accepted in the United States of America.

MANAGEMENT'S RESPONSIBILITY

The Company's management is responsible for the overall accuracy of the statutory basis financial statements and their conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance. In this regard, management is also responsible for establishing and maintaining effective internal control over financial reporting.

OBJECTIVES OF INTERNAL CONTROL OVER FINANCIAL REPORTING

Internal control over financial reporting is a process effected by those charged with governance, management, and other personnel and designed to provide reasonable assurance about the achievement of the entity's objectives with regard to reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control over the safeguarding of assets against unauthorized acquisition, use, or disposition may include controls related to financial reporting and operations objectives. Generally, controls that are relevant to an audit of statutory basis financial statements are those that pertain to the entity's objective of reliable financial reporting (i.e., the preparation of reliable statutory basis financial statements that are fairly presented in conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance).

INHERENT LIMITATIONS OF INTERNAL CONTROL OVER FINANCIAL REPORTING

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented, or detected and corrected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	Current Year Member Months
1. Health Maintenance Organizations	57,314	57,740	57,829	58,930	60,971	704,091
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	57,314	57,740	57,829	58,930	60,971	704,091
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

	Source of Enrollment	Total Members at End of 1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	6 Current Year Member Months
1.	Health Maintenance Organizations	60,971	62,682	63,108	60,010	60,043	740,276
2.	Provider Service Organizations	0	0	0	0	0	0
3.	Preferred Provider Organizations	0	0	0	0	0	0
4.	Point of Service	0	0	0	0	0	0
5.	Indemnity Only	0	0	0	0	0	0
6.	Aggregate write-ins for other lines of business	0	0	0	0	0	0
7.	Total	60,971	62,682	63,108	60,010	60,043	740,276
	DETAILS OF WRITE-INS						
0601.							
0602.							
0603.							
0698.	Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699.	Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	Current Year Member Months
1. Health Maintenance Organizations	60,043	61,192	66,847	67,772	67,875	798,995
2. Provider Service Organizations	0	0	0	0	0	0
3. Preferred Provider Organizations	0	0	0	0	0	0
4. Point of Service	0	0	0	0	0	0
5. Indemnity Only	0	0	0	0	0	0
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	60,043	61,192	66,847	67,772	67,875	798,995
DETAILS OF WRITE-INS						
0601						
0602						
0603						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

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, 2014

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)

Minnesota	**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:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

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 and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) 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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2014 was $78,282,268,950 (based on the last reported sale price of $81.75 per share on June 30, 2014, 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 30, 2015, there were 953,695,161 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 2015 Annual Meeting of Stockholders. 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

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers, students and other individuals and serves the nation's active and retired military and their families through the TRICARE program. 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 (formerly UnitedHealthcare International) includes Amil, a health care company providing health and dental benefits and hospital and clinical services to individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving 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 that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance across eight business markets: local care delivery, care management, consumer engagement, distribution services, health financial services, operational services and support, health care information technology and pharmacy services.

Through UnitedHealthcare and Optum, in 2014, we managed over $165 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; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

UnitedHealthcare

UnitedHealthcare's market position is built on:

- national scale;
- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as OptumRx pharmacy benefit products and services, certain OptumHealth care management and local care delivery services and OptumInsight health information and technology solutions, consulting and other services.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include a total of over 850,000 physicians and other health care professionals and approximately 6,100 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 Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

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, individuals and military service members in the TRICARE west region. UnitedHealthcare Employer & Individual provides nearly 29 million Americans access to health care as of December 31, 2014. 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 that 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.

UnitedHealthcare Employer & Individual also offers a variety of insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves 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 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 that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers.

In recent years, UnitedHealthcare Employer & Individual has diversified its model more extensively, distributing through professional employer organizations, associations, private equity relationships and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. In 2014, UnitedHealthcare Employer & Individual launched UnitedHealthcare Marketplace, a new shopping platform for employers seeking to offer their employees flexibility and a choice of UnitedHealthcare plans. UnitedHealthcare Employer & Individual is also participating in select multi-plan exchanges that they believe are structured to encourage consumer choice. Direct-to-consumer sales are also supported by participation in multi-carrier health insurance marketplaces for individuals and small groups through exchanges. In 2014, UnitedHealthcare Employer & Individual participated in 13 state public health care exchanges, including four individual and nine small group exchanges. In 2015, we are participating in 23 individual and 12 small group state public exchanges.

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provide the flexibility to meet the needs of employers of all sizes, as well as individuals shopping for health benefits coverage. UnitedHealthcare Employer & Individual has seen increased demand for consumer driven health plans and new network approaches with lower costs, as well as more convenient care options for consumers. UnitedHealthcare Employer & Individual emphasizes local markets and leverages its national scale to adapt products to meet specific local market needs.

UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). The market for health benefit products is shifting, with benefit and network offerings shaped, at least in part, by the requirements and effects of the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation), employer focus on quality and employee engagement, and the urgent need to align the system around value.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans, such as Choice and Options PPO, to more traditional indemnity products. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products and Tools. 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 and consumer education. During 2014, more than 32,000 employer-sponsored benefit plans, including more than 300 employers in the large group self-funded market, purchased HRA or HSA products from us. UnitedHealthcare Employer & Individual's consumer engagement tools support members with access to benefit, cost and quality information through online and mobile applications, such as Advocate4Me, myHealthcare Cost Estimator and Health4Me. Using innovative tools and technology, UnitedHealthcare and Optum's applications are helping people address a broad range of health related issues, including benefits and claims questions, finding the right doctor, proactive support for appointments and issue resolution, health education, clinical program enrollment and treatment decision support.

Value Based Products. UnitedHealthcare Employer & Individual's suite of consumer incentive products increases individual awareness of personal health and care quality and cost for heightened consumer responsibility and behavior change. These products include: Small Business Wellness, which is a packaged

wellness and incentives product that offers gym reimbursement and encourages completion of important wellness activities. For mid-sized clients, SimplyEngaged is a scalable activity-based reward program that ties incentives to completion of health improvement activities, while SimplyEngaged Plus provides richer incentives for achieving health goals. For large, self-funded customers, the UnitedHealthcare Healthy Rewards program offers a flexible incentive design to help employers choose the right activities and include appropriate biometric outcomes that best fit the needs of their employee population. UnitedHealth Personal Rewards leverages a tailored approach to incentives by combining personalized scorecards with financial incentives for improving biometric scores, compliance with key health treatments and preventive care.

Essential Benefits Products. UnitedHealthcare Employer & Individual's portfolio of lower cost products provides value to consumers through innovative plan designs and unique network programs like UnitedHealth Premium®, which guide people to physicians recognized for providing high-quality, cost-efficient care to their patients. This approach to essential benefits is designed to deliver sustainable health care costs for employers, enabling them to continue to offer their employees coverage at more affordable prices. For example, UnitedHealthcare Employer & Individual's tiered benefit plans offer enhanced benefits in the form of greater coinsurance coverage and/or lower copays for people using UnitedHealth Premium® designated care providers.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefits management programs, which complement its service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, improving health and decreasing medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts and individuals), 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 Know Your Numbers (biometrics) and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life, and disability product offerings through an integrated approach including a network of more than 58,000 vision professionals in private and retail settings, and nearly 75,000 dental offices.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans is the provider of health care services for nearly 3 million active duty and retired military service members and their families in 21 states

(West Region) under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract began on April 1, 2013, and includes a transition period and five one-year renewals at the government's option.

UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration and customer service.

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 individuals. 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. It has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a spectrum of risk-based Medicare products that may be purchased by individuals or on a group basis, including Medicare Advantage plans, Medicare Prescription Drug Benefit (Medicare Part D) and Medicare Supplement products that extend and enhance traditional fee-for-service coverage. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 29% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2014, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: 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 employer groups and agent 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 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 and in some cases consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which members reside; demographic factors such as age, gender, and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement had approximately 3 million people enrolled in its Medicare Advantage products as of December 31, 2014.

Medicare Advantage plans are designed to compete at the local level, taking into account member and care provider preferences, competitor offerings, our historical financial results, our quality and cost initiatives and the long-term payment rate outlook for each geographic area. Starting in 2012, and phased in through 2017, the Medicare Advantage rate structure and quality rating bonuses are changing significantly. See Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information.

UnitedHealthcare Medicare & Retirement offers innovative care management, disease management and other clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage

products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to reach out to those members and create individualized care plans that 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. UnitedHealthcare Medicare & Retirement offers two stand-alone Medicare Part D plans: the AARP MedicareRx Preferred and the AARP MedicareRx Saver Plus plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' 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, 2014, UnitedHealthcare enrolled approximately 8 million people in the Medicare Part D programs, including more than 5 million individuals in the stand-alone Medicare Part D plans and approximately 3 million in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving more than 4 million seniors through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers plans in all 50 states, the District of Columbia, and most U.S. territories. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at diverse price points. These products cover the various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), SNPs, integrated Medicare-Medicaid plans (MMP) and other federal, state and community health care programs. As of December 31, 2014, UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served more than 5 million beneficiaries. Health Reform Legislation provided for optional Medicaid expansion effective January 1, 2014. For 2015, 13 of our state customers have elected to expand Medicaid, an increase of one state since 2014. For further discussion of the Medicaid expansion under Health Reform Legislation, see Part II, Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations."

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 that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and our participation are:

- Temporary Assistance to Needy Families, primarily women and children – 21 markets;
- CHIP – 21 markets;

- Aged, Blind and Disabled (ABD) – 16 markets;
- SNP – 14 markets;
- Medicaid Expansion – 13 markets;
- Long-Term Services and Supports (LTSS) – 12 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 6 markets
- childless adults programs for the uninsured – 4 markets; and
- MMP – 1 market.

These health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those 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. They often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. These individuals also tend to 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.

The LTSS market represents only 6% of the total Medicaid population, yet accounts for more than 30% of total Medicaid expenditures. The LTSS population is made up of over 4 million individuals who qualify for additional benefits under LTSS programs who represent a subset of the more than 16 million ABD Americans. Currently, only one-quarter of the ABD population and approximately 20% of the LTSS eligible population are served by managed care programs. States are increasingly looking for solutions to not only help control costs, but to improve quality for the complex medical challenges faced by this population and are moving with greater speed to managed care programs.

There are more than 9 million individuals eligible for both Medicare and Medicaid. This group has historically been referred to as dually eligible or MMP. MMP beneficiaries typically have complex conditions with costs of care that are far higher than typical Medicare or Medicaid beneficiaries. While these individuals' health needs are more complex and more costly, they have been historically served in unmanaged environments. This market provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid funding and improve people's health status through close coordination of care.

Total annual expenditures for MMPs are estimated at more than $390 billion, or approximately 13% of the total health care costs in the United States. As of December 31, 2014, UnitedHealthcare served more than 315,000 people with complex conditions similar to those in an MMP population in legacy programs through Medicare Advantage dual SNPs. As of December 31, 2014, UnitedHealthcare Community & State had been awarded new MMP business taking effect in 2015 in Ohio and Texas.

UnitedHealthcare Global

UnitedHealthcare Global participates in international markets through national "in country" and cross-border strategic approaches. UnitedHealthcare Global's cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals

around the world. UnitedHealthcare Global's goal is to create business solutions that are based on local infrastructure, culture and needs, and that blend local expertise with experiences from the U.S. health care industry. As of December 31, 2014, UnitedHealthcare Global provided medical benefits to more than 4 million people, principally in Brazil, but also residing in more than 125 other countries.

Amil. Amil provides health and dental benefits to nearly 7 million people. Amil operates more than 30 acute hospitals and approximately 50 specialty, primary care and emergency services clinics across Brazil, principally for the benefit of its members. Amil's patients are also treated in its contracted provider network of nearly 27,000 physicians and other health care professionals, approximately 2,100 hospitals and more than 7,600 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. Amil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare Global includes other diversified global health services operations with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;
- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a 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, physicians' practices, hospitals and clinical facilities seeking to modernize the health system and support the best possible patient care and experience.
- Those who pay for care: insurers, employers and government agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently.
- Those who innovate for care: life sciences and research focused organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Using advanced data analytics and technology, Optum helps improve overall health system performance by optimizing care quality, reducing costs and improving the consumer experience and care provider performance. Optum is organized in three reportable segments:

- OptumHealth focuses on care delivery, care management, consumer engagement, distribution and health financial services;
- OptumInsight delivers operational services and support and health information technology services; and
- OptumRx specializes in pharmacy services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and financial needs of more than 63 million unique individuals. OptumHealth enables population health management through programs offered by employers, payers, government entities and, increasingly, directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth works to optimize the care delivery system through the creation of high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health management and by focusing on caring for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, and on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed fee per individual served. For its 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 markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, the Veterans Administration and other federal procurement agencies). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and local care delivery businesses.

OptumHealth is organized into two major operating groups: Collaborative Care and Consumer Solutions Group (CSG).

Collaborative Care. Collaborative Care's major product offerings include local care delivery, complex population management and mobile care delivery.

- Local Care Delivery. Local care delivery serves patients through a collaborative network of care providers aligned around total population health management and outcomes-based reimbursement. Within its local care delivery systems, OptumHealth works directly with medical groups and Independent Practice Associations to deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. OptumHealth is directly affiliated with clinics and physicians who provided care to more than 2 million patients in 2014.
- Complex Population Management. Complex population management services focus on improving care for patients with very challenging medical conditions by providing the optimal care in the most appropriate setting. Complex population management is focused on building and executing integrated solutions for payers, governmental agencies, accountable care organizations and provider groups for the highest cost patient segment of the health care system with focus on optimizing patient outcomes, quality and cost effectiveness. In addition, complex population management provides hospice services in 17 markets in the United States.
- Mobile Care Delivery. OptumHealth's mobile care delivery business provides occupational health, medical and dental readiness services, treatments and immunization programs. These solutions serve a number of government and commercial clients including the U.S. military.

CSG. CSG includes population health management services, specialty networks, distribution and financial services products.

- Population Health Management Services: OptumHealth serves nearly 38 million people through population health management services, including care management, complex conditions (e.g., cancer, neonatal and maternity), health and wellness and advocacy decision support solutions.

- Specialty Networks. Within specialty networks, OptumHealth serves more than 57 million people by offering them access to proprietary networks of provider specialists in the areas of behavioral health management (e.g., mental health, substance abuse), chiropractic, physical therapy, transplant, infertility, kidney and end stage renal disease.
- Distribution: This business provides health exchange capabilities to help payers, market aggregators and employers meet the needs of the consumers they serve. OptumHealth provides call center support, multi-modal communications software, data analysis and trained nurses that help clients acquire, retain and service large populations of health care consumers.
- Financial Services: This business serves the health financial needs of individuals, employers, health care professionals and payers. OptumHealth is a leading provider of consumer health care accounts. OptumHealth also offers electronic payment solutions to manage compliance and improve the administrative efficiency of electronic claim payments. As of December 31, 2014, Financial Services and its wholly owned subsidiary, Optum Bank, had $2.8 billion in customer assets under management and during 2014 processed $85 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight provides technology, operational and consulting services to participants in the health care industry. Hospital systems, physician practices, commercial health plans, government agencies, life sciences companies and other organizations that constitute the health care system use OptumInsight to help them reduce costs, meet compliance mandates, improve clinical performance, achieve efficiency and modernize their core operating systems to meet the changing needs of the health system landscape.

Many of OptumInsight's software and information products, advisory consulting arrangements and outsourcing contracts are delivered over an extended period, 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 that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. OptumInsight's aggregate backlog at December 31, 2014, was $8.6 billion, of which $4.8 billion is expected to be realized within the next 12 months. This includes $2.9 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2013, adjusted for the January 1, 2014 business realignment discussed in Note 13 of Notes to Consolidated Financial Statements included in Part II, Item 8, "Financial Statements," was $7.5 billion including $2.7 billion related to intersegment agreements. The increase in 2014 backlog was attributable to a revenue management services acquisition and general business growth, partially offset by services performed on existing contracts. OptumInsight cannot provide any assurance that 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.

OptumInsight provides capabilities targeted to the needs of four primary market segments: care providers (e.g., physician practices and hospitals), payers, governments and life sciences organizations.

Care Providers. Serving four out of five U.S. hospitals and tens of thousands of physician practices, OptumInsight provides capabilities that help drive financial performance, meet compliance requirements and deliver health intelligence. OptumInsight's offerings in clinical workflow software, revenue management tools and services, health IT and analytics help hospitals and physician practices improve patient outcomes, strengthen financial performance and meet quality measurement and compliance requirements, as well as transition to new collaborative and value based business models.

Payers. OptumInsight serves approximately 300 health plans by helping them improve operational and administrative efficiency, meet clinical performance and compliance goals, develop strong provider networks, manage risk and drive growth. OptumInsight also helps payer clients adapt to new market models, including health insurance exchanges, consumer driven health care and engagement, pay-for-value contracting and population health management.

Governments. OptumInsight provides services to government agencies across 36 states and the District of Columbia. Services include financial management and program integrity services, policy and compliance consulting, data and analytics technology, systems integration and expertise to improve medical quality, access and costs.

Life Sciences. OptumInsight's Life Sciences business provides services to more than 200 global life sciences organizations. OptumInsight's services use real-world evidence to support market access and positioning of products, provide insights into patient reported outcomes and optimize and manage risk.

OptumRx

OptumRx provides a full spectrum of pharmacy benefit management (PBM) services to more than 30 million Americans nationwide, managing more than $40 billion in pharmaceutical spending annually and processing nearly 600 million adjusted retail, home delivery and specialty drug prescriptions annually. OptumRx's PBM services deliver a low cost, high-quality pharmacy benefit through retail network contracting services, home delivery and specialty pharmacy services, manufacturer rebate contracting and management and a variety of clinical programs such as step therapy, formulary management, drug adherence and disease and drug therapy management programs. As of December 31, 2014, OptumRx's network included more than 67,000 retail pharmacies and two home delivery pharmacy facilities in California and Kansas.

The home delivery and specialty pharmacy fulfillment capabilities of OptumRx are an important strategic component of its business, providing patients with convenient access to maintenance medications, offering a broad range of complex drug therapies and patient management services for individuals with chronic health conditions and enabling OptumRx to help consumers achieve optimal health, while maximizing cost savings.

OptumRx provides PBM services to a substantial majority of UnitedHealthcare members. Additionally, OptumRx manages specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses with services including patient support and clinical programs designed to ensure quality and deliver value for consumers. This is crucial in managing overall drug spend, as biologics and other specialty medications are the fastest growing pharmacy expenditures. OptumRx also provides PBM services to non-affiliated external clients, including public and private sector employer groups, insurance companies, Taft-Hartley Trust Funds, TPAs, managed care organizations (MCOs), Medicare-contracted plans, Medicaid plans and other sponsors of health benefit plans and individuals throughout the United States. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that 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 that 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 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 amount 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 risk adjustment and reinsurance data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that 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. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies that are held by our Optum businesses and UnitedHealthcare Military & Veterans business, such as our TRICARE West Region contract with the DoD.

Certain of our businesses, such as UnitedHealthcare's eyeglass manufacturing activities and Optum's high acuity clinical workflow software, hearing aid products and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration (FDA). Our business is also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

Health Care Reform. Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system.

Among other requirements, Health Reform Legislation expanded dependent coverage to age 26, expanded benefit requirements, eliminated certain annual and lifetime maximum limits, eliminated certain pre-existing condition limits, required coverage for preventative services without cost to members, required premium rebates if certain medical loss ratios (MLRs) are not satisfied, granted members new and additional appeal rights, created new premium rate review processes, established a system of state and federal exchanges through which consumers can purchase health coverage, imposed new requirements on the format and content of communications (such as explanations of benefits) between health insurers and their members, introduced new risk sharing programs, reduced the Medicare Part D coverage gap and reduced payments to private plans offering Medicare Advantage.

Health Reform Legislation and the related federal and state regulations are affecting how we do business and could impact our results of operations, financial position and cash flows. The full impact of Health Reform Legislation remains difficult to predict and is not yet fully known. See also Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" for a discussion of the risks related to Health Reform Legislation and related matters.

Privacy, Security, and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), 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. ICD-9, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States is anticipated to be replaced by ICD-10 code sets on October 1, 2015, and health plans and providers will be required to use ICD-10 codes for such diagnoses and procedures for dates of services on or after such date.

The Health Information Technology for Economic and Clinical Health Act (HITECH) significantly expanded the privacy and security provisions of HIPAA. HITECH imposes additional requirements on uses and disclosures of health information; includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission 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. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

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 require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

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 that is 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 benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for 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 that, where implemented 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. In 2014, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment Model Act that requires us to maintain a risk management framework and file a self-assessment report with state insurance regulators. The first report will be filed with Connecticut, our lead regulator, in 2015, and annually thereafter. 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 Health Reform Legislation, which may affect our operations and our financial results.

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

that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany 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, MCO, utilization review (UR), TPA, or care provider-related regulations and licensure requirements. These regulations differ from state to state, and may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that 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 distributions laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that 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.

Guaranty Fund Assessments. Under state guaranty fund laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or similar lines of business. Assessments are generally based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an insolvent insurance company's claims through state guaranty association assessments in future periods.

Pharmacy Regulation. OptumRx's home delivery pharmacies must be licensed as pharmacies in the states in which they are located. Our home delivery pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In addition to the laws and regulations in the states where our home delivery pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also apply, including the requirement to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. As our home delivery pharmacies maintain certain Medicare and state Medicaid provider numbers, their participation in the programs requires them to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery 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 PBM businesses.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that 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 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. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states 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 that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). 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.

Consumer Protection Laws. Certain of our businesses participate in direct-to-consumer activities and are subject to emerging regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that 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 that 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 that 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 encompass, among other matters, tax, 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) that vary from jurisdiction to 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 Amil business subjects us to Brazilian laws and regulations affecting the managed care and to insurance industries and regulation by Brazilian regulators including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, whose approach to the interpretation, implementation and enforcement of industry regulations 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 that regulate 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 and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Anthem, Inc., Cigna Corporation, Health Net, Inc., Humana Inc., Kaiser Permanente, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association,

and, with respect to our Brazilian operations, several established competitors in Brazil, and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Caremark Corporation, Express Scripts, Inc. and Catamaran Corporation. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength; and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including by maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. 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, UnitedHealthcare and Optum 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 proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2014, we employed approximately 170,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 10, 2015, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	62	Chief Executive Officer
David S. Wichmann	52	President and Chief Financial Officer
Eric S. Rangen	58	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	61	Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum
Marianne D. Short	63	Executive Vice President and Chief Legal Officer
D. Ellen Wilson	57	Executive Vice President, Human Capital

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. Hemsley is Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. From May 1999 to November 2014, Mr. Hemsley also served as President of UnitedHealth Group.

Mr. Wichmann is President and Chief Financial Officer of UnitedHealth Group. Mr. Wichmann has served as President of UnitedHealth Group since November 2014 and Chief Financial Officer of UnitedHealth Group since January 2011. From April 2008 to November 2014, Mr. Wichmann also served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006.

Mr. Renfro is Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum. Mr. Renfro has served as Vice Chairman of UnitedHealth Group since November 2014 and Chief Executive Officer of Optum since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. 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.

Ms. Wilson is Executive Vice President, Human Capital of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. 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 that 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 Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Conduct. We make periodic reports and amendments available, free of charge, 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, Wells Fargo Shareowner Services, 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: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 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," "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 that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement 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 that 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. They 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 that are difficult to predict or quantify.

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. Premium revenues from risk-based benefits products comprise nearly 90% of our total consolidated revenues. 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. In this regard, Health Reform Legislation established minimum MLRs for certain health plans and authorized HHS to maintain an annual price increase review process for commercial health plans, which could make it more difficult for us to increase the prices of our products. In addition, our OptumHealth Local Care Delivery business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable 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 is typically at a fixed monthly rate per individual served for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. Although we base the 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, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly drugs, treatments and technology, 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 2014 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2014 would have been reduced by approximately $190 million, excluding any offsetting impact from premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, our results of operations could be materially and adversely affected.

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. Some of our UnitedHealthcare and Optum businesses hold 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. In addition, under state guaranty fund laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or similar lines of business. Any such assessment could expose our insurance entities to the risk of paying a portion of an insolvent insurance company's claims through state guaranty association assessments in future periods.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that 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 that 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, which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, FDA regulations, state telemedicine regulations, debt collection laws, banking regulations, distributor and producer licensing requirements, state corporate practice of medicine doctrines, fee-splitting rules, health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business 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 must also obtain and maintain regulatory approvals to market many of our products, increase prices for certain regulated products, 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 to HHS for monitoring purposes on many of our products. Geographic and product expansions 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.

Some of our businesses operate internationally and consequently face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. The regulatory

environments and associated requirements and uncertainties regarding tax, licensing, tariffs, intellectual property, privacy, data protection, investment, capital (including minimum solvency margin and reserve requirements), management control, labor relations, fraud and corruption present compliance requirements and uncertainties for us that are different from those faced by U.S.-based businesses. We have acquired and may in the future acquire or commence additional businesses based outside of the United States, which may subject us to foreign and U.S.-based laws specific to the products and services we acquire or develop outside of the United States. For example, our Amil business subjects us to Brazilian laws and regulations affecting the managed care and insurance industries, which vary from comparable U.S. laws and regulations, and to regulation by Brazilian regulators, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are also subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA. 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 also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation, such as Health Reform Legislation and associated exchanges. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

Health Reform Legislation could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

Due to its complexity, ongoing implementation and continued legal challenges, Health Reform Legislation's full impact remains difficult to predict and could adversely affect us. For example, Health Reform Legislation includes specific reforms for the individual and small group marketplace, including guaranteed availability of coverage, adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (resulting in benefit changes for many members) and actuarial value requirements resulting in expanded benefits or reduced member cost sharing (or a combination of both) for many policyholders. In addition, if we do not maintain certain minimum loss ratios, we are required to rebate ratable portions of our premiums to our customers. These changes can cause significant disruptions in local health care markets and adjustments to our business, all of which could materially and adversely affect our results of operations, financial position and cash flows.

Health Reform Legislation required the establishment of health insurance exchanges for individuals and small employers and requires insurers participating on the health insurance exchanges to offer a minimum level of benefits and includes guidelines on setting premium rates and coverage limitations. While risk adjustment applies to most individual and small group plans in the commercial markets, actual risk adjustment calculations and transfers could materially differ from our assumptions. Our participation in these exchanges involves uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows. In addition, pending legal challenges to the availability of tax subsidies to participants in federal exchange marketplaces could significantly disrupt the health insurance market and negatively affect our business.

Our results of operations, financial position and cash flows could be materially and adversely affected if fewer individuals gain coverage under Health Reform Legislation than we expect, if we are unable to attract these new individuals to our UnitedHealthcare offerings, or if the demand for Health Reform Legislation related products and capabilities offered by our Optum businesses is less than anticipated.

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 that 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, CHIP and our TRICARE West Region contract with the DoD, 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, as is a typical feature of many government contracts, termination of the contract for the convenience 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 that 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. For 2014, CMS asked plans to submit additional information indicating whether or not medical conditions were diagnosed in a clinical setting. CMS has indicated that it will publish further guidance on the treatment of risk adjustment data in early 2015. 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 that 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. In the event any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, 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 Health Reform Legislation, CMS has a system that provides various quality bonus payments to plans that meet certain quality star ratings at the local plan level. The star rating system considers various measures adopted by CMS, including, among other things, quality of care, preventative services, chronic illness management and customer satisfaction. Beginning in 2015, 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 that our plans can offer, which could

materially and adversely affect our results of operations, financial position and cash flows. In addition, under Health Reform Legislation, Congress authorized CMS and the states to implement MMP managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MMP demonstration programs for dually eligible beneficiaries, 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 adjusting 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, and certain of our local plans have been selected for audit. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. In February 2012, CMS published a final RADV audit and payment adjustment methodology. The methodology contains provisions allowing retroactive contract level payment adjustments for the year audited, beginning with 2011 payments, using an extrapolation of the "error rate" identified in audit samples and, for Medicare Advantage plans, after considering a fee-for-service "error rate" adjuster that will be used in determining the payment adjustment. Depending on the error rate found in those audits, if any, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

We have been and may in the future become involved in routine, regular, and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for compliance with coding and other requirements under the Medicare risk-adjustment model. Such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in 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.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive 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 sensitive personal information are 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. For example, the HITECH amendments to

HIPAA imposed further restrictions on our ability to collect, disclose and use sensitive personal information and imposed additional compliance requirements on our business. While we have prepared for the transition to ICD-10 as a HIPAA-regulated entity, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

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 sensitive personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include 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 that is 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 sensitive 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, including 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, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business as a home delivery pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM businesses would be materially and adversely affected by our inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our home delivery or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our home

delivery or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

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, Brazil and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, 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 that give such competitors a competitive advantage. In addition, our competitive position may be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other care professionals). 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. Additionally, 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, health care usage, and in the effective navigation of the health care system we may be challenged by new technologies and market entrants that could disrupt our existing relationship with health plan enrollees in these areas. 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 that demonstrate 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 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 that may be costly, distract managements' attention 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 that 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/hospital organizations or multi-specialty physician groups, may have significant market

positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations; practice management companies (which are companies that aggregate physician practices for administrative efficiency); and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that 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.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation 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 that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. 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 whom 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 those cases, we do not have a pre-established understanding about the amount of compensation that is 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 that does not clearly specify dollar terms. In some instances, providers may believe that 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 certain businesses, including OptumHealth Local Care Delivery and Amil, depend on maintaining satisfactory physician employment relationships. The primary care physicians that 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. There is and will likely be 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 primary care 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 health insurance and HMO competitors of UnitedHealthcare. Our business could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or 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. 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 litigation 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 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 are also 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. Although 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 that 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 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 that 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 upon efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and to 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 that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management 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 may include political instability, government intervention, discriminatory regulation, and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that 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 independent producers and consultants with whom we do not have exclusive contracts and for whose services and allegiance we must compete intensely. Our sales would be materially and adversely affected if we were 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 commissions.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

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 can cause lower enrollment or lower rates of renewal in our employer group plans and our non-employer individual plans. Unfavorable economic conditions have also 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 retrospectively 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 insurance

companies and HMOs 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, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and 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, 2014. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our net investment income and require us to write down the value of our investments, which could materially and adversely affect our profitability and shareholders' equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that 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 shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and credit ratings could be materially and adversely affected.

As of December 31, 2014, goodwill and other intangible assets had a carrying value of $36.6 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 that we acquire perform in a manner that is 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 shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

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 ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of

the data in our information systems. 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. In addition, 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 information 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 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. 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 that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. 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 the health information technology market may 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, that result in security breaches that disrupt our operations or result in the unintended dissemination of sensitive 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 sensitive personal information 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 U.S. due to our information technology systems and international business operations. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. 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 or 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 potential liability for us, damage our brand and reputation, or otherwise harm our business.

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.

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 upon dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by 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 upon the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek prior approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed 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 cycle, 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.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit 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 throughout the industry. 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 that our current credit ratings will be maintained in the future. Downgrades in our credit ratings, should they occur, could materially increase our costs of or ability to access funds in the debt and capital markets and otherwise materially increase our operating costs.

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 "Litigation Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of 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 PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 30, 2015, there were 13,946 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE and cash dividends declared for our last two fiscal years were as follows:

	High	Low	Cash Dividends Declared
2014			
First quarter	$ 83.32	$69.57	$0.2800
Second quarter	$ 83.05	$73.61	$0.3750
Third quarter	$ 88.85	$78.74	$0.3750
Fourth quarter	$104.00	$80.72	$0.3750
2013			
First quarter	$ 58.26	$51.36	$0.2125
Second quarter	$ 66.19	$57.01	$0.2800
Third quarter	$ 75.88	$64.65	$0.2800
Fourth quarter	$ 75.54	$66.72	$0.2800

DIVIDEND POLICY

In June 2014, our Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $1.50 per share, paid quarterly. Since June 2013, we had paid an annual cash dividend of $1.12 per share, paid quarterly. 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 2014

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, 2014	3	$ 87	3	79
November 30, 2014	4	96	4	75
December 31, 2014	3	100	3	71
Total	10	$ 94	10	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2014, the Board 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 GRAPHS

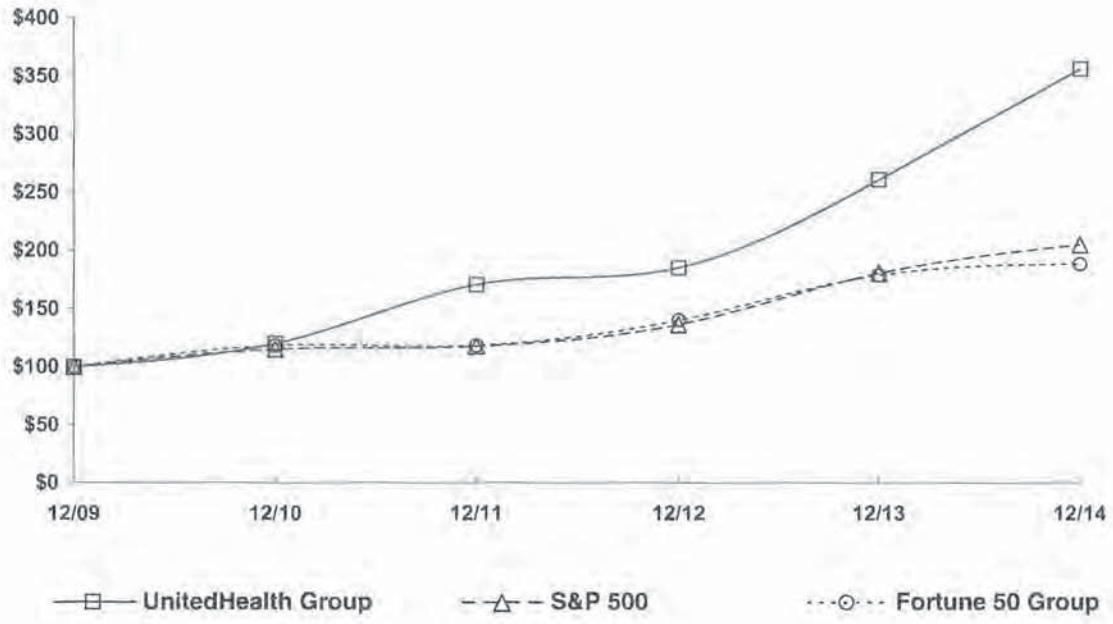
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group") for the five-year period ended December 31, 2014. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2014. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2009 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50 Group



	12/09	12/10	12/11	12/12	12/13	12/14
UnitedHealth Group	$100.00	$119.89	$170.47	$185.11	$261.07	$356.25
S&P 500 Index	100.00	115.06	117.49	136.30	180.44	205.14
Fortune 50 Group	100.00	118.15	118.12	139.95	178.88	188.42

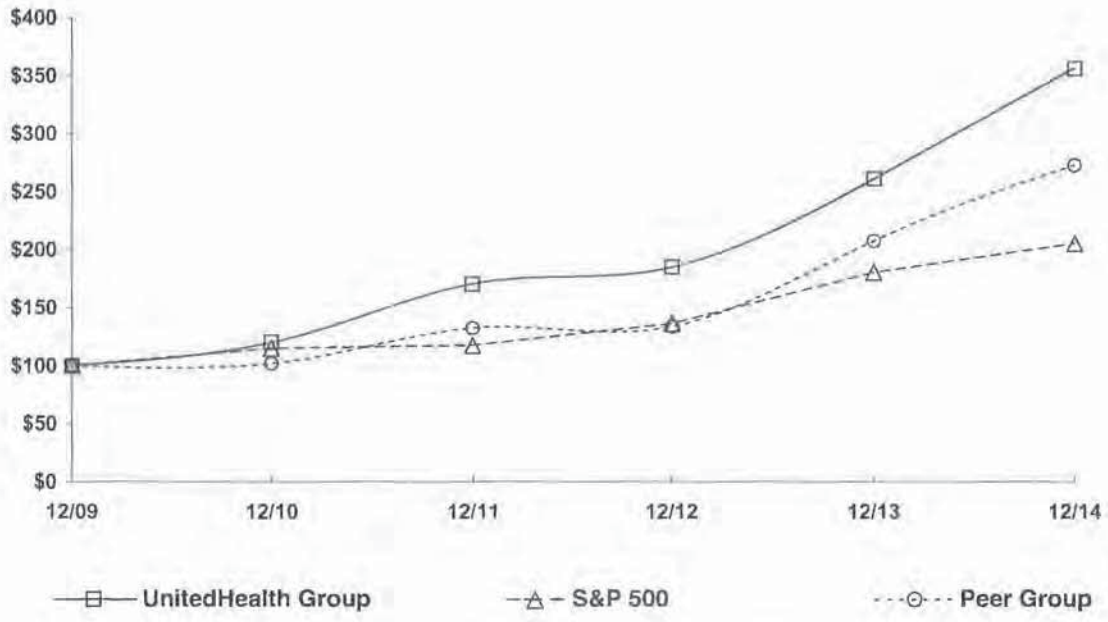
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Anthem Inc., Cigna Corporation and Humana Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index, and Peer Group



	12/09	12/10	12/11	12/12	12/13	12/14
UnitedHealth Group	**$100.00**	**$119.89**	**$170.47**	**$185.11**	**$261.07**	**$356.25**
S&P 500 Index	**100.00**	**115.06**	**117.49**	**136.30**	**180.44**	**205.14**
Peer Group	**100.00**	**101.88**	**132.34**	**133.68**	**207.73**	**272.75**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Year Ended December 31, 2014	2013	2012 (a)	2011	2010
Consolidated operating results					
Revenues	$130,474	$122,489	$110,618	$101,862	$94,155
Earnings from operations	10,274	9,623	9,254	8,464	7,864
Net earnings attributable to UnitedHealth Group common shareholders	5,619	5,625	5,526	5,142	4,634
Return on equity (b)	17.3%	17.7%	18.7%	18.9%	18.7%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 5.78	$ 5.59	$ 5.38	$ 4.81	$ 4.14
Diluted earnings per share attributable to UnitedHealth Group common shareholders	5.70	5.50	5.28	4.73	4.10
Cash dividends declared per common share	1.4050	1.0525	0.8000	0.6125	0.4050
Consolidated cash flows from (used for)					
Operating activities	$ 8,051	$ 6,991	$ 7,155	$ 6,968	$ 6,273
Investing activities	(2,534)	(3,089)	(8,649)	(4,172)	(5,339)
Financing activities	(5,293)	(4,946)	471	(2,490)	(1,611)
Consolidated financial condition					
(as of December 31)					
Cash and investments	$ 28,063	$ 28,818	$ 29,148	$ 28,172	$25,902
Total assets	86,382	81,882	80,885	67,889	63,063
Total commercial paper and long-term debt	17,406	16,860	16,754	11,638	11,142
Redeemable noncontrolling interests	1,388	1,175	2,121	—	—
Shareholders' equity	32,454	32,149	31,178	28,292	25,825
Debt to debt-plus-equity ratio	34.9%	34.4%	35.0%	29.1%	30.1%

(a) Includes the effects of the October 2012 Amil acquisition and related debt and equity issuances.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters of the year presented.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

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 Item 8, "Financial Statements." Readers are cautioned that 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 that 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."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Business Trends

Our businesses participate in the U.S., Brazilian and certain other international health economies. In the U.S., health care spending comprises approximately 18% of gross domestic product and has grown consistently for many years. 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 and regulatory changes, including enacted health reform legislation in the United States, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations. Our review of regulatory considerations involves a focus on minimum MLR thresholds and the new risk adjustment, risk corridor and reinsurance provisions that impact the small group and individual markets. We will continue to balance growth and profitability across all of these dimensions. Overall, we continue to be under pressure from ongoing market competition in commercial products and from government payment rates.

The intensity of commercial pricing competition depends on local market conditions and competitive dynamics. Health plans have generally reflected the Industry Tax and Reinsurance Programs (together, ACA Fees) in their pricing. Conversely, the industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted pricing trends. Having reflected the additional cost step-ups in 2014 related to the ACA Fees, we anticipate health plans' pricing returning to a more normal inflation rate in 2015.

Annual commercial premium rate increases are subject to federal and state review and approval procedures. While our rates and rate filings are developed using methods consistent with the standards of actuarial practice, we have experienced regulatory challenges to proposed premium rate increases in certain states, including California and New York.

The Medicare Advantage rate structure is changing and funding has been cut in recent years, with additional reductions to take effect in 2015, as discussed below in "Regulatory Trends and Uncertainties." We are taking actions to respond to these funding reductions, but the reductions adversely affected after-tax earnings for our Medicare business during 2014, and we expect our 2015 Medicare MLR to be slightly higher than in 2014.

We expect continued Medicaid revenue increases due to anticipated growth in our offerings; we also believe that the reimbursement rate environment creates the risk of downward pressure on Medicaid net margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We advocate for actuarially sound rates that are commensurate with our medical cost trends and 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 are primarily related to unit costs, utilization and prescription drug costs. Consistent with our experience in recent years, our 2014 cost trends were largely driven by continued unit cost pressure from health care providers. Although the weak economic environment combined with our medical cost management strategies has had a favorable impact on utilization trends in recent years, the impacts of Health Reform Legislation, namely mandated essential health benefits and limits on out-of-pocket maximums, are exerting upward pressure on medical cost trends. The primary drivers of prescription drug trends continue to be unit cost pressure on brand name drugs and a shift towards expensive new specialty medications, including new hepatitis C therapies.

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. Delivery system modernization and payment reform are critical and the alignment of incentives between key constituents remains an important theme.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2014, we served nearly 3 million people through the most progressive of these arrangements, including full-risk, shared-risk and bundled episode-of-care payment approaches. As of December 31, 2014, our contracts with value based spending total nearly $37 billion annually, up significantly from recent years.

This trend is creating needs for health management services that 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 Health Reform Legislation and other regulatory items. For additional information regarding Health Reform Legislation and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage rates have been cut over the last several years, with additional funding reductions to be phased-in through 2017 as a result of (a) changes to CMS Medicare Advantage benchmark rates; (b) Health Reform Legislation; and (c) the Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, which reduced Medicare Advantage and Medicare Part D payments (Sequestration). The CMS final notice of 2015 Medicare Advantage benchmark rates and payment policies includes additional significant reductions for 2015. These industry level reductions, including the impact of the Industry Tax described below, resulted in revenue reductions and incremental assessments totaling more than 6% of revenue in 2014 and more than an additional 3% in 2015, against a typical industry forward medical cost trend of 3%. The impact of these cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. These factors affected our plan benefit designs, market participation, growth prospects and expectation of earnings for our Medicare Advantage plans for 2015.

Health Reform Legislation directed HHS to establish a program to reward high-quality Medicare Advantage plans beginning in 2012. 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. In addition, star ratings affect the amount of savings a plan has to generate to offer supplemental benefits, which ultimately may affect the plan's membership and revenue. The historical expanded star bonus program, which paid bonuses to qualifying plans rated 3 stars or higher expired after 2014. In 2015, quality bonus payments will be paid only to plans rated 4 stars and higher. For the 2015 star bonus payment year, more than 37% of our Medicare Advantage members are enrolled in plans rated 4 stars or higher. We currently expect a similar percentage of members to be enrolled in such plans for the 2016 payment year. We are dedicating substantial resources to advance our quality scores and star ratings to strengthen our local market programs and further improve our performance for the 2017 and 2018 payment years.

The ongoing reductions to Medicare Advantage funding place 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 reductions. These adjustments will 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, implement or increase member premiums over the monthly payments we receive from the government, and decide on a county-by-county basis where we will offer Medicare Advantage plans. For 2015, we have added premiums in certain markets; one-third of our members that had previously purchased $0 premium products will be impacted. We may experience some reduction in membership in the plans with the greatest premiums additions, but we expect overall growth in Medicare Advantage membership in 2015.

In the longer term, we also may be able to mitigate some of the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. As Medicare Advantage reimbursement changes, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Industry Tax and Premium Stabilization Programs. Health Reform Legislation includes an Industry Tax levied proportionally across the health insurance industry for risk-based products, which began January 1, 2014. The industry-wide amount of the annual tax was $8 billion in 2014 and increases to $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will equal the annual tax for the preceding year increased by the rate of premium growth for the preceding year. In 2015, we expect that our share of the Industry Tax will be $1.8 billion compared to $1.3 billion in 2014.

With the introduction of state health insurance exchanges and other significant market reforms in the individual and small group markets in 2014, Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs encompass: a Reinsurance Program; a temporary risk corridors

program; and a permanent risk adjustment program. The Reinsurance Program is a temporary program that will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements. The total three year amount of $25 billion for the Reinsurance Program will be allocated as follows: $20 billion (2014 - $10 billion, 2015 - $6 billion, 2016 - $4 billion) subject to increases based on state decisions, to fund the reinsurance pool and $5 billion (2014 and 2015 - $2 billion, 2016 - $1 billion) to fund the U.S. Treasury. While funding for the Reinsurance Program will come from all commercial lines of business, only market reform compliant individual businesses will be eligible for reinsurance recoveries.

For detail on the Industry Tax and Premium Stabilization Programs, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Exchanges and Coverage Expansion. Across markets, we and our competitors are adapting product, network and marketing strategies to anticipate new or expanding distribution channels including public exchanges, private exchanges and off exchange purchasing. Effective in 2014, states have either created their own public exchange, entered a partnership exchange or relied on the federally facilitated exchange for individuals and small employers. The exchanges have created new market dynamics that have impacted and could further impact our existing businesses, depending on the ultimate member migration patterns for each market. In 2014, commercial fully insured membership expanded industry-wide with more than 7 million consumers served through the individual public exchanges alone. Self-insured enrollment remained relatively stable, but there has been an increased interest in post-reform alternatives such as private exchange solutions. Our level of participation in public exchanges is determined on a state-by-state basis. Each state is evaluated based on factors such as growth opportunities, our current local presence, our competitive positioning, our ability to honor our commitments to our local customers and consumers, and the regulatory environment. In 2014, we participated in 13 state public exchanges, including four individual and nine small group exchanges. In 2015, we are participating in 23 individual exchanges and in 12 small group exchanges.

Health Reform Legislation also provided for optional expanded Medicaid coverage that became effective in January 2014. We participate in programs in 24 states and the District of Columbia, and of these, 12 states opted to expand Medicaid for 2014. For 2015, 13 of our state customers have elected to expand Medicaid. The Congressional Budget Office forecasts that due to Medicaid expansion, a total of 13 million people will have obtained coverage through Medicaid by the end of 2016, and we are actively seeking to build market share serving the needs of these Medicaid expansion beneficiaries and their state sponsors.

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, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
Revenues:							
Premiums	$115,302	$109,557	$ 99,728	$5,745	5%	$ 9,829	10%
Services	10,151	8,997	7,437	1,154	13	1,560	21
Products	4,242	3,190	2,773	1,052	33	417	15
Investment and other income	779	745	680	34	5	65	10
Total revenues	130,474	122,489	110,618	7,985	7	11,871	11
Operating costs:							
Medical costs	93,257	89,290	80,226	3,967	4	9,064	11
Operating costs	21,681	19,362	17,306	2,319	12	2,056	12
Cost of products sold	3,784	2,839	2,523	945	33	316	13
Depreciation and amortization	1,478	1,375	1,309	103	7	66	5
Total operating costs	120,200	112,866	101,364	7,334	6	11,502	11
Earnings from operations	10,274	9,623	9,254	651	7	369	4
Interest expense	(618)	(708)	(632)	(90)	(13)	76	12
Earnings before income taxes	9,656	8,915	8,622	741	8	293	3
Provision for income taxes	(4,037)	(3,242)	(3,096)	795	25	146	5
Net earnings	5,619	5,673	5,526	(54)	(1)	147	3
Earnings attributable to noncontrolling interests	—	(48)	—	(48)	nm	48	nm
Net earnings attributable to UnitedHealth Group common shareholders	$ 5,619	$ 5,625	$ 5,526	$ (6)	—%	$ 99	2%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 5.70	$ 5.50	$ 5.28	$ 0.20	4%	$ 0.22	4%
Medical care ratio (a)	80.9%	81.5%	80.4%	(0.6)%		1.1%	
Operating cost ratio	16.6	15.8	15.6	0.8		0.2	
Operating margin	7.9	7.9	8.4	—		(0.5)	
Tax rate	41.8	36.4	35.9	5.4		0.5	
Net earnings margin	4.3	4.6	5.0	(0.3)		(0.4)	
Return on equity (b)	17.3%	17.7%	18.7%	(0.4)%		(1.0)%	

nm = not meaningful

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Return on equity is calculated as annualized net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2014 year-over-year operating comparisons to 2013 and other 2014 significant items.

- Consolidated revenues increased by 7%, Optum revenues grew 25% and UnitedHealthcare revenues increased 5%.
- ACA Fees favorably affected our 2014 medical care ratio (110 bps), and unfavorably impacted our operating cost ratio (120 bps) and effective income tax rate (510 bps).
- Earnings from operations increased by 7%, including an increase of 32% at Optum partially offset by a decrease of 2% at UnitedHealthcare.
- Diluted earnings per share to UnitedHealth Group shareholders increased 4% to $5.70 and included the negative year-over-year impact of approximately $1.00 per share in ACA Fees, ACA Medicare rate cuts and other ACA impacts.
- As of December 31, 2014, there was $738 million of cash available for general corporate use and 2014 cash flows from operations were $8.1 billion.

2014 RESULTS OF OPERATIONS COMPARED TO 2013 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during the year ended December 31, 2014 were primarily driven by growth in the number of individuals served in our public and senior markets businesses and growth across all of Optum's businesses.

Medical Costs and Medical Care Ratio

Medical costs during the year ended December 31, 2014 increased due to risk-based membership growth in our public and senior markets businesses. To the extent possible, we included the reform fees and related tax impacts in our pricing; since the ACA Fees are included in operating costs, this decreased our medical care ratio in 2014. This decrease from ACA fees was partially offset by the impact of lower levels of favorable medical cost reserve development.

Operating Cost Ratio

The increase in our operating cost ratio during the year ended December 31, 2014 was due to the introduction of ACA Fees and services business growth and acquisitions, partially offset by productivity and operating performance gains.

Income Tax Rate

The increase in our income tax rate resulted primarily from the nondeductible Industry Tax.

See Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" and "Industry Tax and Premium Stabilization Programs" in the "Executive Overview" above for more information on the Industry Tax and ACA Fees.

Reportable Segments

Prior period segment financial information has been recast to conform to the 2014 presentation. See Notes 2 and 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
Revenues							
UnitedHealthcare	$119,798	$113,725	$103,332	$6,073	5%	$10,393	10%
OptumHealth	11,032	9,855	8,147	1,177	12	1,708	21
OptumInsight	5,227	4,714	4,257	513	11	457	11
OptumRx	31,976	24,006	18,359	7,970	33	5,647	31
Optum eliminations	(489)	(458)	(364)	31	7	94	26
Optum	47,746	38,117	30,399	9,629	25	7,718	25
Eliminations	(37,070)	(29,353)	(23,113)	7,717	26	6,240	27
Consolidated revenues	$130,474	$122,489	$110,618	$7,985	7%	$11,871	11%
Earnings from operations							
UnitedHealthcare	$ 6,992	$ 7,132	$ 7,687	$ (140)	(2)%	$ (555)	(7)%
OptumHealth	1,090	949	538	141	15	411	76
OptumInsight	1,002	831	656	171	21	175	27
OptumRx	1,190	711	373	479	67	338	91
Optum	3,282	2,491	1,567	791	32	924	59
Consolidated earnings from operations	$ 10,274	$ 9,623	$ 9,254	$ 651	7%	$ 369	4%
Operating margin							
UnitedHealthcare	5.8%	6.3%	7.4%	(0.5)%		(1.1)%	
OptumHealth	9.9	9.6	6.6	0.3		3.0	
OptumInsight	19.2	17.6	15.4	1.6		2.2	
OptumRx	3.7	3.0	2.0	0.7		1.0	
Optum	6.9	6.5	5.2	0.4		1.3	
Consolidated operating margin	7.9%	7.9%	8.4%	—%		(0.5)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
UnitedHealthcare Employer & Individual	$ 43,017	$ 44,847	$ 46,509	$(1,830)	(4)%	$ (1,662)	(4)%
UnitedHealthcare Medicare & Retirement	46,258	44,225	39,257	2,033	5	4,968	13
UnitedHealthcare Community & State	23,586	18,268	16,422	5,318	29	1,846	11
UnitedHealthcare Global	6,937	6,385	1,144	552	9	5,241	nm
Total UnitedHealthcare revenues	$119,798	$113,725	$103,332	$ 6,073	5%	$10,393	10%

nm = not meaningful

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, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
Commercial risk-based	7,505	8,185	9,340	(680)	(8)%	(1,155)	(12)%
Commercial fee-based	18,350	19,055	17,585	(705)	(4)	1,470	8
Commercial fee-based TRICARE	2,895	2,920	—	(25)	(1)	2,920	nm
Total commercial	28,750	30,160	26,925	(1,410)	(5)	3,235	12
Medicare Advantage	3,005	2,990	2,565	15	1	425	17
Medicaid	5,055	4,035	3,830	1,020	25	205	5
Medicare Supplement (Standardized)	3,750	3,455	3,180	295	9	275	9
Total public and senior	11,810	10,480	9,575	1,330	13	905	9
International	4,425	4,805	4,425	(380)	(8)	380	9
Total UnitedHealthcare — medical	44,985	45,445	40,925	(460)	(1)%	4,520	11%
Supplemental Data:							
Medicare Part D stand-alone	5,165	4,950	4,225	215	4%	725	17%

nm = not meaningful

The decrease in commercial risk-based enrollment was a result of disciplined pricing in a continued competitive environment and a decrease in individual policy customers due to customers moving to public exchanges. The decrease in number of people served under commercial fee-based arrangements was primarily attributable to the loss of a large state employer account. Medicare Advantage participation increased slightly year-over-year despite the significant funding reductions, which caused us to exit certain markets in January 2014, reduce product offerings, adjust networks and reduce benefits for 2014. Approximately 60% of the Medicaid growth was driven by Medicaid expansion under the ACA with the remaining growth resulting from the combination of states launching new programs to complement established programs and growth in those traditional programs. Medicare Supplement growth reflected strong customer retention and new sales. The number of people served internationally decreased year-over-year primarily due to price increases in Brazil in response to the increasing costs of mandated health care benefits. In our Medicare Part D stand-alone business, the number of people served increased primarily as a result of new product introductions and strong customer retention.

UnitedHealthcare's revenue growth during the year ended December 31, 2014 was due to growth in the number of individuals served in our public and senior markets businesses; revenues to recover ACA Fees, which resulted in $1.5 billion of additional annual premiums in 2014; and commercial price increases reflecting underlying medical cost trends. These increases were partially offset by decreased commercial risk-based enrollment and a reduced level of Medicare Advantage funding.

UnitedHealthcare's operating earnings for the year ended December 31, 2014 were pressured year-over-year by ACA Fees, Medicare Advantage funding reductions, increased spending on specialty medications to treat hepatitis C and reduced levels of favorable medical cost reserve development. Partially offsetting these factors were growth in our public and senior markets businesses, reduced levels of per-member inpatient hospital utilization and revenue true-ups.

Optum

Total revenues increased for the year ended December 31, 2014 primarily due to pharmacy growth at OptumRx and growth at OptumHealth.

The increases in Optum's earnings from operations and operating margins for the year ended December 31, 2014 were driven by revenue growth and increased productivity, partially offset by investments at OptumHealth and OptumInsight.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth during 2014 primarily due to acquisitions and growth in local care delivery and subacute care services.

Earnings from operations and operating margins for the year ended December 31, 2014 increased primarily due to revenue growth and cost efficiencies, offset in part by investments to develop future growth opportunities.

OptumInsight

Revenue, earnings from operations and operating margins at OptumInsight for the year ended December 31, 2014 increased primarily due to the growth and expansion in revenue management services and government exchange services, partially offset by a reduction in hospital compliance services and investments for future growth.

OptumRx

Increased OptumRx revenue for the year ended December 31, 2014 was due to growth in people served in UnitedHealthcare's public and senior markets, the insourcing of UnitedHealthcare's commercial pharmacy benefit programs, which was completed on January 1, 2014, growth from external clients and an increase in specialty pharmaceutical revenues.

Earnings from operations and operating margins for the year ended December 31, 2014 increased primarily due to growth in scale that resulted in greater productivity and better absorption of our fixed costs, and improved performance in both drug purchasing and home delivery pharmacy fulfillment.

2013 RESULTS OF OPERATIONS COMPARED TO 2012 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during 2013 were primarily driven by the full year effect of 2012 acquisitions, including Amil, growth in the number of individuals served through benefit products and overall organic growth in each of Optum's major businesses. The revenue impact of these factors was partially offset by the reduction in Medicare Advantage rates. Also offsetting the revenue increase was the first quarter conversion of a large fully-insured commercial customer from a risk-based to a fee-based arrangement affecting 1.1 million members. While this conversion reduced our full-year 2013 consolidated revenues by $2.3 billion, the impact to earnings from operations and cash flows was negligible.

Medical Costs and Medical Care Ratio

Medical costs during 2013 increased due to risk-based membership growth in our international and public and senior markets businesses, partially offset by the funding conversion of the large client discussed above. The year-over-year medical care ratio increased primarily due to funding reductions for Medicare Advantage products, changes in business mix favoring governmental benefit programs, and reduced levels of favorable medical cost reserve development.

Operating Costs

The increase in our operating costs during 2013 was due to business growth, including an increase in fee-based benefits and fee-based service revenues and a greater mix of international business, which carry comparatively higher operating costs, partially offset by our ongoing cost containment efforts.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth in 2013 was primarily attributable to the impact of 2012 acquisitions and the growth in the number of individuals served. The effect of these factors was partially offset by the government funding reductions described previously and the customer funding conversion discussed above.

UnitedHealthcare's earnings from operations and operating margins in 2013 decreased compared to the prior year as operating margins were pressured by the funding reductions that decreased revenues and by decreased levels of favorable reserve development.

Optum

Total revenues increased in 2013 primarily due to broad-based growth across Optum's services portfolio with growth in each of Optum's major businesses led by pharmacy growth from the insourcing of UnitedHealthcare commercial customers and external clients.

Optum's earnings from operations and operating margin in 2013 increased significantly compared to 2012, reflecting progress on Optum's plan to accelerate growth and improve productivity by strengthening integration and business alignment.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth in 2013 were primarily due to market expansion, including growth related to 2012 acquisitions in local care delivery, and organic growth.

Earnings from operations and operating margins in 2013 increased primarily due to revenue growth and an improved cost structure across the business, including local care delivery, population health and wellness solutions, and health-related financial services offerings.

OptumInsight

Revenues at OptumInsight in 2013 increased primarily due to the impact of a 2012 acquisition and growth in services to commercial payers.

The increases in earnings from operations and operating margins in 2013 reflected increased revenues, changes in product mix and continuing improvements in business alignment and efficiency.

OptumRx

The increase in OptumRx revenues in 2013 were due to the insourcing of UnitedHealthcare's commercial pharmacy benefit programs and growth in both UnitedHealthcare's Medicare Part D members and external clients. Over the course of 2013, we completed our transition of 12 million migrating and new members to the OptumRx platform from a third-party.

Earnings from operations and operating margins in 2013 increased primarily due to strong revenue growth, pricing disciplines, and greater use of generic medications.

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 financial 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 that may be paid to their parent companies.

In 2014, our U.S. regulated subsidiaries paid their parent companies dividends of $4.6 billion. For the twelve months ended December 31, 2013, our U.S. regulated subsidiaries paid their parent companies dividends of $3.2 billion. See Note 10 of 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 cash flows from operations that are 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 shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013	Increase/ (Decrease) 2013 vs. 2012
Sources of cash:					
Cash provided by operating activities	$ 8,051	$ 6,991	$ 7,155	$1,060	$ (164)
Sales and maturities of investments, net of purchases	799	—	—	799	—
Customer funds administered	—	31	—	(31)	31
Proceeds from common stock issuances	462	598	1,078	(136)	(480)
Issuances of long-term debt and commercial paper, net of repayments	391	152	4,567	239	(4,415)
Other	37	45	—	(8)	45
Total sources of cash	9,740	7,817	12,800		
Uses of cash:					
Common stock repurchases	(4,008)	(3,170)	(3,084)	(838)	(86)
Purchases of property, equipment and capitalized software, net	(1,447)	(1,161)	(1,070)	(286)	(91)
Cash dividends paid	(1,362)	(1,056)	(820)	(306)	(236)
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed	(1,923)	(1,836)	(6,599)	(87)	4,763
Purchases of investments, net of sales and maturities	—	(1,611)	(1,299)	1,611	(312)
Customer funds administered	(638)	—	(324)	(638)	324
Other	(138)	(27)	(627)	(111)	600
Total uses of cash	(9,516)	(8,861)	(13,823)		
Effect of exchange rate changes on cash and cash equivalents	(5)	(86)	—	81	(86)
Net increase (decrease) in cash and cash equivalents	$ 219	$(1,130)	$ (1,023)	$1,349	$ (107)

2014 Cash Flows Compared to 2013 Cash Flows

Cash flows provided by operating activities in 2014 increased primarily due to an increased level of accounts payable and other liabilities including the collection of Reinsurance Program fees in advance of remittance in 2015, partially offset by an increase in government receivables.

Other significant changes in sources or uses of cash year-over-year included: (a) a change in investment activity from net purchases in 2013 to net sales in 2014; (b) an increase in Part D subsidy receivables causing a change in customer funds administered; and (c) increased levels of cash used to repurchase common stock.

2013 Cash Flows Compared to 2012 Cash Flows

Cash flows provided by operating activities in 2013 decreased due to the net effects of changes in operating assets and liabilities, including: (a) an increase in pharmacy rebates receivables stemming from the increased membership at OptumRx, the effects of which were partially offset by (b) increases in medical costs payable due to the growth in the number of individuals served in our public and senior markets and international businesses.

Other significant items contributing to the overall decrease in cash year-over-year included: (a) decreased investments in acquisitions and noncontrolling interest shares (the activity in 2013 primarily related to the acquisition of the remaining publicly traded shares of Amil during the second quarter of 2013 for $1.5 billion);

(b) a decrease in net proceeds from commercial paper and long-term debt, as proceeds from 2013 debt issuances were fully offset by scheduled maturities and the redemption of all of our outstanding subsidiary debt (in 2012, the increased cash flows from common stock issuances and proceeds from issuances of commercial paper and long-term debt primarily related to the Amil acquisition); and (c) increased net purchases of investments.

Financial Condition

As of December 31, 2014, our cash, cash equivalent and available-for-sale investment balances of $27.6 billion included $7.5 billion of cash and cash equivalents (of which $738 million was available for general corporate use), $18.6 billion of debt securities and $1.5 billion of investments in equity securities consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. 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. The use of different market assumptions or valuation methodologies, especially those used in valuing our $384 million of available-for-sale Level 3 securities (those securities priced using significant unobservable inputs), may have an effect on the estimated fair values of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of 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 3.4 years and a weighted-average credit rating of "AA" as of December 31, 2014. 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

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Our bank credit facilities contain various covenants, including covenants requiring us to maintain a debt to debt-plus-equity ratio of not more than 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders' equity, which reasonably approximates the actual covenant ratio, was 34.9% as of December 31, 2014.

Long-Term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases.

In December 2014, we issued $2.0 billion in senior unsecured notes, which included: $750 million of 1.4% fixed-rate notes due December 15, 2017, $500 million of 2.3% fixed-rate notes due December 15, 2019 and $750 million of 2.875% fixed-rate notes due December 15, 2021.

Credit Ratings. Our credit ratings as of December 31, 2014 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	bbb+	Positive
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	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. For example, 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. In June 2014, our Board renewed our share repurchase program with an authorization to repurchase up to 100 million shares of our common stock. As of December 31, 2014, we had Board authorization to purchase up to an additional 71 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2014, our Board of Directors increased our quarterly cash dividend to shareholders to an annual dividend rate of $1.50 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2014, under our various contractual obligations and commitments:

(in millions)	2015	2016 to 2017	2018 to 2019	Thereafter	Total
Debt (a)	$2,103	$4,398	$3,193	$17,997	$27,691
Operating leases	491	715	533	464	2,203
Purchase obligations (b)	176	173	17	6	372
Future policy benefits (c)	127	282	289	1,917	2,615
Unrecognized tax benefits (d)	2	—	—	83	85
Other liabilities recorded on the Consolidated Balance Sheet (e)	207	36	—	1,321	1,564
Other obligations (f)	143	126	44	33	346
Redeemable noncontrolling interests (g)	83	767	538	—	1,388
Total contractual obligations	$3,332	$6,497	$4,614	$21,821	$36,264

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2014.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, the long-term portion has been classified as "Thereafter."
(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."
(f) Includes remaining capital commitments for venture capital funds and other funding commitments.
(g) Includes commitments for redeemable shares of our subsidiaries, primarily the shares owned by Amil's remaining non-public shareholders.

We do not have other significant contractual obligations or commitments that require 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.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2014, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

In May 2014, the Financial Accounting Standards Board issued ASU No. 2014-09 "Revenue from Contracts with Customers (Topic 606)." ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard using either the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. We are currently evaluating the effect of the new revenue recognition guidance.

We have determined that there have been no other recently issued, but not yet adopted, accounting standards that will have a material impact on our Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Each reporting period, we estimate our obligations for medical care services that have been rendered on behalf of insured consumers but for which claims have either not yet been received or processed and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical care services incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim processing backlogs, 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. 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. Substantially all claims related to medical care services are known and settled within nine to twelve months from the date of service. As of December 31, 2014, our days outstanding in medical payables was 47 days, calculated as total medical payables divided by total medical costs times 365 days.

Each period, we re-examine 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, we adjust the amount of the estimates and include the changes in estimates in medical costs in the period in which the change is identified. Therefore, in every 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 2014, 2013 and 2012 included favorable medical cost development related to prior years of $420 million, $680 million and $860 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, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. 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 that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily 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. Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs 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) or our claim processing patterns are different than estimated, our reserves 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, 2014:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 318
(0.50)	212
(0.25)	106
0.25	(105)
0.50	(209)
0.75	(313)

Medical Cost PMPM Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent three 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 by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product

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 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 and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2014:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 635
2	423
1	212
(1)	(212)
(2)	(423)
(3)	(635)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2014, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2014; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2014 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2014 net earnings would have increased or decreased by $67 million.

Revenues

We derive a substantial portion of our revenues from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and health care providers collect, capture, and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information, and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Risk adjustment data for certain of our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us to CMS.

U.S. commercial health plans with MLRs on fully insured products, as calculated under the definitions in Health Reform Legislation, that fall below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals) are required to rebate ratable portions of their premiums to their customers

annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because we are able to reasonably estimate the ultimate premiums of these contracts. Each period, we estimate premium rebates based on the expected financial performance of the applicable contracts within each defined aggregation set (e.g., by state, group size and licensed subsidiary). The most significant factors in estimating the financial performance are current and future premiums and medical claim experience, effective tax rates and expected changes in business mix. The estimated ultimate premium is revised each period to reflect current and projected experience.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Impairment tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step impairment test. First, we can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include 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 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.

Forecasts 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. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends, and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates, and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the "Medical Cost Trend" section of Executive Overview-Business Trends above and the discussion in the "Medical Costs Payable" critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, due to the long-term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, "Business—Government Regulation." For additional discussions regarding how the enactment or implementation of health care reforms and other factors could affect our business and the related long-term forecasts, see Part I, Item 1A, "Risk Factors" and "Regulatory Trends and Uncertainties" above.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. Beyond our selection of the most appropriate risk-free rates and equity risk premiums, our most significant estimates in the discount rate determinations involve our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. Such adjustments include the addition of size premiums and company-specific risk premiums intended to compensate for apparent forecast risk. 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.

We elected to bypass the optional qualitative reporting unit fair value assessment and completed our annual quantitative tests for goodwill impairment as of January 1, 2015. All of our reporting units had fair values substantially in excess of their carrying values.

Intangible Assets. Our recorded separately-identifiable intangible assets were acquired in business combinations and represent future expected benefits but they lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). These intangible assets are initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives, while indefinite-lived intangible assets are evaluated for impairment on at least an annual basis. Both finite-lived and indefinite-lived intangible assets are evaluated for impairment between annual periods if an event occurs or circumstances change that may indicate impairment. Our most significant intangible assets are customer-related intangibles, which represent 71% of our total intangible asset balance of $3.7 billion as of December 31, 2014.

Customer-related intangible assets acquired in business combinations are typically valued using an income approach based on discounted future cash flows attributable to customers that exist as of the date of acquisition. The most significant assumptions used in the valuation of customer-related assets include: projected revenue and earnings growth, retention rates, perpetuity growth rates and discount rates. These initial valuations and the embedded assumptions contain uncertainty to the extent that those assumptions and estimates may ultimately differ from actual results (e.g., customer turnover may be higher or lower than the assumed retention rate suggested).

Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value, and other factors. Following the identification of any potential impairment indicators, we would calculate the estimated fair value of a finite-lived intangible asset (or asset group) using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that an impairment exists, the amount by which the carrying value exceeds its estimated fair value would be recorded as an impairment.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we assess qualitative factors to determine whether the existence of events and circumstances indicates that it is more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value. If, after assessing the totality of events and circumstances, we conclude that it is not more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value, no impairment exists and no further testing is performed. If we

conclude otherwise, we would perform a quantitative analysis by comparing its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not materially impaired in 2014.

Investments

As of December 31, 2014, we had investments with a carrying value of $20.6 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from net earnings and report net unrealized gains or losses, net of income tax effects, as other comprehensive income and as a separate component in shareholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2014, our available-for-sale investments had gross unrealized gains of $423 million and gross unrealized losses of $66 million.

For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell the security before recovery of the entire amortized cost basis or maturity of the security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, and recognized in net earnings, and all other causes, and recognized in other comprehensive income.

For equity securities, we recognize unrealized losses in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the loss in net earnings.

The most significant judgments and estimates related to investments are related to determination of their fair values and the other-than-temporary impairment assessment.

Fair Values. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. We obtain 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, 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, benchmark yields, credit spreads, default rates and prepayment speeds, and non-binding broker quotes. As we are responsible for the determination of fair value, we perform quarterly analyses of the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, we compare:

- prices received from the pricing service to prices reported by a secondary pricing service, our custodian, our investment consultant and third-party investment advisors; and
- changes in the reported market values and returns to relevant market indices and our expectations to test the reasonableness of the reported prices.

Based on our internal price verification procedures and our review of the fair value methodology documentation provided by independent pricing service, we have not historically adjusted the prices obtained from the pricing service.

Other-Than-Temporary Impairment Assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of

impairment and 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. Other factors included in the assessment include the type and nature of the securities and their liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations) as opposed to credit related. We do not expect that trend to change in the near term. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

Our unrealized losses of $66 million and $234 million at December 31, 2014 and 2013, respectively, were primarily caused by market interest rate increases and not by unfavorable changes in the credit standing. We believe we will collect the principal and interest due on our debt securities with an amortized cost in excess of fair value. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are of investment-grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with our investment policy. Total other-than-temporary impairments for 2014, 2013 and 2012 were $26 million, $8 million and $6 million, respectively. Our available-for-sale debt portfolio had a weighted-average credit rating of "AA" as of December 31, 2014. We have minimal securities collateralized by sub-prime or Alt-A securities, and a minimal amount of commercial mortgage loans in default.

The judgments and estimates related to fair value and other-than-temporary impairment may ultimately prove to be inaccurate due to many factors including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available, including changes to current facts and circumstances, or as unknown or estimated unlikely trends develop.

As discussed further in Item 7A "Quantitative and Qualitative Disclosures About Market Risk" a 1% increase in market interest rates would have the effect of decreasing the fair value of our investment portfolio by $683 million.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements.

Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes. We have established a valuation allowance against certain deferred tax assets for which it is more-likely-than-not that some portion, or all, of the deferred tax asset will not be realized.

An uncertain tax position is recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax positions due to changes in tax law resulting from legislation, regulation or as concluded through the various jurisdictions' tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2014 earnings before income taxes would have caused the provision for income taxes and net earnings to change by $97 million.

Contingent Liabilities

Because of the nature of our businesses, we are routinely involved in various disputes, legal proceedings and governmental audits and investigations. We record liabilities for our estimates of the probable costs resulting from these matters where appropriate. Our estimates are developed in consultation with legal counsel, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters.

Estimates of costs resulting from legal and regulatory matters 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, in many cases, we are 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. Similarly, the assessment of the likelihood of assertion of unasserted claims involves significant judgment.

Given this inherent uncertainty, it is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions. We evaluate our related disclosures in each reporting period. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for a discussion of specific legal proceedings including an assessment of whether a reasonable estimate of the losses or range of loss could be determined.

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 that 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 that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers that constitute our client base. As of December 31, 2014, we had an aggregate $1.8 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and record the reinsurance receivable only to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as "A+." As of December 31, 2014, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, (b) foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and (c) changes in equity prices that impact the value of our equity investments.

As of December 31, 2014, we had $9.4 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2014, $12.6 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2014, $17.2 billion of our investments were fixed-rate debt securities and $7.7 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 endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale 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, 2014 and 2013 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2014			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$187	$245	$(1,364)	$(1,846)
1	94	122	(683)	(1,014)
(1)	(54)	(21)	628	1,242
(2)	nm	nm	982	2,770

	December 31, 2013			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$175	$189	$(1,474)	$(1,786)
1	87	95	(756)	(974)
(1)	(52)	(17)	704	1,167
(2)	nm	nm	1,224	2,505

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2014 and 2013, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2014 and 2013, 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 the Brazilian real to the U.S. dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot 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 shareholders' equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2014, a hypothetical 10% and 20% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $430 million and $790 million, respectively. We manage exposure to foreign currency risk by conducting our international business operations primarily in their functional currencies.

As of December 31, 2014, we had $1.5 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates. Valuations in venture capital funds are subject to conditions affecting health care and technology stocks, and dividend paying equities are subject to more general market conditions.

ITEM 8. FINANCIAL STATEMENTS

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2014 and 2013, and the related consolidated statements of operations, comprehensive income, changes in shareholders' equity and cash flows for each of the three years in the period ended December 31, 2014. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014, 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), the Company's internal control over financial reporting as of December 31, 2014, based on the criteria established in Internal Control-Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 10, 2015, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 10, 2015

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 7,495	$ 7,276
Short-term investments	1,741	1,937
Accounts receivable, net of allowances of $260 and $196	4,252	3,052
Other current receivables, net of allowances of $156 and $169	5,498	3,998
Assets under management	2,962	2,757
Deferred income taxes	556	430
Prepaid expenses and other current assets	1,052	930
Total current assets	23,556	20,380
Long-term investments	18,827	19,605
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,954 and $2,675	4,418	4,010
Goodwill	32,940	31,604
Other intangible assets, net of accumulated amortization of $2,685 and $2,283	3,669	3,844
Other assets	2,972	2,439
Total assets	$86,382	$81,882
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$12,040	$11,575
Accounts payable and accrued liabilities	9,247	7,458
Other policy liabilities	5,965	5,279
Commercial paper and current maturities of long-term debt	1,399	1,969
Unearned revenues	1,972	1,600
Total current liabilities	30,623	27,881
Long-term debt, less current maturities	16,007	14,891
Future policy benefits	2,488	2,465
Deferred income taxes	2,065	1,796
Other liabilities	1,357	1,525
Total liabilities	52,540	48,558
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,388	1,175
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; 954 and 988 issued and outstanding	10	10
Retained earnings	33,836	33,047
Accumulated other comprehensive loss	(1,392)	(908)
Total shareholders' equity	32,454	32,149
Total liabilities and shareholders' equity	$86,382	$81,882

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, 2014	2013	2012
Revenues:			
Premiums	$115,302	$109,557	$ 99,728
Services	10,151	8,997	7,437
Products	4,242	3,190	2,773
Investment and other income	779	745	680
Total revenues	130,474	122,489	110,618
Operating costs:			
Medical costs	93,257	89,290	80,226
Operating costs	21,681	19,362	17,306
Cost of products sold	3,784	2,839	2,523
Depreciation and amortization	1,478	1,375	1,309
Total operating costs	120,200	112,866	101,364
Earnings from operations	10,274	9,623	9,254
Interest expense	(618)	(708)	(632)
Earnings before income taxes	9,656	8,915	8,622
Provision for income taxes	(4,037)	(3,242)	(3,096)
Net earnings	5,619	5,673	5,526
Earnings attributable to noncontrolling interests	—	(48)	—
Net earnings attributable to UnitedHealth Group common shareholders	$ 5,619	$ 5,625	$ 5,526
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 5.78	$ 5.59	$ 5.38
Diluted	$ 5.70	$ 5.50	$ 5.28
Basic weighted-average number of common shares outstanding	972	1,006	1,027
Dilutive effect of common share equivalents	14	17	19
Diluted weighted-average number of common shares outstanding	986	1,023	1,046
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	6	8	17
Cash dividends declared per common share	$ 1.4050	$ 1.0525	$ 0.8000

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2014	2013	2012
Net earnings	$5,619	$ 5,673	$5,526
Other comprehensive loss:			
Gross unrealized gains (losses) on investment securities during the period	476	(543)	217
Income tax effect	(173)	196	(78)
Total unrealized gains (losses), net of tax	303	(347)	139
Gross reclassification adjustment for net realized gains included in net earnings	(211)	(181)	(156)
Income tax effect	77	66	57
Total reclassification adjustment, net of tax	(134)	(115)	(99)
Total foreign currency translation losses	(653)	(884)	(63)
Other comprehensive loss	(484)	(1,346)	(23)
Comprehensive income	5,135	4,327	5,503
Comprehensive income attributable to noncontrolling interests	—	(48)	—
Comprehensive income attributable to UnitedHealth Group common shareholders	$5,135	$ 4,279	$5,503

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Shareholders' 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	Total Shareholders' Equity
Balance at January 1, 2012	1,039	$10	$ —	$27,821	$ 476	$ (15)	$28,292
Net earnings attributable to UnitedHealth Group common shareholders				5,526			5,526
Other comprehensive income (loss)					40	(63)	(23)
Issuances of common shares, and related tax effects	37	—	704				704
Share-based compensation, and related tax benefits			594				594
Common share repurchases	(57)	—	(1,221)	(1,863)			(3,084)
Acquisition of noncontrolling interests			(11)				(11)
Cash dividends paid on common shares				(820)			(820)
Balance at December 31, 2012	1,019	10	66	30,664	516	(78)	31,178
Net earnings attributable to UnitedHealth Group common shareholders				5,625			5,625
Other comprehensive loss					(462)	(884)	(1,346)
Issuances of common shares, and related tax effects	17	—	431				431
Share - based compensation, and related tax benefits			406				406
Common share repurchases	(48)	—	(984)	(2,186)			(3,170)
Acquisition of noncontrolling interests and related tax effects			81				81
Cash dividends paid on common shares				(1,056)			(1,056)
Balance at December 31, 2013	988	10	—	33,047	54	(962)	32,149
Net earnings attributable to UnitedHealth Group common shareholders				5,619			5,619
Other comprehensive income (loss)					169	(653)	(484)
Issuances of common shares, and related tax effects	15	—	146				146
Share-based compensation, and related tax benefits			394				394
Common share repurchases	(49)	—	(540)	(3,468)			(4,008)
Cash dividends paid on common shares				(1,362)			(1,362)
Balance at December 31, 2014	954	$10	$ —	$33,836	$ 223	$(1,615)	$32,454

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2014	2013	2012
Operating activities			
Net earnings	$ 5,619	$ 5,673	$ 5,526
Noncash items:			
Depreciation and amortization	1,478	1,375	1,309
Deferred income taxes	(117)	1	308
Share-based compensation	364	331	421
Other, net	(298)	(83)	(231)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(911)	(317)	(130)
Other assets	(590)	(838)	(295)
Medical costs payable	484	509	101
Accounts payable and other liabilities	1,642	459	199
Other policy liabilities	(5)	(221)	(81)
Unearned revenues	385	102	28
Cash flows from operating activities	8,051	6,991	7,155
Investing activities			
Purchases of investments	(9,928)	(12,176)	(9,903)
Sales of investments	7,701	5,706	3,794
Maturities of investments	3,026	4,859	4,810
Cash paid for acquisitions, net of cash assumed	(1,923)	(362)	(6,280)
Purchases of property, equipment and capitalized software	(1,525)	(1,307)	(1,070)
Proceeds from disposal of property, equipment and capitalized software	78	146	—
Other, net	37	45	—
Cash flows used for investing activities	(2,534)	(3,089)	(8,649)
Financing activities			
Acquisition of noncontrolling interest shares	—	(1,474)	(319)
Common stock repurchases	(4,008)	(3,170)	(3,084)
Cash dividends paid	(1,362)	(1,056)	(820)
Proceeds from common stock issuances	462	598	1,078
Repayments of long-term debt	(812)	(1,609)	(986)
(Repayments of) proceeds from commercial paper, net	(794)	(474)	1,587
Proceeds from issuance of long-term debt	1,997	2,235	3,966
Customer funds administered	(638)	31	(324)
Other, net	(138)	(27)	(627)
Cash flows (used for) from financing activities	(5,293)	(4,946)	471
Effect of exchange rate changes on cash and cash equivalents	(5)	(86)	—
Increase (decrease) in cash and cash equivalents	219	(1,130)	(1,023)
Cash and cash equivalents, beginning of period	7,276	8,406	9,429
Cash and cash equivalents, end of period	$ 7,495	$ 7,276	$ 8,406
Supplemental cash flow disclosures			
Cash paid for interest	$ 644	$ 724	$ 600
Cash paid for income taxes	4,024	2,785	2,666

See 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 and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system.

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.

On January 1, 2014, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. The Company's Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, are now included in OptumInsight's results of operations. The Company's reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 13 for segment financial information.

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 revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables, valuations of certain investments, and estimates and judgments related to income taxes and contingent liabilities. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are 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

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, and beginning in 2014, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums

annually. 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 from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the Centers for Medicare & Medicaid Services' (CMS) risk adjustment payment methodology. CMS deploys a risk adjustment model that 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 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. Risk adjustment data for certain of the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company recognizes revenue in the period the related services are performed. 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 both risk-based and 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.

For the Company's OptumRx pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies or home delivery and specialty pharmacy facilities, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if 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. As a result, revenues are reported on a gross basis.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed, and for liabilities for physician, hospital and other medical cost disputes. The Company develops estimates for medical costs incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim processing backlogs, care provider contract rate changes, medical care utilization

and other medical cost trends. The Company estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. 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 the medical costs payable estimates recorded in prior periods develop, 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. Medical costs also include the direct cost of patient care rendered through OptumHealth.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have 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.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of shareholders' equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized 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 security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends either to sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in investment and other income. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.
- For equity securities, the Company recognizes unrealized losses in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the loss in investment and other income.

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 U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the 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 (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

The Company's arrangements with AARP extend to December 31, 2020 for the AARP Program and give the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage and Medicare Part D offerings until December 31, 2020, subject to certain limited exclusions.

Pursuant to the Company's agreement, AARP Program assets are managed separately from its 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 that 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. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the RSF and were $86 million, $101 million and $109 million in 2014, 2013 and 2012, respectively.

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. For more detail on the RSF, see "Other Policy Liabilities" below.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its PBM businesses' 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 PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. 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 non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. The Company generally receives rebates from two to five months after billing.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivable" below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.

- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy.* CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to premium revenues in the Consolidated Statements of Operations and other policy liabilities or other current receivables in the Consolidated Balance Sheets.
- *Drug Discount.* Health Reform Legislation mandated a consumer discount on brand name prescription drugs for Medicare Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Accordingly, amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded as premium revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in unearned revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in medical costs and operating costs, respectively, in the Consolidated Statements of Operations.

The final 2014 risk-share amount is expected to be settled during the second half of 2015, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2014			December 31, 2013		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$1,801	$719	$20	$881	$425	$ —
Other policy liabilities	—	302	—	—	152	214

As of January 1, 2015, certain changes were made to the Medicare Part D individual coverage levels by CMS, including:

- The initial coverage limit increased to $2,960 from $2,850 in 2014.
- The catastrophic coverage begins at $6,680 as compared to $6,455 in 2014.
- The annual out-of-pocket maximum increased to $4,700 from $4,550 in 2014.
- The discount on prescription drugs within the coverage gap increased to 55% from 52.5% in 2014 for brand name drugs and increased to 35% from 28% in 2014 for generic drugs.

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 7 years
Buildings	35 to 40 years
Leasehold improvements	7 years or length of lease term, whichever is shorter
Capitalized software	3 to 5 years

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. First, the Company 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, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

As of December 31, 2014, no reporting unit had a fair value less than its carrying value and the Company concluded that there was no need for any impairment of goodwill.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There were no material impairments of intangible assets during the year ended December 31, 2014.

Accounts Payable and Accrued Liabilities

The Company had checks outstanding of $1.4 billion and $1.3 billion issued from zero balance accounts as of December 31, 2014 and 2013, respectively, which were classified as accounts payable and accrued liabilities and the change in this balance has been reflected within other financing activities in the Consolidated Statements of Cash Flows.

As of December 31, 2014 and 2013, accounts payable and accrued liabilities included accrued payroll liabilities of $1.5 billion and $1.2 billion, respectively.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP Program (described below), health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits" above), accruals for premium rebate payments under Health Reform Legislation, the current portion of future policy benefits and customer balances. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Underwriting gains or losses related to the AARP Program are directly recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. To the extent underwriting losses exceed the balance in the RSF; losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. Changes in the RSF are reported in medical costs in the Consolidated Statement of Operations. As of December 31, 2014 and 2013, the balance in the RSF was $1.5 billion and $1.3 billion, respectively.

Future Policy Benefits and Reinsurance Receivable

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2014, the Company had an aggregate $1.8 billion reinsurance receivable, of which $127 million was recorded in Other Current Receivables and $1.7 billion was recorded in other assets in the Consolidated Balance Sheets. As of December 31, 2013, the Company had an aggregate $1.8 billion reinsurance receivable, of which $136 million was recorded in other current receivables and $1.7 billion was recorded in other assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. As of December 31, 2014, the reinsurer was rated by A.M. Best as "A+."

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 charged to expense as incurred.

Redeemable Noncontrolling Interests

Noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The redeemable noncontrolling interests are primarily related to non-public shareholders of Amil. The following table provides details of the Company's redeemable noncontrolling interests activity for the years ended December 31, 2014 and 2013:

(in millions)	2014	2013
Redeemable noncontrolling interests, beginning of period	$1,175	$ 2,121
Net earnings	—	48
Acquisitions	203	360
Redemptions	—	(1,417)
Distributions	(40)	—
Fair value and other adjustments	50	63
Redeemable noncontrolling interests, end of period	$1,388	$ 1,175

During 2013, the Company increased its ownership of Amil to 90% by acquiring all of Amil's remaining publicly-traded shares.

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) 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 three to four years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at 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 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Company's Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, 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, any unrecognized compensation cost and any related excess tax benefit. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Industry Tax

Health Reform Legislation includes an annual, nondeductible insurance industry tax (Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products that began on January 1, 2014.

The Company estimates its liability for the Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method of allocation over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets. In September 2014, the Company paid its 2014 Industry Tax liability of $1.3 billion.

Premium Stabilization Programs

Since the beginning of 2014, Health Reform Legislation has included three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program; a temporary risk corridors program; and a transitional reinsurance program (Reinsurance Program).

The risk-adjustment provisions of Health Reform Legislation are permanent regulations and apply to market reform compliant individual and small group plans in the commercial markets. Under the program, each covered member is assigned a risk score based upon demographic information and applicable diagnostic codes from the current year paid claims, in order to determine an average risk score for each plan in a particular state and market risk pool. Generally, a plan with a risk score that is less than the state's average risk score will pay into the pool, while a plan with a risk score that is greater than the state's average will receive money from the pool.

The risk corridors provisions of Health Reform Legislation will be in place for three years and are intended to limit the gains and losses of individual and small group qualified health plans. Plans are required to calculate the U.S. Department of Health and Human Services (HHS) risk corridor ratio of allowable costs (defined as medical claims plus quality improvement costs adjusted for the impact of reinsurance recoveries and the risk adjustment program) to the defined target amount (defined as actual premiums less defined allowable administrative costs inclusive of taxes and profits). Qualified health plans with ratios below 97% are required to make payments to HHS, while plans with ratios greater than 103% expect to receive funds from HHS.

The Reinsurance Program is a temporary three year program that is funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements. Only issuers of market reform compliant individual plans are eligible for reinsurance recoveries from the risk pools.

None of the Premium Stabilization Programs had a material impact on the Consolidated Financial Statements in 2014.

Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board issued Accounting Standard Update (ASU) No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" (ASU 2014-09). ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2014				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,614	$ 7	$ (1)	$ 1,620
State and municipal obligations	6,456	217	(5)	6,668
Corporate obligations	7,241	112	(26)	7,327
U.S. agency mortgage-backed securities	2,022	39	(5)	2,056
Non-U.S. agency mortgage-backed securities	872	12	(4)	880
Total debt securities — available-for-sale	18,205	387	(41)	18,551
Equity securities — available-for-sale	1,511	36	(25)	1,522
Debt securities — held-to-maturity:				
U.S. government and agency obligations	178	2	—	180
State and municipal obligations	19	—	—	19
Corporate obligations	298	—	—	298
Total debt securities — held-to-maturity	495	2	—	497
Total investments	$20,211	$425	$ (66)	$20,570
December 31, 2013				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,211	$ 5	$ (21)	$ 2,195
State and municipal obligations	6,902	147	(72)	6,977
Corporate obligations	7,265	130	(60)	7,335
U.S. agency mortgage-backed securities	2,256	23	(61)	2,218
Non-U.S. agency mortgage-backed securities	697	12	(7)	702
Total debt securities — available-for-sale	19,331	317	(221)	19,427
Equity securities — available-for-sale	1,576	9	(13)	1,572
Debt securities — held-to-maturity:				
U.S. government and agency obligations	181	1	—	182
State and municipal obligations	28	—	—	28
Corporate obligations	334	—	—	334
Total debt securities — held-to-maturity	543	1	—	544
Total investments	$21,450	$327	$(234)	$21,543

The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination date as of December 31, 2014 were as follows:

(in millions)	AAA	AA	A	Non-Investment Grade	Total Fair Value
2014	$ 222	$ —	$ —	$ —	$ 222
2013	164	—	—	—	164
2012	81	—	—	—	81
2011	17	—	—	—	17
2010	23	—	—	—	23
2009	6	—	—	—	6
Pre - 2009	354	1	1	11	367
U.S. agency mortgage-backed securities	2,054	2	—	—	2,056
Total	$2,921	$ 3	$ 1	$ 11	$2,936

The Company includes any securities backed by Alt-A or subprime mortgages and any commercial mortgage loans in default in the non-investment grade column in the table above.

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2014, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,822	$ 1,826
Due after one year through five years	6,632	6,709
Due after five years through ten years	5,086	5,212
Due after ten years	1,771	1,868
U.S. agency mortgage-backed securities	2,022	2,056
Non-U.S. agency mortgage-backed securities	872	880
Total debt securities — available-for-sale	$18,205	$18,551

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2014, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 88	$ 88
Due after one year through five years	210	210
Due after five years through ten years	112	113
Due after ten years	85	86
Total debt securities — held-to-maturity	$495	$497

The fair value of available-for-sale investments 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, 2014						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 420	$ (1)	$ —	$ —	$ 420	$ (1)
State and municipal obligations	711	(4)	99	(1)	810	(5)
Corporate obligations	2,595	(17)	464	(9)	3,059	(26)
U.S. agency mortgage-backed securities	—	—	272	(5)	272	(5)
Non-U.S. agency mortgage-backed securities	254	(2)	114	(2)	368	(4)
Total debt securities — available-for-sale	$3,980	$ (24)	$949	$(17)	$4,929	$ (41)
Equity securities — available-for-sale	$ 107	$ (6)	$ 88	$(19)	$ 195	$ (25)
December 31, 2013						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$1,055	$ (19)	$ 17	$ (2)	$1,072	$ (21)
State and municipal obligations	2,491	(62)	128	(10)	2,619	(72)
Corporate obligations	2,573	(51)	103	(9)	2,676	(60)
U.S. agency mortgage-backed securities	1,393	(51)	105	(10)	1,498	(61)
Non-U.S. agency mortgage-backed securities	289	(6)	26	(1)	315	(7)
Total debt securities — available-for-sale	$7,801	$(189)	$379	$(32)	$8,180	$(221)
Equity securities — available-for-sale	$ 180	$ (13)	$ —	$ —	$ 180	$ (13)

The Company's unrealized losses from all securities as of December 31, 2014 were generated from approximately 6,000 positions out of a total of 22,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have 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. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). As of December 31, 2014, 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 Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments, venture capital funds, and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

(in millions)	For the Years Ended December 31, 2014	2013	2012
Total OTTI	$ (26)	$ (8)	$ (6)
Portion of loss recognized in other comprehensive income	—	—	—
Net OTTI recognized in earnings	(26)	(8)	(6)
Gross realized losses from sales	(47)	(9)	(13)
Gross realized gains from sales	284	198	175
Net realized gains (included in investment and other income on the Consolidated Statements of Operations)	211	181	156
Income tax effect (included in provision for income taxes on the Consolidated Statements of Operations)	(77)	(66)	(57)
Realized gains, net of taxes	$134	$115	$ 99

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 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.

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 that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

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

Transfers between 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 2014 or 2013.

Nonfinancial assets and liabilities or financial assets and liabilities that are 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, 2014 or 2013.

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 that 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 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, 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 in the prices obtained from the pricing service.

Fair values of debt securities that 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 venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based on recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

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 that understanding.

Other Assets. The fair values of the Company's other assets are estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-Related Investments. AARP Program-related investments consist 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.

Interest Rate Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

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.

AARP Program-Related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

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 excluding AARP Program-related assets and liabilities, which are presented in a separate table below:

(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, 2014				
Cash and cash equivalents	$ 7,472	$ 23	$ —	$ 7,495
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,427	193	—	1,620
State and municipal obligations	—	6,668	—	6,668
Corporate obligations	2	7,257	68	7,327
U.S. agency mortgage-backed securities	—	2,056	—	2,056
Non-U.S. agency mortgage-backed securities	—	874	6	880
Total debt securities — available-for-sale	1,429	17,048	74	18,551
Equity securities — available-for-sale	1,200	12	310	1,522
Interest rate swap assets	—	62	—	62
Total assets at fair value	$10,101	$17,145	$384	$27,630
Percentage of total assets at fair value	37%	62%	1%	100%
Interest rate swap liabilities	$ —	$ 55	$ —	$ 55
December 31, 2013				
Cash and cash equivalents	$ 7,005	$ 271	$ —	$ 7,276
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,750	445	—	2,195
State and municipal obligations	—	6,977	—	6,977
Corporate obligations	25	7,274	36	7,335
U.S. agency mortgage-backed securities	—	2,218	—	2,218
Non-U.S. agency mortgage-backed securities	—	696	6	702
Total debt securities — available-for-sale	1,775	17,610	42	19,427
Equity securities — available-for-sale	1,291	12	269	1,572
Total assets at fair value	$10,071	$17,893	$311	$28,275
Percentage of total assets at fair value	36%	63%	1%	100%
Interest rate swap liabilities	$ —	$ 163	$ —	$ 163

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, 2014					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$180	$ —	$ —	$ 180	$ 178
State and municipal obligations	—	—	19	19	19
Corporate obligations	46	10	242	298	298
Total debt securities — held-to-maturity	$226	$ 10	$261	$ 497	$ 495
Other assets	$ —	$ 478	$ —	$ 478	$ 484
Long-term debt and other financing obligations	$ —	$18,863	$ —	$18,863	$17,085
December 31, 2013					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$182	$ —	$ —	$ 182	$ 181
State and municipal obligations	—	—	28	28	28
Corporate obligations	47	9	278	334	334
Total debt securities — held-to-maturity	$229	$ 9	$306	$ 544	$ 543
Long-term debt and other financing obligations	$ —	$16,602	$ —	$16,602	$15,745

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.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2014			December 31, 2013			December 31, 2012		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$42	$ 269	$ 311	$ 17	$224	$241	$ 208	$209	$ 417
Purchases	32	105	137	38	71	109	11	71	82
Sales	(1)	(180)	(181)	(10)	(25)	(35)	—	(34)	(34)
Settlements	—	—	—	—	—	—	(1)	—	(1)
Net unrealized gains (losses) in other comprehensive income	1	6	7	(2)	(7)	(9)	—	(14)	(14)
Net realized gains (losses) in investment and other income	—	110	110	(1)	6	5	—	13	13
Transfer to held-to-maturity	—	—	—	—	—	—	(201)	(21)	(222)
Balance at end of period	$74	$ 310	$ 384	$ 42	$269	$311	$ 17	$224	$ 241

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range Low	Range High
December 31, 2014					
Equity securities — available-for-sale					
Venture capital portfolios	$260	Market approach — comparable companies	Revenue multiple	1.0	6.0
			EBITDA multiple	8.0	10.0
	50	Market approach — recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$310				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $74 million of available-for-sale debt securities as of December 31, 2014, which were not significant.

The Company elected to measure the entirety of the AARP Program assets under management at fair value pursuant to the fair value option. See Note 2 for further detail on the AARP Program. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
December 31, 2014			
Cash and cash equivalents	$415	$ —	$ 415
Debt securities:			
U.S. government and agency obligations	409	245	654
State and municipal obligations	—	95	95
Corporate obligations	—	1,200	1,200
U.S. agency mortgage-backed securities	—	340	340
Non-U.S. agency mortgage-backed securities	—	177	177
Total debt securities	409	2,057	2,466
Other investments	—	81	81
Total assets at fair value	$824	$2,138	$2,962
Other liabilities	$ 5	$ 13	$ 18
December 31, 2013			
Cash and cash equivalents	$265	$ —	$ 265
Debt securities:			
U.S. government and agency obligations	426	301	727
State and municipal obligations	—	63	63
Corporate obligations	—	1,145	1,145
U.S. agency mortgage-backed securities	—	414	414
Non-U.S. agency mortgage-backed securities	—	139	139
Total debt securities	426	2,062	2,488
Equity securities — available-for-sale	—	4	4
Total assets at fair value	$691	$2,066	$2,757
Other liabilities	$ 3	$ 11	$ 14

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2014	December 31, 2013
Land and improvements	$ 310	$ 318
Buildings and improvements	2,295	2,051
Computer equipment	1,693	1,519
Furniture and fixtures	675	564
Less accumulated depreciation	(1,982)	(1,760)
Property and equipment, net	2,991	2,692
Capitalized software	2,399	2,233
Less accumulated amortization	(972)	(915)
Capitalized software, net	1,427	1,318
Total property, equipment and capitalized software, net	$ 4,418	$ 4,010

Depreciation expense for property and equipment for 2014, 2013 and 2012 was $532 million, $445 million and $449 million, respectively. Amortization expense for capitalized software for 2014, 2013 and 2012 was $422 million, $411 million and $412 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, 2013	$24,459	$2,818	$3,169	$840	$31,286
Acquisitions	408	48	483	—	939
Foreign currency effects and adjustments, net	(616)	(6)	1	—	(621)
Balance at December 31, 2013	24,251	2,860	3,653	840	31,604
Acquisitions	266	978	591	—	1,835
Foreign currency effects and adjustments, net	(487)	(4)	(8)	—	(499)
Balance at December 31, 2014	$24,030	$3,834	$4,236	$840	$32,940

In 2014, acquisitions were not material to the Company's Consolidated Financial Statements.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2014			December 31, 2013		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$5,021	$(2,399)	$2,622	$4,821	$(2,028)	$2,793
Trademarks and technology	527	(202)	325	433	(191)	242
Trademarks — indefinite-lived	539	—	539	589	—	589
Other	267	(84)	183	284	(64)	220
Total	$6,354	$(2,685)	$3,669	$6,127	$(2,283)	$3,844

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)	2014 Fair Value	2014 Weighted-Average Useful Life	2013 Fair Value	2013 Weighted-Average Useful Life
Customer-related	$314	14 years	$55	12 years
Trademarks and technology	148	6 years	27	12 years
Other	2	14 years	—	
Total acquired finite-lived intangible assets	$464	11 years	$82	12 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)	
2015	$518
2016	487
2017	442
2018	392
2019	288

Amortization expense relating to intangible assets for December 31, 2014, 2013 and 2012 was $524 million, $519 million and $448 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)	2014	2013	2012
Medical costs payable, beginning of period	$ 11,575	$ 11,004	$ 9,799
Acquisitions	—	—	1,029
Reported medical costs:			
Current year	93,677	89,970	81,086
Prior years	(420)	(680)	(860)
Total reported medical costs	93,257	89,290	80,226
Claim payments:			
Payments for current year	(82,374)	(78,989)	(71,832)
Payments for prior year	(10,418)	(9,730)	(8,218)
Total claim payments	(92,792)	(88,719)	(80,050)
Medical costs payable, end of period	$ 12,040	$ 11,575	$ 11,004

For the year ended December 31, 2014, the favorable medical cost reserve development was due to a number of individual factors that were not material. The net favorable development for the years ended December 31, 2013 and 2012 was primarily driven by lower than expected health system utilization levels. In 2012, reserves were also impacted by increased efficiency in claims processing and handling.

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2014			December 31, 2013		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 321	$ 321	$ 321	$ 1,115	$ 1,115	$ 1,115
4.750% notes due February 2014	—	—	—	172	173	173
5.000% notes due August 2014	—	—	—	389	397	400
Floating-rate notes due August 2014	—	—	—	250	250	250
4.875% notes due March 2015 (a)	416	419	419	416	431	436
0.850% notes due October 2015 (a)	625	625	627	625	624	628
5.375% notes due March 2016 (a)	601	623	634	601	641	657
1.875% notes due November 2016 (a)	400	397	406	400	398	408
5.360% notes due November 2016	95	95	103	95	95	107
6.000% notes due June 2017 (a)	441	466	489	441	479	506
1.400% notes due October 2017 (a)	625	616	624	625	613	617
6.000% notes due November 2017 (a)	156	164	175	156	168	178
1.400% notes due December 2017 (a)	750	745	749	—	—	—
6.000% notes due February 2018 (a)	1,100	1,106	1,238	1,100	1,116	1,271
1.625% notes due March 2019 (a)	500	496	493	500	489	481
2.300% notes due December 2019 (a)	500	496	502	—	—	—
3.875% notes due October 2020 (a)	450	450	477	450	435	474
4.700% notes due February 2021 (a)	400	413	450	400	416	436
3.375% notes due November 2021 (a)	500	496	519	500	472	494
2.875% notes due December 2021 (a)	750	748	759	—	—	—
2.875% notes due March 2022 (a)	1,100	1,042	1,104	1,100	981	1,046
0.000% notes due November 2022	15	10	11	15	9	10
2.750% notes due February 2023 (a)	625	604	613	625	563	572
2.875% notes due March 2023 (a)	750	777	745	750	729	698
5.800% notes due March 2036	850	845	1,052	850	845	935
6.500% notes due June 2037	500	495	670	500	495	593
6.625% notes due November 2037	650	646	888	650	645	786
6.875% notes due February 2038	1,100	1,085	1,544	1,100	1,084	1,370
5.700% notes due October 2040	300	298	378	300	298	329
5.950% notes due February 2041	350	348	455	350	348	397
4.625% notes due November 2041	600	593	646	600	593	567
4.375% notes due March 2042	502	486	536	502	486	459
3.950% notes due October 2042	625	611	621	625	611	530
4.250% notes due March 2043	750	740	786	750	740	673
Total commercial paper and long-term debt	$17,347	$17,256	$19,034	$16,952	$16,739	$17,596

(a) Fixed-rate debt instruments hedged with interest rate swap contracts. See below for more information on the Company's interest rate swaps.

The Company's long-term debt obligations also included $150 million and $121 million of other financing obligations, of which $34 million were current as of both December 31, 2014 and December 31, 2013.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2015	$ 1,396
2016	1,121
2017	1,980
2018	1,103
2019	1,027
Thereafter	10,870

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2014, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.4%.

The Company has $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in November 2019 and November 2015, respectively. These facilities provide liquidity support for the Company's $4.0 billion commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2014. The interest rates on borrowings are variable based on term and are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of December 31, 2014, the annual interest rates on the bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.

Debt Covenants

The Company's bank credit facilities contain various covenants including requiring the Company to maintain a debt to debt-plus-equity ratio of not more than 50%. The Company was in compliance with its debt covenants as of December 31, 2014.

Interest Rate Swap Contracts

The Company uses interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its variable rate financial assets. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are considered to be highly effective hedges and all changes in the fair values of the swaps are recorded as adjustments to the carrying value of the related debt with no net impact recorded on the Consolidated Statements of Operations.

The following table summarizes the location and fair value of the interest rate swap fair value hedges on the Company's Consolidated Balance Sheet:

Type of Fair Value Hedge	Notional Amount (in billions)	Fair Value (in millions)	Balance Sheet Location
December 31, 2014			
Interest rate swap contracts	$10.7	$ 62	Other assets
		55	Other liabilities
December 31, 2013			
Interest rate swap contracts	$ 6.2	$163	Other liabilities

The following table provides a summary of the effect of changes in fair value of fair value hedges on the Company's Consolidated Statements of Operations:

(in millions)	For the Years Ended December 31, 2014	2013	2012
Hedge — interest rate swap gain (loss) recognized in interest expense	$ 170	$(166)	$ 3
Hedged item — long-term debt (loss) gain recognized in interest expense	(170)	166	(3)
Net impact on the Company's Consolidated Statements of Operations	$ —	$ —	$ —

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)	2014	2013	2012
Current Provision:			
Federal	$3,883	$3,004	$2,638
State and local	271	237	150
Total current provision	4,154	3,241	2,788
Deferred provision	(117)	1	308
Total provision for income taxes	$4,037	$3,242	$3,096

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)	2014		2013		2012	
Tax provision at the U.S. federal statutory rate	$3,380	35.0%	$3,120	35.0%	$3,018	35.0%
Industry tax	469	4.8	—	—	—	—
State income taxes, net of federal benefit	154	1.6	126	1.4	143	1.7
Tax-exempt investment income	(49)	(0.5)	(53)	(0.6)	(59)	(0.7)
Non-deductible compensation	96	1.0	39	0.5	22	0.2
Other, net	(13)	(0.1)	10	0.1	(28)	(0.3)
Provision for income taxes	$4,037	41.8%	$3,242	36.4%	$3,096	35.9%

The higher tax rate for 2014 is mostly due to the nondeductibility of the Industry Tax. The higher effective income tax rate for 2013 as compared to 2012 primarily resulted from the favorable resolution of various one-time tax matters in 2012.

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)	2014	2013
Deferred income tax assets:		
Accrued expenses and allowances	$ 313	$ 284
U.S. federal and state net operating loss carryforwards	172	257
Share-based compensation	141	200
Long-term liabilities	222	170
Medical costs payable and other policy liabilities	120	155
Non-U.S. tax loss carryforwards	257	110
Unearned revenues	90	65
Unrecognized tax benefits	38	38
Other-domestic	36	57
Other-non-U.S.	141	89
Subtotal	1,530	1,425
Less: valuation allowances	(119)	(207)
Total deferred income tax assets	1,411	1,218
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(1,275)	(1,207)
Non-U.S. goodwill and intangible assets	(496)	(453)
Capitalized software	(506)	(481)
Net unrealized gains on investments	(129)	(31)
Depreciation and amortization	(272)	(268)
Prepaid expenses	(140)	(137)
Other-non-U.S.	(102)	(7)
Total deferred income tax liabilities	(2,920)	(2,584)
Net deferred income tax liabilities	$(1,509)	$(1,366)

Valuation allowances are provided when it is considered more likely than not that 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. Federal net operating loss carryforwards of $129 million expire beginning in 2021 through 2034; state net operating loss carryforwards expire beginning in 2015 through 2034. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2014, the Company had $391 million of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. It is not practicable to estimate the amount of U.S. tax that might be payable on the eventual remittance of such earnings.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2014	2013	2012
Gross unrecognized tax benefits, beginning of period	$89	$81	$129
Gross increases:			
Current year tax positions	—	8	6
Prior year tax positions	4	5	18
Gross decreases:			
Prior year tax positions	—	—	(48)
Settlements	—	—	(10)
Statute of limitations lapses	(1)	(5)	(14)
Gross unrecognized tax benefits, end of period	$92	$89	$ 81

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. During 2014 and 2013, the Company recognized $6 million and $4 million of interest expense, respectively. The Company recognized tax benefits from the net reduction of interest and penalties accrued of $20 million during the year ended December 31, 2012. The Company had $33 million and $27 million of accrued interest and penalties for uncertain tax positions as of December 31, 2014 and 2013, respectively. These amounts are not included in the reconciliation above. As of December 31, 2014, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate, was $92 million.

The Company currently files income tax returns in the United States, various states and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2013 and prior. The Company's 2014 tax year is under advance 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 2007 tax year. The Brazilian federal revenue service — Secretaria da Receita Federal (SRF) may audit the Company's Brazilian subsidiaries for a period of five years from the date on which corporate income taxes should have been paid and/or the date when the tax return was filed. Estimated taxes are paid monthly in Brazil with an annual return due on June 30 following the end of the taxable year.

The Company believes it is reasonably possible that 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 in certain major jurisdictions.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated 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 that may be paid to their parent companies. In the United States, most of these 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 can 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, 2014, the Company's regulated subsidiaries paid their parent companies dividends of $4.6 billion, including $1.5 billion of extraordinary dividends. For the year ended December 31,

2013, the Company's regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $430 million of extraordinary dividends. As of December 31, 2014, $738 million of the Company's $7.5 billion of cash and cash equivalents was available for general corporate use.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $14.7 billion as of December 31, 2014. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $7.1 billion as of December 31, 2014.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, and Total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2014, the Company believes that 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 2014, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock. During 2014, the Company repurchased 49 million shares at an average price of $82.57 per share and an aggregate cost of $4.0 billion.

Dividends

In June 2014, the Company's Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $1.50 per share, paid quarterly. Since June 2013, the Company had paid an annual cash dividend of $1.12 per share, paid quarterly. 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 2014 dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
2014	$1.4050	$1,362
2013	1.0525	1,056
2012	0.8000	820

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted stock and restricted stock units (collectively, restricted shares). As of December 31, 2014, the Company had 25 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, SARs and awards for 11 million restricted shares. As of December 31, 2014, there were also 14 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2014 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	41	$48		
Granted	8	71		
Exercised	(15)	47		
Forfeited	(1)	62		
Outstanding at end of period	33	53	5.3	$1,569
Exercisable at end of period	19	45	3.1	1,085
Vested and expected to vest, end of period	32	53	5.3	1,544

Restricted Shares

Restricted share activity for the year ended December 31, 2014 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	11	$50
Granted	4	71
Vested	(6)	46
Nonvested at end of period	9	61

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2014	2013	2012
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 22	$ 19	$ 18
Total intrinsic value of stock options and SARs exercised	526	592	559
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	71	58	52
Total fair value of restricted shares vested	$437	$ 31	$716
Employee Stock Purchase Plan			
Number of shares purchased	2	3	3
Share-Based Compensation Items			
Share-based compensation expense, before tax	$364	$331	$421
Share-based compensation expense, net of tax effects	314	239	299
Income tax benefit realized from share-based award exercises	231	206	461

(in millions, except years)	December 31, 2014
Unrecognized compensation expense related to share awards	$373
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 and SARs were as follows:

	For the Years Ended December 31,		
	2014	2013	2012
Risk-free interest rate	1.7% - 1.8%	1.0% - 1.6%	0.7% - 0.9%
Expected volatility	24.1% - 39.6%	41.0% - 43.0%	43.2% - 44.0%
Expected dividend yield	1.6% - 1.9%	1.4% - 1.6%	1.2% - 1.7%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.4	5.3	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 and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2014, 2013, and 2012.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. 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 $496 million and $441 million as of December 31, 2014 and 2013, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for 2014, 2013 and 2012 was $449 million, $438 million and $334 million, respectively.

As of December 31, 2014, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2015	$491
2016	386
2017	329
2018	293
2019	240
Thereafter	464

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 or for December 31, 2014, 2013, and 2012.

As of December 31, 2014, the Company had outstanding, undrawn letters of credit with financial institutions of $33 million and surety bonds outstanding with insurance companies of $1.2 billion, primarily to bond contractual performance.

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 that a loss may be incurred.

Litigation Matters

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. Although the Company believes that CDI had never before issued a fine in excess of $8 million, CDI advocated a fine of approximately $325 million in this matter. The matter was the subject of an administrative hearing before a California administrative law judge beginning in December 2009, and in August 2013, the administrative law judge issued a nonbinding proposed decision recommending a fine of $11.5 million. The California Insurance Commissioner rejected the administrative law judge's recommendation and on June 9, 2014, issued his own decision imposing a fine of approximately $174 million. On July 10, 2014, the Company filed a lawsuit in California state court challenging the Commissioner's decision. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the wide range of possible outcomes, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting a regulatory fine in the event of a remand, and the various remedies and levels of judicial review that remain available to the Company.

Endoscopy Center of Southern Nevada Litigation. In April 2013, a Las Vegas jury awarded $24 million in compensatory damages and $500 million in punitive damages against a Company health plan and its parent corporation on the theory that they were negligent in their credentialing and monitoring of an in-network endoscopy center owned and operated by independent physicians who were subsequently linked by regulators to an outbreak of hepatitis C. The trial court reduced the overall award to $366 million. In 2014, the Company settled this and all other pending suits brought by individuals allegedly infected by hepatitis C for an amount that is not material to the Company's results of operations, financial position or cash flows. Although the Company remains party to two class actions brought on behalf of uninfected patients of the endoscopy center seeking the cost of medical monitoring, the Company does not believe these matters are material to its results of operations, financial position, or cash flows.

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, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), 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, the Securities and Exchange Commission (SEC), the Internal Revenue Service, the SRF, the U.S. Department of Labor, the FDIC, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

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.

Guaranty Fund Assessments

Under state guaranty fund laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies. In 2009, the Pennsylvania Insurance Commissioner placed long term care insurer Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation and petitioned a state court for approval to liquidate Penn Treaty. In 2012, the court denied the liquidation petition and ordered the Insurance Commissioner to submit a rehabilitation plan. The court recently set a hearing for July 2015 to consider the latest proposed rehabilitation plan.

If the current proposed rehabilitation plan, which contemplates the partial liquidation of Penn Treaty, is approved by the court, the Company's insurance entities and other insurers may be required to pay a portion of Penn Treaty's policyholder claims through state guaranty association assessments in future periods. The Company intends to vigorously challenge the proposed rehabilitation plan. The Company is currently unable to estimate losses or ranges of losses because the Company cannot predict whether, when or to what extent Penn Treaty will ultimately be declared insolvent, the amount of the insolvency, if any, the amount and timing of any associated guaranty fund assessments or the availability and amount of any premium tax and other potential offsets.

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 presented to the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics 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 because they have similar economic characteristics, products and services, customers, distribution methods and operational processes and operate in a similar regulatory environment. The U.S. businesses also share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology 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 and active and retired military and their families through the TRICARE program (West Region). 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's primary customers oversee Medicaid plans, the Children's Health Insurance Program, and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits.
- *OptumHealth* serves the physical, emotional and financial needs of individuals, enabling consumer health management and local care delivery through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, local care delivery services, consumer engagement and relationship management and sales distribution platform services and financial services.
- *OptumInsight* is a health care information, technology, operational services and consulting company providing software and information products, advisory consulting services, and business process outsourcing services and support to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system use OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.
- *OptumRx* offers pharmacy benefit management services and programs including retail pharmacy network management services, home delivery and specialty pharmacy services, manufacturer rebate contracting and administration, benefit plan design and consultation, claims processing, and a variety of clinical programs such as formulary management and compliance, drug utilization review and disease and drug therapy management services.

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 benefit 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. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that 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 29% for 2014, 2013 and 2012, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 95%, 95%, and 99% of consolidated total revenues for 2014, 2013 and 2012, respectively. Long-lived fixed assets located in the United States represented approximately 73% and 72% of the total long-lived fixed assets as of December 31, 2014 and 2013, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

2014 Business Realignment

On January 1, 2014, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. The Company's Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, are now included in OptumInsight's results of operations. The Company's historical segment results have been restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

Prior period reportable segment financial information has been recast to conform to the 2014 presentation. The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2014								
Revenues — external customers:								
Premiums	$112,645	$ 2,657	$ —	$ —	$ —	$ 2,657	$ —	$115,302
Services	6,516	1,300	2,224	111	—	3,635	—	10,151
Products	3	18	96	4,125	—	4,239	—	4,242
Total revenues — external customers	119,164	3,975	2,320	4,236	—	10,531	—	129,695
Total revenues — intersegment	—	6,913	2,906	27,740	(489)	37,070	(37,070)	—
Investment and other income	634	144	1	—	—	145	—	779
Total revenues	$119,798	$11,032	$5,227	$31,976	$(489)	$47,746	$(37,070)	$130,474
Earnings from operations	$ 6,992	$ 1,090	$1,002	$ 1,190	$ —	$ 3,282	$ —	$ 10,274
Interest expense	—	—	—	—	—	—	(618)	(618)
Earnings before income taxes	$ 6,992	$ 1,090	$1,002	$ 1,190	$ —	$ 3,282	$ (618)	$ 9,656
Total assets	$ 62,405	$11,148	$8,112	$ 5,474	$ —	$24,734	$ (757)	$ 86,382
Purchases of property, equipment and capitalized software	773	212	484	56	—	752	—	1,525
Depreciation and amortization	772	179	433	94	—	706	—	1,478
2013								
Revenues — external customers:								
Premiums	$107,024	$ 2,533	$ —	$ —	$ —	$ 2,533	$ —	$109,557
Services	6,076	819	2,006	96	—	2,921	—	8,997
Products	8	19	92	3,071	—	3,182	—	3,190
Total revenues — external customers	113,108	3,371	2,098	3,167	—	8,636	—	121,744
Total revenues — intersegment	—	6,357	2,615	20,839	(458)	29,353	(29,353)	—
Investment and other income	617	127	1	—	—	128	—	745
Total revenues	$113,725	$ 9,855	$4,714	$24,006	$(458)	$38,117	$(29,353)	$122,489
Earnings from operations	$ 7,132	$ 949	$ 831	$ 711	$ —	$ 2,491	$ —	$ 9,623
Interest expense	—	—	—	—	—	—	(708)	(708)
Earnings before income taxes	$ 7,132	$ 949	$ 831	$ 711	$ —	$ 2,491	$ (708)	$ 8,915
Total assets	$ 61,942	$ 9,244	$6,880	$ 4,483	$ —	$20,607	$ (667)	$ 81,882
Purchases of property, equipment and capitalized software	670	185	363	89	—	637	—	1,307
Depreciation and amortization	766	158	359	92	—	609	—	1,375
2012								
Revenues — external customers:								
Premiums	$ 97,985	$ 1,743	$ —	$ —	$ —	$ 1,743	$ —	$ 99,728
Services	4,780	767	1,807	83	—	2,657	—	7,437
Products	1	21	87	2,664	—	2,772	—	2,773
Total revenues — external customers	102,766	2,531	1,894	2,747	—	7,172	—	109,938
Total revenues — intersegment	—	5,503	2,363	15,611	(364)	23,113	(23,113)	—
Investment and other income	566	113	—	1	—	114	—	680
Total revenues	$103,332	$ 8,147	$4,257	$18,359	$(364)	$30,399	$(23,113)	$110,618
Earnings from operations	$ 7,687	$ 538	$ 656	$ 373	$ —	$ 1,567	$ —	$ 9,254
Interest expense	—	—	—	—	—	—	(632)	(632)
Earnings before income taxes	$ 7,687	$ 538	$ 656	$ 373	$ —	$ 1,567	$ (632)	$ 8,622
Total assets	$ 62,971	$ 8,198	$6,367	$ 3,434	$ —	$17,999	$ (85)	$ 80,885
Purchases of property, equipment and capitalized software	382	163	409	116	—	688	—	1,070
Depreciation and amortization	635	164	411	99	—	674	—	1,309

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2014 and 2013 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2014				
Revenues	$31,708	$32,574	$32,759	$33,433
Operating costs	29,654	30,022	29,856	30,668
Earnings from operations	2,054	2,552	2,903	2,765
Net earnings	1,099	1,408	1,602	1,510
Net earnings attributable to UnitedHealth Group common shareholders	1,099	1,408	1,602	1,510
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.12	1.44	1.65	1.58
Diluted	1.10	1.42	1.63	1.55
2013				
Revenues	$30,340	$30,408	$30,624	$31,117
Operating costs	28,201	28,007	27,993	28,665
Earnings from operations	2,139	2,401	2,631	2,452
Net earnings	1,240	1,436	1,570	1,427
Net earnings attributable to UnitedHealth Group common shareholders	1,192	1,436	1,570	1,427
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.17	1.42	1.56	1.43
Diluted	1.16	1.40	1.53	1.41

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) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that 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, 2014. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2014.

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, 2014 that 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, 2014

UnitedHealth Group Incorporated and Subsidiaries' (the "Company") management 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, 2014. 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, 2014, 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, 2014, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2014.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2014, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. 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, 2014. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel 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 the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2014 of the Company and our report dated February 10, 2015 expressed an unqualified opinion on those consolidated financial statements.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 10, 2015

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 February 10, 2015, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP
(formerly Greenebaum Doll & McDonald PLLC)

Edson Bueno, M.D.
Founder and Chief Executive Officer
Amil

Richard T. Burke
Non-Executive Chairman
UnitedHealth Group

Robert J. Darretta
Retired Vice-Chairman and
Chief Financial Officer
Johnson & Johnson

Stephen J. Hemsley
Chief Executive Officer
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council, a company
focused on improving the governance
processes of corporate boards

Rodger A. Lawson
Chairman
E*TRADE Financial Corporation and
Retired President and Chief Executive Officer
Fidelity Investments — Financial Services

Douglas W. Leatherdale
Retired Chairman and Chief Executive Officer
The St. Paul Companies, Inc.
(currently known as Travelers Companies, Inc.)

Glenn M. Renwick
Chairman, President and Chief Executive Officer
The Progressive Corporation

Kenneth I. Shine, M.D.
Special Advisor to the Chancellor for Health Affairs
The University of Texas System

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE, an international health foundation

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K 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."

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," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 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 2015 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 information required by Item 201(d) of Regulation S-K will be included under the heading "Securities Authorized for Issuance Under Equity Compensation Plans" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

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 2015 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 2015 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 "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2014 and 2013.
- Consolidated Statement of Operations for the years ended December 31, 2014, 2013, and 2012.
- Consolidated Statement of Comprehensive Income for the years ended December 31, 2014, 2013, and 2012.
- Consolidated Statement of Changes in Shareholders' Equity for the years ended December 31, 2014, 2013, and 2012.
- Consolidated Statement of Cash Flows for the years ended December 31, 2014, 2013, and 2012.
- 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 in response to Item 601 of Regulation S-K.

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 30, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on October 26, 2009)
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 November 15, 1988, amended 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)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 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, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	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)
*10.12	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)
*10.13	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)
*10.14	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)

*10.15	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.16	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.17	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.18	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.19	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.20	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.21	Summary of Non-Management Director Compensation, effective as of October 1, 2014 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.22	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)
*10.23	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)
*10.24	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)
*10.25	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.26	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.27	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.28	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)

*10.29	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.30	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.31	Amended and Restated Employment Agreement, dated as of August 8, 2011, between United HealthCare Services, Inc. and Gail K. Boudreaux (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011)
*10.32	Separation and Release Agreement, effective as of November 9, 2014, between United HealthCare Services, Inc. and Gail K. Boudreaux
*10.33	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)
*10.34	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.35	Amended and Restated Employment Agreement, dated as of March 26, 2012, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012)
*10.36	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.37	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)
*10.38	Employment Agreement, effective as of December 15, 2006, between United HealthCare Services, Inc. and Eric S. Rangen (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 18, 2006)
*10.39	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and Eric S. Rangen (incorporated by reference to Exhibit 10.29 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
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 Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
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	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014, filed on February 10, 2015, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Shareholders' Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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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 Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2014 and 2013, and for each of the three years in the period ended December 31, 2014, and the Company's internal control over financial reporting as of December 31, 2014, and have issued our reports thereon dated February 10, 2015; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 10, 2015

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 559	$ 822
Short-term notes receivable from subsidiaries	27	11
Deferred income taxes and other current assets	271	214
Total current assets	857	1,047
Equity in net assets of subsidiaries	44,643	44,301
Long-term notes receivable from subsidiaries	4,635	4,215
Other assets	278	144
Total assets	$50,413	$49,707
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 332	$ 335
Note payable to subsidiary	215	215
Commercial paper and current maturities of long-term debt	1,365	1,935
Total current liabilities	1,912	2,485
Long-term debt, less current maturities	15,891	14,804
Deferred income taxes and other liabilities	156	269
Total liabilities	17,959	17,558
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; 954 and 988 issued and outstanding	10	10
Retained earnings	33,836	33,047
Accumulated other comprehensive loss	(1,392)	(908)
Total UnitedHealth Group shareholders' equity	32,454	32,149
Total liabilities and shareholders' equity	$50,413	$49,707

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, 2014	2013	2012
Revenues:			
Investment and other income	$ 293	$ 252	$ 28
Total revenues	293	252	28
Operating costs:			
Operating costs	1	(9)	(2)
Interest expense	554	618	566
Total operating costs	555	609	564
Loss before income taxes	(262)	(357)	(536)
Benefit for income taxes	96	130	192
Loss of parent company	(166)	(227)	(344)
Equity in undistributed income of subsidiaries	5,785	5,852	5,870
Net earnings	5,619	5,625	5,526
Other comprehensive loss	(484)	(1,346)	(23)
Comprehensive income	$5,135	$ 4,279	$5,503

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, 2014	2013	2012
Operating activities			
Cash flows from operating activities	$ 7,445	$ 5,099	$ 6,116
Investing activities			
Issuance of notes to subsidiaries	(436)	(1,517)	(4,149)
Repayments of notes receivable from subsidiaries	—	275	—
Cash paid for acquisitions	(1,852)	(274)	(3,737)
Capital contributions to subsidiaries	(704)	(942)	(99)
Other, net	(9)	—	—
Cash flows used for investing activities	(3,001)	(2,458)	(7,985)
Financing activities			
Common stock repurchases	(4,008)	(3,170)	(3,084)
Proceeds from common stock issuances	462	598	1,078
Cash dividends paid	(1,362)	(1,056)	(820)
(Repayments of) proceeds from commercial paper, net	(794)	(474)	1,587
Proceeds from issuance of long-term debt	1,997	2,235	3,966
Repayments of long-term debt	(812)	(943)	(986)
Proceeds of note from subsidiary	—	40	30
Other	(190)	(74)	(383)
Cash flows (used for) from financing activities	(4,707)	(2,844)	1,388
Decrease in cash and cash equivalents	(263)	(203)	(481)
Cash and cash equivalents, beginning of period	822	1,025	1,506
Cash and cash equivalents, end of period	$ 559	$ 822	$ 1,025
Supplemental cash flow disclosures			
Cash paid for interest	$ 578	$ 618	$ 547
Cash paid for income taxes	4,028	2,765	2,666

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 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.

Transactions With Subsidiaries. During 2014 the parent company issued intercompany notes of $0.4 billion that were used for the subsidiaries' general corporate purposes. In 2013, the parent company issued intercompany notes of $1.5 billion that were used primarily to fund the purchase of Amil's remaining public shares. Additionally in 2013, the $2.6 billion term note issued in 2012 was reclassified to long-term. During 2012, the parent company completed a non-cash exchange of a $3.9 billion intercompany note to a subsidiary for a new term note of $2.6 billion and an equity interest of $1.3 billion.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.5 billion, $5.3 billion and $7.8 billion in 2014, 2013 and 2012, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of 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 the other financing obligations at a subsidiary that totaled $150 million and $121 million at December 31, 2014 and 2013, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2015	$ 1,362
2016	1,096
2017	1,972
2018	1,100
2019	1,000
Thereafter	10,817

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

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 10, 2015

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
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/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director and Chief Executive Officer (principal executive officer)	February 10, 2015
/s/ DAVID S. WICHMANN **David S. Wichmann**	President and Chief Financial Officer (principal financial officer)	February 10, 2015
/s/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 10, 2015
* **William C. Ballard, Jr.**	Director	February 10, 2015
* **Edson Bueno**	Director	February 10, 2015
* **Richard T. Burke**	Director	February 10, 2015
* **Robert J. Darretta**	Director	February 10, 2015
* **Michele J. Hooper**	Director	February 10, 2015
* **Rodger A. Lawson**	Director	February 10, 2015
Douglas W. Leatherdale	Director	
* **Glenn M. Renwick**	Director	February 10, 2015
* **Kenneth I. Shine**	Director	February 10, 2015
* **Gail R. Wilensky**	Director	February 10, 2015

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

*EXHIBIT INDEX***

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 30, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on October 26, 2009)
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 November 15, 1988, amended 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)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 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, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	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)
*10.12	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)
*10.13	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)
*10.14	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)
*10.15	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.16	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.17	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.18	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.19	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.20	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.21	Summary of Non-Management Director Compensation, effective as of October 1, 2014 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.22	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)

*10.23	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)
*10.24	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)
*10.25	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.26	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.27	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.28	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.29	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.30	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.31	Amended and Restated Employment Agreement, dated as of August 8, 2011, between United HealthCare Services, Inc. and Gail K. Boudreaux (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011)
*10.32	Separation and Release Agreement, effective as of November 9, 2014, between United HealthCare Services, Inc. and Gail K. Boudreaux
*10.33	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)
*10.34	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.35	Amended and Restated Employment Agreement, dated as of March 26, 2012, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012)

*10.36	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.37	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)
*10.38	Employment Agreement, effective as of December 15, 2006, between United HealthCare Services, Inc. and Eric S. Rangen (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 18, 2006)
*10.39	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and Eric S. Rangen (incorporated by reference to Exhibit 10.29 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
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 Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
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	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014, filed on February 10, 2015, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Shareholders' Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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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.

b-8 Bank Reference Letter

WELLS FARGO

Andrew Carline
90 South, 7th Street
Minneapolis, MN 55402
Phone: 612-667-9150
Andrew.p.carline@wellsfargo.com

November 23, 2015

Re: Account Verification

To whom it may concern:

This letter serves as verification that Wells Fargo Bank account number 4122162225 is an active demand deposit account for UnitedHealth Care Insurance Company. Please see funds transfer instructions details below for ACH or Wires.

Account Details:
Wells Fargo Bank, N.A.
420 Montgomery Street
San Francisco, CA 94104

Account Type: Checking
Account Name: UnitedHealth Care Insurance Company
Account Number: 4122162225
Routing Number: 121000248

If you need additional information, feel free to contact me directly at 612-667-9150.

Sincerely,

Andrew Carline
Relationship Associate
Corporate Banking Financial Institutions Group

Jeffrey Stern
Executive Director
Diversified Industrials
Global Corporate Bank

383 Madison Avenue
New York, NY 10179

T 1 212 622 9977
F 1 917 849 4697
jeffrey.x.stern@jpmorgan.com

J.P.Morgan

November 26, 2015

Deborah S McGuire
Associate Director Treasury Solutions
UnitedHealth Group Incorporated
9900 Bren Road East, MN008-T445
Minnetonka, MN 55343

Dear Deborah:

At the request of UnitedHealth Group Incorporated (the "Company"), the parent company of UnitedHealthcare of the Midlands, Inc., below is our experience when dealing with the Company.

JPMorgan Chase Bank, and our related affiliates, has had a significant banking relationship with the Company for over 35 years. Currently we accommodate the company with credit facilities which include a low 10 figure unsecured revolving credit facility. Our dealings over the years with the company have been handled in a very satisfactory manner.

JPMorgan Chase considers the Company to be a valued client and the organization is highly regarded by us.

We are furnishing this letter and the information contained herein to you as an accommodation to the Company and on the condition that this letter and the information contained herein is treated as confidential, that it is not intended to be, and does not constitute, representations regarding the general condition of the Company, its management or its future ability to meet its obligations, that neither we nor any of our officers, employees and agents shall have any liability or responsibility in connection herewith.

Best regards,

Executive Director

THE INFORMATION IN THIS LETTER IS PROVIDED AT THE REQUEST OF UNITEDHEALTH GROUP, INC. THIS LETTER AND ANY INFORMATION PROVIDED IN CONNECTION THEREWITH ARE FURNISHED ON THE CONDITION THAT THEY ARE STRICTLY CONFIDENTIAL, THAT NO LIABILITY OR RESPONSIBILITY WHATSOEVER IN CONNECTION HEREWITH SHALL ATTACH TO JPMORGAN CHASE BANK, N.A., ANY OF ITS SUBSIDIARIES AND/OR AFFILIATES, OR ANY OF THEIR OFFICERS, EMPLOYEES OR AGENTS, THAT THIS LETTER MAKES NO REPRESENTATIONS REGARDING THE GENERAL CONDITION OF THE SUBJECT, ITS MANAGEMENT, OR ITS FUTURE ABILITY TO MEET ITS OBLIGATIONS, AND THAT ANY INFORMATION PROVIDED IS SUBJECT TO CHANGE WITHOUT NOTICE. ALL PERSONS ARE INFORMED THAT THIS RESPONSE IS A STRICTLY CONFIDENTIAL RESPONSE TO A REQUEST AND MAY BE INCOMPLETE. ANY STATEMENT ON THE PART OF JPMORGAN CHASE BANK, N.A., OR ANY OF ITS OFFICERS, AS TO THE RESPONSIBILITY OR STANDING OF ANY PERSON, FIRM OR CORPORATION, OR AS THE VALUE OF ANY SECURITIES, IS GIVEN AS A MERE MATTER OF OPINION FOR WHICH NO RESPONSIBILITY, IN ANY WAY, IS TO ATTACH JPMORGAN CHASE BANK, N.A. OR ANY OF ITS OFFICERS. FURTHERMOEW, NO OFFER OR SOLICITATION ON OUR PART WITH RESPECT TO THE SALE OF PURCHASE OF SECURITIES IS INTENDED OR TO BE IMPLIED.

c. Change of Ownership

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

We anticipate no change in ownership or control of the company during the 12 months following the proposal due date. If any change of ownership were to occur over the life of the contract, we will notify the State.

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d. Office Location

d. Office Location

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

The primary location responsible for performance pursuant to this contract is:

UnitedHealthcare of the Midlands, Inc.
2717 North 118th St., Suite 300
Omaha, NE 68164
402-445-5591

We also have offices at:

5000 Central Park Drive, Suite 204
Lincoln, NE 68504

2501 Capehart Rd.
Offutt AFB, NE 68113

Our leadership team, the primary contract personnel and managers responsible for providing the services under the contract, all work within the state of Nebraska. Our Omaha office provides additional meeting spaces that the Division of Medicaid and Long Term Care (MLTC) can use any time they are on-site to visit our health plan.

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e. Relationships with the State

e. Relationships with the State

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

UnitedHealthcare has held a contract with the state of Nebraska continuously since 1996, during which time we have established a strong working relationship with MLTC. **Our current contract number is 64226 O4**. We are a committed and effective partner of MLTC and were the sole Medicaid managed care organization (MCO) in the state from 2001 to 2010. In August 2010, we became one of two MCOs in 10 eastern counties of Nebraska, also known today as Service Area 1.

In addition to our Medicaid contract, we also have a contract with the Nebraska Department of Administrative Services. We provide medical and pharmacy claims administration for more than 13,000 state employees and their dependents. This contract [51597(O4) and 52764(O4)] was effective July 1, 2012, for an initial term of three years and three, one-year renewal options. The contract has been renewed through June 30, 2016.

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f. Bidder's Employee Relations to State

f. Bidder's Employee Relations to State

If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Sub-Contractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

UnitedHealthcare has one new employee, Troy Bailey, who previously worked for the State of Nebraska at the Division of Health and Human Services (DHHS) as a DHHS office manager. His working title at DHHS was provider relations manager under the program integrity unit. While there, his primary areas of responsibility were provider enrollment and the division's timely filing and enrollment-related legal appeals. Mr. Bailey's separation date from DHHS was May 15, 2015. He started working for UnitedHealthcare on May 18, 2015, as a provider relations advocate for UnitedHealthcare Networks in the Lincoln, Nebraska, area. As a provider relations advocate, he is responsible for working on end-to-end provider claim and call quality; ease of use of physician portal and future service enhancements; and the development and presentation of external provider education programs. He designs and implements programs to build and nurture positive relationships between UnitedHealthcare, providers (e.g., physician, hospital, ancillary) and practice managers.

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g. Contract Performance

If the bidder or any proposed Sub-Contractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

UnitedHealthcare of the Midlands, Inc. (bidder), has not had a contract terminated for convenience, non-performance, non-allocation of funds or any other reason.

To the best of our knowledge and belief, there are no contract terminations with respect to subcontractors by a Medicaid program.

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h. Summary of Bidder's Corporate Experience

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

a) The time period of the project;

b) The scheduled and actual completion dates;

c) The Contractor's responsibilities;

d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

e) Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Sub-Contractor(s) experience must be listed separately. Narrative descriptions submitted for Sub-Contractors must be specifically identified as Sub-Contractor projects.

iii. If the work was performed as a Sub-Contractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Sub-Contractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Sub-Contractor.

Below, we list three project descriptions and provide the information, as requested:

- Table h-1: Kansas – Department of Health and Environment
- Table h-2: Texas – Health and Human Services Commission
- Table h-3: Ohio – Department of Medicaid

Table h-1: Kansas		
i. Description		
Originated in 2013; serves more than 129,300 members **KanCare Managed Care** KanCare Managed Care, originating in 2013, is a state-funded Medicaid program for ABD, CHIP, LTSS and TANF beneficiaries. The program we offer covers comprehensive care, to include multiple waiver populations (i.e., frail elderly, physically disabled and DD/ID, etc.). Services include medical, behavioral health, pharmacy, dental, vision and non-emergent transportation. Care managers (e.g., RNs, community outreach and behavioral health clinicians) deliver hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight.		
a. Time Period of Contract	**b. Scheduled and Actual Completion Dates**	**c. Contractor Responsibilities**
Three years plus two-year extension	**Scheduled Dates** Jan. 1, 2013 – Dec. 31, 2015 to be extended through Dec. 31, 2017 **Actual Completion Dates** Dec. 31, 2015 to be extended through Dec. 31, 2017	Administration of Medicaid managed care for the programs listed above.
d. Reference	**e. Prime Contractor/Subcontractor**	**e. Originally Scheduled Completion Date and Budget**
Susan Mosier 785-296-0461 Facsimile Number N/A *smosier@kdheks.gov*	Prime Contractor	Through Dec. 31, 2015 Capitated
		e. Actual Scheduled Completion Date and Budget
		Through Dec. 31, 2015 $2,650,000,000
ii. Contractor Experience	All of the experience set forth for UnitedHealthcare of the Midlands, Inc., is as a Contractor.	
iii. Work as a Subcontractor	Not applicable	

Table h-2: Texas		
i. Description		
Originated in 1998; serves more than 290,000 members **Texas STAR/Texas CHIP/Texas STAR+PLUS** STAR is a state-funded Medicaid program for ABD, SSI and TANF beneficiaries. This program provides coverage in Brazoria, Fort Bend, Galveston, Harris, Hidalgo, Montgomery and Waller counties. CHIP is a state-funded program for CHIP beneficiaries. This CHIP program provides coverage to children in Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Waller, Walker and Wharton counties. A CHIP perinatal program is included in this coverage. STAR+PLUS is a state-funded program for SSI, SSI-related seniors and LTSS beneficiaries. This is a Medicaid program for people with disabilities. Eligible people include18 and over, SSI, SSI-related seniors and those with disabilities or specific long-term illnesses covered under Medicaid. The STAR+PLUS plan serves members in Burnet, Hays, Travis, Williamson, Caldwell, Bastrop, Lee, Fayette, Nueces, San Patricio, Aransas, Kleberg, Jim Wells, Bee, Kennedy, Brooks, Live Oak, Refugio, Calhoun, Victoria, Goliad, Karnes, Galveston, Brazoria, Waller, Harris, Montgomery, Fort Bend, Austin, Wharton, Matagorda, Jefferson, Polk, Chambers, Liberty, Orange, Hardin, Newton, Jasper, Tyler, San Jacinto and Walker.		
a. Time Period of Contract	**b. Scheduled and Actual Completion Dates**	**c. Contractor Responsibilities**
Three years plus yearly renewals for up to five years	**Scheduled Dates** Aug. 1, 2015 – Aug. 31, 2018 **Actual Completion Dates** Aug. 31, 2018	Administration of Medicaid managed care for the programs listed above.
d. Reference	**e. Prime Contractor/Subcontractor**	**e. Originally Scheduled Completion Date and Budget**
Gary Jessee 512-462-6294 Facsimile Number N/A *gary.jessee@hhsc.state.tx.us*	Prime Contractor	Through Aug. 31, 2018 Capitated **e. Actual Completion Date and Budget** Through Aug. 31, 2018 $4,500,000,000
ii. Contractor Experience	All of the experience set forth for UnitedHealthcare of the Midlands, Inc., is as a Contractor.	
iii. Work as a Subcontractor	Not applicable	

Table h-3: Ohio		
i. Description		
Originated in 2005; serves more than 303,500 members **Covered Families/Children (CFC)/Aged, Blind and Disabled (ABD)** CFC, originating in 2005, is a state-funded program for CHIP and TANF beneficiaries. The Covered Families and Children (CFC) program encompasses Ohio's Healthy Families members (i.e., TANF-related Medicaid consumers) and Ohio's Healthy Start eligibles (SCHIP consumers). ABD, originating in 2005, is a state-funded program for ABD beneficiaries. Our ABD members are enrolled in our full-risk managed care program. It involves the delivery of all Medicaid-covered physical health services, including vision, dental and pharmacy—to eligible recipients in Ohio. Medicaid Expansion, originating in 2014, increased the membership of the CFC and ABD programs by 70,000 additional members during its first year from 2014–2015.		
a. Time Period of Contract	**b. Scheduled and Actual Completion Dates**	**c. Contractor Responsibilities**
Time Period of Contract One year	**Scheduled Dates** July 1, 2015 – June 30, 2016 **Actual Completion Dates** June 30, 2016 Auto-annual renewal	Administration of Medicaid managed care for the programs listed above.
d. Reference	**e. Prime Contractor/ Subcontractor**	**e. Originally Scheduled Completion Date and Budget**
Patrick Stephan 614-752-2600 Facsimile Number N/A *patrick.stephan@medicaid.ohio.gov*	Prime Contractor	Through June 30, 2016 CFC/ABD Capitated
		e. Actual Scheduled Completion Date and Budget
		Through June 30, 2016 CFC/ABD $794,000,000/$287,746,000
ii. Contractor Experience	All of the experience set forth for UnitedHealthcare of the Midlands, Inc., is as a Contractor.	
iii. Work as a Subcontractor	Not applicable	

i. Summary of Bidder's Proposed Personnel/ Management Approach

i. Summary of Bidder's Proposed Personnel/Management Approach

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and a minimum of three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Proposed Management Approach

We remain committed to a strong local presence in Nebraska and look forward to the opportunity to expand our team so we can continue to provide high-quality services to our members, providers, community stakeholders and MLTC. In response to the wider range of responsibilities we will be assuming in the next contract period, we are hiring new positions, including staff who will be located across Nebraska, new clinicians who specialize in behavioral health (BH) and individuals with special needs (i.e., home and community-based services [HCBS], foster care and dual eligible) and staff who provide pharmacy services.

Our service model and approach to delivery will provide Nebraska with a rich resource of state-based partners with the necessary skills and competencies to meet your program needs, now and in the future. Our team understands that MLTC expects our employees, subcontractors and agents to be accountable, responsive, reliable, patient and have well-developed communication skills as set forth by the customer service industry's best practices and processes. MLTC is our customer.

Our primary focus is on efficiently and compassionately transitioning Heritage Health members and assuring continuity of care. As a result of our current relationship with MLTC, we have a special understanding of the needs and concerns of Nebraska's Medicaid and Children's Health Insurance Program (CHIP) enrollees and their families who may be transitioning to a new program.

In the past three years, UnitedHealthcare has implemented new contracts across 18 states that provide services for new or expanded populations of approximately 1,055,100 additional Medicaid members. Our transition process is a multifaceted, member-centered approach that achieves transition success. We focus on goals encompassing risk mitigation, coordination, communication and continuity of care for all stakeholders. We use a continuous improvement process to evaluate implementation performance while maintaining close communication with MLTC stakeholders, including our provider network.

Locally, our team provided a "no noise' implementation of our current contract in 2010 and all subsequent contract changes. This team comprises many of the same individuals who will implement on these new requirements. Our detailed implementation plan is included as Attachment 5 UnitedHealthcare Community Plan of Nebraska Preliminary Implementation Plan Final and is described in Section IV.X Transition and Implementation.

We project hiring our full contingent of staff by Nov. 1, 2016, to allow sufficient time for training and orientation. By the time our new roster is completely hired, we will have 166 new incremental resources

supporting Heritage Health, with total support from 294 full time equivalents (FTEs) of which 53 percent will be located in Nebraska. This significant staffing increase reflects the resources planned to execute on the management of BH and pharmacy services and to serve the new populations in Heritage Health. **These resources also reflect our commitment to create a member and provider call center in Nebraska.** In choosing the location, we will collaborate with the Nebraska Department of Economic Development to consider Nebraska areas and communities that will benefit most from the economic growth and improvement related to a call center installation and workforce availability. For key staff positions, we have assigned interim staff who are subject matter experts until permanent staff are hired.

We are committed to a strong local presence and to delivering high-quality services to our members, providers, communities and MLTC. We offer a comprehensive staffing plan based on our experience executing full-risk managed care contracts across the country. We will be 100 percent ready by go-live and have key staff in place to support implementation. Once in place, we will maintain or exceed this level of in-state staff for our managed care operations under the Nebraska contract. Between contract award and the contract effective date, we will deploy implementation resources from functional areas throughout the organization.

Staffing Plan

Our organizational structure is specifically designed to meet the integrated physical, behavioral and pharmacy needs of the Heritage Health population, serving low-income and special health care needs populations. Our staffing models acknowledge multidisciplinary health care professionals, health information technology, provider support and customer service—all working collaboratively on behalf of our members, providers and state partners.

Through an understanding of the populations we serve, we created our staffing plan and functional staffing chart with an appreciation for the RFP requirements as well as internalizing MLTC goals and leveraging our deep understanding of our State partners. Then we focused on modeling our staffing needs using proprietary workforce models and planning tools as a baseline, building on our experience serving Nebraska Medicaid members and applying the expertise of our affiliate organizations that have been serving specialty populations. We developed these models across our business units, considering the unique and varied needs and requirements of the Heritage Health plan to support efficient managed care operations based on factors such as enrollment, anticipated call volumes and contract requirements. We continually re-evaluate and revise these models to assure consistent, dependable service regardless of enrollment or other changes that can influence work volume. We further refine and adjust the models to reflect the efficiencies we have recognized as a result of investment in technologies deployed to streamline business processes, simplify member experiences and improve administrative accuracy.

Our workforce staffing tools define the knowledge, skills, characteristics and abilities employees should possess by role and number of employees required in each job based upon the defined work process. The models help us calibrate staffing to work effort so we do not overstaff or understaff for this contract. In addition, the models define a management hierarchy for each functional area. Finally, staffing models take into account levels of efficiency; especially ramp-up and training of new staff upon initial hiring, and reflect the time commitment for ongoing employee development and skill enhancement.

Expected Staffing Levels

We use staffing ratio guidelines for certain staff functional areas that acknowledge the health needs of the population served. For example, care coordination staff ratios for populations with more complex needs are lower than ratios used for other groups. These ratio guidelines provide benchmarks to assess staffing

levels and may be adjusted to reflect final contract requirements, the person-centered care employed or actual changes in member care needs.

Nebraska-Specific Knowledge

Nebraska-specific knowledge will be shared with new employees several ways. First, our current Nebraska staff will mentor the new employees. Second, we will look for candidates, especially for the Nebraska-based positions, who are part of the local health care delivery system to supplement our expertise. For example, our chief executive officer (CEO) is a Nebraska native with more than 30 years of health care experience; and our new chief operating officer is a Wisconsin native with more than 20 years of clinical and managed care health care leadership experience, most recently in North Carolina. This blend of local and national experience provides an excellent balance to enable us to build on our strong history while adding new components to our program.

Nebraska employees will complete Nebraska-specific training that provides a comprehensive overview of the Heritage Health initiative and its requirements, contractual and regulatory requirements including fraud, waste and abuse (FWA); nondiscrimination; population health; consent decrees and adverse actions; complaints and appeals; covered benefits; and fines and penalties. Employees also will be educated and trained on HIPAA privacy and security and Heritage Health-specific reporting requirements for privacy breaches. In addition to comprehensive member services training, all employees attend our state-specific training. The state-specific training curriculum is developed for each state and gives our staff the opportunity to truly understand and relate to the specific member populations they serve. We are very proud of serving Nebraska residents with our strong local presence and relationship with MLTC since 1996. We will continue to invite representatives from MLTC, DHHS and other key groups to explain the vision and goals of Heritage Health to our staff.

We assure MLTC that all replacement staff and other new hires working under the contract will have appropriate training and orientation to fulfill the requirements of their positions and provide the highest level of service to our members and MLTC. Training is delivered by on-site trainers, Web-based tools, role-playing and adult learning approaches. Nebraska contract training sessions will occur annually for existing staff and will be provided throughout the year for new hires. We also have developed numerous tools to help member services staff while on the job.

Specific Professionals Who Will Work on the Project

Names, titles and primary work assigned

Our key staff will align with and include all staff required in IV. Project Description and Scope of Work, D. Staffing Requirements, 2. Key Staff Positions. We place a high priority on identifying the best talent from a diverse pool of candidates throughout Nebraska to build a key team integral to the delivery system and dedicated to making a difference in people's lives. For key staff positions, we have assigned interim staff who are subject matter experts until permanent staff are hired.

We only hire candidates who meet the qualifications outlined for the job. Once hired, these new employees undergo a structured orientation to their job. From the high-performing people we hire to the health care services we provide, we advocate the possibilities of unique thinking. We are committed to creating an inclusive environment fueled by innovative ideas. Our employees have diverse cultural backgrounds, beliefs, perspectives and lifestyles; however, they have one thing in common—their ability to excel.

Primary Work Assigned

- ***Kathleen Mallatt, chief executive officer:*** Ms. Mallatt is accountable for overall direction, strategic development, growth and operations of UnitedHealthcare in providing innovative care to the populations in Heritage Health.
- ***Michael Horn, M.D., medical director/chief medical officer:*** Dr. Horn is actively involved in all major clinical and quality management components of our operations. He oversees clinical operation initiatives that focus on clinical excellence and performance improvement.
- ***Charles Freed, M.D., BH clinical director:*** Dr. Freed is responsible for the overall BH clinical affordability functions, including benefit expense management and engagement. He executes the goals of the integrated medical/behavioral/pharmacy team.
- ***Von Grubbs, BH manager:*** Mr. Grubbs is responsible for the successful delivery of cost-effective quality care that incorporates recovery, resiliency and person-centered services.
- ***Sean Jones, chief operating officer:*** Mr. Jones is the primary point of contact for all operational issues and is responsible for management and administration of multiple functions and general business operations.
- ***Jim Elliston, chief financial officer:*** Mr. Elliston oversees all aspects of strategic financial planning, analysis and operations. He executes a disciplined approach to financial performance management and oversees the budget, accounting systems, financial reporting and audit activities.
- ***Tim Langdon, program integrity officer/contract compliance coordinator:*** Mr. Langdon is both the program integrity officer and contract compliance coordinator and reports directly to the Community & State central region compliance officer and to Ms. Mallatt. He is accountable for oversight of all compliance and program integrity aspects for the health plan. Additionally, Mr. Langdon leverages the multiple national UnitedHealthcare teams to execute on the necessary aspects of the compliance program, and oversees monitoring and enforcement of the fraud, waste and abuse compliance program pursuant to state and federal rules and regulations.
- ***Lori Caldwell, grievance system manager:*** Ms. Caldwell adjudicates member and provider disputes arising under the grievance system, including member grievances, appeals and requests for fair hearing and provider claim and disputes.
- ***Associate director, general management/business continuity planning and emergency coordinator:*** This role manages day-to-day operational requirements and oversees UnitedHealthcare's emergency management plan during disasters and assures continuity of care benefits and services for members who may need to be evacuated to other areas of the state or out-of-state.
- ***Cyndi Margritz, RN BSN, quality management coordinator:*** Ms. Margritz provides strategic leadership and direction for the quality improvement and management program.
- ***Patricia Jones, RN, performance and quality improvement coordinator:*** Ms. Jones focuses organizational efforts on the improvement of clinical quality performance measures.
- ***Cyndi Margritz, RN BSN, maternal child health (MCH)/early and periodic screening, diagnostic and treatment (EPSDT) coordinator:*** Ms. Margritz manages the EPSDT program, promoting family planning, preventive health and the pregnancy programs.
- ***Timothy Mergens, M.D., medical management coordinator:*** Dr. Mergens strategizes, develops and directs operations to assure provision of high-quality, cost-effective medical services.
- ***Jeremy Sand, provider services manager:*** Mr. Sand develops the provider network through retention activities.

- ***Lisa Reynolds, member services manager:*** Ms. Reynolds provides expertise and customer service support to members, customers and providers. She also directs phone-based customer interactions to answer and resolve inquiries.
- ***Diane Knutson, claims administrator:*** Ms. Knutson develops, implements and administers a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements and the terms of the contract.
- ***Candace White, provider claims educator:*** Ms. White serves in this fully integrated position with the grievance, claims processing and provider services departments. She facilitates the exchange of information between these departments and in-network/out-of-network providers.
- ***Barbara Palmer, RN MHA, case management administrator:*** Ms. Palmer is accountable for our care coordination and community-based case management programs. She strategizes, develops and directs operations of the health services department and assures culturally sensitive delivery of whole person care.
- ***Cybele Kanin, information management and systems director:*** Ms. Kanin leads the information technology organization by supporting multiple claims platforms and operations, medical management and provider services.
- ***Robert Steffens, encounter data quality coordinator:*** Mr. Steffens organizes and coordinates services and communication between UnitedHealthcare's administration and DHHS to identify, resolve and monitor encounter and data validation/management issues.
- ***Kim Manning, marketing and community outreach director:*** Ms. Manning oversees and directs staff serving as community ambassadors from UnitedHealthcare. She directs her staff to work with communities, assigned regions, service areas and urban areas to foster healthy partnerships and relationships while building brand awareness.
- ***Kim Manning, tribal network liaison:*** As tribal network liaison, Ms. Manning will be instrumental in building partnerships, bridging communication and offering effective solutions to address the many ways we can improve member health outcomes and best practices through a trauma-informed, culturally appropriate care delivery system for Native Americans statewide.
- ***Jeanne Cavanaugh, Pharm.D., pharmacist/pharmacy director:*** Dr. Cavanaugh has overall responsibility for instituting and coordinating all components of the pharmacy program for the health plan.

Description of team leadership, interface and support functions

For all health plan functions, our leadership reviews reports provided by functional areas to evaluate service delivery and seek operational efficiencies. We hold regularly scheduled business reviews, Joint Operating Committees (JOCs) or similar endeavors and forums with leadership from teams or departments and other key personnel. In the reviews, we review performance targets and results, and formulate and review operational improvements plans, progress to plans is gauged and additional relevant topics are discussed. A typical agenda includes the following components:

- Review of functional department or team performance to goals and targets
- Discuss upcoming key projects, innovations and initiatives in support of integration and program goals and establishment of meaningful performance goals
- Review risks, barriers and potential concerns
- Discuss miscellaneous topics and facilitate a roundtable discussion

Depending on the scope of the function, a review may be combined with other functions into a combined business review. The frequency of the reviews also may depend on factors such as the department's performance to goals, high-profile or complex projects, initiatives in the pipeline or other aspects of integrated service delivery.

We maintain key leadership contacts for out-of-state functions, and regular communications occur between the department leads and our leadership on issues that may be more immediate or occur between reviews or are of an escalated nature.

We believe in the local management and delivery of health care services. We also understand the importance of creating programs based on each state's unique delivery and funding systems, regulatory and governing structures. If selected to serve as the contractor for the Heritage Health, we will expand our local organization—an organization that is both empowered with the authority to make decisions that affect local operations and has full access to national resources. As a local health plan serving Nebraska Medicaid members since 1996, we know Nebraska. We value relationships and compassion, and our service in Nebraska reflects our commitment to these values. **We also have a significant benefit over new entrants to Nebraska because we have the key staff and infrastructure already in place. Our implementation is limited to expanding on a framework that is already fully compliant with Nebraska Medicaid requirements.**

Heritage Health will receive increased support during and immediately following program implementation. This increased support early in the program helps promote a smooth transition and is provided through a variety of resources including:

- An implementation team that includes staff experienced in the administrative tasks required to start a new program and staff experienced in working with the various stakeholder groups whose involvement is critical to the success of a new public sector initiative
- Mentoring of the new management team by the management team of other public sector programs so lessons learned can be shared and common operational challenges can be avoided or identified and resolved quickly
- Consultation and support from corporate staff members will be important as we work with the MLTC and stakeholders to design contracts for Heritage Health

The leadership team has the autonomy to make local decisions with ongoing support from our national and regional resources. Our team will base its decisions on our partnership with MLTC and on our mutual need to create a strong transparent program.

Refer to the staffing job descriptions in our response to Question 18 in the Technical Approach section for a full listing of job accountabilities, including team leadership, interface and support functions.

Reporting relationships

The following leadership organization chart, Figure i-1, shows the reporting relationships among key staff and additional required staff.

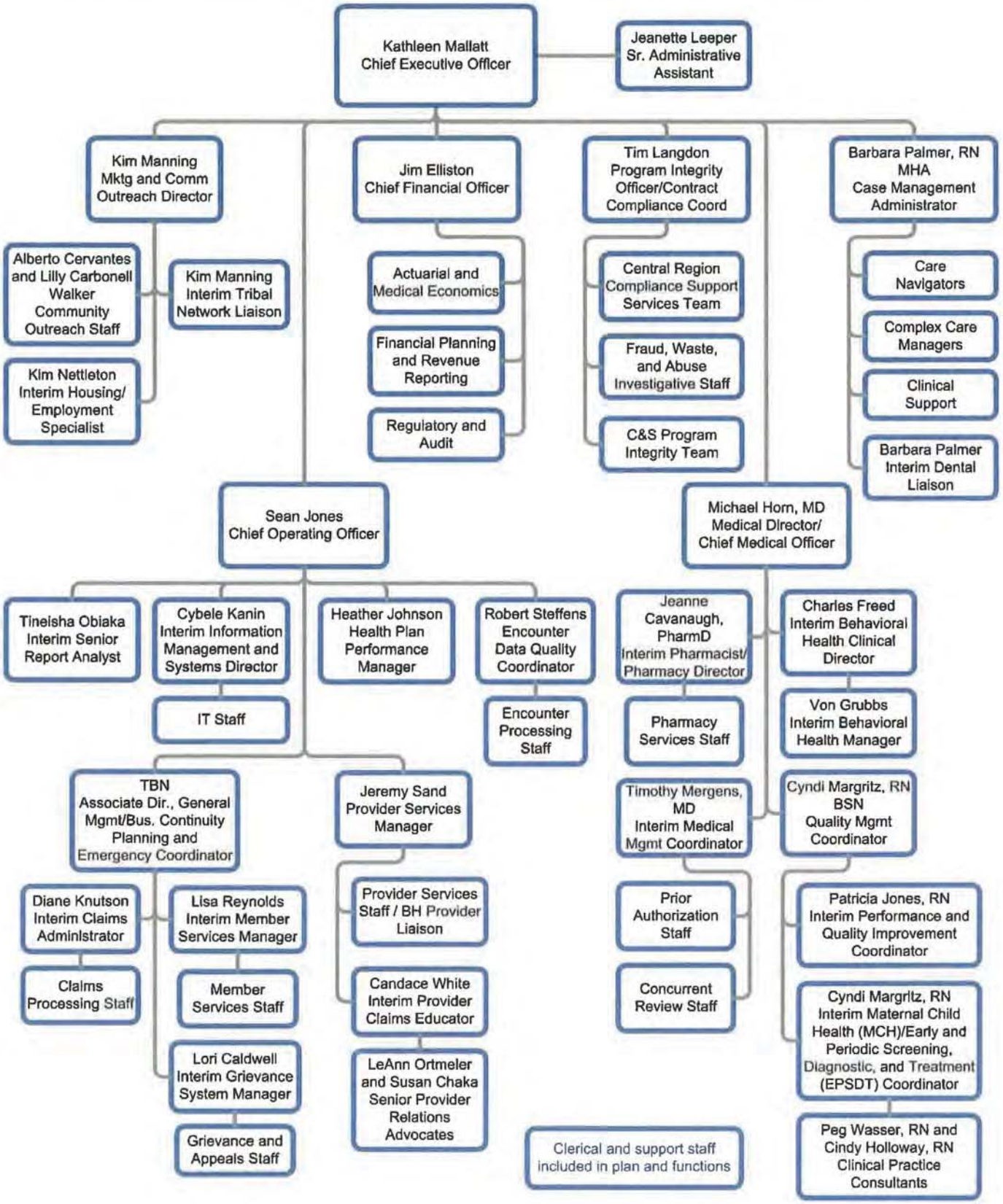

Figure i-1. Nebraska Organizational Chart

Resumes

We have provided resumes of personnel proposed to work on the project behind the Attachment 5 – Key Staff Resumes tab. These resumes include the academic background and degrees, professional certifications, three references and detail the mix of skills necessary to successfully implement and manage the requirements of this bid.

That mix of skills includes a local understanding of the state; and operational, financial, clinical, pharmaceutical, behavioral, cultural, information technology, compliance, program integrity and quality management expertise. Our leadership team's ability to successfully implement Heritage Health requirements in a "no noise" manner comes from their years of experience with both Nebraska Medicaid and UnitedHealthcare and a detailed appreciation of the requirements and purpose of the RFP and the goal of MLTC.

j. Sub-Contractors

j. Sub-Contractors

If the bidder intends to Sub-Contract any part of its performance hereunder, the bidder must provide:

vi. name, address, and telephone number of the Subcontractor(s);

vii. specific tasks for each Subcontractor(s);

viii. percentage of performance hours intended for each Subcontract; and

ix. total percentage of Subcontractor(s) performance hours.

We provide information pertaining to items vi – ix for each proposed subcontractor, as requested, in Table j-1: Affiliate Subcontractors and Table j-2: Non-affiliate Subcontractors. We estimated the percentage of performance hours intended for each subcontract as the percentage of the total contract attributable to the subcontractor.

Table j-1: Affiliate Subcontractors	
FiServ Solutions, Inc.	
Address	255 FiServ Drive, Brookfield, WI 53045
Telephone Number	281-274-6369
Specific Tasks	Identity card processing
Percentage of Performance Hours Intended for Each Subcontract	0.13 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
OptumHealth Care Solutions	
Address	11000 Optum Circle, Eden Prairie, MN 55344
Telephone Number	952-205-2957
Specific Tasks	Chiropractic and physical, occupational and speech therapies network, and credentialing services
Percentage of Performance Hours Intended for Each Subcontract	5.80 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
OptumInsight, Inc.	
Address	11000 Optum Circle, Eden Prairie, MN 55344
Telephone Number	952-205-6164
Specific Tasks	Fraud, waste and abuse; subrogation and payment integrity services
Percentage of Performance Hours Intended for Each Subcontract	1.58 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.

Table j-1: Affiliate Subcontractors	
OptumRx, Inc.	
Address	2300 Main Street, Irvine, CA 92614
Telephone Number	877-309-5345
Specific Tasks	Pharmacy benefit management and other related services (e.g., retail pharmacy network claims processing, mail order pharmaceuticals, specialty pharmaceutical management and clinical programs)
Percentage of Performance Hours Intended for Each Subcontract	2.83 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
United Behavioral Health, Inc. d.b.a. Optum Behavioral Solutions	
Address	425 Market Street, 14th Floor, San Francisco, CA 94105
Telephone Number	888-445-8745
Specific Tasks	Behavioral health management, to include post-hospitalization planning and follow-up; BH outpatient case management, UM for covered BH services; BH quality management; BH network management and development; BH call center services and BH claims processing and payment
Percentage of Performance Hours Intended for Each Subcontract	10.42 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
United HealthCare Services, Inc.	
Address	9900 Bren Rd, Minnetonka, MN 55343
Telephone Number	Local number, in care of: 800-641-1902
Specific Tasks	Management services company for all UnitedHealth Group companies. Services include management, employees, contracting, claims payment, data management and other administrative functions.
Percentage of Performance Hours Intended for Each Subcontract	50.64 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.

Table j-2: Non-affiliate Subcontractors	
BIWORLDWIDE	
Address	7630 Bush Lake Road, Minneapolis, MN 55439-2810
Telephone Number	952-835-4800
Specific Tasks	Baby Blocks member outreach with mailings or limited ad hoc calls
Percentage of Performance Hours Intended for Each Subcontract	0.23 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Burke Research	
Address	500 W. 7th Street, Cincinnati, OH 45203
Telephone Number	513-241-5663
Specific Tasks	Care management member satisfaction surveys
Percentage of Performance Hours Intended for Each Subcontract	0.21 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Decision Support Systems Research	
Address	4150 International Plaza, Suite 900, Fort Worth, TX 76109
Telephone Number	800-989-5150
Specific Tasks	CAHPS consulting and support services
Percentage of Performance Hours Intended for Each Subcontract	0.09 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
DialAmerica	
Address	960 Macarthur Boulevard, Mahwah, NJ 07495
Telephone Number	800-913-3331
Specific Tasks	Access and availability services
Percentage of Performance Hours Intended for Each Subcontract	0.01 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1% of the total work of this national company.
EviCore (CareCore National, LLC d.b.a. eviCore)	
Address	400 Buckwalter Place Boulevard, Bluffton, SC 29910
Telephone Number	800-918-8924
Specific Tasks	Management services for outpatient advanced radiology and cardiology benefits
Percentage of Performance Hours Intended for Each Subcontract	1.01 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.

Table j-2: Non-affiliate Subcontractors	
Intelliride (Transdev North America, Inc. d.b.a. Intelliride)	
Address	720 E. Butterfield Rd, Suite 300, Lombard, IL 60148 Local: 2222 Cuming Street, Omaha, NE 68102
Telephone Number	Local: 402-401-6999
Specific Tasks	Transportation services
Percentage of Performance Hours Intended for Each Subcontract	0.09 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Johnson Anderson and Associates	
Address	2010 Valley Industrial Boulevard South, Shakopee, MN 55379
Telephone Number	952-496-6652
Specific Tasks	Envelopes
Percentage of Performance Hours Intended for Each Subcontract	0.01 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
LanguageLine Solutions, Inc.	
Address	1 Lower Ragsdale Drive, Building Two, Monterey, CA 93940
Telephone Number	831-648-5539
Specific Tasks	Translation services
Percentage of Performance Hours Intended for Each Subcontract	0.01 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Market Strategies International	
Address	17430 College Parkway, Livonia, MI 48152
Telephone Number	734-542-7600
Specific Tasks	Provider satisfaction surveys
Percentage of Performance Hours Intended for Each Subcontract	0.21 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Med Review, Inc.	
Address	1 Seaport Plaza, 199 Water Street, 27th Floor, New York, NY 10038
Telephone Number	212-897-6000
Specific Tasks	Fraud, waste and abuse services for DRG review
Percentage of Performance Hours Intended for Each Subcontract	1.13 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.

Table j-2: Non-affiliate Subcontractors	
Mirixa Corporation	
Address	11600 Sunrise Valley, Suite 100, Reston, VA 20901
Telephone Number	703-683-1955
Specific Tasks	Medication therapy management services
Percentage of Performance Hours Intended for Each Subcontract	0.21 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
RR Donnelley & Sons Company	
Address	35 West Wacker Drive, Chicago, IL 60601
Telephone Number	800-742-4455
Specific Tasks	Mail services
Percentage of Performance Hours Intended for Each Subcontract	0.62 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Silverlink Communications, Inc.	
Address	67 South Bedford Street, Suite 300E, Burlington, MA 01803
Telephone Number	866-279-3080
Specific Tasks	Member incentive outreach
Percentage of Performance Hours Intended for Each Subcontract	0.01 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.
Superior Vision Benefit Management, Inc.	
Address	939 Elkridge Landing Road, Suite 200, Linthicum, MD 21090
Telephone Number	800-243-1401
Specific Tasks	Vision benefit management services
Percentage of Performance Hours Intended for Each Subcontract	0.77 percent
Total Percentage of Subcontractor Performance Hours	The Heritage Health contract represents less than 1 percent of the total work of this national company.

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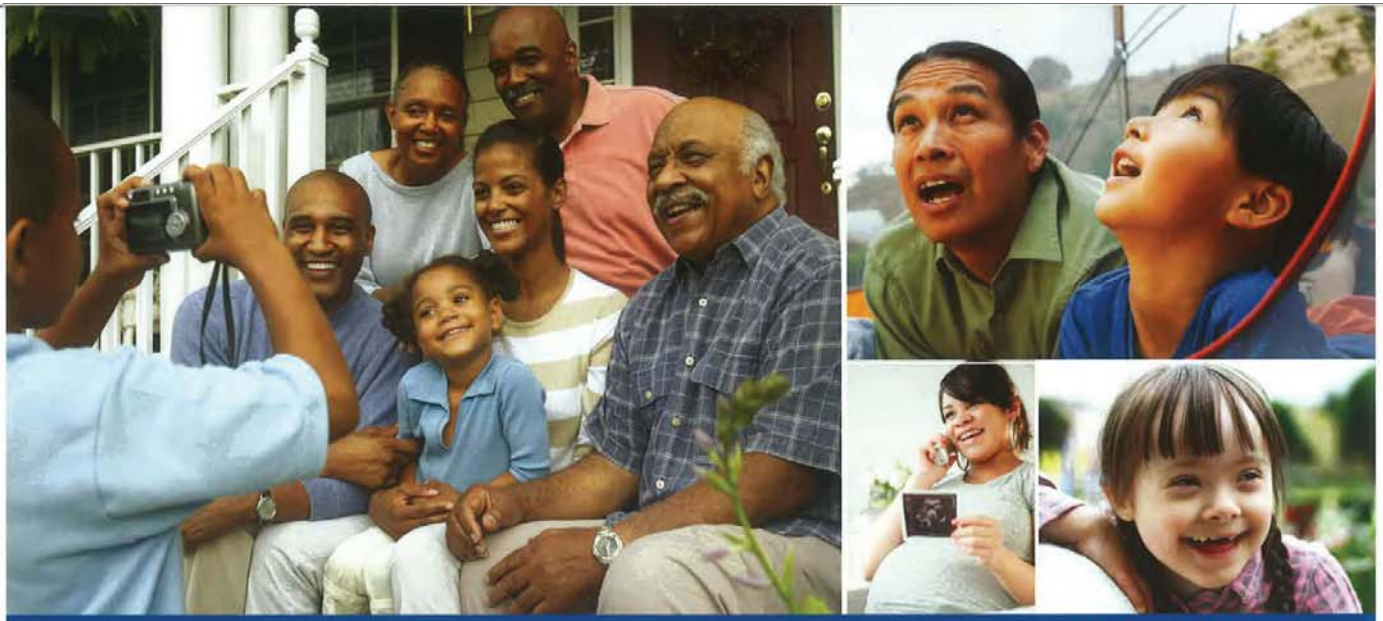

STATE OF NEBRASKA

Request for Proposal for

Nebraska State Purchasing Bureau
Heritage Health

Medicaid Managed Care for Physical Health, Behavioral Health, and Pharmacy Services

Technical Approach

(a. Understanding of the Project Requirements and
b. Response to Proposal Statements and Questions)

Binder 2 of 3

RFP #5151 Z1

ORIGINAL

UnitedHealthcare®
Community Plan

3. TECHNICAL APPROACH

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Attachment 19 Q49-3 Link Introduction
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Attachment 19 Q49-5 Optum Rx PA QRG
Attachment 19 Q49-6 Link Eligibility - Benefits Referral Status
Attachment 19 Q49-7 Fee Schedule QRC

Attachment 19 Q49-8 Electronic Payments and Statement QRC
Attachment 19 Q59 Initial Health Screening Sample
Attachment 19 Q77-1 Provider Profiling Example PCP
Attachment 19 Q77-2 NE HIPR Utilization Summary Report Template
Attachment 19 Q84 Services Requiring Prior Authorization
Attachment 19 Q106 Sample Business Continuity Disaster Recovery Plan
Attachment 19 Q115-1 Member Grievance Systems Report
Attachment 19 Q115-2 PIP Report - Improving Screening and Follow-up for Adolescent Depression
Attachment 19 Q115-3 PIP Report - Reducing Non-Emergent Emergency Department Visits
Attachment 19 Q115-4 Care Management Report

a. Understanding of the Project Requirements

a. Understanding of the Project Requirements

(limited to three pages)

UnitedHealthcare of the Midlands, Inc. (d.b.a. UnitedHealthcare Community Plan of Nebraska, hereinafter referred to as UnitedHealthcare) is privileged to be Division of Medicaid and Long Term Care's (MLTC's) familiar and trusted partner since 1996 focused on improving the health and well-being of Nebraskans. We remain fully committed to supporting the transformation of the Medicaid program through the implementation of the fully integrated, statewide Heritage Health program. The dictionary defines heritage as a special possession, an allotted portion, belonging to us at birth. We view Heritage Health as an opportunity for us to use our best resources to create a *heritage of health* for Nebraska's most vulnerable. We are dedicated to delivering fully integrated, person-centered care reflective of MLTC's vision for Heritage Health making health care a fundamental and special possession for all we serve.

With a history of dedication and passion for providing better health care in Nebraska, we are keenly aware of and sensitive to serving the needs of the Heritage Health populations. This includes coordinating childhood checkups and EPDST for TANF and CHIP members; creating fully integrated care plans for chronically ill Aged, Blind and Disabled (ABD) members; seamlessly coordinating care for Katie Beckett, intellectual and/or developmental disabilities (I/DD), serious mental illness (SMI) and foster care members; and accessing and coordinating care for dual-eligible and non-dual eligible members.

Based upon our long-standing relationship with MLTC and our Medicaid managed care experience, UnitedHealthcare applauds the State in integrating physical and behavioral health (including pharmacy and transplant) and understands the importance of integrated care in achieving the following outcomes:

- Improve health outcomes
- Enhanced integration of services and quality of care
- Emphasis on person-centered care, including enhanced preventive and care management services
- Reduce rate of costly and avoidable care
- Improved financially sustainable system

Our response covers all requirements outlined in the Scope of Work (SOW) and the targeted questions included in Attachment 19 and deliverables in Attachment 5 of Request for Proposal (RFP) #5151 Z1. Our objective is to convey the depth and quality of our experience and past performance and provide a comprehensive understanding of our capabilities. We will demonstrate our commitment as a contractor that develops and provides technology and business procedures designed to enhance the level of customer satisfaction with a local team that is accountable, reliable, responsive and patient, with well-developed communication skills and is a trusted partner to MLTC.

Our Background in Nebraska and Nationally

Our history illustrates our experience and commitment to programs serving Medicaid and CHIP consumers. We have been a committed Medicaid partner in Nebraska for almost 20 years. UnitedHealthcare serves more than 425,000 Nebraskans enrolled in our Medicaid, Medicare and commercial programs. In addition, our medical network in Nebraska consists of more than 2,800 primary care providers, 3,500 specialists, 102 hospitals, 49 urgent care centers and convenience clinics. We are contracted with 56 percent of Medicaid-enrolled behavioral health providers and our remaining target list includes: 600 individual BH providers, including 100 prescribers; 111 groups including RHCs and 7 FQHCs; 32 facilities, including CACs with BH services.

For more than 33 years, UnitedHealthcare has been committed to our mission of *helping people live healthier lives* by providing solutions for Medicaid and CHIP programs across the country. We offer support to low-income consumers in 24 states and the District of Columbia, serving more than 5.3 million people. We operate health plans that meet the unique needs of local populations while leveraging the national resources and practical innovations, medical knowledge and efficiencies of UnitedHealth Group.

The UnitedHealthcare Framework for Person-Centered Care

Delivering on MLTC's vision of integrated care requires a person-centered focus, which is at the heart of our clinical and member service model is fundamental to how our services are organized and delivered. Our person-centered care model is the foundation for how we **support** our members and their family/caregiver, **organize** health care services, **engage** providers and community resources (including accountable care organizations [ACOs] and health homes), and **enable** proactive health promotion, treatment and recovery-oriented best practices that are grounded in respect for each member's cultural diversity, personal beliefs and health preferences.

Our critical role is to ensure that the comprehensive needs of individuals - physical health, behavioral health (BH) and social determinants are addressed in a timely and highly integrated manner that produces positive health outcomes and improved quality. In doing this, we must take into account that individuals receiving Medicaid are diverse in their needs and the health care approaches that work best to address them. Our person-centered care approach also supports effective population health management by implementing integrated care coordination approaches tailored for the specific populations we serve. We systematically collect and analyze data about members and their health risks; plan and deliver care in ways that distinguish between levels and types of care coordination required to improve health outcomes; and continuously monitor and course-correct as necessary to ensure progress and cost effectiveness.

The following highlights and examples illustrate the more detailed information provided in the full response to the RFP and SOW and how we will employ our proven, person-centered model to support the Heritage Health program.

Beyond the Traditional - Serving Individuals and Populations with Complex Needs

We have a rich history of supporting the needs of the highly complex populations to be served by the Heritage Health. Experience serving similar individuals has shown that we must meet members' physical health and BH needs as well as coordinate covered benefits and align non-covered services to support functional and social supports to improve health outcomes. We focus beyond the delivery of traditional health benefits by supporting the holistic needs of our members.

Beyond the Medical Model – Accountable, Integrated Care

Our team-based approach brings distinct benefits to members and fosters overall quality and cost-effectiveness. Our interdisciplinary care teams bring together physical and BH clinicians and other licensed and non-licensed professionals such as home and community-based service (HCBS) specialists who are aligned to an individual's unique needs and circumstances.

Our interdisciplinary care teams include local BH specialists and seamlessly integrate physical and behavioral health care. As part of our person-centered model, we integrate resources with demonstrated effectiveness such as peer, substance use, transition, and crisis supports.

Based upon individual needs, our BH professionals may serve in a lead role as an individual member's care manager. This expertise enables us to fully understand and align our efforts with the Nebraska health home initiative.

Local Knowledge and Staff

To achieve this holistic alignment of benefits and services, we orient our service delivery around the care coordination staff located in members' communities who bring the local knowledge of patterns of care, and ways to foster individuals' ability to live in the most integrated setting possible. In addition to the local expertise of our own UnitedHealthcare care managers, we leverage the care coordination efforts of our affiliated health systems and health home provider practices.

New Team Roles for Community Health Workers

Engaging and interacting with our members in their own communities strengthens care coordination, and leads to reductions in avoidable hospitalizations, ER use, and other inappropriate acute and urgent services, while improving overall quality. We deploy community health workers (CHWs) to find and engage our members who are in the greatest need for support and care coordination and arm them with tools like Healthify to leverage their community roots and relationships.

Addressing Social Determinants

We know that barriers to optimal health outcomes can often be outside of health care altogether. These social determinants can stand in the way of our members' ability to access care and successfully manage their own health. To address this, we developed myConnections. Through our myConnections solutions—including financial, employment, and coordination of social services, we will support our members' needs beyond health care—truly holistic person-centered care.

Leading Edge Data and Information System Supports

We have invested in a sophisticated information platform and suite of applications that has proven highly effective in individual member and population health management as well as supporting the evolving needs of Medicaid programs. We support providers and members with automated tools to complete and follow up on screenings and comprehensive assessments and develop plans of care. We recognize the importance of linking the participants of each member's care network to coordinate services. Our care coordination platform, CommunityCare, supports timely information flow, communication pathways and team-based health care decision-making. Through CommunityCare we deploy and make available to our providers and care teams a suite of **automated, evidence-based risk assessment and stratification tools**. These tools enable us to identify members who have the greatest needs and align appropriate levels of care coordination over time in support of the MLTC's goals to improve system efficiencies. We complement CommunityCare with tools such as Impact Pro to identify individuals who may be at risk for future health care needs. This tool allows for the efficient allocation of health care resources to focus interventions, identify gaps in care and improve overall quality for the members we serve.

Ready for Statewide Medicaid Fully Integrated Managed Care

UnitedHealthcare is amply equipped to help MLTC successfully implement the Heritage Health program. In addition to our current experienced local Medicaid team, we are in the process of recruiting and training additional staff required to fully support the needs of our new and existing members, including a local member and provider services service center. The location of this center will align with our State's needs for economic development and workforce availability.

Over the past two decades of caring for the health of Nebraska Medicaid members, UnitedHealthcare has learned from and worked through previous "no noise" implementations; refined approaches; achieved unparalleled results; and identified, implemented, and shared innovations and best practices. We look forward to continuing our mission of helping people live healthier lives as a valued and reliable partner to MLTC as it continues its quest to transform the delivery of quality health care for Heritage Health members.

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b. Attachment 19 – Proposal Statements and Questions

b. Response to Proposal Statements and Questions in Attachment 19 – Proposal Statements and Questions

General

1. If applicable, describe the MCO's proposed risk bearing partnerships/relationships including designated functions of each entity, and how delegated functions will be overseen. *2 pages*

Risk-bearing partnerships/relationships as defined by the Division of Medicaid and Long Term Care (MLTC) are providers with whom the managed care organization (MCO) has a value-based contract or providers with whom an MCO has a contract including physician incentive plans and capitation payments. Based upon this definition, there are two areas of risk-bearing partnerships/relationships; they are capitated subcontractors and providers with value-based contracts and/or physician incentive plans.

Capitated Subcontractors

The majority of our services are delivered to our members and providers by UnitedHealth Group employees through a management services agreement with our affiliate UnitedHealthcare Services, Inc. Subcontractors that fall under the UnitedHealth Group umbrella are identified as affiliated. We also subcontract select services with organizations outside of UnitedHealth Group, which are identified as nonaffiliated. It should be noted that there is a very small number of capitated subcontracts. The affiliated capitated subcontractor is **United Behavioral Health, Inc. d.b.a. Optum Behavioral Solutions** who is responsible for behavioral health (BH) management. The non-affiliated capitated subcontractor is **Superior Vision Benefit Management, Inc.**, who is responsible for the vision benefit management services.

We monitor both groups to assure compliance with laws, regulations and contract requirements. Audits performed by compliance, business functional areas, plan personnel or other organizational areas identify, prevent and correct regulatory risk for the organization. Monitoring activities provide verification that the compliance program is effective and drives routine feedback on organizational performance and compliance with applicable laws, regulations and company policies.

When selecting subcontractors, our vendor management team evaluates each vendor for quality, accessibility, financial strength and cost. Vendors that handle member data or have direct connectivity to our system have a thorough data security assessment conducted to verify we can fully integrate these vendors with our own internal systems and processes.

Once we select a subcontractor, we execute an agreement to govern the operating relationship. The operating document incorporates a description of the required functions and service levels; the process by which we assess performance, the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate), and the authority of MLTC and the executive team to drive change.

Oversight of Value-Based Contracts and/or Physician Incentive Plans

In our value-based contract models wherein providers share in financial risk, we recognize it is imperative that we evaluate and monitor both their risk readiness and historical performance. Before engaging in any shared risk program with a provider, we conduct an extensive assessment of their organizational structure, experience with risk arrangements with other MCOs and the cultural capabilities necessary to support their success in this type of partnership. We also implement the safeguards necessary to verify that the appropriate protections are in place for all parties to the contract. This includes compliance with the federal regulations governing physician incentive plans including but not limited to 42C.F.R.417.479,

establishing requirements for provider stop loss, reinsurance and financial reserve requirements based upon the level of provider financial risk being assumed.

We will submit any contract templates that include an incentive plan to MLTC for review and approval a minimum of 60 calendar days before their intended use. We understand any provider incentive plan must receive prior MLTC approval. We also understand we must disclose the following information in advance to MLTC:

- Services furnished by physician/groups that are covered by any incentive plan
- Type of incentive arrangement (e.g., withhold, bonus or capitation)
- Percent of withhold or bonus (if applicable)
- Panel size, and if patients are pooled, the method used
- If the physician/group is at substantial financial risk, documentation that the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss

We will notify the MLTC of any risk-sharing agreements we negotiate with a provider within 15 calendar days of any contract signing with the provider containing this provision. We understand any provider contract that includes capitation payments must require the submission of encounter data within 90 calendar days of the date of service. As applicable, the provider contracts must comply with the requirements set forth in Section IV.I Provider Network Requirements of this Request for Proposal (RFP) and in compliance with 42 CFR 434.6. We will maintain all provider contracts in compliance with the provisions specified in 42 CFR 438.12 and 42 CFR 438.214, as well as this RFP. We understand the MLTC reserves the right to direct us to terminate or modify any provider contract if MLTC determines that the modification or termination is in the best interest of the State.

Once we implement provider risk contracts, we actively engage with providers to assure that they are successful in improving quality outcomes and reducing avoidable medical expense. We provide baseline and retrospective performance reports aligned with their contractual performance metrics. For Accountable Care Organization (ACO) and patient-centered medical home (PCMH) programs, we support providers with clinical consultative support and a suite of analytical capabilities, data and reporting tools to help them identify opportunities for improvement. We offer an array of industry-leading tools and capabilities for our ACO partners. Finally, given our experience with Medicare, Medicaid and commercial plans, we have extensive experience testing and implementing our ACO strategies, tools and supports across a varied and diverse population.

Since 1999, we have had a value-based arrangement in place with UniNet Healthcare Network. This agreement aligns providers who work with us in a shared savings structure. Oversight of the UniNet Shared savings contract involves:

- Administration of a withhold
- Quarterly joint operating meetings attended by clinical and senior leadership
- Data reporting of monthly paid claims and a monthly performance review
- Quality collaboration which focuses on closing gaps in care
- Clinical collaboration around members who are super utilizers and ER high utilizers, collaborative care conferences, education on program benefits and populations

2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.

UnitedHealthcare has not had any monetary or non-monetary regulatory actions or sanctions imposed by any federal or state regulatory entity within the last five years. We received one letter of deficiency in January 2014, when our encounter submission rate dropped below 95 percent. Since February 2014, our encounter submission rate has remained at or above the 95 percent threshold.

We received two corrective action plans (CAPs) in the last five years, both of which have been resolved. In August 2011, MLTC issued a CAP related to open or closed panel status of a provider file sent to MLTC. We immediately corrected the issue. In February 2013, MLTC issued a CAP regarding claims payment and network adequacy. We worked collaboratively with MLTC and providers to correct the issue.

Attachment 19 Q2 Regulatory Actions and Sanctions contains all monetary and non-monetary regulatory actions or sanctions and corrective action plans imposed by any federal or state regulatory entity within the past five years for our parent company, affiliates and subsidiaries.

3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.

UnitedHealthcare of the Midlands, Inc., is not currently, and has not been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. Our parent company, affiliates and subsidiaries likewise are not currently, and have not been within the past five years, the subject of a criminal or civil investigation by a state or federal agency.

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III.G. Insurance Requirements

4. Describe the risk analysis, assumptions, cost estimates and rationale supporting the MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship. *2 pages*

Risk Analysis

Our current reinsurance agreement has been effective since Jan. 1, 2005, and covers losses only in the event of the Company's insolvency. The risks covered by the Insolvency Only reinsurance include:

- Payment of claims incurred but unpaid as of the date of insolvency with respect to non-contracted providers
- An extension of benefits for persons confined for noncustodial care in an inpatient facility at the date of insolvency
- A continuation of coverage provided under any policy until the policy's next renewal date (policy anniversary) or through the 60th day following insolvency, if later

This reinsurance agreement addresses the requirements of Nebraska Revised Statutes section 44-32,143, regarding the risk of insolvency. The Company believes its insolvency to be an unlikely event. With regard to the Company's other risks, refer to the "Rationale" statement below.

Cost Estimates

The Company pays UnitedHealthcare Insurance Company monthly reinsurance premiums equal to 0.4 percent of its direct earned premiums. In the unlikely event of insolvency, the reinsurer would be liable for any medical costs as described above under "Risk Analysis." The reinsurer does not receive any premiums paid by (or on behalf of) members after insolvency.

Rationale

As noted above (under "Risk Analysis"), the current reinsurance agreement is intended to address the risk of the Company's insolvency. Because the reinsurance agreement provides coverage only in the event of insolvency, which is considered an unlikely event, the Company is at risk for all benefit coverage under contract for the foreseeable future. The Company is adequately capitalized to maintain the business it writes and proposes to write—it has capital and surplus of $22,098,642, which is 208 percent of the regulatory requirement. The Company also has a history of profitable operation. Accordingly, no reinsurance is considered necessary beyond the insolvency reinsurance already discussed.

Reinsurance through Related Parties

The Company's reinsurance agreement will continue to be with its affiliate, UnitedHealthcare Insurance Company (NAIC #79413). UnitedHealthcare Insurance Company is an insurance affiliate of the Company under the common control of the ultimate parent, UnitedHealth Group Incorporated. UnitedHealthcare Insurance Company is a financially solvent insurance company with financial strength comparable to most external reinsurance companies. Therefore, entering into a related party agreement is seen as a sound business strategy by all parties involved.

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IV.B. Eligibility and Enrollment

5. Provide a comprehensive discussion of the MCO's approach to maximizing the number of members who have a relationship with a PCP, including:

The strategy the MCO will use initially, and on an ongoing basis, to ensure PCP selection within 30 calendar days.

Examples of successful strategies and lessons learned in encouraging PCP relationships. *2 pages*

PCP Assignment

Since July 2012 when PCP assignment became an MCO responsibility, we have welcomed 128,870 new Heritage Health members into our health plan consistently meeting PCP assignment requirements with 100 percent of all members assigned a PCP within 30 calendar days. We take great pride in our efforts to encourage effective provider-patient relationships.

We believe maximizing the number of members who have a relationship with a PCP goes beyond PCP assignment. Assignment sets the relationship in motion, but every interaction we have with the member, via member services advocates (MSAs), community health workers (CHWs), our navigator team and case managers, we encourage them to develop a relationship with their PCP. Once this important relationship is established, the member is more likely to participate in his/her own health care by scheduling and attending appointments, and following his/her provider's plan of care. The result is a healthier member who understands how to access care and manage his/her individual health conditions.

We currently meet PCP assignment requirements for Nebraska Medicaid member PCP assignment and, we will comply with the requirements for the Heritage Health program as specified in Section B. Eligibility and Enrollment, 5. PCP Assignment in IV. Project Description and Scope of Work. We currently follow MLTC-approved written policies and procedures for PCP assignment, and we will amend these as needed for the Heritage Health program.

Initial strategy for PCP selection: We outreach to new members within 10 days of receiving the enrollment file. New members receive their member ID card within our *welcome card carrier letter*, which requests members who have not selected a PCP to contact our member services center within 10 business days to receive assistance making their PCP selection. When the member responds to our request and contacts member services, our MSA is able to quickly locate a PCP that meets the member's needs and is accepting new patients. We mail new ID cards following PCP selection or assignment.

We use our *welcome calls* to new members as an opportunity to gather information and provide assistance with member needs, including PCP selection or PCP change. These calls, made within the required 15 business days of sending the welcome packet, also enable our new Nebraska members to ask questions and obtain assistance in making an appointment with their PCP.

Other personal interactions with our staff provide opportunities for assisting the member in making a PCP selection. If a member calls our *member services center* for any reason, our MSA can engage them in a discussion about the importance of a PCP, help them select the PCP and schedule an appointment. In addition, our CHWs provide outreach in local communities, locating, engaging and advocating for Nebraska members to access care. CHWs assist members with selecting a PCP and making an appointment.

Ongoing strategy for PCP assignment: For members who do not select a PCP within 30 days of enrollment, we use our Provider Recommendation Engine (PRE) for auto-assignment based upon the MLTC algorithm and MLTC quality measures. Auto-assignment rules applied via PRE are based upon:

- A historical provider relationship recognized through claims history, also meeting age, sex and geographic proximity requirements
- The current PCP assignment of an enrolled immediate family member, if the member does not have a historical provider relationship, also meeting age, sex and geographic proximity requirements
- Age, sex and geographic proximity, if the member does not meet the criteria for historical or family PCP assignment

Within the PRE, we have the ability to review the member's location and important demographics (e.g., language), resulting in a logic-based auto-assignment to a PCP able to meet the member's needs effectively.

If a member selects a PCP who has reached their maximum physician/patient ratio, has a closed panel, or has restrictions or limitations, we contact the member and provide assistance with selecting an alternate PCP. If we cannot reach the member after three attempts, we use the PRE auto-assignment logic as described above to select a PCP on behalf of the member. For our members who did not initially select a PCP, we will send a replacement ID card with the PCP's name and telephone number(s) within 10 business days of selection or auto-assignment. Cards are mailed within a replacement card carrier letter that informs the member his/her PCP's name is printed on the new ID card, and the member can contact member services for a PCP change. The replacement card carrier letter also informs members that they must destroy their previous UnitedHealthcare member ID card and use the replacement ID card. Following assignment, we provide a PCP Assignment and Transfer Report to MLTC. Members with dual eligibility are not required to select a new PCP.

Strategies and lessons learned in maximizing PCP relationships: We find that the most successful strategy to encourage PCP relationships is to empower our members in the selection process. Self-selection is a vital element for member engagement, particularly for our new members who already have established PCP relationships. Our staff receives training on motivational coaching and our MSAs assist members with PCP selection and schedule appointments to initiate the relationship. Other interactions come through care managers assigned to at-risk members, and our CHWs who work in the field, locating members, engaging them and helping them establish a PCP relationship. Our incentive programs, such as UnitedHealthcare Baby Blocks™, encourage members to establish PCP relationships. We also send cobranded letters with federally qualified health centers (FQHCs) to encourage PCP selection. As we continue our ongoing development of online member capabilities, we expect over the life of the contract that Heritage Health members will be able to view PCP recommendations and select a PCP via our member portal (*myuhc.com*) and our mobile application (*UnitedHealthcare Health4Me™*). Members may change their PCP at any time, empowering them to initiate a new PCP relationship, regardless of the reason.

Assisting Our Member to Find the Right PCP

Our member, Jeanne, requested reassignment to a new PCP. She requested a female PCP who is also an OB/GYN. Jeanne wanted her new PCP to be located close to her home. Our care manager, Sharon W., worked with a UniNet staff member to locate a female OB/GYN physician with an office close to Jeanne's home. The search was successful and Sharon assisted with PCP reassignment and obtaining an appointment for Jeanne with her new PCP. Jeanne was very happy with Sharon's assistance and the PCP change that fully met her requests.

6. Describe the MCO's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership. Include the process for resolving discrepancies between these files and internal membership records. *1 page*

Our National Eligibility and Enrollment Experience in 2014

Electronic eligibility file transactions processed in 2014: 722,224. Eligibility transactions processed in 2014: 727,695.

We currently have a process in place for using the eligibility and enrollment files from MLTC to manage membership. We will amend our existing process as needed to align with Section B. Eligibility and Enrollment in IV. Project Description and Scope of Work, and submit the updated process to MLTC for approval within 60 calendar days prior to the new contract start date. Our dedicated eligibility team will continue to work closely with MLTC to maintain accurate and timely eligibility files. Eligibility and enrollment files provide core member information necessary for the transactions we conduct with or on behalf of our members. Our process confirms that member data loads and updates in our systems accurately and timely so members can access providers, use all available services, receive review for care coordination opportunities, and participate in quality management programs. We describe our process for using the files to manage membership below:

- We accept the daily enrollment file from the enrollment broker, via ASC X12N 834 Benefit Enrollment and Maintenance transaction.
- Upon acceptance, we load and process the file daily, incorporating into our core transaction processing system, Community Strategic Platform (CSP), where the Subscriber/Family module collects and stores member demographics, ethnicity, language preference, disabilities, special circumstances (e.g., pregnancy) and eligibility. CSP tracks eligibility, and provides member-tailored benefits administration, reporting, member services and claims payment.
- We provide data to our Strategic Management Analytic Reporting Tool (SMART) data warehouse for reporting and data analytics.
- We securely submit new member data for ID card and welcome packet fulfillment.
- We confirm membership information is available to the member portal and provider portal (so providers can verify eligibility information).
- We provide membership information to applicable partners.

We understand we are responsible for weekly reconciliation of enrollment/disenrollment files. For reconciliation, CSP provides automatic error alerting, which initiates manual correction by our eligibility team. CSP also produces a daily error report that details the nature of the discrepancy, the resolution and the before-and-after data element in question. We will provide written notification of data inconsistencies to MLTC within 10 calendar days of file receipt.

In addition, we understand we will receive a monthly file that lists members for whom we received a capitation payment and the amount. Upon receipt, our eligibility team compares and reconciles the roster of members against our internal records to verify there are no discrepancies. To guarantee data integrity, we compare membership files and look for changes in name, gender, group number, phone number, address, birth date, effective date and Social Security number. We generate a batch input file for electronic update into CSP and produce an exception report identifying member information not meeting electronic update criteria. We review exception reports and make corrections, as needed. We will comply with the reconciliation requirements, notifying MLTC of any discrepancies within three months of file receipt.

7. Describe the interventions the MCO will use prior to seeking to disenroll a member who requests disenrollment outside the annual open enrollment period. Provide examples of scenarios in which the MCO has effectively intervened to avert disenrollment of a member or members. *2 pages*

Continuity of relationships, whether with a provider or MCO, is an important element in confirming that members receive uninterrupted care. When a member seeks to disenroll outside of the annual open enrollment period and we become aware of the request, we take immediate steps to learn why the member wants to disenroll. We work with the member and seek interventions to resolve the issues that are influencing the member's disenrollment request, and provide the member with information so he/she can make an informed decision. We will comply with all requirements specified in Section B. Eligibility and Enrollment, Section 7. Disenrollment in IV. Project Description and Scope of Work.

Interventions for Members who Request Disenrollment Outside the Annual Open Enrollment Period

It is rare that we receive notification directly from a member of his/her intent to disenroll outside the annual open enrollment period. If we receive a notification about disenrollment, it is often related to loss of Medicaid benefits. If a member contacts us to request disenrollment, we work with him/her on a personal level to resolve the request. We discuss these interactions below:

- ***If we receive a member call through our member services center to discuss a disenrollment request, the MSA will work diligently to identify any barriers and resolve the concerns.*** Our *Advocate4Me* member services model is instrumental in this endeavor by providing a single point of contact, a well-trained experienced MSA, who "owns" the member's request from initial contact to resolution. MSAs have the ability to seek specialized assistance from a team of experts, including clinical and BH staff, pharmacy and others, so that they are able to provide a thorough solution to the matter, regardless of complexity. If our MSA identifies a potential member disenrollment request, he/she takes immediate steps toward resolution through various forms of outreach with the appropriate area within our health plan and with the member. If attempts to communicate with the member are unsuccessful, MSAs may reach out to the member's PCP for assistance. MSAs document all disenrollment prevention activities in the member's record.
- ***For at-risk members assigned to a care manager, the care manager works with the member to resolve requests that may be prompting the member to contemplate disenrollment.*** We understand the importance of continuity of care for all members, specifically members in our care management program. In addition to working with the member, the care manager will work with all members of the care team to overcome any barriers and resolve the request.
- ***Our local field-based CHWs are able to intervene and provide successful resolutions for members considering disenrollment.*** CHWs personally connect with members, providing the education and resources they need to access timely and appropriate care. Through the personal interactions that CHWs cultivate with members, they are able to understand any concerns the member may be facing and identify solutions to overcome the problems. If needed, the CHW may also refer the member to a care manager to further assist with clinical needs. Additional examples of activities that our CHWs perform include making and attending provider appointments; arranging non-emergency transportation services; connecting members to community resources; participating in interdisciplinary care planning; and helping members who notice symptoms of worsening chronic conditions to seek help from their PCP.

We currently follow an internal written policy to identify appropriate actions for member disenrollment, including members who request disenrollment outside the annual open enrollment period. For the

Heritage Health program, we will amend our existing policy as needed to align with Section B. Eligibility and Enrollment, 7 Disenrollment in IV. Project Description and Scope of Work.

Examples of Scenarios in which we have Effectively Intervened to Avert Member-Requested Enrollment

Staff Assistance with Medication Needs Successfully Averts Disenrollment

Our field care advocate, Maranda S., reached out to the mother of our 8-year-old member, Danny, who had been referred for behavioral health follow-up. Danny's mother informed Maranda that she was planning to disenroll Danny from UnitedHealthcare because of a medication issue. Danny's prescription medication for the treatment of ADD was not covered, and he was unable to swallow the covered medication. Maranda asked Danny's mother to provide her with the name of the non-covered medication. Maranda researched the medication and discovered that it was added to the formulary as of Jan. 1, 2015. Maranda then contacted the pharmacy to discuss Danny's prescription and that his prescription medication had been added to the new formulary. The pharmacist researched the claim and noted that the medication was denied in September, prior to activation of the new formulary. Maranda contacted Danny's mother and provided the information about the medication coverage and her conversation with the pharmacy. She also provided Danny's mother with her contact information for follow-up if there was any difficulty having Danny's prescription filled. Danny's mother expressed her gratitude for Maranda's assistance and stated she was no longer interested in disenrolling Danny from UnitedHealthcare.

Staff Assistance with Out-Of-State Services Successfully Averts Disenrollment

Our Medicaid member, Claudia, needed to obtain specialized services outside of Nebraska in the state of Minnesota. To obtain the services, Claudia planned to request disenrollment from our health plan. Luann A., one of our care managers, contacted Claudia and provided education that disenrollment was not necessary. Luann offered to assist Claudia and her PCP in working with the out-of-network provider to obtain the services that Claudia needed, that were not available in Nebraska. Luann coordinated the necessary services and assisted Claudia with arranging transportation and lodging. Claudia was grateful for Luann's assistance and retained her membership with UnitedHealthcare.

While it is uncommon that we receive notification from a member of his/her intent to disenroll outside the annual open enrollment period, when we do, we take immediate action to resolve the member's concerns. We are proud that our members rarely want to leave us, and we will continue to serve them with industry-leading customer service, consistent with MLTC's request for customer service that is accountable, responsive, reliable, compassionate and demonstrative of effective and culturally competent communication skills.

8. Describe the MCO's process to identify unborn individuals anticipated to begin coverage at the time of birth. Describe the operational process to obtain identifying information when the unborn status changes to newborn. *1 page*

We recognize the importance of providing newborns with immediate health care. We currently, and will continue to, comply with newborn enrollment requirements as specified in Section B. Eligibility and Enrollment, 4. MCO Enrollment Procedures, d. Newborn Enrollment in IV. Project Description and Scope of Work.

Process to Identify Unborn Individuals

In preparation for newborn coverage, we begin by identifying expectant mothers through the following methods:

- Pregnancy indicator on the MLTC enrollment file
- Lab/physician/pharmacy claims analysis
- New member welcome call and initial health screening
- Information provided by members/caregivers, PCPs, OBs, FQHCs, MLTC and our staff, including MSAs, care managers and CHWs
- Our *Member Handbook* requests that members contact our member services staff, in addition to the Department of Health and Human Services (DHHS), when they become pregnant or give birth

In addition to the methods listed above, we are exploring the use of Nebraska Health Information Initiative (NeHII) data for identification of expectant mothers.

Upon receipt of the Unborn file, we send an MLTC-approved, State-requested letter to the expectant mother requesting her to contact ACCESSNebraska to report her baby's birth. If our staff learns of a member's pregnancy, we provide her with the information to contact ACCESSNebraska. In addition, the expectant mother is referred to our UnitedHealthcare Healthy First Steps® maternity team that provides her with information about our Baby Blocks incentive program and reinforces the importance of contacting ACCESSNebraska. We have also educated and will continue to educate hospital social workers to assist the mother in notifying ACCESSNebraska regarding the baby's birth. Upon the mother's birth notification, MLTC updates their system by adding the baby as a new member, and we receive notification via the enrollment file.

Process to Obtain Information when Unborn Status Changes to Newborn

Our provider regulatory addendum requires providers to notify us when our members who are expectant mothers give birth. Providers deliver birth notification to us via the hospital admission, authorization process. To reinforce the birth notification contractual requirement, and for reporting the mother's PCP selection for her newborn, we provide education to providers, social workers, nurses, claims and admissions departments. We have conducted training for staff at hospitals in our current 10-county service area, including CHI Health, University of Nebraska Medical Center, Methodist Women's Hospital, Bryan Medical Center and Fremont Health via WebEx, on-site training and by providing direct contact information. We are committed to delivering ongoing education related to this contractual requirement to current and new providers and hospitals (including social workers, nurses, claims and admissions departments) for the Heritage Health program via on-site training (e.g., town halls), Web-based tools, provider advocates, our provider newsletter and email blasts.

9. Describe the MCO's approach to working with other MCOs in the event a member changes his/her MCO during ongoing operations of the program. Describe how the MCO will work with other MCOs to ensure a seamless transition and transfer of relevant information. *1 page*

We realize that continuity of care is as important for members who leave our health plan as it is for our new members, and we will comply with the requirements in Section X, Transition and Implementation, 6. Transitioning of Managed Care Members and Operations in IV. Project Description and Scope of Work. We are committed to seamless transitions and follow formal written policies and procedures to confirm coordination, assuring a transfer of services with a positive outcome and no disruption to the member's care. We collaborate with the receiving MCOs, BH MCOs, pharmacy benefits manager and providers to develop and implement plans of care for members who require them during the transition, and deliver all services contained in the plans. We will coordinate care transition and manage, coordinate and monitor transitions of care for members regardless of the reason for the transition. We will provide the receiving MCO with member information that will minimally include:

- Service information
- Emergency telephone numbers
- Instructions on how to obtain additional services for each member affected by the transition
- Any pending grievances, appeals and member/provider service issues

We will have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings. We will communicate all service pre-authorizations to confirm appropriate claims handling. If the member changing his/her MCO is a high-risk member who has been referred for care management, the assigned care manager will work with the care team to make sure all provider appointments, supplies and services are communicated to the receiving MCO. In addition, the care manager may schedule a conference with the care team to confirm preparations for the transfer and confirm continuity of care.

Member Transition to Another MCO

We worked to assist one of our ABD members, Claire, who had been living at a nursing home and wanted to attend college in Omaha. Claire has multiple medical conditions requiring a wheelchair and ventilator. Claire's assigned care manager, Luann A., assisted with living arrangements, confirming back-up electricity and plans for care in the event of an electrical outage or caregiver absence. Claire's care team included Luann, Claire's caregiver, PCP, pulmonary specialist and local psychologist. Claire had a successful school year and decided to move out of our service area while on summer break to live with a relative.

Luann worked with Claire and her care team in transitioning Claire to her new MCO, locating and making appointments with physicians, a new psychologist, caregiver and DME provider—and confirming the required DME were ordered and delivered to Claire's new address. A care conference, scheduled by Luann, occurred with all parties attending, including the League of Human Dignity, whom Luann had enlisted previously for assistance. Luann's planning and involvement facilitated a successful move for Claire, and an uninterrupted transition to her new MCO.

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IV.C. Business Requirements

10. Describe the approach the MCO will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.

UnitedHealthcare and our parent company, UnitedHealth Group, are committed to providing Heritage Health members with access to high-quality medical care while complying with federal, state and local laws, regulations and other requirements of MLTC and the Heritage Health program. These include all relevant provisions in 42 CFR, Part 438, Managed Care; Title 471 Nebraska Administrative Code (NAC) Nebraska Medical Assistance Program Services; Title 477 NAC, Medicaid Eligibility; and Title 482 NAC, Nebraska Medicaid Managed Care.

We have been serving Medicaid members in Nebraska since 1996. For nearly 20 years, our local compliance and legal team has been operational and has continually gained expertise in complying with the 438 provision as well as titles 471, 477 and 482 as they have evolved. With our legal counsel located in Lincoln, Nebraska, and our compliance leadership located in Omaha, Nebraska, we are able to closely monitor and track Nebraska regulations locally. Jim Watson, a native Nebraskan with more than 10 years of Medicaid legal experience in Nebraska with UnitedHealthcare, is the plan's legal counsel. Mr. Watson's experience spans compliance, regulatory affairs and legal responsibilities, giving him unique insight into how work in each intersects. Tim Langdon, a native Nebraskan and attorney as well, has brought to UnitedHealthcare nine years of experience in managing compliance and legal programs for multistate health systems. Together, they lead efforts in Nebraska to ensure compliance with Part 438 and titles 471, 477 and 482.

This Nebraska presence provides the context for interpretation of both the Federal (Part 438) and State (Titles 471, 477 and 482), allowing our team to make operational changes needed to ensure continued compliance with titles 471, 477 and 482.

As a leading organization in health and wellness, our work is intimately connected each day with the lives of our members, requiring constant attention to compliance, ethics and integrity to make certain their every need is met. Just as with members, MLTC, employees, regulators, health care professionals and investors expect the highest level of honesty and integrity in their dealings with us.

The UnitedHealth Group Compliance and Ethics Program leverages national processes and expertise to support activities that occur locally in business operations to uphold and enforce ethical and compliant practices. National resources used by the Nebraska Compliance and Ethics Program include executives from the legal, ethics, government relations, compliance education and UnitedHealth Group privacy offices. The combined experience and oversight of these departments makes certain the Nebraska plan achieves business objectives in compliance with applicable laws, regulations, standards of conduct and UnitedHealth Group policies.

As specified by **42 CFR 438.608**, the Nebraska Compliance and Ethics Program aligns with the seven elements of an effective compliance and ethics program. It serves as a blueprint for ethical and compliant practices for our officers, employees, providers and subcontractors to make certain member, State and other regulators' needs are met while complying with the 438 provision as well as titles 471, 477 and 482.

We also recognize the importance of detection, prevention and correction in a compliance and ethics program, and have met and continue to meet MLTC contractual expectations, including measures to combat fraud, waste and abuse (FWA).

Compliance with Nebraska Law

We have been working under and complying with the provisions of title 482, which governs MCOs in Nebraska, since its inception. Title 482 addresses eligibility and enrollment, covered services, coordination with the enrollment broker, BH, quality, and rights and responsibilities, including appeals and grievances. The deep experience of our local team in complying with the provisions of NAC 482 has also led to success in understanding its coordination and intersection with titles 471 (fee-for-service) and 477 (eligibility). A recent example of this occurred with the inclusion of hospice services in the Nebraska MCO benefits package. Our care management team comprehensively reviewed the fee-for-service hospice requirements at 471 NAC 36, and elsewhere, as the basis for a plan to communicate the change to and manage it for members and providers. The result was a no-noise implementation of the hospice benefit by our plan and compliance with the new requirement. It also resulted in a smooth transition for families during a difficult time in their loved ones' lives.

Compliance with Proposed Rule (CMS-2390-P)

On June 1, 2015, CMS published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. We reviewed the Proposed Rule in detail and provided appropriate feedback to CMS. We will continue to engage with CMS and monitor for final publication. We will submit 90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier), a plan that details the processes and timeline we will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan will take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.

Our Approach: Seven Core Elements of an Effective Compliance and Ethics Program

The Compliance and Ethics Program is the vehicle through which we develop, implement, maintain and monitor compliance in Nebraska. Through written policies and procedures, the Compliance and Ethics Program enables us to operate with the highest ethical standards expected by MLTC and to build integrity in our work, furthering a local culture of compliance.

To make certain we honor our commitment to high standards of ethics and integrity, the Compliance and Ethics Program incorporates the seven elements of an effective program, as outlined in **42 CFR 438.608**. These seven elements are essential to the implementation of a comprehensive, effective compliance and ethics program in Nebraska:

1. Establish written standards, codes of conduct, policies, procedures and controls specific to Nebraska that promote our commitment to compliance, address specific areas of potential fraud and ensure compliance with state laws, including titles 471, 477 and 482, contract requirements and federal regulations.
2. Exercise effective compliance and ethics oversight through program governance by both the Nebraska-based program integrity officer/contract compliance coordinator, Tim Langdon, JD, and the Nebraska Compliance Oversight Committee (COC) charged with operating and monitoring the Compliance and Ethics Program. Additionally, the Nebraska program integrity officer submits reports to the board of directors and reports operationally to both Laura Freedy, the UnitedHealthcare Central Region Community & State compliance officer and Kathleen A. Mallatt, the local UnitedHealthcare Community Plan chief executive officer (CEO).

UnitedHealthcare Community & State is the business segment of UnitedHealthcare Group dedicated to meeting the health care needs of Medicaid-eligible individuals.

3. Develop and implement ongoing, effective education and training programs for all affected employees, including regular presentations at Nebraska leadership meetings and small group education sessions.
4. Establish effective lines of communication and reporting mechanisms to receive complaints from Nebraska constituents to ensure the anonymity of complainants to protect them from retaliation and establish clear processes and structure for addressing compliance concerns quickly and effectively.
5. Facilitate consistent enforcement and discipline of violations against employees who have violated internal compliance policies, applicable statutes, regulations or state contract requirements.
6. Monitor and audit compliance and ethics programs for effectiveness in Nebraska.
7. Respond appropriately to incidents and take steps to prevent future incidents.

Element 1: Establish Written Standards, Codes of Conduct, Policies, Procedures and Controls

The Compliance and Ethics Program expects employees and contractors to abide by the law and adhere to the company's contractual obligations. The program includes the following compliance policies and program materials:

- Nebraska-specific Supplemental Compliance and Ethics Program documentation to address product or state health plan-specific requirements is drafted, as required
  - CE-001 Attachment A: Policy and Procedure Template
  - CE-001 Attachment B: Department Codes and Numbering System
  - CE-001 Attachment D: Standard Operating Procedure (SOP) Template
  - CE-002 Fraud, Waste and Abuse Reporting
  - CE-003 Nebraska State Deliverables
  - CE-004 Handling Potential HIPAA Violations
  - CE-004 Attachment A: Privacy Incident Report Form
  - CE-005 Risk Assessment
  - CE-005 Attachment A: Risk Assessment
  - CE-006 Attachment A: UnitedHealthcare Government Programs Anti-FWA Program 2015
  - CE-006 Fraud and Abuse Prevention and Detection
  - CE-007 Regulatory Requirements Tracking
  - CE-008 Compliance CAP
  - CE-008 Attachment A: CAP Template
- UnitedHealth Group Code of Conduct – Our Principles of Ethics and Integrity (Code of Conduct)
- UnitedHealthcare Government Programs Compliance Program
- UnitedHealthcare Government Programs Fraud, Waste and Abuse Program
- UnitedHealth Group Policy – False Claims Act Policy
- UnitedHealth Group Employee Handbook

Nebraska-Specific Policies and Procedures

Nebraska-specific compliance and ethics policies and procedures have been in place as required by our contract and law. These policies and procedures are reviewed and updated as needed at least annually and provide the local framework for guiding the Nebraska Compliance and Ethics program.

Code of Conduct

The UnitedHealth Group Code of Conduct and related policies promote compliance with legal and regulatory requirements, foster ethical conduct by employees and contractors and provide guidance for employees and contractors on their conduct. We communicate the Code of Conduct to new employees and reinforce it through ongoing employee training programs that include either attestation or assessment activities to ensure review and understanding. The Code of Conduct also includes provisions for reporting suspicions of noncompliant, unethical or fraudulent activity.

Government Programs Compliance Program

The UnitedHealthcare Government Programs Compliance Program provides a national framework for local compliance programs and includes established policies and procedures pertaining to compliance, auditing, privacy and security, and progressive discipline.

Fraud, Waste and Abuse Program

The UnitedHealthcare Government Programs Fraud, Waste and Abuse Program includes established policies, procedures and standards of conduct pertaining to the detection and investigation of potential FWA to verify both federal and Nebraska dollars are protected. The Fraud, Waste and Abuse Program also includes robust payment prevention, recovery and reporting elements in effect in Nebraska.

False Claims Act Policy

This policy addresses the Federal False Claims Act and provides information related to the Act's provisions, administrative remedies for false claims and whistleblower protections. The policy also covers Nebraska laws that include civil and criminal penalties for false claims, along with whistleblower protections.

Up-to-date policies are available to all employees through UnitedHealthcare's internal website and also via Nebraska-specific electronic and hard copy storage systems.

Element 2: Exercise Compliance and Ethics Oversight through Effective Program Governance

The UnitedHealthcare Community & State chief compliance officer, Chris Zitzer, Mr. Langdon and the COC, leads the Compliance and Ethics Program, along with the Fraud, Waste and Abuse Program. The program is implemented via an oversight and governance framework that focuses on the structures and processes necessary to drive improved compliance outcomes. Results of Compliance and Ethics Program and Fraud, Waste and Abuse Program activities in each health plan are periodically reported to (1) the UnitedHealthcare Government Programs Corporate Responsibility and Compliance Oversight Committee and (2) the UnitedHealthcare Community & State Nebraska Medicaid Compliance Oversight Committee. The Compliance and Ethics Program and the Fraud, Waste and Abuse Program are approved annually through this governance structure.

The governance structure presented in Figure IV.C-1 Compliance Organizational Chart below is responsible for implementing and overseeing the Compliance and Ethics Program for Heritage Health and includes:

- UnitedHealthcare program integrity officer
- UnitedHealthcare CEO
- UnitedHealthcare board of directors
- UnitedHealthcare COC
- UnitedHealthcare Community & State chief compliance officer

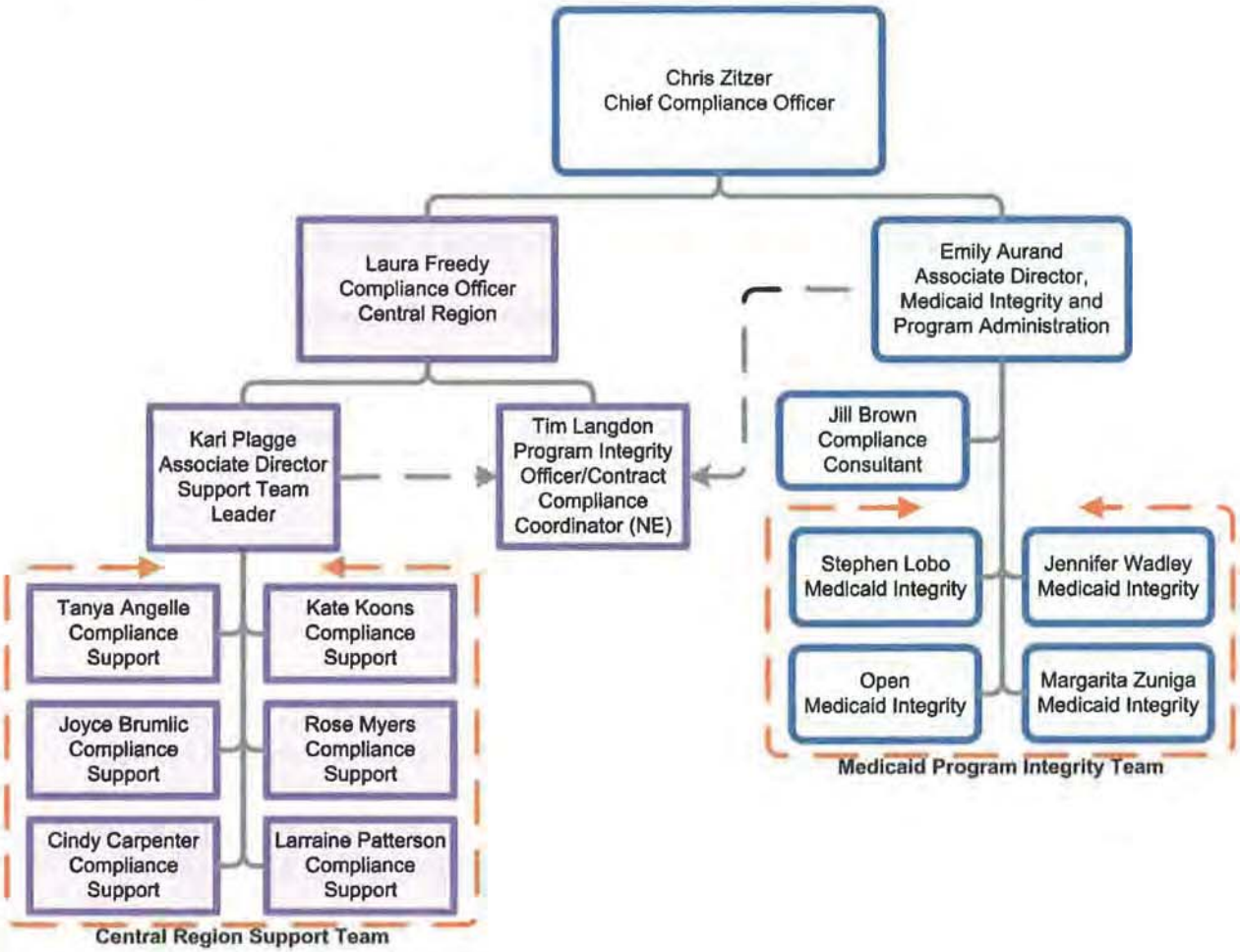

Figure IV.C-1. Compliance Organizational Chart

UnitedHealthcare Program Integrity Officer

UnitedHealthcare's Nebraska program integrity officer, Tim Langdon, manages the execution and coordination of the Nebraska Compliance and Ethics Program while also leveraging the national UnitedHealth Group's Compliance and Ethics Program and other Community & State compliance resources. He directly accesses regional and national senior management, including Mr. Zitzer and local legal counsel to ensure compliance with MLTC's contract requirements and state and federal laws and regulations. Mr. Langdon:

- Functions as the local UnitedHealthcare compliance and ethics leader accountable to CEO, Kathleen Mallatt and Ms. Freedy, providing oversight and monitoring of the Compliance and Ethics Program.
- Reports compliance activity to the UnitedHealthcare Nebraska Medicaid Compliance Oversight Committee and reports issues to the UnitedHealthcare board of directors.

- Identifies and manages compliance risk through collaboration with business partners and reports compliance risk and progress made toward remediating risk to the UnitedHealthcare COC.
- Investigates and responds to Code of Conduct or other UnitedHealth Group policy violations.
- Verifies policies and procedures are created and maintained to address UnitedHealthcare requirements and that they align with UnitedHealth Group policies.
- Coordinates regulatory audit activity with UnitedHealthcare Government Programs Audit Management and the appropriate functional areas.
- Facilitates and monitors any regulatory corrective action plans (CAPs). Reviews processes and functional areas to verify the Compliance and Ethics Program complies with current state contract requirements regarding compliance and FWA prevention, detection and reporting.
- Makes certain the Compliance and Ethics Program complies with state and federal fraud and abuse laws and regulations.
- Reviews and revises, no less than annually, the compliance and FWA policies to meet changing regulations or trends.
- Verifies employees, providers, subcontractors and members receive training and education by overseeing a comprehensive program that addresses FWA prevention, detection and reporting; and encourages reporting of suspicions of noncompliance, unethical behavior and FWA without fear of retaliation.
- Develops and implements a well-defined reporting process, promoted among all employees, to report suspicions of noncompliance, unethical behavior and FWA without fear of retaliation.
- Maintains and monitors systems and tools to detect and help investigate FWA.
- Independently investigates and acts on compliance matters.
- Refers potential member and provider FWA cases to the Nebraska Medicaid Program Integrity Unit and the Medicaid Fraud and Patient Abuse Unit (MFPAU) with the Nebraska Attorney General's Office.
- Regularly attends and participates in quarterly meetings with the Nebraska Medicaid Program Integrity unit and bi-annual Program Integrity Collaboration meetings with all MCOs and Nebraska Medicaid Program Integrity.
- Provides oversight of the services managed by subcontractors.

UnitedHealthcare Community & State Chief Compliance Officer

Mr. Zitzer serves as the overall leader for national Compliance Program activities and oversees UnitedHealthcare's Compliance and Ethics Program, including FWA, in collaboration with Mr. Langdon.

UnitedHealthcare Chief Executive Officer

Ms. Mallatt understands that the business owns compliance, and along with Mr. Langdon, makes sure the Compliance and Ethics Program is upheld, all contractual, state and federal requirements and regulations are met, and that organizational risks are remediated. Ms. Mallatt was awarded a national integrity award by UnitedHealthcare Community & State as a sign of her commitment to living the value of integrity every day, including the commitment to meeting the highest compliance and ethics standards. Mr. Langdon is accountable to Ms. Mallatt and reports and escalates information directly to her as needed.

UnitedHealthcare Compliance Oversight Committee

The COC acts as a Nebraska-based oversight and governance body and is accountable to the UnitedHealthcare board of directors. The COC meets quarterly, or more often if needed, and includes Mr.

Langdon, Ms. Mallatt, medical director/chief medical officer (CMO) Michael Horn, M.D., chief operating officer (COO) Sean Jones, quality management coordinator Cyndi Margritz RN, director of operations Heather Johnson, case management administrator Barbara Palmer RN, provider services manager Jeremy Sands, marketing/community outreach director Kim Manning, and UnitedHealthcare legal counsel Jim Watson.

The COC assists Mr. Langdon with oversight and monitoring of the Nebraska operations, assessment of compliance risk areas, and review of policies and procedures. The COC also addresses Nebraska Medicaid program changes and evaluates their impact to business processes, taking action when necessary. Ultimately, the COC facilitates the implementation of and adherence to the Compliance and Ethics Program and reviews and assesses its overall effectiveness.

UnitedHealthcare Board of Directors

Mr. Langdon and the COC are accountable to the board of directors. Mr. Langdon reports compliance information to the UnitedHealthcare board of directors. Additionally, the UnitedHealth Group board of directors receives reports on key compliance information from the Audit Committee.

Element 3: Develop and Implement Ongoing, Effective Education and Training Programs

We provide training and education on the Compliance and Ethics Program for both individuals and entities. The training and education curriculum emphasizes awareness of the Compliance and Ethics Program, and focuses on the obligation to report suspicions of unethical or illegal behavior, understanding of the FWA operation, including general Medicaid fraud and privacy and security requirements and expectations.

We provide training and education through various communication channels, including:

- Annual training courses
- Specialty training courses
- In-person training sessions
- On-the-job training
- Written materials
- Professional association and industry training

One example of local compliance training and education is our quarterly *Compliance Corner* newsletter distributed to the Nebraska health plan. Recent newsletters have included information on HIPAA privacy and security, the False Claims Act and UnitedHealth Group's nonretaliation policy and the importance of reporting concerns.

Training During Onboarding of New Employees

Training outlined below is required during onboarding for all new employees. New employees must complete and attest to this training within 30 calendar days of hire. Supervisors are responsible for making sure that each employee reporting to them completes the applicable training.

- Compliance, Ethics and Integrity Program overviews (Code of Ethics)
- Fraud, waste and abuse, including:
  - Examples of potential FWA issues and schemes
  - Resources available for reporting suspected instances of FWA
  - Pertinent laws and regulations review, including federal False Claims Act and Whistleblower Protection and the Nebraska False Claims Act (Neb. Rev. Stat. 68-935)
- HIPAA privacy and security
- Records management

- Organizational chart, including the program integrity officer and program integrity investigator(s)
- Conflicts of interest
- Harassment prevention awareness
- UnitedHealthcare's Code of Conduct
- Compliance and Ethics HelpLine

The onboarding training program for Nebraska staff will be expanded to include additional information on:

- Procedures for the timely, consistent exchange of information and collaboration with MLTC
- Provisions of 42 CFR 438.610 related to prohibited affiliations and all relevant state and federal laws, regulations, policies, procedures and guidance (including CMS's Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by MLTC, DHHS, CMS, the Office of Inspector General, including updates and amendments to these documents or any such standards established by MLTC

Ongoing Training after New Hire

Ongoing training and education will be provided based upon UnitedHealthcare-specific requirements, an employee's job function and responsibilities, and at a minimum will include the requirements outlined in Section IV.O.9 related to FWA, the compliance plan, false claims recoveries (Deficit Reduction Act of 2005 – Section 6032) and the Code of Conduct.

Additional Training Program Information

The training program also will provide for:

- Evidence of completed, effective education for the program integrity officer Tim Langdon, our employees, providers and members about the compliance plan, FWA, erroneous payments and how to report any allegations regarding any of them.
- Effective lines of communication between Mr. Langdon and our employees, MCOs, providers, MLTC and its designee(s).
- Established written policies for all employees (including management), and any subcontractor or agent of the entity that include detailed information about the False Claims Act and the other provisions named in Section 1902(a)(68)(A) of the Social Security Act. We maintain detailed information about our policies and procedures for detecting and preventing FWA. In addition, our employee handbook contains a specific discussion of the laws described in the written policies and the whistleblower rights and protections of and for employees.
- Education regarding our toll-free provider compliance hotline number and an accompanying explanatory statement distributed to our members and providers through our *Member Handbook* and *Provider Administrative Guide*.
- Creation and dissemination of written materials for educating employees, managers, providers and subcontractors about health care fraud laws, including our policies and procedures for preventing and detecting FWA and the rights of employees to act as whistleblowers.

Tracking of Training

We manage mandatory training through the Web-based LearnSource system, which automatically tracks required training for all employees. The LearnSource system documents completion of training programs and human resources maintains the records. LearnSource also generates automated reminders to employees who are due to complete annual training and managers whose employees have not completed

the required training. Compliance and Ethics Program staff monitors ongoing completion rates through review of compliance training completion reports on a quarterly basis, at minimum, and facilitates follow-up activities with employees and managers. Targeted compliance or job function training may be managed through LearnSource or by the individual business units conducting the training.

Element 4: Establish Effective Lines of Communication and Reporting Mechanisms

Effective Lines of Communication

Our Compliance and Ethics Program requires a communication and awareness strategy across business functions to confirm that compliance resources, initiatives and other projects are communicated to employees, managers and directors, COC members and all other appropriate parties.

This strategy ensures that compliance expectations, including employees' responsibilities to report potential noncompliance or unethical behavior, and ongoing compliance efforts are communicated to employees through a variety of mechanisms, including the training programs described previously, electronic mail, internal newsletters, posters and face-to-face meetings. As the program integrity officer, Mr. Langdon is the primary resource available to all Nebraska employees for compliance-related information for the Nebraska Medicaid program. The compliance staff also participates in new employee training, encouraging employees to contact them with compliance concerns. Additional compliance information is disseminated in highly trafficked areas via posters and flyers placed in break rooms or close to office printers. Managers are also expected to discuss legal requirements, company policies and contractual and regulatory obligations with their employees and evidence their commitment by their own conduct.

Reporting Mechanisms

All employees are required to report known or suspected noncompliance or unethical behavior. Failure to report suspected violations, misconduct or noncompliance is grounds for employee disciplinary action. UnitedHealth Group expressly prohibits retaliation for good faith reports. Employees and others can report suspected misconduct to the UnitedHealthcare program integrity officer, a supervisor, the legal department, the internal audit department, UnitedHealth Group corporate security or anonymously through the UnitedHealth Group Compliance & Ethics Help Center, a website that provides for anonymous and confidential reporting. To the extent possible, UnitedHealth Group takes reasonable precautions to maintain the confidentiality of those who report integrity or compliance concerns.

UnitedHealthcare Community & State monitors issues reported through these mechanisms and continually evaluates the effectiveness of the various communication channels available for FWA reporting and engages with its business partners to adapt to changing business needs. UnitedHealthcare Community & State responds to questions and refers tips of suspected fraud, waste and abuse to its analysts and the appropriate investigative functions for review and assessment. We investigate all reports of alleged noncompliance or unethical behavior and implement corrective actions as appropriate, based upon the results of investigations.

For escalated issues received from the Nebraska regulators, Mr. Langdon serves as the primary contact. Account management staff receives, manages and responds to escalated regulatory issues and concerns. Those who are accountable for regulatory relationship management work closely with the business areas to assess identified issues and facilitate corrective action as necessary.

Element 5: Ensure Consistent Enforcement and Discipline of Violations

UnitedHealth Group requires that all employees comply with laws, regulations, Compliance and Ethics Program policies and other requirements applicable to its businesses. Unethical or illegal acts cannot be

justified by saying they were for the good of UnitedHealth Group or UnitedHealthcare or were directed by a higher authority in UnitedHealth Group. No employee is ever authorized to commit or to direct another employee to commit, an unethical or illegal act. Furthermore, employees cannot use a contractor, agent, consultant, broker, distributor or other third party to perform any act not allowed by law, the Code of Conduct, the Compliance and Ethics Program, UnitedHealth Group or Compliance and Ethics Program policies or any applicable state or federal regulatory requirements or contractual obligation.

Our goal is to promote proper conduct and avoid the need for discipline. However, all violations of state or federal law, the Code of Conduct, the Compliance and Ethics Program or our policies and contractual obligations are taken seriously. UnitedHealth Group strives to enforce disciplinary guidelines fairly and consistently throughout the organization, and managers are encouraged to work with human capital to implement disciplinary measures. When it is determined that disciplinary action is necessary, such action may include verbal, written and final warnings, suspension or termination. Employees who commit criminal or illegal acts may face immediate termination and possible legal action. Finally, UnitedHealth Group reserves the right to terminate an employee at any time for any reason with or without prior disciplinary counseling or notice to the employee.

Enforcement and disciplinary guidelines are publicized via the Code of Conduct, the Compliance and Ethics Program, the Fraud, Waste and Abuse Program, the UnitedHealth Group employee handbook, UnitedHealth Group's policy center and through communication methods such as UnitedHealth Group's intranet sites, memos and newsletters.

Element 6: Monitor and Audit Compliance and Ethics Programs for Effectiveness

A key focus of the Compliance and Ethics Program is to measure our own effectiveness. The monitoring activities performed by compliance, business functional areas, UnitedHealthcare personnel or other organizational areas, serve to identify, prevent and correct regulatory risk for the organization. Monitoring activities also are intended to provide verification that the Compliance and Ethics Program is effective and drive routine feedback on organizational performance and compliance with our policies, applicable laws and regulations.

Our compliance infrastructure incorporates monitoring activities that support the Compliance and Ethics Program at the business operations level. Activities include, but are not limited to, internal audits and reviews, internal operational/functional area reporting of key compliance metrics through a quarterly compliance scorecard and implementation of appropriate corrective action where necessary. Results of these activities are then tracked, trended and reported.

Quarterly Compliance Scorecard

UnitedHealthcare Community & State has developed a standardized internal scorecard that is used by each state plan, including Nebraska. The scorecard includes both subjective and objective measures on all aspects of the program containing, but not limited to, program oversight, training and education, privacy and security, policies and procedures, performance monitoring of operational metrics, FWA activities, including referrals to MLTC, and regulatory enforcement activity, including CAPs.

Internal Monitoring and Auditing

We continually evaluate and measure the success of the Compliance and Ethics Program with the use of an internal audit function. We conduct annual and as-needed internal audits of functional areas and areas of interest on a risk basis, focusing on the highest risks. The results from these audits are included in quarterly compliance reports and are presented at regular Nebraska COC meetings, and key compliance matters are reported to this group.

These internal audits detect noncompliance and misconduct, and the results are used to identify risk areas and opportunities for improvement. Elements of the program include:

- Collection, reporting and comparison of audit and monitoring results and findings
- Analysis of results to identify risk areas
- Focused reviews where applicable
- Submission of reports as required and requested by MLTC
- Implementation of internal CAPs to address identified risk items

Business units develop internal CAPs to cure identified deficiencies, remediate noncompliance matters, and uphold compliance with all contractual requirements and state and federal regulations. Additionally, we employ self-monitoring activities to assess programs and processes, evaluate process data and suggest internal process and systemic improvements. Mr. Langdon also initiates self-monitoring and auditing of compliance with laws, policies and regulatory obligations.

Risk Assessment Processes

As part of the Compliance and Ethics Program, Mr. Langdon conducts a Compliance Risk Assessment at least annually to identify compliance risks so they may be evaluated and prioritized.

The Compliance Risk Assessment is documented, and risks are ranked to determine which will have the greatest impact. A mitigation plan is then established in collaboration with the accountable business leads and reviewed at least quarterly at the Nebraska COC meeting to assess progress made toward remediation. Risk Assessments are also completed annually at the regional and national levels. National remediation plans are divided by functional area, and the compliance and ethics regional compliance officers and Mr. Zitzer collaborate to determine solutions for items identified in these remediation plans.

Possible risk sources include:

- CAPs required by regulators
- Internal and external auditing and monitoring
- State sanctions
- Internal corrective action plans (iCAPs)
- Compliance exit interviews
- Ethics and Integrity reports

Items identified on the Risk Assessment provide the basis for internal auditing and monitoring strategies.

Element 7: Respond Promptly to Detected Offenses and Develop Corrective Action Initiatives to Prevent Future Incidents

The Compliance and Ethics Program, in conjunction with the appropriate business areas, promptly responds to all credible reported concerns and instances of identified noncompliance and suspected misconduct. Compliance staff reviews the matter and determines if further action is warranted. If appropriate, timely and reasonable inquiries are made, and preliminary investigations are conducted by identified compliance, legal or special investigations personnel.

When appropriate, corrective and disciplinary actions are taken in response to the associated findings to promptly reduce the potential for recurrence and support ongoing compliance with applicable regulatory requirements. If required, timely reports are made to state regulatory agencies. Corrective actions are designed to address underlying issues contributing to program noncompliance or violations and to prevent future program noncompliance.

11. Describe how the bidder meets the Federal definition of a MCO. Include a copy of the COA from the Department of Insurance. *1 page, excluding copy of COA*

UnitedHealthcare of the Midlands, Inc. has been a licensed HMO in the state of Nebraska since 1984, and it therefore meets the federal definition of an MCO. Attachment 19 Q11 is our Certificate of Authority.

12. Describe the MCO's proposed approach for collaboration with other entities and programs, as required in Section IV.C.6. *3 pages*

Over the last few decades, continuous collaboration with a broad range of community agencies and government organizations has been a hallmark of our person-centered approach. We coordinate with organizations to get members the care and services they need and to solicit feedback to improve our processes. In addition to the organizations we currently collaborate with listed in Section IV.C.6, we are eager to continue our collaborative approach with other agencies, as demonstrated by our outreach, just in the last year, to **more than 160 community and provider-based organizations and associations**. Developing community relationships has long been the responsibility of both our senior administrative and clinical team and our community outreach staff under the direction of Kim Manning, marketing and community outreach director. These activities are guided by our policies and procedures and are integrated into our annual goals and objectives. We report these activities and opportunities to integrate services during our weekly leadership team meetings and the Healthcare Quality and Utilization Management (HQUM) Committee. We have identified key staff members to serve as accountable owners with each of the DHHS divisions and other entities that serve our members.

DHHS Division of Behavioral Health

As we take on responsibility for managing behavioral health (BH) services for our members, we realize how critical it is that we coordinate with the Division and also with each of the Regions. To determine how we can best partner with each of the entities, we met with Sheri Dawson, director of the Behavioral Health Division, and with the administrators of each of the six regions. Although each region has its own set of responsibilities and stakeholders, their recommendations were similar:

- Assign a single staff member through whom we can route all our requests, especially related to individual members that we are serving in common
- Participate regularly in meetings (e.g., meetings of all providers in a region, difficult case reviews in a region, policy discussions)
- Minimize provider administrative workloads by streamlining prior authorization and concurrent review processes
- Include the Division in mailings, trainings and similar outreach efforts so we can develop joint initiatives when appropriate, such as strengthening crisis response systems or expanding access to medication management, which will benefit all Nebraskans, regardless of how their health care services are provided

In response to these discussions, we will be working with MLTC and the other awarded MCOs to develop an in-depth outline that will incorporate key information on available services, key staff contacts, referral processes, agreements to share in initiatives and similar cross-program efforts. We are committed to providing a key liaison with each Region and the Division as well as to working with them on joint projects. As a first step, we will be contracting with Region 3 to make additional peer support services available to our members who live in the Kearney area. If it proves successful, we will attempt to replicate the pilot in other areas in the future.

To gain insight into BH needs across the state, we have met with other entities and programs, including the BH Education Center of Nebraska, the Nebraska Alliance of BH Providers and the BH Support Foundation. We also met with advocacy organizations such as the National Alliance for the Mentally Ill, the Mental Health Association and the National Federation of Families. The recommendations most commonly provided to us centered on: be as flexible as possible in our approach to serving individuals

and supporting system transformation; seek and incorporate stakeholder input; advocate for evidence-based and promising practices; and operate as transparently as possible. Our proposed design has incorporated these recommendations in a number of ways, including designating staff to maintain strong communications and regular meetings with these and similar local organizations.

Division of Children and Family Services

We have already met with Doug Weinberg, director of the Division of Children and Family Services. The recommendation from Mr. Weinberg is to improve services and programming for foster care through collaboration across all systems of care for foster care children, not solely focused on health. Consistent with his recommendation, we partner with these organizations that benefit foster care:

Foster CARE Closet: This organization is the only one in Nebraska that provides youth in the foster care system with clothing. The organization builds hope and self-esteem for youth in crisis by providing quality clothing at no cost. In 2014, we facilitated communication between Foster CARE Closet and the Christy Heights Community Center in Omaha for use of their gym space for distribution of clothing to youth in foster care. We were the only health plan invited to attend the two-day event.

KVC Nebraska: KVC Nebraska is a child welfare and BH care organization that provides foster care and intensive in-home services. UnitedHealthcare sponsored a **2015 Resource Family Conference** for foster parents in Lincoln. More than 600 foster parents, children and volunteers came together to network, learn from national speakers and experts and enjoy family activities. In addition to sponsorship, we presented training materials during the training sessions.

Youth Emergency Services (YES): YES provides street outreach, emergency shelter, transitional housing and maternity housing for runaway and homeless youth that need access to services. By collaborating with YES, we can reach a vulnerable population and ensure that needs well beyond just clinical are met. Our BH peer support specialist, BH care manager and CHWs will be part of the collaborative team working with YES to influence behavior with educational efforts for foster youth that are aging out of the system. We are committed to providing YES with educational resources such as UnitedHealthcare On My Way™ to teach youth aging out of foster care how to navigate the complex social support systems, including health care.

Various organizations: Oftentimes, foster children's belongings are placed in a plastic garbage bag as they are moved from placement to placement. To give them a sense of comfort and permanency, we are donating more than 2,300 backpacks to various foster care organizations to give to children as they are placed in new foster homes. The backpacks provide a convenient and helpful way to keep the child's belongings safe.

Division of Developmental Disabilities

We continue to meet and support 28 organizations that serve members with disabilities, including, but not limited to: Nebraska Association of Services Providers, Arc of Nebraska, Arc of Omaha, League of Human Dignity, Disability Rights Nebraska, Munroe Meyer Institute, PTI-Nebraska, Autism Center of Nebraska, Goodwill, Collaborative Industries and Mosaic. For instance, on Oct. 31, 2015, we delivered a presentation at the Arc of Nebraska board meeting. Board feedback from our presentation has enabled us to better prepare to provide medical, behavioral and pharmacy services to help members live a life of quality and independence. The Board was appreciative of our focus on collaboration around employment and integration into the community. We will continue to engage Arc of Nebraska to understand, learn and adjust our approaches for person-centered care. Due to DHHS staffing changes, we were unable to meet with the director prior to RFP release, but will meet with Courtney Miller, director of the Division of Developmental Disabilities, as soon as permissible to get her input on ongoing collaboration.

The Nebraska Department of Education Early Development Network

We are a proactive partner with schools in underserved areas in our current service area. Through our successful partnership with 4-H, we combat hunger and food insecurity and help families with budgeting, grocery shopping, meal planning and preparation. We also continue to meet and support a number of organizations that offer educational initiatives in Nebraska, including but not limited to: Educare, Head Start, Nebraska Association of School Nurses, school-based clinics, D.R.E.A.M. and Omaha and Lincoln public schools. One example of collaboration with these organizations includes inviting Educare to host the community baby showers, where they have been able to connect with many new families. As soon as permissible, we will meet with Melody Hobson, administrator.

Community Agencies—Aging and League of Human Dignity Waiver Offices

Members of our senior staff met with Dennis Loose, interim executive director of the Eastern Nebraska Office on Aging and Mike Schafer, executive director for the League of Human Dignity. Throughout next year, we will again meet with the other seven Area Agencies on Aging throughout Nebraska, and continue to meet with providers, disability advocates, nursing homes, State agencies and mental/behavioral health associations to explore how we can further advance our efforts to connect members to support services and avoid duplication of services.

Office of Probation

We understand that there is overlap between juvenile and adult correctional systems and BH issues. We are well aware that many individuals who are on probation have significant treatment needs, especially in the area of mental health and substance use disorders (MH/SUD) services. We would like to discuss nationally recognized programs such as jail diversion and drug court pilots to see if there are opportunities to help members avoid incarceration. Drug courts often offer a treatment alternative to drug and alcohol addicts and young criminals, steering them to stability and recovery instead of prison. As soon as possible, we will meet with Ellen Fabian Brokofsky, state probation administrator, and Tony Green, administrator for the Office of Juvenile Services.

Other Programs and Initiatives Related to Primary Care and Behavioral Health Integration and Pharmacy Management

As we have in the past, we will continue to collaborate with local and state agencies to enhance the health and well-being of our members. Our pharmacy director, Jeanne Cavanaugh, will be involved in the MLTC Pharmacy & Therapeutics (P&T) Committee and DUR Board as well as regular meetings with MLTC to strengthen program performance and delivery. Our case management administrator, Barb Palmer, is a member of the diabetic self-management task force (SME) set up by MLTC and led by Kathy Goddard. The goals of the task force are to increase access, referrals and reimbursements for American Association of Diabetes Educators (AADE)-accredited and American Diabetes Association (ADA)-recognized programs. We have disseminated this focus to our staff and implemented a process by which our CHWs share information via *Healthify* when they encounter diabetic members needing additional resources.

13. Describe if any of the MCO's Medicaid MCOs are accredited by NCQA and, if not currently accredited in Nebraska, how it will attain accreditation for its Nebraska MCO. Please describe any unsuccessful accreditation attempts in other states. *1 page*

UnitedHealthcare of the Midlands, Inc., d.b.a. UnitedHealthcare Community Plan (UnitedHealthcare), holds a current NCQA accreditation status of "Commendable." We received **an overall rating of four out of five stars in NCQA's Medicaid Health Insurance Plan Ratings 2015–2016**, making our MCO the **only Medicaid plan in Nebraska to reach a four-star performance level** and the highest rated among all Medicaid plans in the state.

Further demonstrating our organization-wide commitment to quality, 18 of our 24 Medicaid health plans hold NCQA accreditation and United Behavioral Health, d.b.a. Optum Behavioral Solutions, has full accreditation from NCQA for the behavioral health management services that will support Heritage Health members under the new contract. The following subsidiaries of our parent company also hold NCQA accreditation for health care products and services: UnitedHealthcare Medicare & Retirement, UnitedHealthcare Employer & Individual and UnitedHealthcare Military & Veterans.

In Nebraska, we have achieved and maintained a "Commendable" accreditation by creating a local infrastructure of industry-recognized quality standards and approaches, supported by an experienced team of professionals who are dedicated to providing Nebraska members with an outstanding health care experience. Our team understands that quality is *everyone's* responsibility. Our pursuit of quality outcomes is a day-to-day effort, and we independently evaluate plan performance efforts against these standards. Our aggressive efforts to meet and exceed NCQA accreditation standards demonstrate our organization's focus and commitment to quality. We hope that this rigorous external review of our communication, product and service offerings is a clear signal to MLTC that their members have unobstructed access to quality health care.

We have designed policies, procedures and processes to obtain the highest level of quality performance. We manage a comprehensive Quality Assessment and Performance Improvement program grounded in the use of meaningful data and, therefore, we welcome external scrutiny of our performance. As a long-term MLTC contractor, we have demonstrated our commitment to the program and have fully cooperated with external audits with the goal of performance improvement.

Accreditation Background

UnitedHealthcare has never experienced suspension or revocation of accreditation for any product in any state, nor have we experienced any unsuccessful accreditation attempts in other states. We make NCQA standards part of our day-to-day operations and daily work processes and resource them appropriately. This cross-functional process touches all parts of our efforts in Nebraska, supported by our corporate culture of **Integrity, Compassion, Relationships, Innovation and Performance**. We confirm continuous compliance with NCQA accreditation standards through annual reevaluation of our accreditation status based upon the current year's HEDIS and CAHPS results. We use both national and local quality rating systems to inform ongoing recommendations for accreditation excellence.

14. If applicable, describe any restriction of coverage for counseling or referral services the MCO is required to provide because of moral or religious obligation. Describe how the MCO will provide members with access to those services. *1 page*

UnitedHealthcare does not restrict coverage for any services because of moral or religious objections.

UnitedHealthcare does not place any constraints on the coverage, reimbursement or delivery of services based upon moral or religious grounds. We provide access to all Medicaid services covered under our contract with MLTC. Our provider agreements contain a clause that allows the provider to refuse to provide any service that they find objectionable because of moral or religious grounds. If this situation occurs, our member services or care management staff helps the member access another provider who is willing to provide the service.

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IV.D. Staffing Requirements

15. Describe the organization's number of employees, lines of business, and office locations. Submit an organizational chart showing the structure and lines of responsibility and authority in the company. Include the organization's parent organization, affiliates, and subsidiaries that will support this contract. *3 pages, excluding organizational chart*

Distinguishing our bid is a local Nebraska team of seasoned leaders and partners led by our CEO Kathleen Mallatt, a native Nebraskan who is responsible for the administration and management of all aspects of the contract. Our local leadership team has many years of Medicaid managed care experience; some of this leadership team has been involved with Medicaid managed care in Nebraska since it began in 1996. We bring the best combination of local management and staff in Nebraska and UnitedHealth Group's vast national resources and support. Our staff demonstrates cultural sensitivity and familiarization with the health care delivery system. Most importantly, our Nebraska-based staff is available and accessible to MLTC and our local communities to understand and respond to the issues and challenges for the Heritage Health population.

Through an understanding of the populations we serve, we created our staffing plan and functional staffing chart with an appreciation for the RFP requirements as well as internalizing MLTC goals and leveraging our deep understanding of our State partners. We then used UnitedHealthcare workforce models and planning tools to develop an efficient and cost-effective model. We developed these workforce models across our business units to support efficient managed care operations based upon enrollment fluctuations, anticipated call volumes and contract requirements. We continually evaluate and revise these models as needed to verify consistent, dependable service regardless of enrollment or other changes that may directly influence work volume. They are further refined and adjusted to reflect the efficiencies we recognize as a result of significant investment in technologies deployed to streamline business processes, simplify member experiences and improve administrative accuracy.

Number of Employees

Nationwide, we currently employ 128 resources to serve our Nebraska Medicaid members. Locally, in combination with UnitedHealth Group's other business lines, such as our commercial and Medicare services and Optum, we employ more than 270 employees that live and work in Nebraska.

Lines of Business

We are a Nebraska corporation and hold a Nebraska certificate of authority to operate a health maintenance organization. We are a part of UnitedHealthcare Community & State, the business segment of UnitedHealth Group dedicated to proactively meeting the health care needs of Medicaid-eligible individuals. With more than 5.3 million members in 24 states, we provide a variety of Medicaid programs, including Medicaid programs like the Nebraska Medicaid Managed Care Program (NMMCP), CHIP, and Medicare programs for dual-eligible and long-term care populations.

We bring the technical expertise and resources of the nation's leaders in health care services to Nebraska. Through our alliances with other UnitedHealth Group companies, we seamlessly support and create innovative solutions:

- ***UnitedHealthcare Community & State:*** Includes Medicaid; Temporary Assistance for Needy Families (TANF); Children's Health Insurance Program (CHIP); Aged, Blind and Disabled (ABD); Dual-Eligible Special Needs Plan (D-SNP) and Long-Term Services and Supports (LTSS)
- ***UnitedHealthcare Medicare & Retirement:*** Includes Medicare; Medicare Advantage; Prescription Drug Plans and Medicare Supplement plans

- ***UnitedHealthcare Employer & Individual:*** Includes commercial group and individual plans
- ***UnitedHealthcare Military & Veterans:*** Serves the U.S. Department of Defense by providing coverage to more than 2.7 million active duty or retired military service members and their families
- ***OptumHealth:*** Includes OptumHealth Care Solutions; Optum Behavioral Solutions; NurseLine℠ and other specialty services
- ***OptumInsight:*** Provides payment integrity, consulting, health information systems and data management services, including Impact Pro™
- ***OptumRx:*** Provides pharmacy benefits manager services to UnitedHealthcare

Office Locations

The primary office location is:

2717 North 118th St., Suite 300
Omaha, NE 68164
402-445-5612

We also have offices at:

5000 Central Park Drive, Suite 204
Lincoln, NE 68504

2501 Capehart Rd.
Offutt AFB, NE 68113

Organizational Chart

As a part of UnitedHealth Group, we have access to the expertise and resources of one of the nation's leaders in health care services. Nationally and locally, we have extensive experience serving people who need physical, social, BH and community-based services. By applying the strengths of our diverse organization, our local Nebraska leadership team benefits from accessing corporate resources, knowledge, experience and evolving best practices of our clinical, operational and cost-containment efforts from other states.

The following Figure IV.D-1 Staffing Requirements Organizational Chart reflects our relationship with our parent organizations and affiliated business entities.

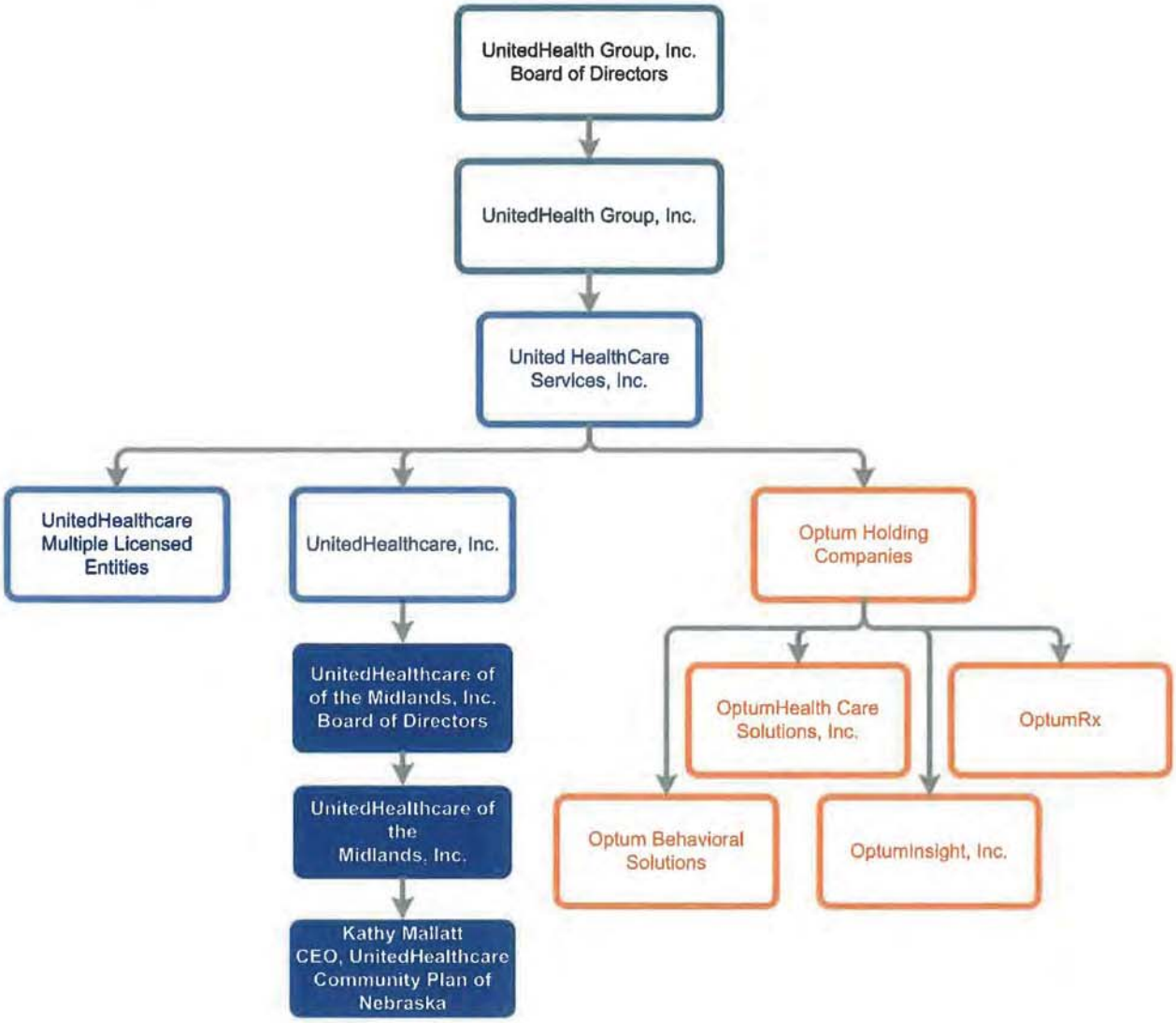

Figure IV.D-1. Staffing Requirements Organizational Chart

16. Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart."

Nebraska Organizational Chart

As we build a more comprehensive infrastructure to support Heritage Health, we will leverage our current Nebraska Medicaid leadership team while bringing in national experts to deliver broad leadership support. Our organizational structure is designed specifically to meet the integrated physical, behavioral and pharmacy needs of the Heritage Health population, serving low-income and special health care needs populations. CEO Kathleen Mallatt is accountable for the overall direction, strategic development, growth and operations of UnitedHealthcare in providing innovative care to the populations in Heritage Health.

As seen in the following Figure IV.D-2 Nebraska Organizational Chart, our proposed go-live organizational structure will be a mix of local, Nebraska-based leadership supported by our national team. Led by Ms. Mallatt, CFO Jim Elliston, medical director/CMO Dr. Horn and COO Sean Jones, we present a highly qualified and dedicated staff of professionals. These individuals understand the Nebraska health care market and the challenges faced by our members. We will use our experience and knowledge from other UnitedHealth Group companies, our national team and leaders from other Community & State Plans serving similar populations to achieve a smooth implementation and introduce best practices in our Nebraska operations. For key staff positions that are not currently filled, we have assigned interim staff who are subject matter experts until permanent staff are hired.

Replacement of Key Staff

We have available and ready contingent staffing resources to fill gaps while we recruit a replacement of key staff, if needed. We fill a resource gap by leveraging trained/skilled resources through our national functions or employees in other health plans. These resources can be dedicated to the Nebraska contract until replacements can be named. Our recruitment teams specialize in various functional areas to make certain we identify the right external resources and look in the right places for the most qualified candidates. If there is no clear successor for an open position, we recruit positions both internally and externally.

UnitedHealthcare Leadership and Functional Teams

The following organization chart represents our leadership team and functional teams supporting Heritage Health, including health services, quality, compliance, provider relations, member services, information technology and administrative operations.

We project hiring our full contingent of staff by Nov. 1, 2016, to allow sufficient time for training and orientation. By the time our new roster is completely hired, we will have 166 new incremental resources supporting Heritage Health, with total support from 294 full-time equivalents of which 53 percent will be located in Nebraska. This significant staffing increase reflects the resources planned to execute on the management of BH and pharmacy services and to serve the new populations in Heritage Health. **These resources also reflect our commitment to create a member and provider call center in Nebraska.** In choosing the location, we will collaborate with the Nebraska Department of Economic Development to consider Nebraska areas and communities that will benefit most from the economic growth and improvement related to a call center installation and workforce availability.

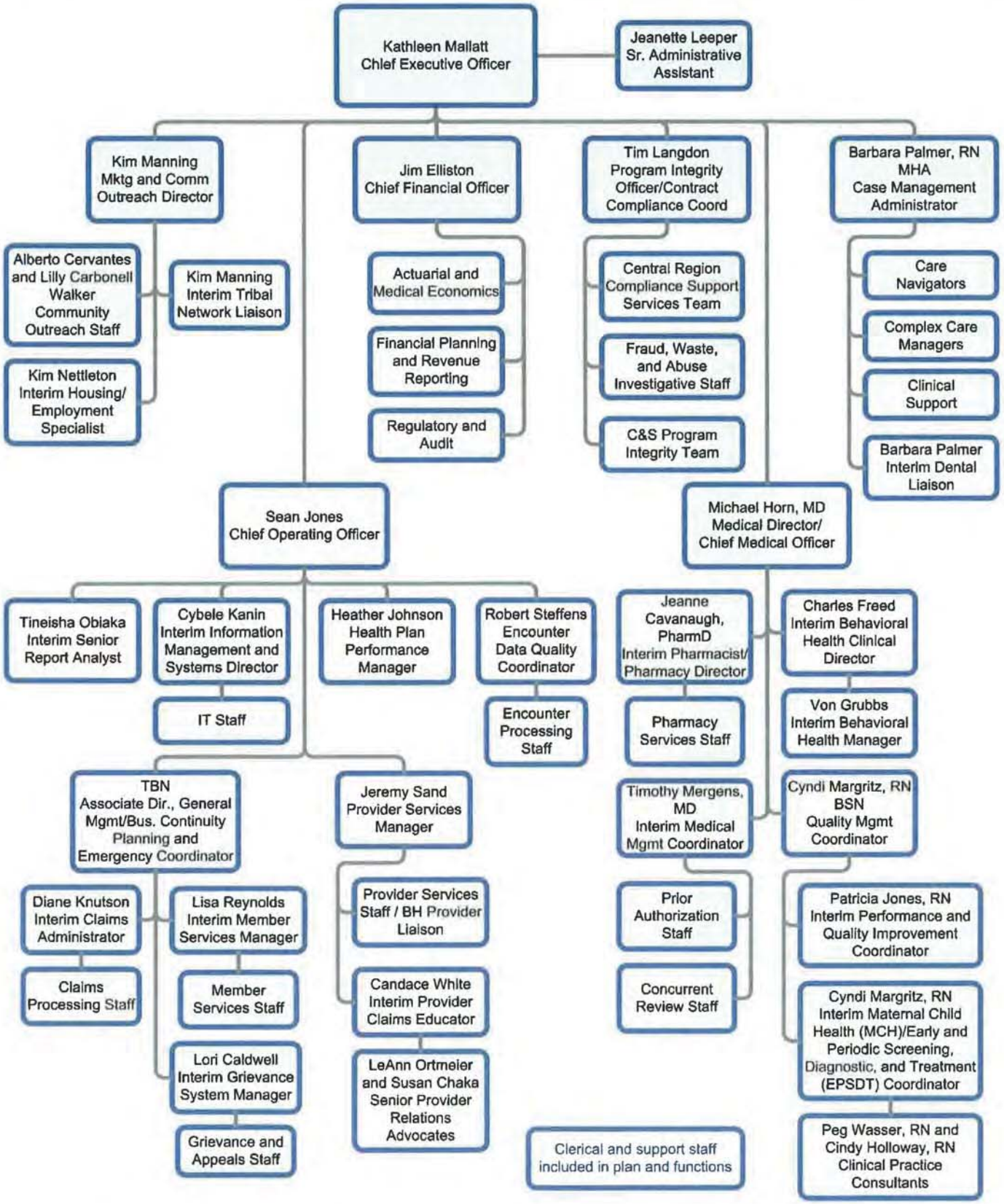

Figure IV.D-2. Nebraska Organizational Chart

17. In table format, indicate the proposed number of FTEs for each key staff and additional required staff for discrete time periods (no longer than 3 month intervals) from contract award through 6 months after the start date of operations and whether or not positions are located in Nebraska. Label this table "Proposed FTEs by Time Period."

Table IV.D-1: Proposed FTEs by Time Period

Function	In State	Contract Award Date 3/15/2016 to 6/15/2016	6/16/2016 to 9/15/2016	9/16/2016 to 12/15/2016	12/16/2016 to 3/15/2017	3/16/2017 to 6/30/2017	4/1/2017 to 6/30/2017
Chief Executive Officer	**Yes**	1	1	1	1	1	1
Medical Director/Chief Medical Officer	**Yes**	1	1	1	1	1	1
Behavioral Health Clinical Director	**Yes**	1	1	1	1	1	1
Behavioral Health Manager	**Yes**	1	1	1	1	1	1
Chief Operating Officer	**Yes**	1	1	1	1	1	1
Chief Financial Officer	**Yes**	1	1	1	1	1	1
Program Integrity Officer/ Contract Compliance Officer	**Yes**	1	1	1	1	1	1
*Grievance System Manager	**Yes**	-	1	1	1	1	1
Business continuity planning and emergency coordinator	**Yes**	1	1	1	1	1	1
Quality Management (QM) Coordinator	**Yes**	1	1	1	1	1	1
*Performance and quality improvement coordinator	**Yes**	-	-	1	1	1	1
*Maternal child health (MCH)/early and periodic screening, diagnostic and treatment (EPSDT) coordinator	**Yes**	-	-	1	1	1	1
Medical Management Coordinator	**Yes**	1	1	1	1	1	1
Provider Services Manager	**Yes**	1	1	1	1	1	1
*Member Services Manager	**Yes**	-	1	1	1	1	1
*Claims Administrator	**No**	-	1	1	1	1	1
Provider Claims Educator	**Yes**	1	1	1	1	1	1

Table IV.D-1: Proposed FTEs by Time Period							
Function	**In State**	**Contract Award Date 3/15/2016 to 6/15/2016**	**6/16/2016 to 9/15/2016**	**9/16/2016 to 12/15/2016**	**12/16/2016 to 3/15/2017**	**3/16/2017 to 6/30/2017**	**4/1/2017 to 6/30/2017**
Case Management Administrator	**Yes**	1	1	1	1	1	1
*Information Management Director	**Yes**	-	-	1	1	1	1
*Encounter Data Quality Coordinator	**No**	-	-	1	1	1	1
Tribal Network Liaison	**Yes**	1	1	1	1	1	1
Pharmacist/Pharmacy Director	**Yes**	1	1	1	1	1	1
Prior Authorization Staff NE	**Yes**	2	8	11	12	12	12
Prior Authorization Support	**No**	5	5	5	7	7	7
Concurrent Review Staff NE	**Yes**	6	7	10	11	11	11
Concurrent Review Support	**No**	1	1	1	1	1	1
Clerical & Support Staff NE	**Yes**	5	5	5	4	4	4
Provider Services Staff NE	**Yes**	6	14	18	18	18	18
Provider Services Support	**No**	1	1	2	2	2	2
Member Services Staff NE	**Yes**	2	9	9	10	10	10
Member Services Support	**No**	-	-	-	1	1	1
Claims Processing Staff	**No**	25	33	36	36	33	33
Encounter Processing Staff	**No**	1	1	1	1	1	1
Care Management Staff NE	**Yes**	9	13	49	51	51	51
Care Management Support	**No**	1	1	4	4	4	4
FWA Investigative Staff	**Yes**	5	7	7	7	7	7
Disease & Care Management	**Partial**	6	6	23	27	27	27
Pharmacy Services	**Partial**	9	9	14	14	14	14
Network Operations	**Partial**	12	16	16	16	16	15

Table IV.D-1: Proposed FTEs by Time Period							
Function	**In State**	**Contract Award Date 3/15/2016 to 6/15/2016**	**6/16/2016 to 9/15/2016**	**9/16/2016 to 12/15/2016**	**12/16/2016 to 3/15/2017**	**3/16/2017 to 6/30/2017**	**4/1/2017 to 6/30/2017**
Grievances & Appeals Staff	**No**	6	6	8	9	9	9
Clinical Quality Management	**Partial**	5	5	11	11	11	11
Corporate Administration/IT Support	**No**	21	21	24	25	25	25
Marketing & Community Outreach	**Yes**	3	5	5	5	5	5
Total Nebraska Staff		**145**	**190**	**280**	**294**	**291**	**290**

- **Interim subject matter experts will fill position until permanent staff are hired*
- *Staffing reflects ramp up for go-live (implementation) as well as onboarding of steady state resources*
- *Dental Liaison role included in 'Care Management Staff NE' section*
- *Behavioral Provider Liaison included in 'Provider Services Staff NE' section*
- *Proposed FTEs by time period does not include staffing for Fee For Service Claims Management & Processing (Section Z)*

18. Provide job descriptions (including education and experience qualifications) of employees in key staff positions. *1 page per job description*

Staffing Job Descriptions

Our Nebraska team is led by Ms. Mallatt who has led Medicaid in Nebraska since June 2010. Ms. Mallatt has been involved in Medicaid managed care in Nebraska since 1996. She has overall responsibility for plan administration, delivery of fully integrated services, comprehensive care planning and management, member and provider services and support, administrative simplification and efficiencies, quality, performance improvement, program integrity, innovation and development. The following job descriptions are representative of the primary responsibilities assigned to each key staff member.

Chief Executive Officer, Kathleen Mallatt

Position Overview

Ms. Mallatt is accountable for overall direction, strategic development, growth and operations of UnitedHealthcare in providing innovative care to the populations in Heritage Health. The goal of this position is to provide executive oversight and leadership so the needs of the members are met and contractual compliance is achieved. She holds the most senior leadership position having demonstrated experience in people leadership, strategic planning and organizational, operational and technical skills.

Responsibilities:

- Effectively develops strategic goals and turns those goals into specific operating and business plans executed
- Validates regulatory compliance
- Reviews medical expense drivers and creates plans to reduce waste and increase the affordability of our programs
- Represents our organization at external events and organizations; interacts with Community & State leaders on behalf of Nebraska consumers and State partners

Qualifications:

- Bachelor's degree or equivalent combination of education and experience; master's degree in business administration preferred
- Ten or more years of operations experience in a Medicare/Medicaid industry, at-risk managed care environment
- Experience in strategic planning and development
- Demonstrated successful leadership skills in program execution and people management
- Proven leadership skills in both internal and external environments

Medical Director/Chief Medical Officer, Michael Horn, M.D.

Position Overview

Medical director/CMO, Michael Horn, M.D., is actively involved in all major clinical and quality management components of our operations. He oversees clinical operation initiatives that focus on clinical excellence and performance improvement.

Responsibilities:

- Administers all medical management activities and oversees all clinical functions, including disease management and care coordination programs, the development of clinical care guidelines and utilization management (UM)

- Develops, implements and provides medical interpretation of medical policies and procedures, including but not limited to service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the grievance system
- Serves as the chair of the Healthcare Quality and Utilization Management Committee (HQUM), the Quality Assessment and Performance Improvement Committee (QAPIC) and the Clinical and Provider Advisory Committee (CPAC)
- Responsible for implementation and management of the quality improvement program; leads and executes medical expense management and clinical quality activities
- Actively participates in any scheduled quality committee meetings as directed by MLTC

Qualifications:

- A minimum of three years of training in a medical specialty and five years of experience post-training providing clinical services
- A physician with a current, unencumbered Nebraska medical license
- Board certification in his/her specialty
- Managed Medicaid experience

Behavioral Health Clinical Director, Charles Freed, M.D.

Position Overview

Behavioral health clinical director, Charles Freed, M.D., is responsible for the overall BH clinical affordability functions, including benefit expense management and engagement. He executes the goals of the integrated medical/behavioral/pharmacy team and he is responsible for Level of Care guidelines and UM protocols. Dr. Freed oversees and manages the BH clinical program, UM, management and care coordination activities. He takes an active role in the MCO's medical management team and in clinical and policy decisions. In addition, Dr. Freed's role as BH clinical director, we are excited about supplementing our BH staff with a recovery/resiliency manager and two peer support specialists as we feel strongly that they will have an important impact with Heritage Health members.

Responsibilities:

- Coordinating all areas of the MCO for BH services including quality management, UM, network development and management, providers services, member outreach and education, member services, contract compliance and reporting
- Provides clinical case management consultations and clinical guidance for contracted PCPs treating BH-related concerns not requiring referral to BH specialists
- Develops comprehensive care management programs for youth and adults with BH concerns, typically treated by PCPs, such as ADHD and depression
- Develops targeted education and training for MCO PCPs who commonly encounter BH issues
- Achieves appropriate utilization by performing reviews, denials, peer reviews and appeals; consults with care management staff; uses data to identify opportunities for improvement and implements strong action plans for both Medicaid enrollees
- Implements a recovery philosophy working closely with the Recovery & Resiliency staff by maintaining a knowledge base in rehabilitation and recovery principles and innovations; models principles of engagement, empowerment and learning with colleagues and employees; and trains all staff in the practical implications of these principles with a particular emphasis on care management, alternative levels of care and network sufficiency

- Validates systematic screening for BH-related disorders by using standardized or evidence-based approaches
- Promotes preventive BH strategies
- Completes all medical necessity reviews when care managers are unable to authorize continuation of services

Qualifications:

- Practicing psychiatrist or psychologist with an unrestricted license in Nebraska
- Minimum of five years of combined clinical experience in mental health and substance use disorder services and must be knowledgeable about primary care/BH integration
- Experience working with community-based programs and resources that aid the Nebraska Medicaid population
- Knowledge of post-acute care planning such as home care, discharge planning, case management and disease management
- Data analysis and strong organizational skills necessary

Behavioral Health Manager, Von Grubbs

Position Overview

Behavioral health manager Von Grubbs is responsible for the successful delivery of cost-effective quality care that incorporates recovery, resiliency and person-centered services. He collaborates closely with clinical operations, network, quality, account management and all other departments supporting our Nebraska Medicaid business. He administers and deploys business processes and technology-enabled solutions to deliver benefit to providers and members in Nebraska.

Responsibilities:

- Verifies that the MCO's BH operations, providers and subcontractors comply with the terms of the contract
- Contributes to local market performance against both utilization and financial targets
- Identifies and analyzes local market trends, service gaps and the development of mitigation (to include HCQAIs) in coordination with clinical operations functional leads and other matrix partners
- Leads the development of any market-required clinical processes (e.g., development of job aids and quick review guides)
- Acts as the clinical contact to address routine and complex member issues and concerns
- Confirms the timely completion of all clinical and affordability contract deliverables including the collection and delivery of required clinical operations customer reporting as well as developing action plans to address performance issues
- Works closely and collaborates with clinical operations directors, managers and supervisors in the effective delivery of services and to make certain utilization and customer goals are met
- Serves as a presence in the community with community providers, state agencies and advocacy agencies/groups

Qualifications:

- Nebraska-licensed BH professional, such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist, or mental health counselor

- Minimum of master's degree in psychology, counseling or social work or a bachelor's degree in nursing required
- Minimum of eight years of leadership and administrative experience
- Minimum of five years of experience in public sector or BH care required
- Thorough understanding of managed care principles, models and financing required with a minimum of two years of experience working in a corporate managed health care environment strongly preferred
- Prior experience in public sector mental health or nonprofit community mental health, with knowledge of Medicaid populations
- Experience in a recovery-oriented delivery system greatly preferred
- Experience in recovery and resiliency practices and programs

Chief Operating Officer, Sean Jones

Position Overview

Chief operating officer Sean Jones serves as the primary point of contact for all operational issues and is responsible for the management and administration of multiple functions and general business operations. Mr. Jones manages the daily operations of multiple levels of staff and multiple functions and departments across our company to meet performance requirements. He is responsible for formulating sound business strategies and operational plans. Reporting to Ms. Mallatt, Mr. Jones is accountable for operational results.

Responsibilities:

- Establishes business metrics required to meet state partner, member and care provider requirements and achieve key goals
- Coordinates the tracking and submission of all contract deliverables
- Facilitates and cooperatively manages with the business new law implementation and acceptance into the business; coordinates and develops regulatory relationships and active interaction with regulatory agencies
- Provides consultative expertise/guidance and promotes compliance with laws and regulations with business partners to validate effective responses to changing laws

Qualifications:

- Bachelor's degree; master's degree preferred
- Ten or more years of experience within a regulatory and health care compliance environment
- Ability to communicate clearly with internal partners and external regulatory agencies and effectively represent our interests
- Structures business disciplines to facilitate quick, data-based decisions and confirms accountability for execution
- Evaluates outcomes based upon qualitative and quantitative measures and adjusts accordingly

Chief Financial Officer, Jim Elliston

Position Overview

Chief financial officer Jim Elliston oversees all aspects of strategic financial planning, analysis and operations. Mr. Elliston executes a disciplined approach to financial performance management and oversees the budget, accounting systems, financial reporting and audit activities.

Responsibilities:

- Provides financial oversight, including financial planning and analysis
- Complies with State Medicaid program regulatory requirements (e.g., quarterly/annual filings) and other program operational areas (e.g., rate changes, fee schedule changes, revenue reconciliation, reporting)
- Establishes detailed budgets and identifies, quantifies and prioritizes strategic initiatives to realize these budgets
- Reports (financial and operational data) to region and site leaders

Qualifications:

- Bachelor's degree in finance or accounting required
- Seven or more years of progressive professional experience in finance or accounting
- Experience in cost accounting and capital investments
- Must effectively support and train and perform transactional-based finance and accounting transactions

Program Integrity Officer, Tim Langdon, J.D.

Position Overview

Program integrity officer Tim Langdon, J.D., serves as the program integrity officer and reports directly to Community & State central region compliance officer Laura Freedy and to Ms. Mallatt. He is accountable for monitoring changes to laws and regulations to verify compliance with state and federal laws, regulations and mandates.

Responsibilities:

- Oversees monitoring and enforcement of the fraud, waste and abuse (FWA) compliance program pursuant to state and federal rules and regulations
- Executes the provisions of the compliance plan, including FWA policies and procedures, investigating unusual incidents and implementing corrective action plans
- Assumes authority to assess records and independently refer suspected member fraud, provider fraud, and member abuse cases to MLTC and other duly authorized enforcement agencies
- Confirms that established processes and procedures are in place that meet regulatory and contract requirements regarding the receipt, investigation, resolution and reporting of fraud and abuse against us or our members
- Serves as the liaison among UnitedHealthcare and state agencies, law enforcement and federal agencies

Qualifications:

- Bachelor's degree or appropriate experience
- Minimum of three to five years of experience in direct management of a compliance program
- Solid experience in managed care and government programs
- Experience leading audits and major program initiatives

Grievance System Manager, Lori Caldwell

Position Overview

Grievance and appeals manager Lori Caldwell adjudicates member and provider disputes arising under the grievance system, including member grievances, appeals and requests for fair hearing and provider

claim and disputes. This position processes and resolves complaints, grievances and appeals and is responsible for the grievance system.

Responsibilities:

- Oversees completion of member, provider and regulatory complaint cases in a specified time frame
- Prepares appeal and grievance cases for presentation to triage and resolution team
- Works with internal departments to resolve complaints
- Acts as a liaison with regulatory agencies regarding member complaints

Qualifications:

- Bachelor's degree or equivalent experience
- Minimum of five years of management/supervisory experience in the health care field
- Experience with Medicare, Medicaid and managed care in a variety of health care settings

Associate Director of General Management/Business Continuity Planning and Emergency Coordinator

Position Overview

The associate director of general management/business continuity planning and emergency coordinator manages day-to-day operations, maintaining accountability for financial and non-financial results. Provides subject matter expertise in project management, project scope definition, risk identification, project methodology and resource allocation. Oversees the emergency management plan during disasters and ensures continuity of care benefits and services for members who may need to be evacuated to other areas of the state or out of state.

Responsibilities:

- Monitors required reporting and provides direction on findings
- Manages improvements in operational performance based upon quantitative and qualitative metrics
- Identifies and resolves technical, operational and organizational problems inside and outside the health plan
- Defines Incident (Event) Management and Business Continuity program objectives and strategies, timetables, budget and resources requirements
- Oversees research, analysis, testing, evaluation and reporting on all aspects of Incident (Event) Management and Business Continuity programs

Qualifications:

- Bachelor's degree required; master's degree preferred
- Eight to 10 years of related managed care experience in business continuity, emergency management or disaster recovery (DR) planning
- Five or more years of project management experience
- Ability to function as a leader in crisis management situations
- Knowledge of and experience related to publicly funded government health care programs (e.g., Medicaid, Medicare or state health care programs for the uninsured)

Contract Compliance Coordinator, Tim Langdon, J.D.

Position Overview

Tim Langdon, J.D., will serve as the contract compliance coordinator and will be primarily responsible for making certain all UnitedHealthcare functions comply with the terms of the Contract. Mr. Langdon collaborates with our legal counsel to conduct Nebraska-specific legal research and monitors changes to requirements to mitigate risks and achieve compliance. He supports the collection of data for regulatory filings and he coordinates and develops reports, projects and assessment tools to verify compliance. He may also develop compliance communications and drive problem resolution for the business.

Responsibilities:

- Serves as the primary liaison with DHHS (or its designee) to facilitate communications among MLTC, state contractors and our executive leadership and staff
- Oversees and directs, as applicable, process improvement plans and corrective action plans for surveys, accreditations, External Quality Review Organizations (EQROs) and state audits within the scope of quality management and improvement
- Promotes compliance with all HIPAA and privacy regulations, coordinates reporting to MLTC and reviews the timeliness, accuracy and completeness of reports and data submissions to MLTC
- Confirms the health plan has established processes and procedures to meet regulatory and contract requirements regarding receipt, investigation, resolution and reporting of fraud and abuse against the health plan or its members
- Coordinates with legal counsel, government programs compliance investigations and others as needed to conduct investigations, coordinate development and implement appropriate corrective action
- Collaborates with business staff to develop and implement monitoring and auditing procedures as appropriate to determine the level of compliance with key regulatory requirements
- Coordinates all external regulatory audit activity and resulting corrective actions with the government programs audit management team
- Works with operational leaders to confirm understanding and communication of plan-level regulatory contract requirements
- Confirms that standards and processes are in place to validate our vendor engagement meets regulatory and business requirements for effective pre-contracting evaluation and service level requirements, ongoing monitoring and contract termination activities

Qualifications:

- Bachelor's degree; master's degree or J.D. preferred
- Minimum of three to five years of experience in direct management of a compliance program
- Experience in managed care and government programs
- Experience leading audits and major program initiatives

Quality Management Coordinator, Cyndi Margritz, RN, BSN

Position Overview

Quality management coordinator Cyndi Margritz, RN, BSN, provides strategic leadership and direction for the quality improvement and management program. Ms. Margritz leads and develops the overall quality strategy for the health plan, verifying the quality program is proactive, continuously improving,

applies to all product and programs within the state, and includes quality management/regulatory adherence and quality improvement.

Responsibilities:

- Coordinates the work within the Quality Management and Performance (QMP) Centers of Excellence for HEDIS data collection, data analytics and reporting, accreditation, member surveys, regulatory adherence and member activation and engagement
- Applies the expertise, standard process and capabilities of these areas to enhance quality program performance of the plan
- Oversees and directs quality improvement activities and interventions as applicable to close gaps in care and improve outcomes for identified critical quality measures
- Verifies strong HEDIS performance
- Collaborates across business segments to attain or maintain health plan compliance with accreditation standards and contractual requirements as they apply to quality
- Oversees and verifies the creation and submission of reports to meet state contractual requirements including performance improvement projects (PIPs)

Qualifications:

- Nebraska-licensed RN; Certified Professional in Health Care Quality (CPHQ) preferred
- Eight to 10 years of experience leading an integrated and progressive quality organization, preferably within the health care industry
- Experience in quality management and quality improvement as described in 42 CFR §438.200 – §438.242 required
- Experience preparing for and leading accreditation surveys

Performance and Quality Improvement Coordinator, Patricia Jones, RN, BHSA, CCM, CPHQ

Position Overview

Performance and quality improvement coordinator Patricia Jones, RN, reports to Ms. Margritz and serves as MLTC's contact person for quality performance measures.

Responsibilities:

- Focuses organizational efforts on the improvement of clinical quality performance measures
- Identifies population-based member barriers to care and works with the QMP team to identify local-level strategies to overcome barriers and close clinical gaps in care
- Uses data to develop intervention strategies to improve outcomes
- Supports quality improvement program studies with work that ranges from accessing and analyzing provider records, maintaining databases, and researching to identify members' encounter history
- Designs practice-level quality transformation through targeted clinical education and approved materials related to HEDIS/state-specific quality measures for provider and staff education during field visits
- Engages providers in strategies to improve outcomes through collaborative partnerships
- Develops and implements PIPs internally and across MCOs
- Reports quality improvement and performance outcomes to MLTC

Qualifications:

- Bachelor's degree in science or equivalent work experience required; master's degree preferred
- Current unrestricted RN licensure for the state of Nebraska or, at a minimum, a Certified Professional in Health Care Quality (CPHQ) or Certified in Health Care Quality and Management (CHCQM) or have comparable experience and education in data and outcomes measurement as described in 42 CFR §438.200 – §438.242
- More than five years of clinical or field-related experience
- More than two years of experience in quality improvement or a related field such as Six Sigma
- Experience working in Medicaid or Medicare
- Health care and insurance industry experience, including regulatory and compliance preferred
- Knowledge of one or more clinical standards of care, preventive health standards, CMS standards, HEDIS, NCQA and governing and regulatory agency requirements

Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Coordinator, Cyndi Margritz, RN, BSN

Position Overview

Maternal child health/EPSDT coordinator Cyndi Margritz manages development and implementation of medical expense management initiatives. She advises leadership on improvement opportunities regarding medical expense programs and clinical activities that affect medical expense.

Responsibilities:

- Confirms receipt of EPSDT services
- Verifies receipt of maternal and postpartum care
- Promotes family planning services
- Promotes preventive health strategies
- Identifies and coordinates assistance for identified member needs specific to maternal/child health and EPSDT
- Interfaces with community partners
- Conducts program management activities
- Serves as a high-level liaison among members
- Oversees member advocacy
- Validates contract compliance of the program
- Creates and maintains reports

Qualifications:

- Nebraska-licensed RN, physician or physician assistant or has a master's degree in health services, public health, health care administration or other related field and a CPHQ or CHCQM
- Minimum of two years of experience managing a government health program
- Minimum of three years of experience in one of the following areas: NICU, pediatrics, maternity or obstetrics
- Minimum of two years of experience in health care operations

Medical Management Coordinator, Timothy Mergens, M.D.

Position Overview

Medical management coordinator Timothy Mergens, M.D., strategizes, develops and directs operations to assure provision of high-quality, cost-effective medical services.

Responsibilities:

- Verifies adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Validates appropriate concurrent review and discharge planning of inpatient stays is conducted
- Develops, implements and monitors the provision of care coordination, disease management and case management functions
- Monitors, analyzes and implements appropriate interventions based upon utilization data, including identifying and correcting overutilization and underutilization of services
- Monitors prior authorization functions and assures decisions are made in a consistent manner based upon clinical criteria and meet timeliness standards
- Develops and manages the budget related to medical care; directs actions to control targeted costs for inpatient and outpatient services in conjunction with the site medical expense team
- Confirms compliance with state and federal regulations and compliance with company policies and procedures
- Forms internal and external strategic relationships that support program expansion and continuing success

Qualifications:

- Master's degree in health services, health care administration or business administration if not required to make medical necessity determinations
- Nebraska-licensed RN with active license, physician or physician assistant if required to make medical necessity determinations
- Three to five years of leadership and management experience in an organization serving the elder population
- Experience with Medicare, Medicaid and managed care in a variety of health care settings
- Strong negotiation skills, budget management experience and regulatory knowledge
- Leadership and management experience in effective team building and continuous quality improvement programs
- Working knowledge and experience in cross-functional business segments and their integrated influences and relationships
- Effective and experienced in motivating and mentoring others who are not in a direct reporting relationship

Provider Services Manager, Jeremy Sand

Position Overview

Provider services manager Jeremy Sand develops the provider network through retention activities and implements and manages provider orientation, education, training and servicing activities for our provider network. Mr. Sand interacts with local plan leadership and functional teams and regional and national resources to develop and support the provider network.

Responsibilities:

- Coordinates communications between the MCO and its subcontracted providers
- Oversees provider services staff
- Works collaboratively with the Clinical and Provider Advisory Committee to establish methodologies for processing and responding to provider concerns
- Develops provider training in response to identified needs or changes in protocols, processes and forms
- Enhances MCO-provider communication strategies
- Notifies MLTC of correspondence sent to providers for informational and training purposes
- Participates in the MLTC Administrative Simplification Committee
- Oversees the development and maintenance of contracts, forms, materials and other tools related to the provider services team activities
- Monitors provider network for adequate access for member populations
- Monitors providers for contract compliance, provides orientation, training and support as needed
- Researches and develops provider agreements and other contracts and establishes regular contract review
- Performs contract and reimbursement support analysis in support of contract negotiations
- Participates in the development and preparation of network provider listings and services materials as well as the review and analysis of fee schedules
- Helps obtain required credentialing documents from providers as needed

Qualifications:

- Bachelor's degree required, in business or health care preferred; master's degree preferred
- Five or more years working in managed health care plan setting required
- Two or more years of experience working with physicians and other providers
- Proven success in provider contracting and servicing

Member Services Manager, Lisa Reynolds

Position Overview

Member services manager Lisa Reynolds is responsible for providing expertise and customer service support to members, customers and providers. Ms. Reynolds directs phone-based customer interactions to answer and resolve inquiries. She manages the member services staff to enable members to receive prompt resolution of their problems or inquiries and provide the appropriate education about participation in our programs.

Responsibilities:

- Oversees member services functions, including member help line telephone performance; member email communications; member education; member website; member outreach programs; and the development, approval and distribution of member materials
- Oversees the interface with MLTC or its subcontractors regarding member enrollment and disenrollment and other topics
- Plans, develops and manages the quality and productivity of customer service teams
- Verifies accurate staffing and service levels

- Manages inbound customer service call center and daily inventories
- Oversees operational metrics, contract compliance and key performance indicators

Qualifications:

- Bachelor's degree
- Minimum of five years of call center management experience, including knowledge of call center industry required
- Claims adjustment process experience preferred
- Familiarity with health adviser model preferred

Claims Administrator, Diane Knutson

Position Overview

Claims administrator Diane Knutson is responsible for developing, implementing and administering a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements and the terms of the contract.

Responsibilities:

- Validates minimization of claims recoupments
- Meets claims processing timelines
- Meets MLTC's encounter reporting requirements

Qualifications:

- Bachelor's degree or equivalent experience
- Five or more years of previous health care claims experience required
- Two or more years of previous supervisory or managerial experience required
- Three or more years of experience working with government health care programs such as Medicaid and Medicare required

Provider Claims Educator, Candace White

Position Overview

Provider claims educator Candace White serves in a fully integrated position with the grievance, claims processing and provider services departments, which facilitates the exchange of information between these departments and in-network/out-of-network providers.

Responsibilities:

- Educates in-network and out-of-network providers (e.g., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available MCO resources such as provider manuals, websites and fee schedules
- Interfaces with the call center to compile, analyze and disseminate information from provider calls
- Identifies trends and guides the development and implementation of strategies to improve provider satisfaction
- Communicates (e.g., telephonic and on-site) with providers to verify the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices

Qualifications:

- Bachelor's degree or equivalent work experience
- A minimum of five years of management and supervisory experience in the health care field
- Background in insurance or managed care preferably in a customer service or claims environment
- Ability to create and implement strategic plans
- Proven problem-solving skills and ability to translate knowledge to the department
- Experience with the latest claims tools and technologies as well as an understanding of emerging customer care solutions

Case Management Administrator, Barbara Palmer, RN MHA

Position Overview

Case management administrator Barbara Palmer, RN MHA, provides oversight of our care coordination and community-based case management programs. She strategizes, develops and directs operations of the health services department to assure the provision of high-quality, cost-effective medical services. In addition, she assures the culturally sensitive delivery of whole person care by overseeing case management that integrates physical and behavior health.

Responsibilities:

- Oversees assessment, care plan development and care plan implementation
- Directs the development of well-designed clinical policies and processes that are evident in daily workflows that comply with federal and state guidelines
- Directs the integration of quality assurance and clinical adherence activities into clinical practice
- Develops, implements and monitors the integration of care coordination, disease management and case management functions
- Monitors, analyzes and implements appropriate interventions based upon utilization data, including identifying and correcting overutilization and underutilization of services
- Oversees the integrity of member data to assure consistency and accuracy of data for case management decision making
- Implements initiatives to meet the needs of members and validate contract compliance

Qualifications:

- BSN with an active Nebraska license required; master's degree in nursing or health care administration preferred
- Minimum of five years of leadership and management experience in the health care field
- Two or more years of experience with Medicare, Medicaid and managed care in a variety of health care settings

Information Management and Systems Director, Cybele Kanin

Position Overview

Information management and systems director Cybele Kanin leads the information technology organization by supporting multiple claims platforms and operations, medical management and provider services. Collaborating with enterprise technology- solution groups, Ms. Kanin delivers technology that enables the business and supports contract compliance. Ms. Kanin oversees all information technology functions, including establishing and maintaining connectivity with the MLTC information systems and

providing necessary and timely reports to DHHS. This position verifies computer systems reports are accurate and that computer systems operate in an accurate and timely manner.

Responsibilities:

- Holds end-to-end accountability for making the information technology service chain work to deliver to the business, including application delivery, maintenance and systems operations
- Optimizes accuracy of estimation processes and confirms consistency on schedule, cost, scope, benefit implementation are within quality goals
- Integrates architecture to simplify application landscape and architect shared solutions to deliver business functionality including encounter claims submissions, capitation payment, member eligibility, enrollment, and other data transmission interface and management issues
- Verifies implementation readiness and creates and enhances operational processes to increase efficiencies
- Validates information system security and controls, program data transactions, data exchanges and other information system requirements are compliant with the terms of the Contract, and all data submissions required for federal reporting

Qualifications:

- Bachelor's degree or higher level of education or equivalent experience
- Seven or more years of application development/support experience in a large enterprise environment with two or more years of experience leading teams or managing workloads for team members
- Ability and willingness to hold on-call responsibilities to respond to system issues at any time
- Prior experience leading development or support for large, critical applications (preferably on multiple platforms)

Encounter Data Quality Coordinator, Robert Steffens

Position Overview

Encounter data quality coordinator Robert Steffens organizes and coordinates services and communication between UnitedHealthcare's administration and DHHS to identify, resolve and monitor encounter and data validation/management issues. Mr. Steffens serves as the encounter expert to answer questions, provide recommendations and participate in problem-solving and decision-making related to encounter data, submissions and processing. He also analyzes activities related to the processing of encounter data and data validation studies to enhance accuracy and throughput.

Responsibilities:

- Oversees encounter contractual requirements provided by MLTC and confirms actions underway to support those requirements
- Resolves correctable bypass, pended and rejected encounters that can be fixed within the encounter team; performs these resolutions within State-required turnaround times to avoid sanctions
- Coordinates information technology, business intelligence, claims and provider operations, and risk-adjusted rate team to prioritize and schedule efforts to meet these requirements
- Conducts regularly scheduled meetings for information technology review, program review and upstream root cause review

- Defines business requirements so information technology can write system requirements and develops appropriate system support. Defines required service level agreements with information technology on production information technology tasks
- Manages the relationship and coordination of work with upstream drivers such as claims adjudication and configuration for identified systemic issues
- Reviews completeness reporting and identifies any correctable issues or opportunities for improvement; submits the proper request if resolution is outside of the encounter team
- Works with functional areas to document solutions for encounter issue resolution

Qualifications:

- Bachelor's degree in business, finance, health administration or related field required
- Five or more years of experience in business/financial analysis required
- Experience with medical claims, electronic data interchange (EDI) or health care transactions experience strongly preferred
- Working knowledge of relational databases, database structures and database management systems required (SQL)
- Demonstrated process improvement, workflow, benchmarking and evaluation of business processes required
- Experience with Medicaid, encounters or other health plan operations preferred
- Health care experience preferred

Marketing and Community Outreach Director, Kim Manning

Position Overview

Marketing and community outreach director Kim Manning oversees and directs staff who act as community ambassadors from UnitedHealthcare. She directs her staff to work with communities, assigned regions, service areas and urban areas to foster healthy partnerships and relationships while building brand awareness.

Responsibilities:

- Identifies key health issues and concerns as well as community-based programmatic successes within service areas/regions
- Develops opportunities for collaboration with community-based organizations, faith-based organizations, community leaders and advocates, schools and senior centers
- Meets with community-based leaders to gather health-related data; identifies health concerns within a community or region of the state, and develops and maintains collaborative relationships and partnerships
- Provides expertise regarding an assigned region or territory to assist with marketing and product development
- Develops, coordinates and manages large community events such as health fairs and community-related events
- Trains all health plan staff as state-designated certified marketing guidelines subject matter experts to confirm contractual compliance

Qualifications:

- Bachelor's degree or equivalent experience

- Four years of marketing experience
- Four years of demonstrated skills for organizing events and managing workload
- Project management experience preferred
- Experience influencing at many organizational levels, internally and externally

Tribal Network Liaison, Kim Manning

Position Overview

Tribal network liaison Kim Manning will be instrumental in building partnerships, bridging communication and offering effective solutions. Her solutions will address the many ways we can improve member health outcomes and best practices through a trauma-informed, culturally appropriate care delivery system for Native Americans statewide. Ms. Manning interfaces with UnitedHealthcare's Office of Native American Affairs to continue its focus on Native American initiatives and health care programming across the state. She will provide consultation, technical assistance, education and outreach to key stakeholders involved in the development of medical and behavioral care systems for Native Americans. A key accountability of her role is to guide providers and UnitedHealthcare to continually improve the integration of care.

Responsibilities:

- Works with local community providers to develop and facilitate health services that are culturally responsive and holistic and that promote respect for mind/body/spiritual healing
- Collaborates with health providers, patient-centered medical homes, BH homes and other stakeholders (e.g., tribal social services, Bureau of Indian Affairs and state tribal liaisons) to link and support service delivery
- Advocates for American Indian members with case management and member services staff
- Works with our national network team and the local Nebraska provider services team to address provider adequacy in rural and frontier areas
- Serves as the single interface for integrated clinical care (e.g., physical and BH), prevention, education, training and support services such as care coordination, case management, peer and family support, claims and billing and clinical consultation
- Promotes our efforts to reduce suicide and substance abuse in Nebraska's Native American communities through partnership with providers, local resources and our integrated care staff
- Participates on Native American Advisory Boards to address issues concerning operations, services delivered and quality of all covered services, member rights and responsibilities, the resolution of member grievances and appeals, and claims processing and reimbursement issues

Qualifications:

- Bachelor's degree in business or health care
- Minimum of 10 years of health care experience; minimum of three years of experience working in Medicaid or Medicare programs with a focus on the unique issues related to Native American communities
- Proven track record of designing, developing and managing programs to improve outcomes and build stakeholder relationships
- Competency in developing community relations with appreciation of cultural diversity and sensitivity toward target populations

- Ability to interpret and use financial and utilization analysis reports to develop clinical and network performance optimization plans

Pharmacist/Pharmacy Director, Jeanne Cavanaugh, Pharm.D.

Position Overview

Pharmacist/pharmacy director Jeanne Cavanaugh, Pharm.D. has overall responsibility for instituting and coordinating all components of the pharmacy program for the Heritage Health initiative. Her responsibility includes formulary development and consultation, drug rebates, drug UM activities, member and pharmacy issue-resolution management, pharmacy network support, adherence to health plan policies and procedures and regulatory requirements, assisting with integrated care activities, and attendance at all relevant meetings with health plan and external meetings.

Responsibilities:

- Institutes and coordinates management of the pharmacy program benefit, working with local leadership and regional/national pharmacy teams, including our pharmacy benefit manager (PBM)
- Attends MLTC's P&T Committee and Drug Utilization Review (DUR) Commission meetings
- Coordinates with clinical teams (including BH) for an interdisciplinary approach to health care delivery, quality and management of care
- Assures all contractual and regulatory requirements are met for the health plan's pharmacy benefit programs
- Manages high-cost specialty drug use, helps coordinate and manage the pharmacy portion of care for chronic/high-risk/high-cost members

Qualifications:

- Bachelor of Science degree or Pharm.D. in pharmacy from an accredited college or university required; master's degree preferred
- Nebraska-licensed pharmacist with at least five years of experience in pharmacy (any setting)
- Experience in pharmacy managed care or pharmacy UM preferred
- Expertise in pharmacy coding, claims and reimbursement, medication management and formulary development preferred

19. Describe how the MCO's administrative structure and practices will support the integration of the delivery of physical health, behavioral health, and pharmacy services. *4 pages*

Administrative Structure that Supports Integration of Health Care Delivery

UnitedHealthcare of the Midlands was authorized to do business in Nebraska in 1984 and has been serving Medicaid members with a local Nebraska team since 1996. We believe in the local management and delivery of health care services. We will continue to create and enhance our administrative structure and practices based upon MLTC's expected outcomes for the integration of physical and BH managed care to serve Heritage Health members. Our CEO Kathleen Mallat has ultimate authority for the local administrative structure and practices that will support the integration and delivery of physical health, BH and pharmacy services.

Today, UnitedHealth Group serves more than 425,000 Nebraskans. We know Nebraska, and we have more than 270 Nebraska employees and three offices in the state. We are committed to growing our current presence with integrated and comprehensive services that include additional local field-based staff, clinical staff, local provider and member services call center and shared services. Our organizational structure will integrate physical health, BH and pharmacy to fully meet the needs of Heritage Health members. Our service in Nebraska reflects our cultural values of integrity, compassion, relationships, innovation and performance.

Our organizational structure is specifically designed to meet the integrated physical, BH and pharmacy needs of the Heritage Health population, serving low-income and special health care needs populations. Ms. Mallatt and the leadership team work collaboratively to align our integrated delivery strategies, human resources, health information technology (HIT) and reimbursement policies to achieve the MLTC's objectives of improved health outcomes, enhanced integration of services and quality of care with an emphasis on person-centered care, reduced rate of costly and avoidable care, and an improved financial sustainability. Administrative operations; health services delivery including quality, program integrity and compliance; marketing and community outreach; and finance and actuarial are specialized teams dedicated to Nebraska, managed by local key staff as follows.

- ***Operations:*** COO Sean Jones, a licensed professional and substance abuse counselor, leads the integrated operations team. He addresses the needs of our members and providers along the entire operations continuum. Mr. Jones has oversight for member enrollment, contracting, network adequacy, benefit and contract setup, claims processing timeliness and accuracy, encounters accuracy and completeness, member and provider call operations, information systems, value-based contracting and PCMH development, and subcontractor delegation and oversight.
- ***Health Services Delivery:*** Key leadership for physical, BH and pharmacy is integrated under medical director/CMO Michael Horn, M.D., with our BH clinical director Charles Freed, M.D.; pharmacy director Jeanne Cavanaugh, Pharm.D.; case management administrator Barbara Palmer, RN, MHA; and medical management coordinator Dr. Timothy Mergens. Together they provide daily oversight of health services, including risk stratification, care coordination, UM, prior authorization and case management. We also include quality management, performance and quality improvement and maternal and child health/EPSDT, led by Cyndi Margritz, RN, BSN, in this functional area.
- ***Program Integrity and Compliance:*** Mr. Langdon leads the program integrity and contract compliance team. He oversees program integrity and contract compliance-related activities for integrated services. This includes compliance with state and federal rules and regulations, preventing and detecting fraud, coordinating with the special investigations unit and

communicating with MLTC's Program Integrity Unit and the Medicaid Fraud and Patient Abuse Unit (MFPAU) of the Attorney General's Office, coordinating implementation of contract requirements, tracking and submission of contract deliverables and coordination of audits.

- ***Marketing and Community Outreach:*** The marketing and community outreach team is led by Kim Manning and supports health services delivery and member services to offer current, actionable information regarding community resources that address the psychosocial needs of our members, facilitating the delivery of person-centered care. This is accomplished by active statewide outreach, organizing and delivering on-site staff training from community organizations, promoting and participating in local community events, providing updates to *Healthify*—our Web-based social resource tool that helps our staff connect members to more than 2,800 local and available community resources. Ms. Manning is also responsible for all integrated member materials such as the *Member Handbook.*
- ***Finance and Actuarial:*** CFO Jim Elliston leads this area. He oversees the financial-related activities including audit, internal control, accounting, financial analysis, budgeting, revenue management, medical cost analysis, financial reporting, and administrative efficiency to meet the MLTC goals of financial compliance and improving financial sustainability of the system.

Principles and Practices that Support Integration

We follow the overarching principles and practices of integrated health care services across our organization and have a structure in place that efficiently administers these services as follows:

- Integrated, co-located organizational structure for physical, behavioral and pharmacy in Nebraska
- Clear and distinct accountabilities for Heritage Health members, led by Michael Horn, M.D.
- Single call center for member and provider services located in Nebraska
- Statewide provider relations team makes certain that contracts for providers and subcontractors are integrated; subcontractor oversight is combined under one operation leader, Mr. Jones
- Integrated systems and technology support is provided through common platforms for physical health, BH and pharmacy
- For special needs members, such as members who are in foster care or receiving LTSS services, a navigator team develops an integrated, person-centered plan of care inclusive of the member's physical health, BH and pharmacy needs while collaborating with other state-directed care
- UM considers all aspects of a member's needs

Our integrated approach enables us to improve health outcomes and financial sustainability for the system. Further, our care models align members with providers who deliver whole-person, culturally sensitive, person-centered care and validate that appropriate care is provided at each step along the continuum. Our network development plan meets or exceeds MLTC requirements for both network access and managed care benefit coverage. Steps in determining the adequacy of the provider network include analysis of the members to be served in each county, estimating the number of providers needed to all members, type of health care services needed, travel standards, cultural characteristics, normal health care delivery patterns and other region-specific needs/requirements. For all health plan functions, our leaders review the reports provided by functional areas to evaluate service delivery and seek operational efficiencies. We hold regularly scheduled business reviews, JOCs or similar endeavors and forums with leaders from teams or departments and other key personnel. In the business reviews, we evaluate performance targets and results to formulate operational improvements plans, gauge progress on current plans and discuss additional relevant topics. We welcome working with MLTC to take a similar oversight

approach for quarterly business reviews (QBRs) and to establish a meaningful scorecard for measuring performance.

Experience Designing Administrative Structures to Support Integration

When expanding services to new populations in a market such as Nebraska where we have existing operations, we draw on the experience of our local health plans and build on our local experience with insight and assistance from our national experience, including other states that serve the same populations we will be serving. We have a proven record of accomplishment of successfully implementing integrated health care approaches in states similar in size and scope to Heritage Health such as:

- ***Kansas:*** Through the KanCare Managed Care program, we provide comprehensive care for individuals enrolled in TANF, CHIP, ABD, pharmacy, BH and LTSS programs.
- ***New Mexico:*** New Mexico transitioned to an integrated model of care under its new Centennial Care Program Jan. 1, 2014. Through this program, we support the needs of Centennial Care members through an integrated care model offering specialized and routine BH services and pharmacy.
- ***Tennessee:*** As part of a comprehensive Medicaid managed care contract in Tennessee, we deliver integrated services statewide covering more than 471,000 members. TennCare Medicaid provides services to all mandatory Medicaid eligibility groups and some categorically and medically needy voluntary groups, including children, pregnant women, the aged and persons with disabilities.

Linking Major Operational Areas to Drive Integration

Nationally, we are a leader in comprehensive, integrated managed care information systems deployment. Led by our information management and systems director, Cybele Kanin, we integrate disparate technologies and data sources within the functional areas to:

- Present the care team with timely, relevant and actionable information about the member and her/his interactions with the health care system
- Present the claims processing, member services and provider services teams with efficient systems to meet and exceed operations performance requirements
- Provide HIT capabilities to support payment reform and real-time clinical data sharing among providers and payers in support of CMS-defined integrated care models
- Provide our local team with a solution for health plan administration and a targeted, data-driven financial and operational analysis to optimize performance as our programs evolve

Community Strategic Platform

Our FACETS Community Strategic Platform (CSP) is our comprehensive, cohesive technology suite that pairs industry-leading FACETS software and innovative, internally developed components to meet the unique requirements of the populations we serve. CSP has been fully implemented in Nebraska since September 2013 and is the heart of our architecture with interfaces that optimize the exchange of information to other key systems. For example, CSP provides the source data for applications including our UM system, Integrated Clinical User Experience (ICUE), our encounter data submission system, National Encounter Management Information System (NEMIS) and CommunityCare, our HIPAA-compliant integrated coordinated care platform. Our systems are fully interoperable and fluidly exchange information, allowing us to adapt to support current and future Nebraska requirements. We have long maintained an integrated managed care information system that meets the requirements of the MLTC. We

continually evaluate new technological innovations, as we believe they are vital to optimize performance as programs evolve.

CommunityCare

CommunityCare integrates a member's acute care, preventive care, chronic disease management, medical, behavioral and social needs into a comprehensive electronic record. CommunityCare integrates evidence-based medicine gaps in care and hospital admission, discharge and transfer (ADT) messaging and allows providers to input information about interactions with members such as post-ER discharge follow-up and care opportunity outreach. In addition, CommunityCare enables care collaboration by allowing providers, members and caregivers to share access to patients' plans of care.

Health Information Exchange

The use of the health information exchange (HIE) can also aid in the integration of health care services such as the care coordination process. In particular, obtaining real-time hospital, ER and inpatient data are essential for timely notifications and effective care transitions. We have worked with other HIEs nationally to establish MCO data-sharing policies, practices and use cases for improving care coordination using EHR exchange among practices, the HIE and the health plans. We are currently exploring the capabilities of NeHII to meet the need for data exchange elements that are essential to care coordination.

Access to Link

All Nebraska network providers have access to Link, our enhanced, secure provider portal and dashboard that relies on cloud-based technology. Link is supplemented by our public website, *uhccommunityplan.com*, and supported by applications and tools, such as our secure provider portal *unitedhealthcareonline.com*. Together, our provider-based online sites and tools enable health care professionals to connect and collaborate in easily accessible ways that improve the cost structure and quality of their practices.

- This new tool embodies all the best features for electronic submission, decision-making and tracking of prior authorization
- On Link, our Eligibility and Benefits tool eliminates the need for many calls by giving providers greater flexibility in member search features
- This tool also includes our authorization and claims payment systems, streamlining processes for prior authorization requests

In summary, we are committed to continuing our strong local presence and committed to delivering high-quality integrated services to our members, providers, communities and MLTC. We have built a comprehensive staffing plan based upon our experience integrating the delivery of services, developed a strong administrative structure and practices for executing on the requirements and offer comprehensive, managed care information systems to integrate disparate technologies and data sources.

20. Describe how the MCO will train staff on issues that affect its members, including: issues related to housing, education, food, physical and sexual abuse, violence, food security; behavioral health risk and protective factors; finding community resources and making referrals to these agencies and other programs; and meeting the needs of the LTSS population, including individuals with developmental disabilities and mental health concerns. *6 pages*

Overview

We have a multifaceted, innovative strategy for helping our staff understand the populations we serve and the integration of the social determinants of health in our care management strategy. Our objective is to understand and prevent social barriers to care by constantly seeking out and becoming knowledgeable about the unique needs of the populations we serve and the available resources, subsequently creating clear paths between those resources and our members.

Broadly, our strategy is for our staff to understand the social barriers to care and include in-house education presented by local advocacy groups and participating in outreach to learn as much as possible about what our members need. An example of in-house education includes Lunch N Learn programs presented by local advocacy groups and national experts. Outreach includes a variety of visits to, for example, our homeless population, special needs members, tribal leadership and foster care members to identify their specific needs and learn how to refer them to services. These visits are documented and key learnings are shared in meetings such as weekly leadership team meetings, monthly all-team meetings and our Clinical and Provider Advisory Committee (CPAC).

Comprehensive Training Program

We recognize that staff who impact members' care either directly or indirectly must have the requisite knowledge and skills to meet the diverse and unique needs of our members across a spectrum of services and supports, including type of specialty services and level of intensity. Existing and new staff will be trained through a tiered approach using classroom instruction, Web-based tutorials, role-playing, shadowing of senior staff and on-the-job training. We also will develop numerous on-the-job tools such as standardized checklists and screening and assessment tools to assist care coordinators and other staff while they are in the field.

General and Clinical Training

The following Table IV.D-2 General and Clinical Training is a description of our robust, multifaceted training program that we tailor to the position and needs of the audience. For our clinical team, we require a three-week series of training modules followed by three to five weeks in the field with senior staff to align with member and caregiver market needs. This training includes access to a clinical reference library of information for additional or refresher information.

Table IV.D-2: General and Clinical Training Program-Related Training	Administrative-Related Training
Tier One – Orientation/Initial Core Training	
General ▪ Introduction to UnitedHealthcare, managed care and Heritage Health, including populations served, member benefits, covered and non-covered services, and coordination between systems (foster care, adoption support, education, juvenile justice) ▪ Continuity of care including member's ability to stay with existing in-network and out-of-network providers ▪ Collaborating with DHHS Divisions and other agencies	**General** ▪ State, federal and contractual requirements ▪ Introduction to our local health plan departments including member services; NurseLine; provider relations; utilization, care, medical and quality management; and information technology ▪ *Member Handbook*, *Provider Directory*, *Provider Administrative Guide*, *Healthify*, Web-based member and provider portals ▪ Pharmacy services including formulary, preferred

Table IV.D-2: General and Clinical Training

Program-Related Training	Administrative-Related Training
▪ Integrated model: care coordination, disease management, health home, patient-centered medical home ▪ Provider types including specialty, availability and accessibility ▪ Member demographics and at-risk conditions (e.g., neglect, physical or sexual abuse, parental substance abuse or mental illness and separation or loss associated with out-of-home care) ▪ Holistically assessing and engaging the member in maintaining or improving his/her lifestyle **Clinical** ▪ Carved-out services and collaboration with home and community-based services (HCBS) care managers ▪ Symptoms and treatment of medical and BH conditions in the foster care population ▪ Medication management and member medication adherence ▪ Transition support training to help youth transition from foster care to independence, including developing a transition plan, helping the member build a support network, and working with public and private community agencies to enhance available services and supports ▪ Person-centered planning, such as identifying the individual's specific nonmedical goals	drug list (PDL), and 72-hour supply requirements ▪ Care coordination processes including referral and reciprocal sharing of information ▪ Website availability for member/caregiver, transitioning youth and provider information ▪ Complaint and appeal processes including the role of the ombudsman team ▪ Provider reporting and incentive programs ▪ Provider claims, complaints and appeals ▪ Quality assurance and performance improvement ▪ Advisory groups and committees ▪ Available local and statewide resources, such as *Healthify* ▪ Vital timelines in the evaluation and delivery of services to members ▪ Cultural, linguistic, gender, sexual orientation or gender identity, socioeconomic, spiritual and disability diversity and sensitivity including Nebraska expectations ▪ Compliance including FWA ▪ Confidentiality and HIPAA ▪ Reciprocal sharing of information **Clinical** ▪ Integrated screening and assessment tools ▪ Utilization management (UM) guidelines, clinical practice guidelines and evidence-based practices ▪ Referral processes ▪ Authorization requests ▪ Access to and documentation in CommunityCare platform
Tier Two – Ongoing, Ad Hoc and Annual Training	
General ▪ State, federal and contractual requirements ▪ Member benefits/covered services changes ▪ Performance improvement initiatives ▪ Significant provider network changes ▪ Provider profiling and reporting ▪ Website changes ▪ Community resources updates ▪ Compliance including FWA ▪ Cultural, linguistic, gender, sexual orientation or gender identity, socioeconomic, spiritual and disability diversity and sensitivity including Nebraska expectations **Clinical** ▪ Program, policy and procedural changes such as changes related to care coordination, CommunityCare platform clinical practice guidelines and medication utilization review program	
Tier Three – Clinical Reference Library (Clinical-Specific Training)	
▪ Web-based job aids, presentations and quick reference guides ▪ Bulletins and newsletters regarding key processes or theories in care coordination	

Table IV.D-2: General and Clinical Training	
Program-Related Training	**Administrative-Related Training**
▪ In-person and webinar-driven training for program changes or process improvements ▪ Care coordination receives weekly training through supervision, team meeting and clinical rounds ▪ In-person monthly staff trainings and monthly bulletins communicated via email for all staff ▪ Reminders of key processes or theories in care coordination ▪ Latest research on best practices for supporting children in foster care and adoption support	

All Team Training

Additional trainings are offered to our local and national teams to gain an appreciation for the needs of those we serve in Nebraska, to learn about new services and to build the skills of our team. In 2015, national webinar trainings included: Understanding what is included in the I/DD Toolkit for Providers; a Healthcare and Housing training that included the series, Keys to Being a Good Partner, Identifying and Serving Those with Complex Needs; Supportive Housing; an Overview of Medicaid Populations we serve; and *Advocate4Me* serving the I/DD community (described below).

Advocate4Me Training

Our current *Advocate4Me* training covers the following topics:

- ***Active coaching on desired member interactions:*** Our *Advocate4Me* training includes active coaching on desired member interactions, such as using plain language to explain benefits, health care system and other information. We offer video examples of potential member "barriers" to giving that convey what members may be going through in addition to trying to understand their health and benefits.
- ***Conversation aids:*** Our training uses conversation aids in scenario-based training. They emphasize the importance of compassion in handling a member call and the content that will address the member's question together. In addition, they include how to address resistant statements made by members related to the health actions they are advised to take, and how to help members overcome those barriers, both real and perceived.
- ***Healthify:*** Our training offers instruction on how to leverage our *Healthify* tool, which enables advocates to locate and refer members to community organizations established specifically to meet underlying socio-economic challenges that may affect a member's health. Advocates also refer members to services using State-supplied websites.

Lunch N Learns

We have a long history of providing services to Nebraska Medicaid members and engaging local partners to educate our team on the challenges our members face. We know that to be truly person-centered, we need to understand the community services available to our members. Our training includes relationships with advocate groups and community-based organizations on the social determinants that affect specific populations.

We reach out to new local and national partners to present one-hour Lunch N Learn programs so our staff can connect Nebraska resources to the needs of the populations we serve. These trainings are available to our local, regional and national teams serving our Heritage Health members, regardless of location. For example, we held a Lunch N Learn program presented by the Nebraska Urban Indian Health Coalition, Inc. & Indian Center, Inc., called "Soaring over Meth and Suicide Prevention Program." In Nebraska and other states, Native American youth suicide is at an epidemic level. We are developing a program whereby we sponsor tribes to expand and enhance their programming around suicide issues. One of our

community outreach specialists is involved in a coalition whose mission is to develop youth suicide-prevention programs. In March 2016, we will begin staff and provider education on supporting individuals with I/DD, offering training modules to facilitate the integration of physical, BH and cultural competence training. This will allow us to bring additional resources to providers. In 2016, we will increase the frequency of internal cultural learning opportunities to address physical health, BH and co-occurring conditions. This approach fosters a trusting relationship among the member and caregivers. For example, we would like to receive a cultural understanding of the Native American's unique cultural, health and spiritual healing briefs and the support for the elders. We also have talked with NAMI Nebraska and the Nebraska Family Support Network about inviting volunteers to present their perspective on individuals and families who receive treatment. We also draw on the resources of our national team and our other Medicaid plan leaders in other States. Recently, members of the health plan traveled to Niobrara to visit with the Santee Sioux, Winnebago, Ponca and Omaha Tribal Clinic's billing managers. With the desire to be culturally sensitive, the team contacted Carolyn Morris, Ph.D., director of Government Affairs, UnitedHealthcare Office of Native American Affairs, before attending the meeting to gain a better appreciation for the customs and cultural awareness and to understand communication styles.

The following Table IV.D-3 outlines our local Lunch N Learn offerings to clinical and nonclinical staff in 2015 alone. Requests made to community organizations and state or local agencies to present have been well received and, as a result, we are increasing the number of presentations.

Table IV.D-3

Presentation Date	Organization	Topic(s) Covered	Social Determinant(s)
May 13, 2015	Together	▪ Food Pantry ▪ Specialized Counselors on Staff ▪ Sustainability through on-site Garden ▪ Client Access to Computer Lab	▪ Homelessness Prevention ▪ Food and Financial Insecurity ▪ Transportation Needs ▪ Documentation Needs
June 15, 2015	Heart Ministry Center	▪ Food Pantry ▪ Clothing Closet ▪ Free Medical and Dental Care Programs ▪ Social Workers and Case Management ▪ Job Training and Self-Sufficiency Programs	▪ Homelessness Prevention ▪ Food and Clothing Insecurity ▪ Job Loss and Training
July 27, 2015	Nebraska Urban Indian Health Coalition, Inc. & Indian Center, Inc.	▪ Session centered on "Soaring Over Meth and Suicide" Prevention Program ▪ Issues around youth suicide	▪ Behavioral Health Needs ▪ Homelessness ▪ Community Outreach
Sept. 15, 2015	Partnership4Kids	▪ Goal Setting and Group Mentoring Program for underserved students ▪ Creating foundations for success from kindergarten to careers	Underserved youth lack of role models or structure in home environment or setting

Table IV.D-3			
Presentation Date	**Organization**	**Topic(s) Covered**	**Social Determinant(s)**
Oct. 21, 2015	Parent Training Information (PTI) Nebraska	Nebraska statewide resources for families of children with disabilities or special health care needs	Families of I/DD or Special Needs Children are faced with many challenges in today's world
Nov. 19, 2015	Brain Injury Association of Nebraska	▪ Advocate for the welfare, rights and dignity of individuals who have experienced a brain injury ▪ Supportive ongoing training about brain injuries for individuals ▪ Promote all phases of brain injury research	▪ Brain injury prevention, education, advocacy and support ▪ Lack of community awareness
Dec. 16, 2015	Special Olympics Nebraska	▪ Overview of the Special Olympics programs, including Health Athlete Screening, Project Unify, Athlete Leadership Program and Healthy Habits	▪ Intellectual disabilities understanding ▪ Need for volunteer coaches and mentors

Outreach to Specific Populations and Special Programs

The second component of our strategy for training staff on programs addressing social determinants of health is our consistent and targeted outreach and special programs for the populations we serve, including homeless, foster care and BH members. The learnings from these visits are shared with our leadership team at employee meetings and with various committees. These learnings are essential to helping us develop our annual goals and strategy to better serve our members. We have also shared the following learnings with MLTC during our monthly MCO meetings.

Visits to Homeless Shelters

In 2015, we conducted 15 visits to homeless shelters to learn about homeless issues and, how we can reach this population with services. We have a national relationship with the Corporation for Supportive Housing (CSH) and we are developing strategic partnerships with local housing resources in many states to support cities and organizations working to end chronic homelessness. CSH has worked with UnitedHealthcare over the past two years creating Lunch N Learn trainings for staff focused on education around housing, supportive housing and homelessness services. More than 1,000 employees across UnitedHealthcare have already accessed that training, and Nebraska staff will have access through LearnSource, our national Web-based training library.

Foster Children Aging Out

We actively participate with foster care children through a new initiative for us—educating foster parents and helping teens who are "aging out." The app tool for these teens is called "On MyWay." One of our local outreach staff is a foster parent and has connected us to foster care programs throughout the state to learn about their needs and to refer members to services. We also provide backpacks for children to store their belongings as they are placed with a new foster family. We will introduce the app to our clinical and nonclinical staff.

Project Harmony

Project Harmony is a new MCO initiative and provides effective, immediate and sensitive support to children who are victims or suspected victims of abuse and neglect and their non-offending family members. Our work with Project Harmony grew out of a conversation with State Senator Kathy Campbell and information she shared during a visit. A child-centered facility, Project Harmony assembles a multidisciplinary team comprising law enforcement, investigative, social service, medical and referral professionals dedicated to protecting children and prosecuting offenders. Project Harmony enhances the communication among professionals by co-housing in one facility Project Harmony, the Omaha Police Department-Child Victim/Sexual Assault Unit, and Nebraska Health and Human Services-Child Protection Services. Barbara Palmer, RN MHA, case management administrator, has been attending the Connections meetings that address the needs of children with chronic medical needs.

Project Search

Project Search is a high school transition program that provides training and education intended to lead to employment for individuals with disabilities. This program is an ongoing learning opportunity for the health plan that includes support for the Business Email Mentor Program for Project Search students. Students compose a business email that is sent to the business professional mentor to read and compose a response. From this volunteer opportunity, our staff gains valuable insight into how best to communicate by email with I/DD individuals so these individuals gain experience composing business emails.

Finding Community Resources and Making Referrals

As Figure IV.D-3 shows, our staff uses *Healthify,* a social resource Web-based tool that helps our care managers, navigators, community health workers (CHWs), member services and community outreach staff connect members to more than 2,800 local community resources in seconds. These services include, but are not limited to food, housing, employment, education, support groups, transportation, child care and clothing. *Healthify* also tracks the services our members need. The chart at right shows by percentage the types of services our teams search for to assist our members; housing and food in particular continue to be a high priority for those we serve. *Healthify* is accessible through any device that can connect to the Internet. As such, staff that interact with members in the field can access *Healthify* with their smartphones. New staff receiving access to *Healthify* also receives initial training on the tool together with an outline of best practices. Webinar training is offered weekly and describes searching, filtering, and how to edit and add resources. This training is an opportunity for new staff to become familiar with *Healthify* and ask questions so we can be the best resource possible toward connecting our members with the social and BH services they need. To make certain our staff provide accurate information, *Healthify* has teamed with a call center that validates all site information and routinely performs re-verification checks so user edits, additions and site changes are accurately displayed. Our staff uses the *Healthify* tool with confidence as they refer our members to services in the community.

Figure IV.D-3. UnitedHealthcare staff use the *Healthify* tool to track the types of services our teams search for to assist our members.

In summary, we learn about our populations in Nebraska several ways: Lunch N Learn programs, outreach, training and through our *Healthify* tool, that connects members to services. Taken together, this multifaceted approach helps us understand our members' needs and, as a result, means we can focus on the right areas to provide the best service to those who need it most.

21. Describe how the MCO will coordinate with the MLTC Dental Benefits Manager, including processes for reciprocal referral for needed services. Include the MCO's plan to identify a dental services liaison. *2 pages*

Coordinating with the MLTC Dental Benefits Manager

We have experience coordinating carved-out dental services in Nebraska. Barbara Palmer, RN, MHA, case management administrator, serves as our dental services liaison. As staff positions are filled for Heritage Health, Ms. Palmer will transition this responsibility to a leader on her team. Ms. Palmer currently works with the member's PCP to coordinate the delivery of carved-out dental services to members in a timely manner, particularly for medically necessary dental services identified during routine EPSDT dental screenings. We have established policies and procedures to coordinate the delivery of core benefits and services and we will include coordination with the MLTC dental benefits manager.

Integration and coordination of physical and oral health services is a priority because of the connection between medical and dental health. Our experience shows access to dental services reduces the incidence and treatment costs of a variety of diseases and conditions. We will provide educational information for PCPs in our *Provider Administrative Guide*, reinforcing the importance of timely dental services for children and promoting integration of primary care and dental services. Per EPSDT, we expect and encourage PCPs to provide certain dental procedures (e.g., application of dental varnishes) in a primary care setting. PCPs work closely with members, CHWs, navigators and care managers to educate members and families about dental hygiene and access available preventive dental care services. Our case manager navigator or CHW works with the member, PCP, as needed, and the Nebraska Medicaid dental benefits manager staff to coordinate the member's needed dental services. To coordinate dental benefits with MLTC's Medicaid dental benefits manager, we will:

- Establish and maintain formal processes to identify members needing referrals to dental services
- Assist PCPs, the dental benefit program manager and members with the dental coordination referral process
- Share relevant clinical information with the MLTC dental benefits manager (with member consent)
- Further establish a relationship with the Nebraska Dental Association and key dental leaders across the State to facilitate services and share relevant and timely information
- Incorporate input from dental professionals on the plan of care, including monitoring care and health outcomes; invite these professionals to participate in joint case rounds and consult on medication management, and request their input on strategies for promoting member engagement in care and positive behaviors, particularly for members with periodontal disease and are pregnant or have chronic conditions

Reciprocal Referrals Enhance Health Outcomes

We use the following process for reciprocal referral for needed services:

- Members call us to request information on dental benefits
- Our member services advocate or care manager helps the member find a participating MLTC dentist, addresses transportation needs and helps schedule a dental appointment if needed
- Case management administrator Barbara Palmer, RN MHA, or Michael Horn, M.D., assist for special health care needs such as arranging for anesthesia
- If a dentist or the MLTC dental benefits manager identifies the need for physician services, our dental services liaison is available to coordinate services with the member's PCP or a specialist

We identify members who need dental services through the following methods:

- Health Status Assessments
- Member, family and PCP or pediatrician referrals
- Claims data (e.g., using the ER for dental emergencies)
- Admission, discharge and transfer (ADT)/hospital data
- Universal Tracking Database (UTD) reports of gaps in care (e.g., the case manager reviews gaps in care and takes the steps necessary to close gaps related to dental care)

For members participating in the care management program, the member's care navigator or a CHW serving on the member's interdisciplinary care team provide referrals and other assistance to connect members to the MLTC dental benefit program and dental resources available in the community. This is accomplished under the direction of Ms. Palmer. Information and assistance for all members is available from member services staff, in the *Member Handbook* or via our member portal (*myuhc.com*).

In addition to our process, we offer the following training and outreach:

- Training for PCPs on dental-related HEDIS measures, the availability of covered dental services for the EPSDT-eligible members and how to refer members to the MLTC Medicaid dental benefits manager for identified dental needs
- Criteria and processes for reciprocal referrals between UnitedHealthcare and the MLTC Medicaid dental benefits manager, including cross-training of respective staffs on referral processes
- Education and information for members and providers targeting specific chronic conditions, the importance of preventive oral health, and the warning signs of oral health problems exacerbating chronic conditions; for example:
  - We encourage PCPs to refer pregnant members and members with diabetes or other chronic conditions to dental services. CHWs can link members to community-based services
  - Because of the link between periodontal disease and early newborn deliveries for pregnant women, our Healthy First Steps case managers encourage pregnant women to seek dental care and refer them to community-based dental services, as appropriate
  - We encourage PCPs, including pediatricians to follow the American Academy of Pediatrics (AAP) Periodicity Schedule and refer the child's parent to a dentist to begin dental preventive checkups and preventive treatments at age 1
- UnitedHealthcare will be collaborating with Charles Drew Health Center and OneWorld Community Health Centers on dental health fairs at schools, community organizations and Head Start sites. Care given on the dental mobile unit will help reduce dental caries and improve overall dental health, which can be directly linked to good health and school success

Our approach to integrate and coordinate physical and oral health services to serve Nebraska is a proven process that identifies members who need dental services, then applying our experience coordinating carved-out dental services in Nebraska to offer education and connect those members to the MLTC dental benefit program and other resources. Our highly qualified clinical team and proven referral process means our Heritage Health members will benefit from a reduction in the incidence and treatment costs of a variety of diseases and conditions.

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IV.E. Covered Services and Benefits

22. Provide the MCO's definition of medical necessity. Describe the process for developing and periodically reviewing and revising the definition. Describe the degree to which the definition is consistent with or differs from MLTC's definition of medically necessity per 471 NAC 1-002.02A. *3 pages*

Medical Necessity Definition

For nearly 20 years, we have supported our clinicians and providers in using sound clinical judgment in applying our medical necessity definition and clinical practice guidelines to our members' individual needs and conditions including consideration of the member's social determinants. Our established clinical care and utilization management processes, policies and procedures ensure every member receives the most appropriate physical and behavioral health (BH) services, supports, medications and supplies for his/her condition at the right time and in the right amount and environment. Led by our medical director/CMO, Dr. Horn, we have built our Nebraska Medicaid program on our medical necessity definition for physical and BH services, supports and medications based upon 471 NAC 1-002.02A as follows:

- Medically appropriate
- Necessary to meet the basic health needs of the member
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the client or his/her physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency
- Of demonstrated value
- No more intensive level of service than can be safely provided

We have ensured our medical necessity definition is aligned with MLTC's definition and reflective of the needs of our members' in Nebraska. We accomplish this by broadening our clinical practice guidelines (CPGs) and clinical and utilization management (UM) processes including prior authorization (PA) policies and procedures for physical health, BH and pharmacy services in alignment with nationally recognized best practices.

Process for Developing, Reviewing and Revising the Definition

Since developing our initial medical necessity definition in collaboration with our MLTC partners, we have continually reviewed and revised the definition to ensure it remains accurate, relevant and provides the best foundation for overseeing the care of our members. Dr. Horn and our multidisciplinary clinical team review and update our medical necessity definition annually and upon federal and state changes. In addition, our clinical team conducts ongoing review for utilization trends and issues that may support changes to our medical necessity definition and CPGs through the following types of activities:

- Analyzing and comparing current and historical UM data such as ER use, PA, concurrent review and retrospective review data

- Monitoring appeals decisions to make sure overturned decisions are factored into any revisions to our medical necessity definition as well as to identify any provider or health plan staff training opportunities
- Considering feedback from members through our Member Advisory Committee, grievances and appeals processes and member satisfaction surveys
- Researching clinical studies from nationally recognized sources such as the American Medical Association, American Psychiatric Association and National Community Pharmacist Association
- Considering feedback from members through our Member Advisory Committee, grievances and appeals processes and member satisfaction surveys
- Evaluating local practices to identify Nebraska-specific best practices

Recommendations for changes and/or updates to our medical necessity definition are presented to our Quality Assurance and Performance Improvement Committee (QAPIC) and our Healthcare Quality and Utilization Management Committee (HQUM) for review and approval. Our UM Program Description includes criteria and procedures for evaluating our medical necessity definition which is submitted to MLTC for written approval on an annual basis.

Education and Training on Medical Necessity

We recognize the key to understanding medical necessity lies in education and training. We have provided education on medical necessity to more than 425,000 members in Nebraska including 60,000 members who receive their health care through Medicaid, 6,411 medical and specialty providers, 1,233 BH providers and our Nebraska employees this year alone. We ensure our members, providers and employees receive and understand our medical necessity definition, clinical criteria and guidelines, care management and UM processes including PA through the following:

- ***Members.*** Our members receive information on medical necessity upon enrollment and subsequently through a variety of means available to them in the language of their choice. This includes our welcome packet that includes our *Member Handbook,* which is also available through our secure member website, *myuhc.com*. Members obtain information through their providers and can contact us directly through our member call center, *Advocate4Me,* and NurseLine that is available 24 hours a day, seven days a week. Our care managers, care navigators and community health workers (CHWs) also provide information on medical necessity to members, through frequent interactions with members in the community. We notify our members of updates and revisions as they occur through *Member Handbook* updates at *myuhc.com* and in newsletters and targeted mailings.
- ***Providers.*** We know that our providers spend more face-to-face time with our members and have the greatest opportunity to provide information and support to assure our members access the health care they need. As a result, we make sure our providers receive information on and understand medical necessity through our initial, ongoing, ad hoc and annual trainings through written materials, Web-based forums, town halls and face-to-face interactions as needed. This includes, but is not limited to, our *Provider Administrative Guide*, *Behavioral Health Toolkit* and *I/DD Toolkit* located on our secure provider portal and dashboard, *Link*—our provider-based online sites and tools that allows our providers easy access to our medical necessity definition and clinical criteria during the PA process. We distribute updates and revisions on *Link* and in our provider newsletter, *Practice Matters*, as well as through fax blasts and secure emails to

participating providers at least annually, upon changes and to non-participating providers upon request.

- ***Health Plan Staff.*** We maintain a multifaceted UM training program that assures our clinical staff understands our medical necessity definition and has the expertise and knowledge necessary to review services that require prior authorization while consistently applying clinical criteria. Our dedicated trainers, in collaboration with experienced UM clinicians, train all new and current clinical staff on medical necessity using classroom, Web-based, role-playing and person-centered techniques. As seen in Table IV.E-1 below, we also assure appropriate decision-making that adheres to medical necessity through our:

Table IV.E-1

Resource	Description
Utilization Management System	Our UM system includes an automated tasking and reminder system that supports our UM clinicians through the authorization process. For example, our clinicians are required to open tasks that follow our CPGs during the review and if those tasks are not closed during the process, an alert is sent to the clinician's supervisor for assistance in completing the authorization and additional intervention such as coaching, additional training and load balancing.
Inter-Rater Reliability (IRR) Reviews	Our IRR reviews compare decisions among our UM clinicians for similar cases and then uses statistical measures to assess consistency and identify potential sources of inconsistency. Upon completion of the assessment, the results are reviewed by management and are reported to our HQUM committee for process revision consideration and/or corrective action, as indicated. IRR reviews are completed annually on all UM staff and on an ad hoc basis as concerns, trends or inconsistencies are identified.
Retrospective Audit	Clinical auditors review records from clinician and physician reviewer caseloads using a standardized tool that evaluates appropriate documentation of the review and demonstration of adherence to medical necessity, CPGs and required time frames. Audit thresholds are 95 percent and individual audit results are provided to each clinician reviewer and his/her supervisor. For those clinicians falling below our established threshold, a remediation plan is put in place including additional training on policies and procedures, guidelines and application of criteria. We also use these results to outreach our providers for learning opportunities related to inappropriate PA requests.

We communicate medical necessity definition updates to our health plan staff using various means of communication through our intranet including webcasts, online learning modules and other learning methods.

Consistency with MLTC's Definition of Medical Necessity

UnitedHealthcare's definition of medical necessity is consistent with MLTC's definition of medical necessity and 471 NAC 1-002.02A. Our definition is at the core of our clinical and utilization processes that are flexible to the individual needs of our members by ensuring they receive the most appropriate care for their conditions. We will assure our definition continues to align with the MLTC definition and meets the needs of our members in the Heritage Health program in a respectful and supportive way by making sure our members, providers and health plan staff understand the definition and how it is consistently applied through our education and outreach activities.

23. Provide a description of the value added services the MCO proposes to offer to members. For each service:

Define and describe the service.

Identify the category or group of members eligible to receive the service if it is not appropriate for all members.

Note any limitations or restrictions that apply to the service.

Identify the types of providers responsible for providing the service.

Propose how and when members and providers will be notified of the service's availability.

Describe how a member may obtain/access the service.

Describe how the MCO will identify the expanded benefit in administrative or encounter data.

As an organization that has provided Medicaid services to Nebraskans since 1996; and is dedicated to *helping members live healthier lives*, we share MLTC's vision of Heritage Health. As we have done for decades, we continue to look for ways to innovate our value-added services to help Nebraskans foster a heritage of health.

Our priority is to help bring about the change necessary to make Nebraska the healthiest state in the country. We want to work with members to inspire a healthier lifestyle and to affect permanent, positive changes to their overall physical, emotional and BH. The following expanded services and benefits align with MLTC's goals through the following value-added services:

Providing Medically Appropriate and Cost-Effective Services to Reduce ER Visits:

- UnitedHealthcare myMoney Connect™
- myWork Connect
- Adult Flu Shots
- Adult Physicals
- Waived Copayments
- myCommunity Connect
- Asthma Care Program Pilot
- Adult Male Circumcisions
- Peer Support Program

Improving Birth Outcomes:

- myMoney Connect
- Baby Blocks
- myCommunity Connect
- Member Baby Showers

Improving Outcomes through Coordination and Integration of Physical and BH Services:

- myMoney Connect
- myWork Connect
- Waived Copayments
- myCommunity Connect
- Peer Support Program
- KidsHealth Online Support Center

Added Incentives for Caregivers and Members with complex or special needs Populations:

- Special Needs Planning Guide
- Wandering and Elopement Benefit

Providing Medically Appropriate and Cost-Effective Services

Our approach to reducing costly and unavoidable care begins with wellness incentives and benefits. We tailor our prevention programs and educational materials to specific Medicaid populations, and we apply effective outreach to mitigate recurrence of unavoidable care that aligns with our overall care coordination strategy.

We are including our new, innovative myConnections programs, including myMoney Connect, myCommunity Connect and myWork Connect, in this proposal. myConnections is an innovative

approach to meeting the social determinants that often stand as a barrier to achieving optimal health. A substantial amount of health care costs for Nebraska and complexities for members is tied to social barriers that, on the surface, have nothing to do with health care. Examples of these include:

- Lack of financial management tools and financial literacy which can result in fewer funds available to address basic necessities
- Lack of steady employment which can affect behavioral health and has a direct impact on an individual's overall health
- Lack of ability to easily access services can result in reduced quality and poor outcomes

We developed myConnections to remove barriers that exist because of social determinants to improve the outcomes of the members we serve and the long-term outcomes for their communities and the state. As our experience expands with myConnections, we will work with MLTC to explore the expansion of our pilots to additional areas of the state.

UnitedHealthcare myMoney Connect™	
Definition and Description of Service	At UnitedHealthcare, we are more than health care, and we are always thinking of new ways to engage our members. UnitedHealthcare myMoney Connect is designed to promote health, well-being and financial independence for Heritage Health members. The program provides a reloadable prepaid debit MasterCard® to Medicaid members with an integrated wellness rewards program, enabling them to earn incentives for taking steps to improve their health. By helping to motivate positive health behaviors and closing gaps in care, myMoney Connect qualifies as an innovative payment program that is improving health outcomes and enabling state Medicaid programs to reduce costs. After enrolling at *UHCmyMoneyConnect.com*, program participants receive a reloadable myMoney Connect prepaid debit MasterCard to make purchases or pay bills. To access myMoney Connect program details, members must either download the mobile app or access it online. Members then will be able to view their personalized financial and wellness reward opportunities, manage their funds and close any gaps in care. The Card can be used anywhere MasterCard is accepted. Members then earn financial incentives (i.e., wellness rewards) for completing healthy activities, such as visiting their PCP based upon personalized gaps in care. To simultaneously help improve health outcomes and reduce costs, the gaps in care are personalized for the member based upon the individual's specific needs. Members' gaps in care are based upon HEDIS codes such as annual dental exams and breast cancer screenings. By completing preventive wellness activities tied to gaps in care, members are able to earn rewards. Members can load their own funds to the Card in a number of ways. For example, they can designate part or all of their paycheck, load other regular sources of income onto the Card or use the MasterCard® rePower® network to add cash at hundreds of thousands of locations nationwide. Members can manage their funds and rewards loaded to the Card through a mobile app or online. Participants can use their UnitedHealthcare myMoney Connect prepaid debit MasterCard for a variety of everyday and health-related purchases. As a few examples, members can spend wellness rewards they earn toward healthy living, such as pharmacies, dependent care, childcare services and after-school programs; transportation such as bus tickets and taxis; telecommunication service; family entertainment including museums, movies and zoos; and everyday living expenses such as groceries and discount stores. There is no cost for members to sign up for UnitedHealthcare myMoney Connect,

UnitedHealthcare myMoney Connect™	
	no monthly fees, as well as no credit check. This program is subject to prior approval by MLTC.
Category or Group of Member Eligible to Receive Services	All UnitedHealthcare Medicaid members are eligible for this incentive.
Limitations or Restrictions	To participate in the program, a member must have an approved UnitedHealthcare Medicaid member ID number as proof of eligibility. Members also will be asked to provide additional program-related information for required validation, including a Social Security number or ITIN. The cardholder must be 18 years or older to participate.
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	***Members:*** Qualified members over age 18 will receive notifications through Medicaid allowed outreach and at *UHCmyMoneyConnect.com.*
Description of how Members Obtain Service	Members register for the reloadable prepaid debit MasterCard program via our website at *UHCmyMoneyConnect.com*, where information is collected including their UnitedHealthcare member ID, address, Social Security number or ITIN email address and phone number to validate program eligibility. When members complete wellness activities, rewards are loaded to the Card as defined in the member materials and website.
Description of Identification of Benefit in Admin or Encounter Data	Administrative data
Aligned with MLTC Goals	This program provides an important resource to help people improve their overall health by enhancing their financial health. Financial stress is a leading cause of unhealthy behaviors and has been linked with poor health outcomes. Among other benefits, the program engages members in their health care and financial management, reduces costs by driving healthy behavior, drives behaviors that lead to financial stability and helps to close gaps in care. The program also is helping reduce the reliance on predatory financial services, offering program participants access to money faster to help pay daily bills.

UnitedHealthcare myCommunity Connect™	
Definition and Description of Service	We are introducing a mobile myCommunity Connect as a pilot for rural Nebraska. myCommunity Connect creates a centralized location for our members to visit to share their needs, assesses them for programs for which they are eligible, and refers them to services. myCommunity Connect enables our members in rural areas to have their holistic and social needs met in parts of the state, which are often underserved. The myCommunity Connect allows our members, working through a CHW, to address comprehensively members' needs rather than struggling to work within a highly fragmented delivery system for social services. myCommunity Connect serves as a hub for all services within individual geographies. myCommunity Connect is supported by the foundation offered by myData Connect. myData Connect is an innovative tool that combines analytics to determine eligibility for services with a robust search engine to collect data about all available services (regardless of source of payer) within an individual community and neighboring communities. myData Connect allows our CHWs in

UnitedHealthcare myCommunity Connect™	
	the myCommunity Connect to identify all available resources to meet a member's needs and make referrals. Through myData Connect, we are able to track referrals to measure efficacy and to provide feedback to community organizations about the services they provide.
Category or Group of Member Eligible to Receive Services	Members within the pilot area which is to be determined.
Limitations or Restrictions	No limitations
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	Members and providers in the target geographies will be informed when myCommunity Connect is available. CHWs and care managers will refer members when they believe the services of myCommunity Connect will benefit the member.
Description of how Members Obtain Service	Members in the pilot geographies can access the services of myCommunity Connect when it is available within their community.
Description of Identification of Benefit in Admin or Encounter Data	Administrative Data
Aligned with MLTC Goals	Reduction in non-emergent use of the ER, improving birth outcomes, improved outcomes through coordination and integration of prevention-focused physical and behavioral health services in community-based settings.

UnitedHealthcare myWork Connect™	
Definition and Description of Service	We know that Medicaid consumers are healthier when they have the opportunity to be engaged in meaningful employment. myWork Connect is the innovative program that will be linked to the myCommunity Connect pilot in rural Nebraska to assist our members in finding employment or moving to more stable employment. myWork Connect, similar to the myCommunity Connect brings the fragmented pieces of the employment puzzle together to support our members in practicing the skills needed to find employment, aligning services to prepare for pre-employment activities like interviewing, as well as coordinating the multitude of employment seeking services. Through this pilot, we will measure the impact of myWork Connect on our members' ability to find and maintain employment as well as provide feedback to the public and private employment services in rural Nebraska to improve employment opportunities for Medicaid recipients.
Category or Group of Member Eligible to Receive Services	All members
Limitations or Restrictions	No limitations
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	Members either will be informed about accessing myWork Connect through myCommunity Connect or may be referred from their CHW or care manager for employment supports.
Description of how Members Obtain Service	Members can access myWork Connect resources through the mobile myCommunity Connect.

UnitedHealthcare myWork Connect™	
Description of Identification of Benefit in Admin or Encounter Data	Administrative Data
Aligned with MLTC goals	Reduction in non-emergent use of the ER, improving birth outcomes, improved outcomes through coordination and integration of prevention-focused physical and behavioral health services in community-based settings.

Asthma Care Program Pilot	
Definition and Description of Service	In 2016, we will pilot an intervention to improve asthma care in Omaha where well-identified asthma disparities exist, particularly in the eastern portion of Douglas County. While death rates due to asthma have been decreasing the past 20 years, there continues to be a greater impact in Douglas County, and African Americans have an average annual death rate twice as high as Caucasians. Due to these recognized asthma disparities in Omaha, we aim to empower those in most need of assistance. The goals of the pilot are to improve self-management skills and medication adherence by providing inhaler attachments capable of automatically tracking usage. These sensors can connect to mobile applications, providing asthma education, medication reminders and other self-management tools. Primary benefit of the program will be improved asthma control level as measured by increased control medication adherence, reduced rescue inhaler use, and reduced hospitalizations and ER visits.
Category or Group of Member Eligible to Receive Services	This 12-month pilot will provide sensors to as many as 100 members residing in Omaha with persistent asthma and demonstrated difficulties managing their disease. We will use ER utilization reports and inpatient census reports to identify members with persistent asthma whose utilization reflects a high-risk or complex condition that could be improved with better medication adherence. Following the pilot and the reported outcomes, we will expand the program.
Limitations or Restrictions	We will offer identified members two sensors, one each for rescue and controller medication inhalers, and instructions on use of the device and downloading the mobile applications. The pilot program will be initially limited to 100 members residing in Omaha with persistent asthma.
Providers Responsible for Providing the Service	A third-party device manufacturer will provide the sensors and Web-based tools to eligible members identified by UnitedHealthcare.
How and When Members and Providers are Notified of Service	***Members:*** Through direct mailing, telephonic or face-to-face outreach, we will offer enrollment in this asthma care program to members who have had an asthma-related hospitalization or ER visit within the past 12 months and an asthma medication ratio below 50 percent. ***Providers:*** PCPs caring for our members enrolled in the program will receive notification of the member's participation and information describing the respiratory monitoring and readmission reduction program through a program-description provider letter.
Description of how Members Obtain Service	Through either telephonic or face-to-face outreach, we will offer enrollment of the asthma care program to members who have had an asthma-related hospitalization or ER visit within the past 12 months and an asthma medication ratio below 50 percent. Once the member registers online, he/she will receive the sensors and instructions to download the mobile application.
Description of Identification of Benefit in Admin or Encounter Data	Administrative data

Asthma Care Program Pilot	
Aligned with MLTC Goals	Reduction in non-emergent use of the ER

Adult Flu Shots, Vaccinations and Immunizations	
Definition and Description of Service	We understand the criticality of adherence to adult immunization and vaccination practices, especially for those populations who are at risk for preventable diseases. In addition to the core offerings for preventive care, we offer all adult members pneumonia; flu and shingles shots; routine vaccinations and immunizations.
Category or Group of Member Eligible to Receive Services	We provide this benefit to all adult members in TANF, I/DD and ABD populations.
Limitations or Restrictions	We cover medically appropriate flu shots and adult vaccinations and immunizations that are not covered under the Medicaid benefit for members 21 years of age and older.
Providers Responsible for Providing the Service	Members can visit their network providers to receive their immunizations and vaccinations.
How and When Members and Providers are Notified of Service	*Members:* All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/CHWs. *Providers:* All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	Members can visit their network provider to receive their vaccinations and immunizations.
Description of Identification of Benefit in Admin or Encounter Data	Encounter data
Aligned with MLTC Goals	Reduction in non-emergent use of the ER

Adult Physicals	
Definition and Description of Service	We believe it is important to offer adults an option for a physical. It is our belief that self-care and prevention is one important key to a healthy lifestyle.
Category or Group of Member Eligible to Receive Services	We provide these services for all adult members.
Limitations or Restrictions	We cover physicals for adults over the age of 21.
Providers Responsible for Providing the Service	Members can visit their in-network PCP to receive their physical.

Adult Physicals	
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	Members can visit their in-network PCP for this service.
Description of Identification of Benefit in Admin or Encounter Data	Encounter data
Aligned with MLTC goals	Reduction in non-emergent use of the ER

Adult Male Circumcisions	
Definition and Description of Service	There is some evidence that points to reduced risk of urinary tract infections, some sexually transmitted diseases, and protection against penile cancer in circumcised men. As such, we will offer adult male circumcisions for our members.
Category or Group of Member Eligible to Receive Services	We provide these services for all adult male members.
Limitations or Restrictions	We offer this service if not covered by a state benefit.
Providers Responsible for Providing the Service	Eligible adult males should consult with their network provider.
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	Members can obtain service through network provider.
Description of Identification of Benefit in Admin or Encounter Data	Encounter data
Aligned with MLTC goals	Reduction in non-emergent use of the ER

Improved Birth Outcomes

We are committed to continuing to work together with MLTC to improve the health of the public. One area of focus is healthy babies who grow to be healthy children. With the understanding that the rate of pre-term births needs to be improved, our goal is to reduce the incidence of pre-term delivery and low-birth-weight babies for our members.

UnitedHealthcare Baby Blocks™	
Definition and Description of Service	Baby Blocks offers a unique approach to achieving improved health outcomes for pregnant women and mothers with children up to 15 months. Through the dual appeal of an engaging Web application and attractive rewards, Baby Blocks reminds and rewards members for attending appointments during their pregnancy and into the first 15 months of their baby's life. The program uses mobile-optimized engagement tools, including an easy enrollment process, appointment reminders and health tips. We deliver rewards to women who complete important provider visits during the 24-month program. Members can choose between two practical items at each stage: ▪ *Baby Blocks enrollment:* Durable, black diaper bag or Old Navy gift card ▪ *24-week prenatal:* Nursing cover or teething rattle with mirror ▪ *32-week prenatal:* First aid kit or tabletop toy ▪ *Birth:* Digital thermometer or rubber duck bath thermometer ▪ *Postpartum visit:* Fisher Price sorting blocks or Old Navy gift card ▪ *Six-month well-child:* Dental care kit or baby feeding kit ▪ *Lead screening:* Childproofing kit or children's book ▪ *15-month well-child:* Shower/bath accessories for mother or soft puzzle As of 2015, more than 2,300 Nebraska members have enrolled in Baby Blocks, with more than 50,000 members enrolled nationwide. More than 1,700 babies have been born to our members in Nebraska, and nearly 700 children have completed the program.
Category or Group of Member Eligible to Receive Services	All Heritage Health members who are pregnant women and mothers with children up to 15 months are eligible.
Limitations or Restrictions	Members are eligible for rewards following enrollment in the program. We do not provide retroactive rewards.
Providers Responsible for Providing the Service	We partner with an organization, BI Worldwide, to administer this program.
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com*, our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. The community outreach team provides information at Community Baby Showers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	Members enroll in Baby Blocks through *uhcbabyblocks.com*. Once enrolled in the program, individuals track their progress in the Baby Blocks application, available online and on mobile devices. After members obtain each reward level, they select their reward, which we distribute via mail.

UnitedHealthcare Baby Blocks™	
Description of Identification of Benefit in Admin or Encounter Data	Administrative data
Aligned with MLTC Goals	Improved birth outcomes

Member Baby Showers	
Definition and Description of Service	To recognize this special time and share in the excitement of our pregnant members' lives, we invite our pregnant members to a baby shower we hold quarterly. We arrange these baby showers at different locations and venues to reach a large cross-section of our members. All pregnant members can attend at any time and receive health and safety education and information about community resources. We partner with community organizations such as Charles Drew Health Center, Community Action Partnership, Completely Kids, Early Childhood Training and Education, Educare of Omaha and Lincoln, Family Housing Advisory Services, Metro Omaha Tobacco Action Coalition, MilkWorks, Nebraska Breastfeeding Coalition, Nebraska Department of Health and Human Services, People's Health Center, Omaha Public Schools and OneWorld Community Health Center to set up information booths to assist our attendees. A OneWorld Community Health Center educator reinforces the importance of prenatal, postpartum care and baby well-child check-ups. In addition, members draw for gifts such as strollers, car seats and other presents for attending. Our community outreach specialist is available to conduct the baby showers in Spanish as well. We held our first member baby shower at the Charles Drew Health Center, an FQHC, and we have had seven more baby showers since then with 158 participants to date in Nebraska in December 2014 and year-to-date. The goals of the baby showers include: closing gaps in care, educating members on healthy pregnancy, caring for themselves and the baby, and the impact of substance use during pregnancy. The key to success is the collaborative community partners' participation. Our community partners value the opportunity to collaborate and share educational information regarding health and wellness for mom and baby.
Category or Group of Member Eligible to Receive Services	This program is available to all pregnant Heritage Health members.
Limitations or Restrictions	No limitations or restrictions.
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com, special member invitation,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	We mail invitations to all pregnant members. Any member who is interested in attending can RSVP by calling member services.

Member Baby Showers	
Description of Identification of Benefit in Admin or Encounter Data	Administrative data
Aligned with MLTC Goals	Improved birth outcomes

Improved Outcomes for Physical and Behavioral Health

Our delivery of covered benefits and services is encompassed in, and integral to, our person-centered, fully integrated model of care. Our model embraces each member's unique and holistic needs and the impact of the member's beliefs on his/her health care delivery. Our person-centered approach to care coordination engages and empowers our members and their families and caregivers, in collaboration with physicians and other health care professionals. The following value-added services complement our integrated model of care to more fully engage members and empower them to take control of their health.

Peer Support Program	
Definition and Description of Service	Our peer support program provides any of the following to a member who is living with a severe and persistent mental illness: ▪ Information about severe and persistent mental illnesses or serious emotional disturbance ("BH conditions"), evidence-based treatment and approaches to self-care ▪ Information about the subjective, lived experience of a person with a BH condition ▪ The opportunity to learn a range of skills including problem-solving, communication, managing crises, promoting recovery and resilience, and managing stress ▪ Information which promotes the member's ability to effectively communicate with providers and the service system ▪ Information about local services and community-based resources This program complements the member's BH treatment services. It may be delivered while the member is receiving BH treatment or in advance of the start of BH treatment to facilitate engagement in care. The provider of peer-to-peer services reduces the likelihood that the member will become isolated and increases the likelihood that the member will feel empowered and engaged.

Category or Group of Member Eligible to Receive Services	The member has a BH condition and any one of the following criteria must be met:
	▪ The member requires information about:
	  ▪ Their BH condition, evidence-based treatment and approaches to self-care
	  ▪ Information about local services and community-based resources
	▪ The member could benefit from learning skills such as problem-solving, communication, managing crises, promoting recovery and resilience, and managing stress.
	▪ The member could benefit from information, which promotes the member's ability to communicate effectively with providers and the service system.
	▪ The member is receiving BH treatment, or the member is likely to engage in treatment with peer-to-peer services and supports.

Peer Support Program	
Limitations or Restrictions	▪ Peer support program is available in BH Regions 3, 4 and 5 through a pilot phase, pending evaluation of outcomes. ▪ The member must be able to participate actively in the peer support program. ▪ The member (or his/her legal representative) must consent to receive peer services and supports.
Providers Responsible for Providing the Service	Region 3 BH services and UnitedHealthcare for Regions 4 and 5
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	Members' BH provider or one of their integrated team members will refer members to services. A peer support specialist outreaches to the member to explain what peer services and supports are, assesses member for engagement/readiness and initiates services with the member's consent.
Description of Identification of Benefit in Admin or Encounter Data	Administrative data
Aligned with MLTC Goals	Reduction in non-emergent use of the ER, improved outcomes through coordination and integration of prevention-focused physical and behavioral health services in community-based settings.

Waived Copayments	
Definition and Description of Service	To encourage members to adhere to well visits, BH appointments and medication schedules, we will waive any copays on covered physical, BH and pharmacy services.
Category or Group of Member Eligible to Receive Services	All members are eligible.
Limitations or Restrictions	We waive copayments for all covered medical, behavioral and pharmacy services. We exclude non-covered services.
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider advocate visits to provider offices throughout the year.
Description of how Members Obtain Service	Not applicable, as there is no "service" to obtain; members will simply not have to pay a copay for their health care services.

Waived Copayments	
Description of Identification of Benefit in Admin or Encounter Data	Encounter data
Aligned with MLTC Goals	Reduction in non-emergent use of the ER, improved outcomes through coordination and integration of prevention-focused physical and behavioral health services in community-based settings.

KidsHealth Online Support Center	
Definition and Description of Service	The *KidsHealth* online resource center is a trusted health information center with an interactive design that provides parents and their children with more than 200 videos and 10,000 articles on a variety of family-focused health topics in a fun, engaging way. Families can find information on general and behavioral health; growth and development; diseases and conditions; infections; nutrition and fitness; school and family life; first aid and safety; emotions and behavior; doctors and hospitals. These educational tools empower members to take charge and gain knowledge about their health to better manage their conditions. This translates to better health care delivery choices—when they understand the importance of regular preventive care visits, they are less likely to visit the ER. *KidsHealth* includes resources to assist high-risk members to adopt a healthy lifestyle and manage their conditions; e.g., diabetes, asthma, depression and stress. For instance, the *KidsHealth* Asthma Center provides videos, articles and tools such as, "Asthma Basics," "Dealing with Asthma Triggers," "If You Think Your Child is Suicidal", "Handling Flare-Ups" and "Alexis' Story." The information provided meets individual needs by age (parent, kid, teen), language (English and Spanish) and learning style (written, audio, video). A survey of 14,000 users found that 92 percent learned something new, and 86 percent thought the amount of information was "just right." *KidsHealth* partners rated *KidsHealth* content a 4.7 on a scale of 1 to 5. They stated that the likelihood of recommending *KidsHealth* to a friend was rated 4.8. Our marketing and community outreach team prints articles and information found on *KidsHealth* as educational materials and handouts at community events; it is not just an online resource.
Category or Group of Member Eligible to Receive Services	All members and their caregivers can access *KidsHealth* Online.
Limitations or Restrictions	No limitations
Providers Responsible for Providing the Service	UnitedHealthcare provides this service to our members through a partnership with the Nemours Foundation Center for Children's Health Media.
How and When Members and Providers are Notified of Service	We promote *KidsHealth* through our *Member Handbook* and publication in member and provider newsletters. We provide promotional bookmarks and flyers at outreach events, member baby showers and through our Healthy First Steps Welcome Kits. The community outreach team shares the information at health fairs and school events.
Description of how Members Obtain Service	Members can access *KidsHealth* through a link on our public website, *uhccommunityplan.com* or directly through *UHCCommunityPlan.com/NEkids*. Members can also access *KidsHealth* articles, tools and videos via tablet and smartphone.

KidsHealth Online Support Center	
Description of Identification of Benefit in Admin or Encounter Data	Administrative data
Aligned with MLTC Goals	Integration of prevention-focused physical and behavioral health services in community-based settings.

Caregiver Supports for Members with Complex Needs

Children and young adults with disabilities have many unique needs that require thoughtful consideration and an awareness of their challenging circumstances. We understand how those needs may be further complicated by psychosocial and environmental challenges. Children and families face many challenges—from emotional, behavioral and learning difficulties, to navigating the health and social services system—that may impede their overall health and well-being. To mitigate these challenges, we offer the following services.

Special Needs Planning Guide	
Definition and Description of Service	Caring for individuals with special health care needs involves challenges that the average caregiver cannot understand. The Special Needs Planning Guide provides resources to the families of members with special health care needs to ease the challenge through resources and information. The Special Needs Planning Guide is a thorough, easy-to-read resource that gives parents a chronological guide for each stage from birth to adulthood. Caregivers will get comprehensive advice and strategies on how to address factors, such as financial, legal, governmental, family and support and emotional.
Category or Group of Member Eligible to Receive Services	All Heritage Health members with I/DD, ABD and Katie Beckett are eligible for this benefit.
Limitations or Restrictions	Service is limited to one book per household.
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	***Members:*** All members, their caregivers and parents will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	Members or their families can contact member services or their care management team to request the book, which will then be mailed to them.
Description of Identification of Benefit in Admin or Encounter Data	Administrative data

Wandering and Elopement Benefit	
Definition and Description of Service	Wandering, also called elopement, is an important issue that affects some individuals with disabilities, their families and the community. There are steps that caregivers, teachers, health care providers and others can take to help keep adults and children safe. Wandering is when someone leaves a safe area or a responsible caregiver, resulting in a risk of injury or harm. This goes beyond the brief time that a toddler might run off from a caregiver. As health care professionals, we are keenly aware of wandering as a safety issue. Part of our role will be addressing safety concerns as part of a member's plan of care and helping caregivers come up with prevention and response plans. We will provide members and families with door and window alarms (up to six per household) as one tool to aid and support minimization of wandering without caregiver awareness.
Category or Group of Member Eligible to Receive Services	All members with I/DD or ABD are eligible for this benefit.
Limitations or Restrictions	We will provide up to six door and window alarms, per household per calendar year, if identified in the member's plan of care.
Providers Responsible for Providing the Service	UnitedHealthcare
How and When Members and Providers are Notified of Service	***Members:*** All members will receive notifications through the *Member Handbook*, available through *uhccommunityplan.com*; *HealthTalk,* our member newsletter, mailed quarterly; *myuhc.com,* our secure member website, available for self-service 24 hours a day, seven days a week; member services advocates, available 7 a.m. to 7 p.m. CT; and care management/community health workers. ***Providers:*** All contracted providers receive notification of the benefits through quarterly newsletters, periodic webinars/town halls, our *Provider Administrative Guide* and periodic provider services visits to provider offices throughout the year.
Description of how Members Obtain Service	To request this benefit, caregivers and members can contact member services or their care managers.
Description of Identification of Benefit in Admin or Encounter Data	Administrative data

Our extensive experience providing innovative and enhanced value-added services to Nebraska Medicaid members and 5.3 million members across 24 states allows us to be confident our value-added services address the needs of Heritage Health members to improve health outcomes. Building upon our core programs and competencies, the above value-added services will enhance members' physical, behavioral and social well-being and ultimately lead to improved health outcomes.

24. Describe the MCO's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the MCO's system for tracking each member's screening, diagnosis and treatment to ensure services are delivered within the established time frames. *4 pages*

The promotion of comprehensive and preventive health care services to our members is an integral part of our quality program. As part of the EPSDT program, we will continue to work closely with Nebraska members and their families to offer children from birth to age 21 the best pediatric health care possible, including comprehensive preventive health benefits. Since 1996, we have served Nebraska Medicaid members, demonstrating our understanding of the importance of providing all young people with a solid start to a healthy lifestyle. We accomplish this through the promotion of well-baby, well-child, dental, vision, hearing, BH and lead screenings, communicating to parents and guardians who are responsible for children under age 21 and tracking their screening and preventive activities through multiple channels. As proof of our commitment to these efforts, ***our network providers have completed more than 46,500 screenings related to EPSDT in 2015.***

Approach to EPSDT Member Education and Outreach

Building on methods already in place in Nebraska and leveraging those deployed nationwide, we employ multiple communication strategies to enhance member participation in the EPSDT program. Our comprehensive EPSDT preventive services efforts are resourced and supported by key staff that include Michael Horn, M.D., medical director/chief medical officer and Cyndi Margritz, maternal child health (MCH)/EPSDT coordinator. Our approach includes proactively identifying members in need of EPSDT services, timely outreach and communication to members and key stakeholders, and tracking EPSDT screenings for compliance.

Identifying Members for EPSDT Screening

Timely identification of members in need of preventive screenings is a priority in improving overall member outcomes and helps to ensure that achieves and maintains state and federal compliance related to the provision of EPSDT services. To determine which members need preventive services, our care management team and CHWs use our Universal Tracking Database (UTD), an internally designed relational database that accommodates multiple data inputs. The database provides member-level data for a variety of internal uses, such as identifying overutilization and underutilization of preventive health services based upon HEDIS criteria per age and gender. The system performs weekly measurement of quality scores based upon ongoing claims submissions, monitors clinical indicators and identifies areas for improvement prior to the HEDIS reporting time frame—a unique capability in the marketplace. ***This database is used by our team at every member touch point, is used by our member services team, our CHWs, our clinical care team, and is reported to our network providers.***

We seek to capitalize on every member touch point to promote timely access to preventive care, tests and treatment. Our highly trained member services advocates (MSAs) have multiple opportunities to address gaps in care, such as during new member welcome calls and whenever a member calls for service. The MSAs have the ability to view a member's gaps in care through *Advocate4Me,* inclusive of the member's EPSDT schedules for themselves and their family members. Our MSAs take every opportunity to encourage adherence to EPSDT periodicity schedules when communicating with members. Post-EPSDT screening, our MSAs can assist members by coordinating referrals for medically necessary follow-up treatment from an EPSDT screening by proactively calling the member and working directly with the network providers to ensure appointments are available and referral processes are followed.

Collaboration with providers to identify members in need of preventive services is another important focus of our efforts to promote wellness and close gaps in preventive care. Currently, the UTD feeds a

report that is available online to our providers to assist with timely identification of members in need of these important services. In the future, providers will use *CommunityCare* to access the preventive care gap listings. *CommunityCare* allows providers and the care management team to identify—quickly and proactively—a member's gaps in care, including needed EPSDT services. The platform provides PCPs with information including the member's Medicaid ID, a record of each service event, appointments, a record of all immunizations, a listing of the member's durable medical equipment (DME) along with the ability to capture notes and store attachments.

Outreach and Communication to Key Stakeholders

We are aware and have a deep understanding of the complexity and diversity of the populations we serve in Nebraska. Our approach to EPSDT member education is respectful, multilingual and cognizant of the effect of health disparities (e.g., Maternal & Child Health) that currently exist in Nebraska. We recognize cultural differences, socioeconomic and housing differences, spiritual- and faith-based differences and, how these differences may affect an individual's desire and ability to engage in preventive health care. In addition to focusing on individual needs, we also take a population health approach to understanding the needs of members, closing the gap on EPSDT screenings and reducing health disparities.

We use several methods to communicate effectively with members, families and providers to educate them on the importance of preventive EPSDT screenings. We design our member educational materials to be helpful, relevant, inclusive and respectful of the cultural and linguistic diversity in Nebraska. We collect quarterly data on ethnicity and preferred written and spoken languages from the self-reported data in the 834 file and we use this data to identify the major cultural and linguistic groups we serve. We provide bilingual staff and interpreter services at all points of contact during all hours of operation including the 711 National Telecommunications Relay Service (TRS) TTY line.

Member Communication

Efforts to educate our members about the importance of EPSDT services begin at initial enrollment and continue throughout a member's journey with UnitedHealthcare. The content of our member communications include the benefits of preventive health services, a description of EPSDT services, recommended periodicity schedules and information on how to obtain services. Based upon our experience with Nebraska Medicaid members, we continue to use a number of member outreach tools and communication pieces, which are tailored to the needs of members and their families. Our member communication efforts include the following:

- ***EPSDT Monthly Postcard Reminders:*** We mail an EPSDT reminder postcard, as seen in Figure IV.E-1, to members 0 to 21 years of age, during their birth month to remind them of the services that are needed and to encourage them to schedule an appointment with their PCP. ***More than 51,000 postcards have been mailed to members in 2015.***
- ***Baby Blocks:*** Our Baby Blocks program encourages pregnant women and new mothers to attend their prenatal, postpartum and well-baby appointments and provides incentive rewards for preventive health actions. Online and mobile reminder tools encourage pregnant members to keep their wellness appointments and sends appointment reminders.
- ***Member Newsletters:*** Our member newsletter, *HealthTalk*,

Figure IV.E-1. EPSDT Monthly Postcard Reminders

provides members and their families with health education and benefit information, encouraging them to seek preventive care.

- ***Member Website:*** Our member website (*myuhc.com*) provides education on well visits, shots and vaccines, and the need for EPSDT screenings. We have designed the website to meet the unique needs and challenges of our members by accommodating fifth grade reading levels, language translation and culturally appropriate content.
- ***Member Handbook:*** Our *Member Handbook* provides an explanation of the free services available to Medicaid members under age 21 through the EPSDT benefit, including periodic and as-needed health exams, vision, dental and hearing care, and all necessary diagnostic and treatment services to verify healthy growth and development.
- ***Health Fairs:*** We engage local organizations to sponsor screening events and health fairs where we can provide education and literature on annual checkups and other health-related issues. For example, through our partnership with Completely Kids, an Omaha-based organization working to educate and empower children and low-income families, we provided health education to over 300 families at an elementary school family night event in May of this year.

Quality Initiatives Achieve EPSDT Compliance

Using monthly member mailings that communicated age-appropriate preventive care screenings and services, we implemented a successful member incentive program as part of a comprehensive member outreach. We achieved the plan-established goal of ***increasing the well child (ages 3, 4, 5 and 6) annual visit measure rate of compliance by 3 percent.***

Provider Communication

We understand the importance of communicating and collaborating with providers to connect their members with necessary EPSDT screenings. We distribute educational materials on EPSDT periodicity schedules annually, supply up-to-date screening guidelines and support notification of screenings due to members assigned to that provider. When our prospective HEDIS and EPSDT detailed reports indicate an overall opportunity to promote better adherence to the schedule, we increase education to the broader network or to specific providers. In Nebraska, we use face-to-face support through our RN clinical practice consultants (CPCs), *HEDIS in a Box* educational material, cobranded provider letters and automated calls, online tools and innovative technology as described in more detail below.

- ***Nebraska Clinical Practice Consultant Program.*** In 2015, we began a program that pairs highly skilled quality improvement RNs, known as CPCs with high-volume providers. These nurses focus on provider education and collaboration with special attention given to the provision of evidenced-based medicine resulting in care gap closure and adherence to clinical practice guidelines. CPCs are able to provide member-level detail to providers to target gap closure efforts and improve member outcomes.
- ***Cobranded Provider Letters and Automated Call Campaigns.*** We collaborate with select high-volume providers to implement cobranded letter and automated call campaigns to heighten awareness of immunizations and other preventive services such as the EPSDT benefit. Members receive a letter from their PCP and UnitedHealthcare to inform them that their child is due for an EPSDT visit along with a request to schedule an appointment. We follow up with an automated call to encourage members to schedule a visit with their PCP. Through October of this year, we mailed 4,418 cobranded letters to Nebraska Medicaid members and their families.
- ***Engaging Providers Online.*** Providers have the information they need to conduct outreach to members that require immunizations or other preventive services through a variety of online touch

points, such as the provider portal that offers information and resources to support providers in accessing their specific member list by age, last screening date and HEDIS compliance. As described previously, *CommunityCare* also engages providers online regarding care gap closure.

Tracking EPSDT Screenings and Compliance

Our UTD and our innovative *CommunityCare* technology allow us to track preventive care and EPSDT compliance on an ongoing basis. These tools allow MSAs, CPCs, clinical care teams and providers to view near-real-time data on gap closure providing us the opportunity to target and outreach to members still in need of services throughout the year. Our CPCs use member-level detailed reports that enable them to work with providers to close gaps in care. Once we identify a member with a gap, outreach activities are completed and our reminder process begins. Using an internal tracking system (e.g., claims, encounter data) to identify consistently noncompliant members, we make multiple attempts to contact the member or the member's parent or guardian to reinforce the importance of the EPSDT benefit and preventive screening.

Innovations

We are committed to transforming health care and are continuously exploring and testing new ideas, and cultivating diverse partnerships to develop a simpler, more intelligent and cost-effective health care system for everyone. The following programs are part of our organization-wide commitment to new approaches in EPSDT preventive care:

- ***EPSDT Email:*** In 2015, we launched a pilot to communicate with members and their parents/guardians that "opted in" to begin receiving targeted email reminders on preventive care. We continue to evaluate the pilot's effectiveness for 2016.
- ***UnitedHealthcare myMoney Connect™:*** myMoney Connect allows members to earn funds on a MasterCard debit card by completing personalized wellness incentives tied to gaps in care. Members manage the program through an easy-to-use mobile application or online. We are proposing myMoney Connect as a member reward program for compliance with the EPSDT periodicity schedule for themselves or their family.
- ***EPSDT Consumer Marketing Database Initiative:*** We are working on a national pilot program to support EPSDT member engagement to determine which interventions work most effectively to achieve EPSDT compliance and to determine how each strategy "lifts" HEDIS rate improvements. Through a multimodal combination of outreach efforts such as Televox calls, targeted mailings, targeted live calling and appointment scheduling, we can determine the most effective approach to reach a member by state, to determine variations in member receptiveness based upon their cultural and linguistic preferences.

25. Describe the MCO's plan to utilize telehealth for any services in the benefits package, including how the MCO will incorporate member preference for in-person or telehealth service, how it will be operationalized throughout the state, and how its use relates to the MCO's utilization management strategies. *3 pages*

Our Telehealth Program

We have substantial experience overseeing the coordinated delivery of health care services to our members through telehealth capabilities. We will further support the delivery of a broad range of physical and behavioral health services to members in our Heritage Health program, at no cost to members, through virtual health visits, telehealth and telemonitoring.

With nearly 30 years of experience in Nebraska and 20 years in Nebraska Medicaid, we are knowledgeable about and committed to addressing the challenges associated with providing high-quality, holistic, person-centered health care close to home in Nebraska's rural and frontier communities. We know that primary challenges include:

- Limited access to primary, BH and other specialty care because of the lack of providers in certain areas of the state
- Unnecessary use of the ER, hospitalizations and readmissions
- Meeting the often complex needs of populations with special health care needs who may have limited mobility and higher needs for specialty medical, BH and pharmaceutical services and supports
- Limited health information technology that supports ongoing provider education, promote peer-to-peer interactions and improve provider productivity

We are working with local organizations to enhance existing capabilities in the state and leverage our Nebraska knowledge and national expertise to implement new initiatives and programs that promote the integration of telehealth technologies that improve timely access to care, clinical efficiency, capacity to deliver care and outcomes for members in our Heritage Health program.

- ***Working with local organizations:*** We are exploring collaborations with local organizations that have a long, rich history of delivering improved clinical services using telehealth technology for members in Nebraska, such as the Nebraska Statewide Telehealth Network, University of Nebraska Medical Center (UNMC), Indian Health Center, Richard Young Hospital, Bryan Health and Premier Psychiatry. An example of a potential collaboration is with UNMC's Diabetes Center to use telemedicine for follow-up care

UnitedHealthcare's Telehealth Experience across the Nation

- Neurology services to children with complex conditions living in remote Navajo Nation communities in Arizona
- Virtual clinic primary care used as an ER alternative is being deployed in commercial markets in January 2016
- Medicaid virtual clinic pilot offering same services at no cost to members is being tested with Medicaid in New Mexico and will be expanded for use in favorable Medicaid markets in 2016
- Postsurgical speech therapy services to Native Americans with complex conditions living in remote Tohono O'odham tribal communities in Arizona
- Pulmonology services to members with complex conditions patients in Roswell, NM, saving hundreds of miles each way to see a specialist
- Dermatology consultations to FQHC PCP in Arizona, Hawaii and New Mexico using store and forward specialists in California to improve continuity of care through follow up when referred outside their medical homes for treatment
- BH services to improve clinical efficiencies and provider capacity in FQHCs and group practices in rural communities in Kansas, New Mexico, Tennessee and Washington
- Partnering with Doctor On Demand, Optum's NowClinic and American Well's Amwell to provide video-based virtual visits in 47 states and Washington D.C.
- Telemonitoring pilot for 30-day post-discharge for members with CHF in Arizona and New York

for members with diabetes who live in rural areas and often have to drive several hours to appointments. We are also working with several BH Regions to expand current telehealth capabilities by offering technology resources and support.

- ***Leveraging local and national expertise:*** Nationally, UnitedHealthcare Community & State, and many of our state Medicaid programs nationwide have experience implementing innovative telehealth programs that leverage technology to extend the reach of primary and specialty care services in rural areas where resources are limited. This includes working with specialty providers and FQHCs to improve access to services, such as pediatrics, neurology, orthopedics, pulmonology, dermatology and speech therapy. For example, we have worked with providers to implement solutions, such as home telehealth, remote patient monitoring, telepsychiatry and online provider access, in Kansas, New Mexico, Tennessee and Washington. We will leverage the learnings from these experiences in Nebraska.

Assuring Member Preference for In-Person or Telehealth Service Delivery

We will support member choice in how to receive physical and BH care services, whether in-person or through telehealth services, through a continued focus on providing a robust provider network that assures access to and availability of health care services. We will augment this by helping members and providers understand that telehealth options reduce wait times for access to specialty care, increase member convenience and reduce the cost and inconvenience of traveling long distances. We will educate members and providers in a variety of ways, including:

- ***Conducting statewide member education forums*** to provide information on telehealth benefits; where and how to access telehealth services; the accessibility of virtual health clinics through our free *Health4Me* mobile app; and member rights and responsibilities when using telehealth technologies, such as the member's ability to operate the equipment or having someone available to assist them.
- ***Including telehealth information in our member and provider materials***, such as our *Member Handbook*, *Provider Administrative Guide*, newsletters and secure websites.
- ***Educating community-based workers and health plan staff*** who have direct or indirect contact with our members including our member services advocates, NurseLine staff, care managers, community health workers, peer specialists and utilization management staff on telehealth to promote information sharing during interactions with members.
- ***Implementing a series of innovative telehealth initiatives and pilots*** in Nebraska described in the table below.

Initiatives and Pilot Programs to Operationalize Telehealth Service Delivery Statewide

We understand efforts made in developing telehealth capabilities among our network providers will improve timely access to quality care for all enrollees regardless of their managed care organization affiliation. The following Table IV.E-2 presents the initiatives and pilot programs we intend to implement in Nebraska to improve statewide access to high-quality, integrated health care.

Table IV.E-2: Improving Statewide Access to Care Through Telehealth
Clinical Efficiency Initiative
This initiative improves clinical efficiency and expands provider capacity by reducing the number of patients that fail to show for their scheduled appointment. UnitedHealthcare studies show a direct relationship between high no-show rates and the number of miles patients must travel for their clinic appointment. Introducing telehealth sites in locations that accommodate patients traveling the farthest reduces clinic no-show rates. The increased productivity benefits the provider, increases clinical efficiency, improves access to care and improves access to

Table IV.E-2: Improving Statewide Access to Care Through Telehealth
timely care for members. We will work with rural and frontier-based group practices and available FQHCs to initiate/expand telehealth capabilities to increase their ability to deliver services to members. We will provide operational, technical and clinical resource support, including specialty-specific clinical protocols, training materials for clinicians, educational materials for members, surveys and templates. We will work with providers to develop data-driven measurement tools to report utilization, clinical and financial cost benefit outcomes and target specific service delivery gaps or clinic pain points, such as improving clinical efficiencies and expanding capacity. Success metrics include continuity of care, quality, follow up and timely access to care. We will also address opportunities for horizontal expansion by targeting other locations and vertical expansion by targeting additional subspecialties.
Behavioral and Physical Health Integration Initiative
This initiative focuses on expanding access to integrated physical and BH services by providing psychiatric assessments to members, without having to refer them for services outside the community, through virtual BH clinics in established primary care clinics. Virtual BH clinics will support the patient-centered medical home; improve continuity of care, follow-up and member satisfaction; improve access to integrated care; promote holistic care plan development; and improve cross-consultation among providers by improving information sharing to prevent service duplication and contra-indicated treatments. We will identify and support rural and frontier specialty-provider practices and FQHCs who wish to expand their practices by offering a virtual BH clinic and provide operational, technical and clinical resource support.
Remote Patient Telemonitoring (RPM) Pilot
This pilot is integral to our strategy to improve quality of care and member outcomes and reduce unnecessary or inappropriate use of health care services, such as unnecessary inpatient readmissions. Through this pilot, we will implement high-touch telemonitoring solutions to help manage the care of members who have been hospitalized two or more times for the same condition within the last 12 months and with chronic disease, such as congestive heart failure or other related comorbid conditions and who are capable of or have someone who is able to use the equipment. RPM helps us achieve improvement objectives by providing medication management, promoting adherence with seven-day and 30-day post-discharge visits and providing virtual clinic visit services to members in areas where the delivery of telehealth services from the member's residence is allowed.

Telehealth and Our Utilization Management Strategies

Our telehealth initiatives are integral to our UM strategies for reducing unnecessary ER use, hospitalizations and hospital readmissions described more fully in Section IV.N Utilization Management, Question 88 of this response. Delivering coordinated services and supports to members where they live by using our telehealth programs will provide members with timely, convenient services and supports when they need them such as post-discharge care, thereby reducing their need to use the ER.

Our telehealth plan will improve access to care through technology-assisted service delivery for members in our Heritage Health program. We will continually assess the impact of our telehealth initiatives on unnecessary ER use, hospitalizations and readmissions particularly for members with special health care needs. As a leader in telemedicine, telemonitoring and virtual health care, we will use our deep experience with innovative methods of increasing access to care and include members and providers in taking Nebraska's use of telehealth to the next level.

26. Describe the MCO's experience with an integrated pharmacy benefit in other states and specify the type of plan and enrollment. Provide a preliminary work plan identifying key milestones, tasks, and accountability for implementation of Pharmacy Services as described in the RFP. *3 pages, excluding preliminary work plan*

Experience with Integrated Pharmacy Benefits in Other States

Our 20 affiliate health plans nationwide possess more than 30 years of combined experience overseeing the delivery of integrated pharmacy benefits to individuals who receive their health care through Medicaid and Medicare programs through close collaboration with state partners, prescribers, pharmacies and our pharmacy benefits manager (PBM).

The following Table IV.E-3 demonstrates the states in which UnitedHealthcare currently oversees the provision of comprehensive pharmacy services to more than 5 million individuals who receive their health care benefits through government-sponsored programs including TANF/CHIP; ABD, expansion and LTSS:

Table IV.E-3

State	Type of Plan	Enrollment
Arizona	TANF/CHIP, ABD, Expansion, LTSS	490,928
Delaware	TANF/CHIP, ABD, Expansion, LTSS	102,620
Florida	TANF/CHIP, ABD, LTSS	370,702
Hawaii	TANF/CHIP, ABD, LTSS	53,163
Iowa	TANF/CHIP	9,446
Kansas	TANF/CHIP, ABD, LTSS	129,351
Louisiana	TANF/CHIP, ABD	288,865
Maryland	TANF/CHIP, ABD, Expansion	175,751
Massachusetts	LTSS	15,610
Michigan	TANF/CHIP, ABD, Expansion	254,856
Mississippi	TANF/CHIP, ABD	284,229
New Jersey	TANF/CHIP, ABD, Expansion, LTSS	497,225
New Mexico	TANF/CHIP, ABD, Expansion, LTSS	92,544
New York	TANF/CHIP, ABD, Expansion, LTSS	524,301
Ohio	TANF/CHIP, ABD, Expansion	303,569
Pennsylvania	TANF/CHIP, ABD, Expansion	238,502
Rhode Island	TANF/CHIP, ABD, Expansion	83,867
Tennessee	TANF/CHIP, ABD, LTSS	520,943
Texas	TANF/CHIP, LTSS	291,192
Washington	TANF/CHIP, ABD, Expansion	207,737

We support and applaud MLTC's decision to integrate the pharmacy benefit to better serve members in the Heritage Health program and look forward to working closely with MLTC to developing and implementing an integrated pharmacy program. See Attachment 19 Q26 Pharmacy Preliminary Implementation Work Plan for our preliminary implementation work plan that identifies key milestones, tasks and accountability for implementation of the pharmacy benefit in Nebraska.

Our successful PDL management processes resulted in a generic utilization rate of 85.7 percent in 2014 for our Medicaid programs nationwide.

Pharmacy Integration

In collaboration with MLTC; Dr. Horn, our medical director/chief medical officer; Jeanne Cavanaugh, Pharm.D., our pharmacy director; and our PBM, OptumRx, we will leverage both our national and local expertise to develop and integrate Nebraska-

specific pharmaceutical management processes, policies, procedures and systems into our infrastructure that will comply with state, federal, and contract requirements.

OptumRx delivers pharmacy benefits through more than 67,000 community and retail pharmacies nationwide and is **the first PBM in the country to earn all four "URAC Pharmacy Quality Management" accreditations: PBM, Drug Therapy Management, Mail Service and Specialty Pharmacy.** Within Nebraska, we have **over 465 chain and independent pharmacies**.

As illustrated in Figure IV.E-2, at the heart of our experience is our holistic pharmacy delivery model that supports the design, development, implementation and ongoing management of the pharmacy benefit through the following core program elements:

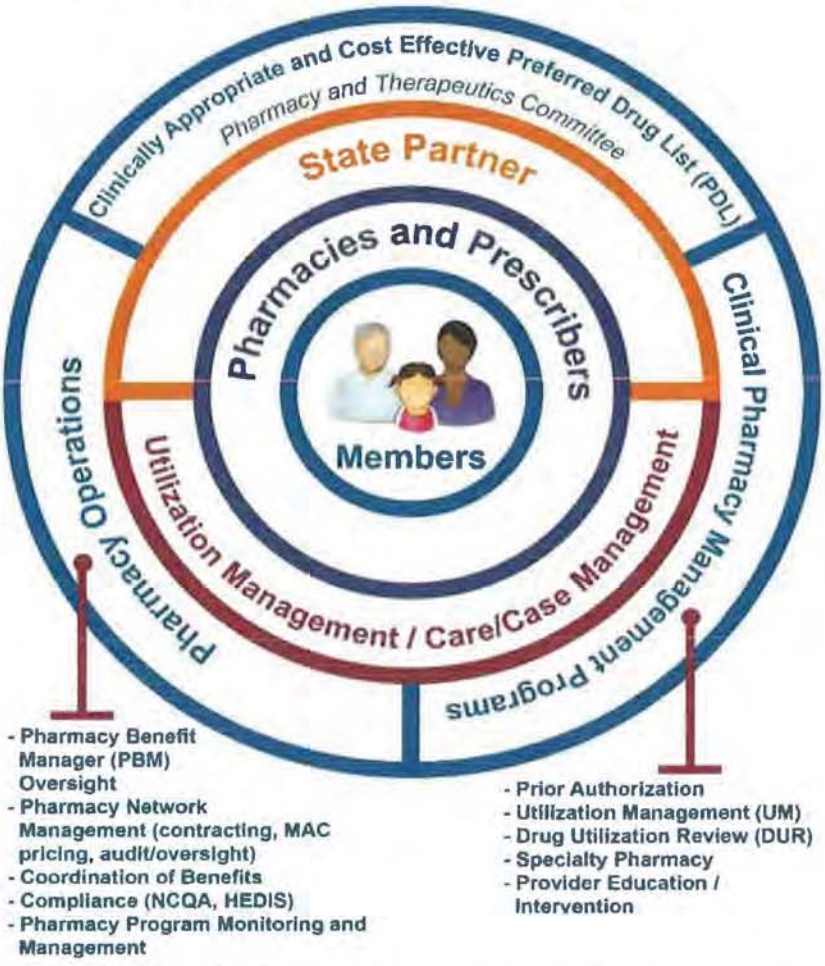


Figure V.E-2. UnitedHealthcare collaborates with our members, pharmacies and prescribers, PBM, MLTC partners, health plan staff and community-based resources to assure member access to needed high-quality medications.

- ***Committees and Oversight:*** Our organizational structure comprises a number of multidisciplinary committees that will include key pharmacy staff and external resources such as MLTC and local pharmacists as appropriate to support the definition, development and ongoing review of our pharmaceutical management procedures. These planning and oversight committees will include our Medication Therapy Management Oversight Committee, Drug Utilization Review Board, Clinical Advisory Committee and Quality Assurance and Performance Improvement Committee.

  In addition to participating on MLTC's P&T Committee and working with Nebraska's Pharmacy Association, our committee structure will assure our clinical pharmacy programs improve or maintain the health and quality of life for our members by maximizing safety and minimizing the frequency of underutilization or overutilization, inappropriate or medically unnecessary care and fraud and abuse.

- ***Preferred Drug List (PDL) Management:*** We have extensive experience implementing and managing state-prescribed PDLs, health plan generated PDLs and common PDLs. We will cover all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit, implement the Nebraska Medicaid PDL, conduct communication and data exchanges between MLTC

pharmacy staff and our health plan staff, assure integration of the PDL into our claims platform, and capture and communicate all drug recalls and withdrawals.

- ***Pharmacy Network Development and Management:*** Our approach will promote access for all of our members in the Heritage Health program. While building our network, and following implementation, we will perform access analysis using MLTC's contracted pharmacy provider listing and pharmacy claims data to identify non-contracted pharmacy providers including independent pharmacies that are crucial to serving our members in rural and frontier areas. We will solicit participation from these identified providers in our pharmacy network. *For example, we will identify and contract with local independent pharmacies through utilization data that meet the needs of our members in rural and frontier-based areas.* To enhance access, we also will implement our NCQA-accredited mail order pharmacy program.
- ***Specialty Pharmacy:*** OptumRx's program has been in operation since 1999 and it is NCQA-accredited. We will leverage this experience and work with MLTC to improve appropriate utilization and reduce cost through a cohesive infrastructure and delivery mechanism, clinical management of members who use specialty medications, an integrated database of medical and pharmacy claims and maximization of value-based pharmaceutical contracting and reimbursement opportunities.
- ***Education and Outreach:*** We will provide comprehensive education to our members, providers and health plan staff on the pharmacy benefit initially and on an ongoing basis through a variety of opportunities including written materials (e.g., *Member Handbook*, member and provider newsletters), Web-based resources (e.g., PDL, *Provider Administrative Guide, I/DD Toolkit, BH Toolkit)*, community-based forums such as town halls and one-on-one interactions through our community-based care managers and CHWs.
- ***Information Technology (IT) Systems:*** Our IT systems are readily flexible and scalable to support the integration of pharmacy benefits into our infrastructure such as claims, real-time audits, automated prior PAs, predictive modeling, reporting, and member, provider, and pharmacy information and communication. This includes our care management system, CommunityCare, which provides near real-time pharmacy data to our clinicians, providers and member services advocates to support our members.

These core elements combined with our experience and collaboration with MLTC will support a seamless, timely transition and the ongoing provision of high-quality, effective and safe medications to our members in the Heritage Health program.

27. Describe how the MCO will ensure compliance with the Mental Health Parity and Addiction Equity Act, including how the MCO will evaluate and measure its compliance. *3 pages*

Compliance with the Mental Health Parity and Addiction Equity Act

We recognize that nearly one in five Americans faces mental illness; mental health and substance use disorders (MH/SUD) often interfere with an individual's ability to engage in needed services; and challenging and chronic medical conditions are often accompanied by MH/SUD conditions such as depression, anxiety and opioid addiction. As a result, we not only assure access to our MH/SUD services and supports is no more restrictive than for our medical and surgical services, we actively reach out to our members diagnosed with a BH condition or to those members we identify with a BH claim.

Although the BH benefit in Nebraska has historically been carved-out, our integrated affiliate health plans across the nation are industry leaders in assuring clinical and financial models are parity compliant. Our Heritage Health processes, policies and procedures will comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) at all levels of our program. To further enhance our efforts, medical director/CMO, Dr. Horn, and our BH clinical director, Dr. Charles Freed, will participate on the BH Integration Advisory Group.

Upon the passage of MHPAEA in 2008 and the release of Proposed Rules for Medicaid, we implemented a national MHPAEA compliance workgroup, comprising network, regulatory, clinical and legal subject matter experts to conduct a thorough review of and respond to the impact of MHPAEA on all key organizational functions such as benefits, clinical care management processes and network contracting. We will leverage this expertise to assure ongoing parity compliance by:

- Providing education, expert consultation and recommendations to our providers regarding compliance with MHPAEA
- Requiring and supporting our PCPs in conducting BH screenings and referrals for potential or actual BH conditions
- Assuring clinical care management techniques applied to MH/SUD benefits are comparable to and applied no more stringently than the techniques applied to medical/surgical benefits
- Requiring that the criteria for medical necessity determinations for MH/SUD benefits are available to any current member, potential enrollee or contracting provider 24 hours a day, seven days a week online and providing pertinent sections of proprietary American Society of Addiction Medicine (ASAM) guidelines for SUD upon request
- Eliminating copayments for all medical and MH/SUD services in Nebraska
- Offering peer-to-peer consultations as needed following inappropriate authorization requests to ensure our providers understand the provisions of MHPAEA
- Making sure that member materials include a clear description of MH/SUD services and levels of care benefits
- Providing clear communication to members and providers for any denial of services, reimbursement or payment including the reason for the denial and instructions for filing grievances and/or appeals
- Maintaining accessible BH provider networks in urban, rural and frontier service areas

We will assure the processes used for MH/SUD are comparable to and applied no more stringently than those applied to medical/surgical benefits by aligning our policies and procedures with the MHPAEA including, but not limited to, the following:

- Definition and use of medical necessity and clinical criteria
- Care management processes
- Clinical reviews and utilization management including prior authorization (PA)
- Step therapy protocols
- Out-of-network access
- Fraud, waste and abuse
- Network development and standards for provider admission to our network
- Value-based contracting

Our members will have transparent access to the necessary information and support to compare non-quantitative treatment limitations (NQTLs) of medical/surgical benefits and MH/SUD benefits. This includes our medical necessity definition; available MH/SUD services and supports; PA processes; appeals, grievances and state fair hearings information; and who to ask for assistance in understanding the requirements of and NQTLs for MHPAEA. This information will be included in our *Member Handbook* and on our secure member website, *myuhc.com.* We also will include links on *myuhc.com* to CMS (*cms.gov/CCIIO*) and Substance Abuse and Mental Health Services Administration (*samhsa.gov*) that provide additional information on the processes, strategies, evidentiary standards and other factors used to apply NQTLs. We contractually require our providers to adhere to the provisions of the MHPAEA. In addition, our health plan staff is trained on MHPAEA and will assist members and their families in understanding this information as needed. This includes our in-state member call center staff, NurseLine employees, community health workers (CHWs) and care managers.

Evaluating and Measuring Compliance with MHPAEA

In support of this commitment, we will use detailed quantitative treatment limitation and NQTL data collection tools. These tools support the documentation of the quantitative testing required by parity (substantially all and predominant testing) and alignment of the NQTL applied to MH/SUD benefits. We will set quantitative limits however will not impose different requirements for BH PA than medical PA requirements. **UnitedHealthcare is committed to spending less time on PA processes for BH services and more time on evaluating accessibility, availability and quality of services being provided.** We look for ways to make our PA processes for members and prescribers more friendly and efficient. For example, by layering in an automated diagnosis check into our system for attention deficit disorder medications, we are able to authorize these in an automated fashion, eliminating the need for a PA request.

Under the direction of Dr. Horn, our multidisciplinary clinical team will continually evaluate and measure our ongoing compliance with MHPAEA. Our focus will continue on monitoring treatment patterns and providers through the analysis of claims data and management of our PA, concurrent and retrospective review and care management processes through the following:

- ***Claims Data:*** We will review and analyze claims data for BH services to identify changes in spending following member and provider education on MHPAEA. For example, we will monitor claims data to identify members with a BH diagnosis who may be receiving more or less services than what is expected and best practice for the member's identified condition including analyses of inpatient days, medication management, psychotherapy utilization and prescriptions. We will assess for any increases in MH/SUD diagnoses, outliers, multiple visits per week and potential patterns of fraud, waste and abuse.

- ***Prior Authorization:*** PA has historically been required more frequently for BH outpatient services than medical outpatient services. We monitor PA requests to assure our providers understand that only non-routine BH outpatient and specialized BH services require PA such as psychological testing and electroconvulsive therapy. For example, because we always authorize appropriate prescribing for attention deficit disorder, we have layered in an automated diagnosis check into our system that automatically authorizes these requests, eliminating the manual submission of a PA request.
- ***Concurrent Review:*** We recognize that concurrent review is frequently used for BH outpatient services while infrequently used for medical outpatient care; therefore, PA requirements for BH services will decrease and the need for reauthorization will be reduced as well. For example, we will monitor for standard services that exceed best practice time frames and providers with members who have long lengths of care.

To assure our medical management techniques for MH/SUD are comparable to and applied no more strictly than the medical management techniques that are applied to medical and surgical benefits, UnitedHealthcare will revise our policies and procedures accordingly, and will educate our members and train our providers and health plan staff as follows:

- ***Members:*** We will provide MHPAEA information and education to our members in our *Member Handbook* and on our secure member website *myuhc.com*. Information will include member rights and responsibilities; our medical necessity definition and clinical criteria; PA processes; and who to contact with questions or concerns about access to MH/SUD services including our network providers, MSAs, NurseLine staff, CHWs, care managers and health plan supervisors as needed.
- ***Providers:*** We will provide MHPAEA information to our providers during orientation and ongoing activities through written materials, webinars, town halls and online materials including our *Provider Administrative Guide*. Peer-to-peer consultation for MH/SUD services will be available 24 hours a day, seven days a week. We will identify providers with outliers (e.g., frequent requests for inpatient services) through our review processes and will participate in ad hoc training with our provider advocates and/or peer-to-peer consultation as needed.
- ***Health Plan Staff:*** We will train our staff on MHPAEA and affected policies and procedures including, but not limited to, member services, NurseLine, disease management, care management, utilization management, and grievances and appeals staff. This will occur during new hire, ongoing, annual and ad hoc trainings through a variety of modalities such as classroom, Web-based and mentoring activities.

We will conduct ongoing monitoring of provider and health plan compliance with MHPAEA through a variety of means including our review of member appeals and grievances, member satisfaction surveys, PCP screening of and referring members to MH/SUD services, medication utilization including psychotropic drugs, inpatient utilization, inter-rater reliability reports and GeoAccess reports. These reviews will allow us to determine and respond to changes in access to and utilization of MH/SUD services and supports.

IV.F. Member Services and Education

28. Describe member services processes including:

"I love how quick and easy the call was. It was straight to the point and very clear about exactly what we had to do. I thank you all very much. I don't feel that I have wasted any time at all on the matter ... it was handled perfectly. Absolutely great!"

–Member quote recorded during Nebraska Member Service post-call survey

We understand and fully agree with the requirements set forth in Section C. Customer Service in II. Procurement Procedures. Our robust experience and longstanding connection to MLTC since 1996 bolster our continued commitment to exceeding basic customer service standards and responding to member needs by providing reliable, accurate and straightforward one-stop member services experiences to Medicaid populations in Nebraska. We have **continually exceeded our service standards**; 30 seconds average speed to answer with an actual average of 19 seconds, and 5 percent abandonment rate with an actual average of 2 percent, since 2010. The requirements in Section C resonate soundly with our organization and are supported by a recent transition to our new, consumer-centric member services model, *Advocate4Me*.

An award-winning member services model, *Advocate4Me is* a complete re-thinking of the traditional member experience, emphasizing a simple, personally relevant interaction that focuses on helping members resolve their issues and offers them additional support to maintain and improve their health. This evolution in our service model was the result of using human-centered design methodologies, including member interviews, to generate ideas, concepts and prototypes that were tested and iterated with members. *Advocate4Me* provides straightforward, one-stop interactions, with the objective of resolving a wide range of issues and concerns in a single call, while proactively engaging members with information and support tailored to their unique situation. *Advocate4Me* organizes all aspects of support around Nebraska members, and provides them with a single point of contact—the member services advocate (MSA)—for the duration of their issue. MSAs "own the inquiry," staying with the member to make sure his/her problem or question is resolved. This level of accountability helps to remove the burden from members. MSAs are empowered to answer questions and solve issues, including benefits and claims, provider search and selection, appointment scheduling, and seamless connections with wellness, clinical and behavioral health (BH) resources.

Advocate4Me directs member calls through *intelligent routing* (discussed below) to the appropriate MSA best suited to assist them and address the reason for their call, significantly reducing the need for call transfers and repeat calls, and simplifying the member experience. Through comprehensive training, and data and analytics, we equip our MSAs to support each member in a thorough, personalized manner. MSAs are empowered to anticipate members' needs by *leveraging extensive member data* available on their desktops. Our systems notify MSAs of opportunities to assist members on issues ranging from PCP selection, appointments and closing gaps in care, empowering MSAs to work with the member on resolving his/her immediate questions and taking steps to maintain or improve his/her health. As needed, MSAs connect members with care managers, providers, social workers, BH clinicians and a myriad of specialty resources. The following Figure IV.F-1 represents our nationwide results thus far, including all of our lines of business that employ *Advocate4Me*.

Figure IV.F-1. The graphic above demonstrates the excellent performance results we are experiencing due to our award-winning *Advocate4Me* member services model. These results translate into enhanced member experiences.

We will serve Heritage Health members through a prompt connection to our experienced, well-trained staff Monday through Friday from 7:00 a.m. to 7:00 p.m. Central time, exceeding the minimum requirements of the new contract. In alignment with our commitment to MLTC, **our Heritage Health member services call center will be located in Nebraska.**

Managing member expectations, eliminating gaps in care and delivering service with compassion is at the heart of our member services model. We set high standards around customer service and are continuously evolving to make sure we deliver customer satisfaction in keeping with our core values of integrity, compassion, relationships, innovation and performance.

Training of customer service staff (both initial and ongoing).

Initial training begins by introducing all MSAs to our core customer care philosophy. MSAs experience 11 weeks of rigorous training where they receive the tools and information they need to provide comprehensive assistance for our members. The member services team uses *MyCoach*, an electronic document repository that provides MSAs with valuable state-specific information, access to global standard operating procedures and job aids. Using *MyCoach,* our MSAs assist callers with navigating local resources and the health care system. We also provide training for handling urgent/emergent calls, recognizing symptoms of medical and BH crises, pharmacy inquiries, fraud/waste/abuse and disability awareness.

Our MSAs receive training on the enhanced capabilities of our *Advocate4Me* member services model, including the *community services referral module*, to refer members to food banks, job placement and other local resources; *prevention and wellness module* to resolve barriers from closing gaps in care; and *provider processes module* that trains the MSA to offer to schedule appointments, minimizing member effort.

Ongoing training includes information on the very latest in program updates, related changes and requirements. Ongoing training also addresses cultural competency and special health care coordination needs of Nebraska members, including: cultural awareness and understanding of health disparities among cultural groups; treating each person with dignity and respect; communication protocols for members with limited English proficiency; and barriers facing individuals with special health care needs. At least once a year, we will bring in a panel of trained BH peer specialists to provide in-service training for our staff on

the perceptions of members who use our services. We will encourage our network providers to sponsor similar training.

Ongoing training is provided through many methods including *supervisor monitoring* of calls followed by one-on-one coaching; *ad hoc training sessions* led by supervisors and conducted through Web-based tools, one-on-one coaching or team meetings; *general refresher courses* on important topics such as member experience, ethics and confidentiality; *weekly newsletters* to all MSAs that include reminders regarding policy and procedures. Ongoing training also includes compliance instruction on our Code of Conduct.

Compassion Notes

Each telephone interaction provides an opportunity for our member services staff to educate our members and their families, but more importantly to really listen to their needs and make a personal connection. To enhance and extend these connections, our MSAs send handwritten notes, such as get well, sympathy and thank you cards, in addition to other acknowledgements. So far, in 2015, Nebraska member services staff have mailed more than 400 handwritten notes to members and their families in the state.

Routing calls to appropriate persons, including escalation.

Call center technologies manage the flow of incoming calls for efficiency. Our *Adovcate4Me* member services model employs intelligent routing and natural language technology to enable skill-based and priority call routing, successfully linking Nebraska members to the appropriate MSA who is trained and ready to assist with the member's issue or concern.

Through ***intelligent routing***, our *Advocate4Me* technology system matches the member's phone number to the member record, which comprises extensive information including clinical profile, health system utilization, benefits information and previous interactions with member services. The interactive voice response (IVR) system requests that the member speak his/her member ID or Social Security number for appropriate member verification purposes. Using ***natural language technology***, the IVR enables members to identify the reason for their call, thus providing further expedited service. Natural language capabilities recognize more than 70,000 keywords and route the call based upon the member's statement. Collectively, these technologies connect the member to the appropriate resource, providing member-specific data to assist the MSA with call resolution.

Nebraska members can connect directly to NurseLine through the IVR, 24 hours a day, seven days a week. As needed, MSAs make warm transfers to member-assigned care managers, NurseLine or applicable community services. If a warm transfer to a care manager is not possible, the care manager is notified and returns the member's call within 30 minutes.

Our MSAs receive training to recognize issues that require **call escalation or transfer for specific needs**. If unable to resolve a member's issue, the MSA escalates the call, through a warm transfer or three-way conference call, to our subject matter experts (SMEs) for additional support. The SME group is a specialized team within our member services center that provides hands-on support for MSAs. Our MSAs receive comprehensive training on recognizing and responding effectively when a member calls with an urgent need, situation or crisis, or if there is a perception of urgency. We provide training on handling urgent needs and situations during new employee orientation, annually and on an ad hoc basis. MSAs understand emergency protocols and can refer the caller, or make a call, to 911. In addition, MSAs warm-transfer calls to BH crisis lines.

Making information available to customer service staff (the type of information and how it is provided, e.g. hard copy or on-line search capacity).

Our MSAs have desktop access to member data across our systems, allowing for a consistent, integrated, holistic approach to meeting each member's unique needs, as demonstrated in Table IV.F-1:

Table IV.F-1	
Information/Tools	**Source/Description**
Clinical Information	***CommunityCare:*** The system provides a person-centered view of members' data, including clinical information, prescription history, health assessments, plan of care, clinical interventions, frequency and scope of services authorized and used. It identifies members' care level requirements, documents preferences, expressed needs and goals, in addition to input from representatives or family members.
Member Benefits	***Benefit Summary:*** MSAs use the benefit summary to assist callers with benefit information including covered services and services that require authorization. The benefit summary provides information related to the member's program enrollment. These documents are loaded into the MSA's online application and provide a direct link to the benefits and services tied to each member. It also includes information on carved-out services. Information updates occur for all benefit changes, such as the recent addition of hospice services coverage.
Provider Network	***Network Provider Data:*** Includes panel and provider contact information in addition to specialty, board-certification status, geographic location including address and telephone number, office hours, open or closed panels, accessibility for members with a disability, linguistic capabilities, hospital affiliation and more.
Member Assistance	***Interpretation Services:*** Our interpretation services are available by telephone in more than 200 languages to help MSAs assist members in real-time. ***Healthify:*** For Heritage Health members, MSAs will use the *Healthify* database to provide information on social service agencies and local community support.
Eligibility and Claims	***CSP Facets:*** The system provides MSAs with access to member and provider information, including member eligibility, PCP, benefits information and claims transactions.
State-Specific	***One Source:*** The system trains staff on Nebraska-specific summary level information. Demographic and geographic information are included to provide MSAs with a thorough understanding of the state.
Issue Resolution	***MACESS (online routing system):*** Our internal communication system is used to route issues for resolution between departments. ***MyCoach:*** Our online tool is used to aid in the handling of member calls by providing global and state-specific program information, including job aids and bulletins.
HEDIS Measures	***Universal Tracking Database (UTD):*** This system is the framework where MSAs can access member information to address gaps in care where the member is noncompliant. It also provides MSAs with information on preventive health so they can assist members in identifying advanced symptoms and help members schedule appointments for preventive care screenings and tests.

Handling calls from members with limited English proficiency and persons who are hearing impaired.

Continued Enhancements to Our Communication Capabilities

We track the number of incoming calls from members requesting interpreter services. The top requested languages requested for Nebraska members are Spanish, Karen and Arabic. Collecting and evaluating this information enables us to assign staff, provide training and prepare culturally appropriate materials and other resources for our members in Nebraska.

Upon enrollment, we solicit our members' needs for interpreter and translation services through welcome calls and other interactions, and document these in the member's record, using the knowledge to provide language-appropriate materials. We continually determine the need for changes or additions to verbal and written member tools by collecting data on ethnicity and preferred written and spoken languages. We analyze this data to identify the major cultural and linguistic groups in our service areas to confirm adequate staff preparation and training, and prepare culturally appropriate materials and other resources.

Delivering a consistent member experience as part of our one-stop service model includes focusing on the quality of the interaction

with our members and providing personalized service, including speaking to the member in his/her first language. Our staffing model promotes hiring of bilingual MSAs, and our interpretation services are always available through the member services call center and NurseLine to provide Nebraska members with access to more than 200 languages to meet their communication needs. To provide further assistance to our members with their communication needs, we offer providers the use of our translation services as needed for communication during member appointments.

Our member services call center and NurseLine use the 711 National Telecommunications Relay Service (TRS) TTY line to facilitate communication with hearing-impaired members. We print the contact information on all member mailings and marketing materials. MSAs and RNs receive training on handling calls from TRS operators who are assisting our hearing-impaired members. When the office is closed, the TRS operator leaves a message on the system requesting a call back. We return those messages the next business day using TRS via 711.

Monitoring and ensuring the quality and accuracy of information provided to members.

Quality analysts perform call-monitoring activities on a regular basis to make sure MSAs are providing members with accurate information and adhering to established procedures. We capture and measure call data via a call distribution system. We record all inbound member services calls, including crisis and non-crisis calls, so that we can monitor random samples. Supervisors replay taped MSA calls for quality training purposes at least one day per week, allowing timely quality reviews and recorded feedback, which we provide to our MSAs. Call monitoring provides us with continuous quality improvement and retraining opportunities to confirm member services excellence for Nebraska members. We use Qfiniti, an integrated customer interactions suite, to record calls received in our member services center.

All recorded calls are available for review and analysis through our behavioral analytics capabilities. Behavioral analytics is a behavioral model program that assists our MSAs in matching their communication style to the personality of the caller and uses language-based algorithms to predict caller dissatisfaction (rating the member's level of distress or satisfaction). We use these capabilities to provide ongoing training for our staff, such as identifying verbal cues and the best way to respond. We also use behavioral analytics to deliver performance improvement specifics to our MSAs, enabling continued development of their call-handling abilities and techniques, resulting in excellent customer service.

Monitoring and ensuring adherence to performance standards.

We work diligently to meet and exceed performance service levels to make sure our Nebraska Medicaid members are receiving efficient handling of their issues and concerns. **We consistently exceed performance standards** for the Nebraska Medicaid program and have demonstrated performance metrics for September 2010 through September 2015 in the Table IV.F-2:

Table IV.F-2: Compliance Scorecard	Targets	2010 - 2014 Average
Abandonment Rate %	< 5%	2%
Average Speed of Answer (seconds)	30	19

We will comply with the call-center performance standards for the Heritage Health program referenced in Section F. Member Services and Education, 2. Member Services Call Center by:

- Answering 90 percent of calls within 30 seconds or directing calls to an automatic call pickup system with IVR
- Verifying that no more than 1 percent of incoming calls receive a busy signal

- Maintaining an average hold time of three minutes or less
- Maintaining an abandonment rate of not more than 5 percent
- Returning all voice mails no later than the next business day

We will continue to provide member services reports in an MLTC-approved format.

Member Satisfaction: We use a ***post-call survey*** to assess our members' experience and evaluate staff performance. Callers receive the option to participate in a post-call phone survey allowing them to leave feedback about the experience. Participating members respond to survey questions by applying a rating scale. Our member services quality staff monitors the results on an ongoing basis. This team calibrates data collected, searching for opportunities for improvement, and intervenes to provide training as needed. If a member indicates he/she is dissatisfied with an experience, he/she receives follow up by a supervisor. In 2014, **our member experience survey results indicated high satisfaction from our members in Nebraska, with results averaging 93.8 percent**.

How MSRs will interact with other organizations including MLTC, other MCOs, and other programs/social service entities (e.g., WIC, housing assistance, and homeless shelters).

Member calls can be warm-transferred to entities including, but not limited to, care managers, NurseLine, BH crisis line, support services, state agencies (e.g., ACCESSNebraska), provider's offices and more. Our MSAs conduct a warm transfer by introducing the member and summarizing his/her needs. If necessary, our MSA can contact the entity on a separate call to get information or obtain a return call for the member. A follow-up call from the MSA notifies the member of the call outcome. Our MSAs will use *Healthify*, a Web-based tool, to connect members to relevant and available community resources that deliver services such as food, housing, employment assistance, energy, support groups and clothing. MSAs will be able to warm transfer to these organizations to facilitate services for Heritage Health members.

After hours procedures. *6 pages*

Calls to our member services center after-hours reach our IVR system, which provides instructions for an emergency. Through our IVR, members have the option to speak to an RN, available through NurseLine 24 hours a day, seven days a week and staffed to triage immediate health concerns, in addition to connecting members with a BH crisis line. IVR after-hours messaging informs members that the office is not currently open and provides hours of operation. Members have the option to leave a message through our voice mailbox and obtain a return call the next business day. The voice mailbox provides clear instructions on how to leave a message and contains adequate capacity for member messages.

29. Describe the informational materials the MCO proposes to send to new members. *2 pages*

We have been creating informational member materials for new Nebraska Medicaid members since 1996, meeting all state and federal requirements, and we will continue to build upon our current experience and knowledge to provide high-quality informational materials for new Heritage Health members and their families. We will fully comply with the requirements outlined in Section F. Member Services and Education, 4. Requirements for Member Materials in IV. Project Description and Scope of Work and obtain MLTC approval for all materials. We design our materials to help members understand their health benefits and to encourage them to close gaps in care through regular checkups and maintenance of current health conditions. Member materials support such topics as EPSDT compliance, reduction in ER use, use of prenatal services and more. We understand that new members are concerned with understanding and learning how to use their benefits, and their ability to make appointments with the PCP they choose. Our onboarding process takes these concerns into account with messaging that reassures new members and provides guidance.

We will comply with Heritage Health ID card requirements specified in Section F.9. Member ID Cards and mail the member ID card to new members within 10 days of receiving enrollment information. We understand that members will be issued a minimum of two separate member ID cards: an ID card issued by MLTC to all Medicaid-eligible individuals that is not proof of eligibility, but can be used by providers to access the State's electronic eligibility verification system; and an ID card issued by the member's MCO. Heritage Health ID cards will include the member's name, the member's Medicaid ID number, the enrollment broker's toll-free number, our name and address, member instructions for emergencies, the member's PCP name and applicable telephone numbers, our member services number and appropriate numbers for filing grievances and reporting fraud. **Our initial contact with the member is our welcome card carrier letter**, which delivers the ID card and critical information to help the member get started without feeling overwhelmed. The welcome card carrier letter provides information about the ID card and benefits start date, and requests members who have not selected a PCP to contact member services for assistance. It provides our member services call center number and encourages members with assigned PCPs to schedule an appointment. In addition, the letter includes information on accessing and navigating our secure member portal (*myuhc.com*) and using our *Health4Me* mobile application.

UnitedHealthcare Community Plan

Bienvenido a UnitedHealthcare Community Plan. Tome unos minutos para leer su Manual para miembros y analizar sus beneficios.

Números de teléfono importantes:

- **Servicios para Miembros** **1-800-641-1902**
  TTY para personas con problemas de audición **711**
  Se encuentran disponibles servicios de intérprete.
  Disponible de lunes a viernes de 7 a. m. a 7 p. m.
- **Línea de enfermería NurseLine℠** **1-877-543-4293**
  Se encuentran disponibles servicios de intérprete.
- **Administración de la Atención Médica** **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **Baby Blocks℠** ..... **www.uhcbabyblocks.com**
- **Vision** **1-800-879-6901**
- **Transporte: IntelliRide (iridenow.com)** **1-855-531-3783**
  En Omaha **402-401-6999**

UnitedHealthcare Community Plan cuenta traslados para asistir a citas del programa Mujeres, Bebés y Niños (Women, Infants and Children, WIC), clases prenatales y para embarazadas, clases sonbadas de ejercicio y nutrición, asesoramiento nutricional y reuniones de Alcohólicos Anónimos.

Spanish **www.myuhc.com/communityplan**

UnitedHealthcare Community Plan

مرحبًا بك في خطة الصحة المجتمعية UnitedHealthcare Community Plan. يرجى قراءة دليل الأعضاء ومراجعة المزايا التي تستحق الحصول عليها.

أرقام هاتفية مهمة:

- خدمات الأعضاء **1-800-641-1902**
  جهاز الهاتف للصم (TTY) للأشخاص الذين يعانون من مشكلات السمع أو النطق **711**
  خدمات الترجمة الفورية متاحة.
  متاح من الاثنين إلى الجمعة، من ٧ صباحًا إلى ٧ مساءً.
- خط التمريض NurseLine℠ المتاح على مدار الساعة وطوال أيام الأسبوع **1-877-543-4293**
  خدمات الترجمة الفورية متاحة.
- إدارة الرعاية **1-877-856-6351**
- Healthy First Steps® **1-877-813-3417**
- Baby Blocks℠ ..... **www.uhcbabyblocks.com**
- Vision **1-800-879-6901**
- IntelliRide (iridenow.com) :النقل **1-855-531-3783**
  في أوماها **402-401-6999**

توفر الخطة المجتمعية UnitedHealthcare Community Plan وسيلة نقل من وإلى مواعيد WIC، الحصول التوعية لرعاية الحمل وحلقات الولادة والنساء الحوامل المخصصة للتمرين والتغذية وخدمات مجموعة مدمني الكحول المجهولين (Alcoholics Anonymous).

Arabic **www.myuhc.com/communityplan**

Figure IV.F-2. The image above is a portion of our Nebraska quick reference card, printed in six languages.

Our second new member mailing is the welcome packet, sent within 10 business days of receiving enrollment notification, which provides the member with extensive plan information. The welcome packet currently provided to Nebraska Medicaid members includes the ***Member Handbook*** (available in English and Spanish), information about our innovative *Health4Me* mobile application and a multilingual welcome card, which provides a list of important phone numbers and helpful reminders about member benefits. The quick-reference card, Figure IV.F-2, is written in the six most

requested languages by our Nebraska members from interpretive services (English, Spanish, Karen, Arabic, Vietnamese and Burmese).

For Heritage Health, we will continue to provide the *Member Handbook*, information on *Health4Me* and the multilingual quick-reference welcome card. The welcome packet for the Heritage Health program also will include information on requesting the *I/DD Information Guide*, *Behavioral Health and Substance Abuse Handbook* and *Special Needs Planning Guide*.

We recognize the importance of providing our Heritage Health members and their families with a comprehensive *Member Handbook* that includes essential information. Our customizable *Member Handbook* is designed to be easy to read, simple to navigate and is organized according to member preferences. Information contained in our current *Nebraska Medicaid Member Handbook* includes, but is not limited to: benefits/covered services/authorizations; using the secure member portal; language and cultural help; initial health risk screening; appropriate utilization of services including emergent and urgent care; member notification of changes that affect eligibility; understanding the PCP's role; the member's rights to change providers and select a different MCO; the member's right to a free second opinion; the policy on referrals for specialty care; our waiver of copayments; carved-out services; information that the member has the right to refuse to undergo any medical service, diagnosis or treatment due to objections based upon religious grounds (including a child's parent or guardian); obtaining assistance with advance directives; information about our physician incentive plan and service utilization policies. Our current *Member Handbook* also includes information on EPSDT, prenatal care and fraud, waste and abuse.

For the Heritage Health *Member Handbook*, we will submit a draft to MLTC for review and approval within a minimum of 120 calendar days prior to the contract start date. The Heritage Health *Member Handbook* will fully comply with all requirements specified in Section F. Member Services and Education, 5. Member Handbook in IV. Project Description and Scope of Work. It will have coverage and benefits information to include BH, pharmacy and transplants. It will contain descriptions and purposes of Medicaid and UnitedHealthcare ID cards, including why both cards are necessary, how they should be used, member responsibility, and that misuse of cards could result in loss of Medicaid eligibility and/or legal action. The Heritage Health *Member Handbook* will include information about appropriate/inappropriate behavior of members when seeing a provider; making, changing and canceling medical appointments; referrals for benefits not furnished by the PCP; immediate notification when filing a workers' compensation claim; state fair hearings; and reporting alleged marketing violations.

Our welcome packet provides instructions for accessing the *Member Handbook* on the member portal and contacting member services to request a hard copy. We notify members at least once a year of the option to receive the *Member Handbook* in electronic and printed formats. We also provide an audio version of the *Member Handbook* in English and Spanish. All materials meet real-time, cultural, linguistic and reading level needs.

The ***Provider Directory*** provides members with the information they need to find a PCP who meets their needs. It includes the type/specialty, location and business hours for every network PCP. For the Heritage Health program, the *Provider Directory* will receive extensive revisions to account for expansion into new counties and integration of BH and pharmacy services. Upon request, we will mail a hard copy of the *Provider Directory* to enrolled member households. Provider searches are also available on our member portal (*myuhc.com*) and free mobile application (*Health4Me*). Members can customize their searches using parameters such as location, name, specialty or condition.

30. Describe the approach the MCO will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the MCO will ensure that materials are at the appropriate reading level. *2 pages*

We understand the importance of providing members with easily understood materials and recognize that if our members are unable to comprehend our communications, they will not receive the information they need to make health decisions and take appropriate action. We provide written materials to our Member Advisory Committee for review and feedback to initiate actionable improvements and enhancements. All of the materials we currently use meet the language and reading level needs of Nebraska Medicaid members, are written at a 6.9 grade-level and are approved by MLTC. We will continue our commitment to members of the Heritage Health program by providing easily understood and culturally proficient materials.

Providing Materials in Non-English Languages

The welcome kit we currently provide to Nebraska members includes a quick-reference card in six languages: ***English, Spanish, Karen, Arabic, Vietnamese and Burmese***.

We currently provide our Nebraska Medicaid members with written materials in Spanish, such as the *Member Handbook (Figure IV.F-3)*, *HealthTalk* newsletter and *Baby Blocks* brochure. We will continue to provide written materials in Spanish to Heritage Health members in compliance with program requirements.

We solicit, verify and document our members' needs for interpreter and translation services during welcome calls and other member interactions with our staff. We continually determine the need for changes to verbal and written member materials by collecting data on ethnicity and preferred written and spoken languages. We analyze this data to identify the major cultural and linguistic groups in our service areas and identify any additional languages that are prevalent among our membership. If Heritage Health enrollment, or potential enrollment, reaches at least 4 percent for a non-English-speaking group, we will publish materials in those languages. We also monitor the languages most requested through our interpretive services line (e.g., number of callers and languages requested) to assess additional needs. In addition to materials mentioned above, communication venues in multiple languages include the following:

Our welcome packet contains a multilingual quick-reference card in the six most requested languages by our Nebraska Medicaid members (English, Spanish, Karen, Arabic, Vietnamese and Burmese).

Our secure member portal, myuhc.com, supports English, Spanish, Creole, Ilocano, Korean, Tagalog, Vietnamese and Chinese.

A comprehensive online educational resource for children, teens and parents that is already available in Nebraska, KidsHealth provides articles and videos in English and Spanish.

Available in English and Spanish, our uhclatino.com site engages Hispanic individuals, providing valuable health information, nutritious recipes and more.

Through a link on our member portal (myuhc.com), Heritage Health members will be able to access our BH support website, liveandworkwell.com, which provides content in English and Spanish.

We will place health education kiosks in clinics and other MLTC-

Figure IV.F-3. Member Handbook. Our *Member Handbook*, a comprehensive resource for members, is available in English and Spanish.

approved areas so that we can reach Heritage Health members with no access to the Internet. Through these kiosks, Heritage Health members will be able to complete their initial health screening and access health and wellness materials in English and Spanish.

Providing Materials in Alternate Formats

We serve the needs of Nebraska Medicaid members by providing written materials in alternative formats in compliance with F. Member Services and Education, 4. Requirements for Member Materials in IV. Project Description and Scope of Work. Alternative formats include Braille, large print, voice recorded audio formats and verbal explanations. Our MSAs are also available to read member materials aloud, if needed, and assist the member in understanding the content. We will provide an audio version of the *Member Handbook* in English and Spanish. To communicate with our hearing-impaired members, we use the 711 National TRS/TTY line and include this telephone contact information on all member mailings and materials.

For our members with cognitive issues, related to disease states (e.g., Alzheimer's) or developmental disabilities, our MSAs receive training to assist using empathetic listening and when necessary, engage the assistance of a care manager for member assistance.

Confirming Appropriate Reading Levels for Member Materials

Just Plain Clear Communications

We develop our materials using our Just Plain Clear® Communications glossary, an internal initiative to enhance health literacy by simplifying communications. Just Plain Clear uses health care and health insurance terms prepared in English and Spanish that are easy to understand. Our goal is to make educational messaging understandable, accessible and actionable.

Providing Member Materials at or below a 6.9-Grade Reading Level

We distribute Nebraska Medicaid member materials written at or below a 6.9-grade reading level, where terminology permits (e.g., certain medical terms may be higher than a 6.9-grade reading level). We regularly review and update member materials to comply with any required reading-level changes in the program and include feedback from members to customize materials to program requirements. We will continue to provide materials at a 6.9-grade reading level for Heritage Health, in compliance with member material requirements.

To confirm that member materials do not exceed the 6.9-grade reading level, we use our proprietary Doc Scrub Readability tool. This tool rates and confirms that the materials we produce are easy to read, understand and act upon, and that they present information in a manner that most members can easily understand. The Doc Scrub database, based upon the Flesch-Kincaid reading level tool, provides us with details such as word count and readability. It notates the reading level and highlights words or sentences that give the document a higher-than-recommended reading level. Upon reviewing the tool's suggestions, we make necessary changes, and the tool updates and displays the new reading level of the document.

31. Provide an overview of the MCO's proposed member website, including how it will satisfy requirements in this RFP. Provide examples of information that will be available on the website and on portals for members. *6 pages*

Meeting the Needs of Our Members – Digitally
We understand the importance of providing easily accessible information and resources for members and potential members. Our public and secure member websites and mobile application have appropriate reading levels, multiple language offerings and culturally appropriate materials. We continue to enhance website accessibility for individuals with disabilities as technology standards evolve.

Our ever-evolving digital landscape serves as a common thread across our physical health and BH programs to facilitate access and increase member engagement wherever and whenever needed. This includes tailored digital communications, mobile and Web-based tools that provide secure access to member support through digital channels, and through shared access to data, empowering our members to make informed and confident choices.

We provide both a public website and a secure member website. Both are compliant with Section 508 of the U.S. Rehabilitation Act and the requirements in Section F. Member Services and Education, 10. Member Website in IV. Project Description and Scope of Work. Further, we understand MLTC must pre-approve website materials. Our websites are culturally competent and provide users with current and accurate information.

Public Website

We provide a public website, *uhccommunityplan.com*, which is accessible without registration. This website provides information about health plans available by ZIP code, specific health plan benefits, pharmacy and drug lists, the *Member Handbook* and a listing of network providers—the same information included in other marketing channels/brochures and posters. The website also provides contact information for assistance with Medicaid questions and enrollment, and undergoes yearly usability testing. Members can link to our secure member portal, *myuhc.com*, from our public website.

Secure Member Portal

Our member website, ***myuhc.com***, Figure IV.F-4, is the hub to all of our decision support, collaborative, transactional, clinical and educational resources. Used by our members across more than 20 Medicaid plans, including Nebraska, the member portal serves all demographics, simplifies the user experience, is personalized (e.g., focused on specific member interests and behaviors) and helps close gaps in care. The portal has won multiple awards, including Gold for Patient Education Portal website, from Digital Health Awards, and the highest honor from World Wide Web Health Awards for excellence in Web-based consumer health content. Members can register on *myuhc.com* and our free mobile application, ***Health4Me*** (more details below), to experience a powerful online tool with features that can help them understand their health plan and make informed timely care decisions.

Figure IV.F-4. Our member portal, *myuhc.com*, provides an organized, user-friendly interface enabling members to navigate the website easily to contact us, locate information and link to other resources.

Our member portal is interactive and accessible using a computer or mobile device. The member portal includes bi-directional communication capabilities, allowing members to send and receive communications. To contact us, members click the "Ask a Question" link, where they are able to complete basic fields to request a call from our member services center. Members receive a call back from an MSA within one business day. For members who need clinical assistance, the ability to chat online with RNs is available 24 hours a day, seven days a week. In addition, members can contact us via our free mobile application *Health4Me*.

Our member portal provides general and up-to-date information about the Nebraska Medicaid program and UnitedHealthcare. We will obtain appropriate approval from MLTC for materials included on the website. To maintain the accuracy of the information we provide on *myuhc.com*, we review and update member materials as needed to comply with program changes or feedback we receive from members. Our digital marketing team continually reviews and updates the member portal to maintain consistency and accuracy of information, and to verify compliance with Nebraska program requirements. The team also uses a change log tracking system that documents all website changes and updates that have taken place. We regularly encourage members to use our online directory, which enables them to receive the most up-to-date information on participating providers and their available benefits and services.

Our member portal is compliant with applicable privacy and security requirements, including HIPAA. Member registration is required to access the secure member portal.

Our member portal is compliant with Section 508 of the Americans with Disabilities Act, meeting standards for people with visual impairments and disabilities. A recent member portal update included

enhancements for accessing all website elements via keyboard, increasing color and text contrast, improving semantic markup, increasing form accessibility and making keyboard navigation more usable. We continue to enhance website accessibility for individuals with disabilities as technology standards evolve.

Directing Member Actions on *myuhc.com*
Our consumer carousel member portal enhancement, scheduled for 2016, will use rotating banners to guide Heritage Health members, directing them to download a *Member Handbook*, complete their health risk screening, and more.

Our member portal complies with MLTC marketing guidelines and will comply with all marketing guidelines for the Heritage Health program.

Our member portal does not require a specific interface or browser and displays on all popular browsers. We test myuhc.com on the following popular browsers: Internet Explorer Version 9 and newer; Safari Version 5.1 and newer; Chrome 23.0.1271.97 and newer; Firefox 17 and newer. Future enhancements will not affect member accessibility.

Our secure member portal is user-friendly and organized for straightforward navigation. The member portal for Nebraska Medicaid members currently includes the following required information specified in Section F. Member Services and Education, 10. Member Website:

- ***The most recent version of the Member Handbook in English and Spanish*** is located in the "Benefits and Coverage" section of the website and via a link on the left side navigation. The member portal will contain a link to the audio versions of *our Member Handbook* in English and Spanish.
- ***Telephone contact information*** to include toll-free member services number and TDD number is located by clicking the "Contact Us" link.
- ***A searchable list of providers*** is available by clicking the main menu item "Physicians and Facilities." Provider searches are also available on our free mobile application *Health4Me* (see below for details). Members can customize their searches using parameters such as location, name, specialty or condition. Mapping and driving directions are available. We follow established processes for maintaining a fully updated provider directory and an online search enables members to receive the most up-to-date information. Information available to the member includes open or closed panel, languages spoken, handicap accessibility, board certifications, hospital affiliations and any available links to the provider, group or hospital website.
- ***A link to the enrollment broker's website*** and the toll-free number is located under "Information Center."
- ***A link to the Medicaid eligibility website (accessnebraska.ne.gov)*** is located under "Information Center."
- ***The latest information on filing grievances and appeals***, such as the process to file a grievance and related information is located in the online *Member Handbook* (Benefits and Coverage).

We understand the value of offering a comprehensive member portal as a resource, and we also believe in optimizing Heritage Health member engagement by providing Web-based guidance that influences his/her behavior. We will accomplish this through our consumer carousel, a member portal enhancement the members log in to schedule for 2016 that uses rotating banners to guide the member toward an action after he/she logs in to the secure member portal. Members who click on a rotating banner land on a page specific to their need. Rotating banners (as demonstrated in the graphic on this page) may include, "Can't find your Member Handbook? Download one below" or "Why take a health assessment?" (See Figure IV.F-5)

Figure IV.F-5. A member portal enhancement planned for 2016 will add our consumer carousel to guide members toward specific actions, such as downloading a *Member Handbook*.

Additional resources available to members on *myuhc.com* include the online health assessment/personal health profile, member ID card, coverage status, benefits search, PCP assignment, health care services history and claims, thus enabling members to review their claims and immediately contact us if they observe any evidence of FWA. The member portal includes a member survey to record the member's website experience. It also enables members to check eligibility and receive information and health reminders specific to their health status. Menus provide options for members that range from obtaining member publications in multiple languages to viewing member responsibilities and privacy information.

The following highlights the major areas of the home page and the member supports and materials built into *myuhc.com*:

- ***Links and Tools:*** Links and Tools connect members to a searchable directory of providers, important information on pharmacy claims and the ability to search for a medical or BH clinician in their area.
- ***Common Questions:*** This section of the portal answers common member questions about the health plan and the safety and connectivity of the site. It provides important information about site registration, how to obtain a member ID card, and locating local physicians and health care facilities.
- ***Member Feedback:*** We have a permanent survey feature on our member portal that collects online visitor feedback and allows us to have a continuous feedback mechanism for site enhancements.

For the Heritage Health program, the secure member portal also will provide seamless links to other important member resources, including:

- ***CommunityCare:*** Our integrated coordinated care platform, *CommunityCare*, facilitates member-specific information sharing with the care manager and interdisciplinary care team participants authorized by the member to access his/her clinical information. Information includes overdue preventive gaps in care, such as cancer screenings, and the member's plan of care goals and action steps.
- ***OptumRx.com:*** *OptumRx.com* provides pharmacy and prescription management online. The site can assist members with prescription adherence by sending text message notifications to remind

them to take their medicine. Members can find medication and lower cost alternatives covered by their plan.

- ***KidsHealth:*** The online *KidsHealth* resource (already available to Nebraska members) provides children, teens and their parents with over 200 videos and 10,000 written or spoken articles on a variety of health and wellness topics to help high-risk members manage their conditions and encourage healthy behaviors among all children, young adults and their parents/guardians. Videos and articles are available in English and Spanish.

Access to Behavioral Health Information and Resources

Award-Winning BH Website
Liveandworkwell.com received the Interactive Media Award's (IMA) Outstanding Achievement Award (health care category) for design, content, feature functionality, usability, standards compliance and cross-browser compatibility. The site also received the eHealthcare Leadership Award.

The Heritage Health secure member portal will provide a link to our award-winning BH website, *liveandworkwell.com*, which provides information on a variety of topics including recovery, well-being support and health management. The site has received Utilization Review Accreditation Commission's (URAC's) website accreditation, NCQA and URAC Health Utilization Management accreditation.

A companion website, *MenteSana-CuerpoSano.com* (Healthy Mind-Healthy Body), also accessed via *myuhc.com*, is the award-winning affiliated site to *liveandworkwell.com* for Spanish-speaking members. *MenteSana-CuerpoSano.com* is not simply a Spanish translation of *liveandworkwell.com*, but provides culturally relevant material for our Hispanic/Latino members. The site contains extensive content and uses a community and family-focused approach in overcoming stigmas to seeking BH care. *MenteSana-CuerpoSano.com* and *liveandworkwell.com* are resources for educational materials and advocacy information, and promote holistic health and wellness as illustrated below.

Educational materials and tools to promote early awareness, detection and prevention of BH disorders are widely available on *liveandworkwell.com*. Members learn of these resources through our *Member Handbook* and interactions with peer support specialists, care managers and providers. Our *liveandworkwell.com* online health and wellness library features more than 12,500 articles, 60 videos and texting programs relating to BH, lifestyle and well-being issues from reliable resources (e.g., Johns Hopkins University).

Liveandworkwell.com also provides users with ***advocacy information***. The "Tools & Programs" link in the Quick Links box offers access to health assessments, tobacco cessation program, personal empowerment self-help programs, online journaling and more. Selecting the "Resources" link in the Quick Links box displays a wide array of directories to help members find local resources including support groups. Each database is searchable by member-directed parameters to locate specific information.

Liveandworkwell.com features ***holistic health and wellness information***. The "Be Well" area addresses healthy living and aging, recovery and resiliency, addictions, mental health and chronic medical conditions. Clinical topics featured include depression, stress, autism, post-traumatic stress disorder (PTSD), grief and alcoholism. Health risk screening tools are included for depression, anxiety, medical comorbidities, diabetes, heart disease, brain trauma and PTSD.

In addition to *liveandworkwell.com*, we are providing a link from our secure member portal (*myuhc.com*) for Heritage Health members to ***Common Ground***, an interactive Web-based resource that enhances provider-patient communications and supports BH self-management. *Common Ground* enables the

member to create a recovery goal, or power statement, on which to focus his/her BH treatment, helping him/her to remain motivated during the treatment period. After the recovery goal/power statement is established, the member completes a questionnaire that focuses on his/her current condition, expectations from treatment and any concerns. Information from the questionnaire electronically transfers to the patient's record and is available to the provider prior to, or at the beginning of, the member's first appointment. This enables the provider to understand and assess the BH issues requiring treatment. The provider also is able to recommend self-help tools and education programs that are available within *Common Ground* to support the member in between appointments.

Mobile Access to Critical Information

Connecting by Smartphone is Health Smart
According to a recent Pew Research Center study, 56 percent of American adults now own a smartphone. Seventy-seven percent of low-income individuals aged 18 to 29 own a smartphone.

For users of our secure member portal, *myuhc.com*, our free ***Health4Me mobile application*** is also available, supplying members and their families with instant access to critical information. Users can simply download the application to their smartphone, Figure IV.F-6, and log on, using their *myuhc.com* login credentials to sign into their account for convenient access to many features, such as viewing claims, locating providers and requesting callbacks from member services and NurseLine.

Health4Me leverages member and claims data to identify preventive services needed by the member. This information is accessible to the member through the "Recommended Care" link on *Health4Me*. In addition, *Health4Me* sends push notification reminders to members letting them know that a care notice is available to view in the secure application.

To support a seamless, single sign-on experience for our members, we provide accessibility to our *Baby Blocks* program through *Health4Me*. Expectant or new mothers can enroll in this interactive incentive program and access it using their smartphone.

Figure IV.F-6. Health4Me Mobile Application

Health4Me provides member access to the member ID card, *Member Handbook*, our contact information, health risk screening, provider searches, coverage and benefits, and recommended care based upon a member's specific gaps in care. In addition to the features that provide helpful information, users can access the "Get Answers" section for two options:

- ***Talk with Us:*** The "Talk with Us" link is available to receive a call back from our well-trained MSAs. Users can ask questions about enrollment, benefits and claims, etc., and receive the answers they need right away.
- ***NurseLine:*** For a call back from one of our experienced RNs, members click the NurseLine link for fast and convenient access to clinical support.

Health4Me recently won the "App of the Year" award as presented by Best in Biz Awards.

Our secure member portal meets all requirements in Section F. 10. Member Website in IV. Project Description and Scope of Work. Both *myuhc.com* and *Health4Me* promote education for members and provide them with convenient methods to access eligibility, benefits, coverage and health information. All of our Web-based member resources are continually evolving to exceed the needs of our members.

32. Discuss the MCO's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the MCO would use to effectively welcome members. *3 pages*

We recognize that improved health outcomes and reduced medical costs are closely linked to increased member participation and education. Our approach to welcoming new members centers on prompt engagement and delivery of learning opportunities. We provide easily understood materials that accommodate members' reading levels to help members understand their plan. In addition, we initiate personal interactions through welcome calls, availability of our trained and experienced MSAs, clinical outreach and CHWs in the field locating and engaging hard-to-reach members. We will employ new member welcome activities for Heritage Health members in compliance with the requirements in Section F. Member Services and Education, 13. Communication with New Members in IV. Project Description and Scope of Work.

Member ID Card

We understand that members will be issued a minimum of two separate member ID cards; an ID card issued by MLTC to all Medicaid-eligible individuals that is not proof of eligibility, but can be used by providers to access the State's electronic eligibility verification system; and an ID card issued by the member's MCO. We will mail the member ID card within 10 days of receiving enrollment information. Heritage Health ID cards will include the member's name, the member's Medicaid ID number, the enrollment broker's toll-free number, our name and address, member instructions for emergencies, the member's PCP name and telephone numbers, our member services contact information, and other numbers for filing grievances and reporting fraud. The member ID card will include prescription-billing information that complies with the standards set forth in the National Council for Prescription Drug Programs' Health Care Identification Card Pharmacy and/or Combination ID Card Implementation Guide at the time of card issuance. In addition to our name, it also will include the prescription benefit manager, and all electronic transaction routing information and numbers required to process a prescription claim electronically.

Our initial contact with the member is our welcome card carrier letter that delivers the member ID card and critical information to help new members get started, without overwhelming them. The welcome card carrier letter requests members who have not selected a PCP to contact our member services center within 10 business days to receive assistance making their PCP selection. It also provides information about the ID card and benefits start date, encourages members to schedule a PCP appointment and includes information on contacting member services. The welcome card carrier letter also provides information on accessing and navigating the secure member portal (*myuhc.com*) and using our *Health4Me* mobile application.

For members who did not initially select a PCP, we will send a replacement ID card with the PCP's name and telephone numbers within 10 business days of selection or auto-assignment. We also will send a replacement ID card within 10 business days if a member reports a lost card, changes his/her name, changes PCPs, or for any reason resulting in a change of information disclosed on the member ID card. Replacement cards are mailed with a replacement-card carrier letter that informs the member that his/her PCP's name is printed on the new ID card, and that he/she can contact member services anytime to change the PCP. The replacement-card carrier letter also informs members to destroy their previous UnitedHealthcare member ID card and use the replacement card instead. For a PCP change, we will comply with forwarding the member's records (or copies of records) within 10 business days of the request for medical record transfer. Members also have the ability to access their member ID card from our secure member portal (*myuhc.com*) and our mobile application (*Health4Me*) for everyday needs or in the event of an urgent situation, such as filling a prescription.

Welcome Packet

The welcome packet currently provided to Nebraska Medicaid members includes the *Member Handbook*, information about our innovative *Health4Me* mobile application and a multilingual welcome card. For the Heritage Health program, we will continue to provide the *Member Handbook*, information on *Health4Me* and the multilingual quick-reference welcome card, which provides a list of important phone numbers and helpful reminders about member benefits. The quick-reference card is written in the six most requested languages by our Nebraska members from interpretive services (English, Spanish, Karen, Arabic, Vietnamese and Burmese). The welcome packet for the Heritage Health program also will include information on requesting the *I/DD Information Guide*, *Behavioral Health and Substance Abuse Handbook* and *Special Needs Planning Guide*.

We recognize the importance of providing our Nebraska members and their families with a comprehensive reference tool that includes essential information. ***Our customizable Member Handbook is designed to be easy to read, simple to navigate and is organized according to member preferences.*** Information contained in our current Nebraska Medicaid *Member Handbook* includes, but is not limited to, benefits/covered services/authorizations; secure member portal; language and cultural help; initial health risk screening; emergent and urgent care; notification of changes that affect eligibility; understanding the PCP's role, medical transportation and more. It also includes information on EPSDT, prenatal care, appropriate use of the ER and fraud, waste and abuse. We will enhance our *Member Handbook* for the Heritage Health program to include BH and pharmacy benefits, and other important additions. Our welcome packet provides instructions for accessing the *Member Handbook* and *Provider Directory* on the member portal and contacting member services to request hard copies. In addition, we notify members at least once a year of the option to receive the *Member Handbook* in electronic and printed formats. We also provide an audio version of the *Member Handbook* in English and Spanish to assist our members. All materials meet real-time, cultural, linguistic and reading grade-level needs.

Welcome Calls

We follow the new member welcome packet with a personal welcome call to all new Nebraska members. We conduct our welcome call within 15 days of the date we send the welcome packet. The importance of the welcome call cannot be overstated. For many members, this is their first experience with us and it is crucial that we use this opportunity to initiate a relationship. Members new to our health plan, or new to managed care, often have a number of questions during their transition including questions on benefits and assistance with changing PCPs. Our new member welcome team, which consists of experienced MSAs, conducts the new member welcome calls. MSAs receive training to anticipate our new members' unique needs. For example, a member may need to transfer a prescription or obtain authorization for a service he/she is currently receiving. MSAs use innovative tools and scripting to provide validated health plan information, answer any immediate questions and address all concerns our new members may have. We will submit welcome call scripts to MLTC within a minimum of 45 days prior to the contract start date and subsequent revisions will be submitted for approval prior to use. Elements communicated in our welcome call include the following:

- Provide an **overview of the program** and covered benefits and services, including behavioral health and pharmacy
- Discuss **member confidentiality requirements**
- Welcome the member; verify demographic information and educate the member on the *Member Handbook, Provider Directory* and the member portal (*myuhc.com*)

- **Confirm the member's PCP assignment,** discuss the importance of the PCP/member relationship, and assist with making an appointment with their PCP
- Provide assistance to the member with needed **referrals to community and social services,** such as WIC
- Conduct the **initial health risk screening** to identify care management needs, including triaging members to address care management needs and the need for additional transitional support (e.g., pregnancy, chronic conditions, barriers to care)
- Discuss the member's **active treatment plan** and receipt of any covered, medically necessary and authorized services
- Discuss the **importance of EPSDT screenings** with members or their families and assist members who need to complete EPSDT screenings that are due or overdue
- Promote **value-added services**, such as adult well checkups and the *KidsHealth* website
- If applicable, discuss accessing **pregnancy programs and resources** such as Baby Blocks
- Ascertain **receipt of the welcome packet** and resend if not received

We conduct welcome calls to Nebraska members in their choice of primary language, through a bilingual MSA or using interpretive services. We make three outbound call attempts at different times of day to maximize the number of members we reach. If we are unable to reach the member, we send a reminder postcard to the address on file. We make special arrangements for members who do not have a telephone or who have special needs and require a face-to-face meeting to complete assessments. We respect and recognize cultural, linguistic, gender, sexual orientation, socioeconomic, and spiritual- and faith-based differences and how they impact an individual's desire and ability to engage in his/her health care decisions. We will provide all required welcome call reports to MLTC within the required time frames.

Additional Welcome Methods

Our member services contact information appears in the welcome card carrier letter, on the member ID card and within the welcome packet. For new members, our member services call center may be their first interaction with us. Our MSAs are prepared to engage and educate new Nebraska members by delivering information and assisting with all concerns. Through *Advocate4Me*, our MSAs receive alerts to gaps in care, such as the need for a wellness exam, and can assist with scheduling an appointment.

When our risk stratification process identifies a member as high-risk, our clinical team conducts outreach through outgoing calls to the member to address health needs. This outreach includes an additional assessment and provides further support. Care navigators are assigned to members within high-needs groups, such as foster children/youth, LTSS, I/DD, ABD and Katie Beckett waiver populations.

Community health workers (CHWs) are non-clinical staff that collaborate with care managers and care navigators to locate and engage difficult-to-find members. Through intensive feet-on-the-street efforts and leveraging their local knowledge of the community and follow up with community organizations, providers or community groups to get updated contact information for our members, CHWs often have success locating and engaging our members.

33. Detail the strategies the MCO will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles. *5 pages*

By influencing member behavior to access health care and community resources, and adopt healthier lifestyles, we can impact MLTC's three priorities: reduction in non-emergent use of the ER; improved birth outcomes through prenatal, postnatal and pregnancy care; and improved outcomes through coordination and integration of prevention-focused physical and behavioral health services in community-based settings. We offer a high-touch, integrated approach to influencing member behavior, combining physical and behavioral health services, and involving social supports when needed. Our strategies to encourage appropriate use of health care resources and adopt healthier lifestyles include:

- Value-added services and programs
- Universal Tracking Database
- Involvement of the PCP
- Gaps in care notifications
- Other methods

[redacted]

If the member is not able to pay for food, our CHW identifies local food pantries and provides the member with contact information. Our CHWs also help to locate assistance for housing, employment and childcare. Their goal is to reduce the socioeconomic barriers to accessing care and managing health.

Value-Added Services and Programs

In addition to using member convenience motivators, such as same-day visits with providers and urgent care centers, our proposed valued-added benefits align with Nebraska's population health priorities. The following value-added programs will be offered to Heritage Health members to influence healthy behaviors:

Reduction in Emergency Room Use

- ***Waiving copayments:*** To encourage members to adhere to well visits, BH appointments and medication schedules, we waive copayments on covered services. We currently waive copayments for covered physical services, and we will extend waiving copayments to BH and pharmacy services.
- ***Adult physicals and immunizations:*** To promote self-care and healthy habits, we provide coverage for adult physicals and immunizations.
- ***Asthma Care Program pilot:*** We will implement an Asthma Care Program pilot in 2016 to facilitate improved asthma control levels, thus reducing hospitalizations and ER visits. The program will improve self-management skills and medication adherence by providing inhaler attachments capable of automatically tracking usage.
- ***Care navigators:*** Care navigators outreach to members who used the ER inappropriately to provide education on emergent and urgent care.

Improved Birth Outcomes

- ***Baby Blocks:*** Our *Baby Blocks* incentive program focuses on instilling healthy habits and practices for expectant mothers. The program reminds and rewards members for attending appointments during their pregnancy and well-baby appointments. Since the program's launch in Nebraska in October 2013, more than 2,200 members have enrolled in *Baby Blocks*.
- ***Community Baby Showers:*** Through community baby showers, we provide education and awareness about prenatal and postpartum care to pregnant women, new moms and their support systems. Through October 2015, we have participated in seven community baby showers in our service area this year, reaching 158 women.

- ***Healthy First Steps:*** Members identified as pregnant are contacted by a member of our maternity and child health team for enrollment in our *Healthy First Steps* maternity care program, enabling us to verify that our members receive the full services they need.
- ***Twitter:*** We furnish health and wellness information related to pregnancy, child birth and general health information applicable to pregnant women through Twitter (*@UHCPregnantCare*). A Spanish version with the same content is available through *@UHCEmbarazada*.
- ***Text4baby:*** Expectant mothers can sign up for the *Text4baby* program to receive informative and educational texts about pregnancy and childcare.

Reduction in Health Disparities

- ***Community health workers (CHWs):*** Our locally based CHWs personally connect with members and influence their behavior by providing education and the resources they need to access timely and appropriate care. Through the personal interactions that CHWs cultivate with members, they are able to identify reasons members are not receiving appropriate care and work to overcome barriers.
- ***Continuum of Care collaboration:*** Continuum of Care organizations serve as the umbrella to most of the agencies that provide homelessness services including shelters, street outreach, meals, access to transitional housing and homelessness prevention. As an example, in Texas, we are working with these organizations to determine if our members are in the Homeless Management Information System database and receiving homelessness services. To bring this approach to Nebraska, we have begun working with the Omaha and Lincoln Continuum of Cares in the state. This collaboration will enable us to locate and engage members who are homeless or in transitory housing and whose information on the eligibility file may be insufficient. Through this collaboration, we will work to locate, engage and introduce CHWs and BH peer supports so that we can help these members to understand their Medicaid benefits and influence their access to health resources and other social supports.

Behavioral Health Management and Substance Abuse Recovery

- ***Peer supports:*** We will provide education through peer support specialists with recovery-oriented care that emphasizes self-direction and member empowerment. Peer support specialists will meet individually with members and conduct groups to help members identify ways to manage their symptoms and live a healthy and productive life, which is the essence of the recovery philosophy. This may include selecting the right provider or learning how to participate actively in treatment. It also may be encouraging the member to become active in available community activities, take self-management training, or finding opportunities for education and/or employment.
- ***Website with information and self-help tools:*** Our BH website, *liveandworkwell.com*, will be accessible through a link on our secure member portal, *myuhc.com.* It provides educational tools to promote early awareness, detection and prevention of BH disorders. The online health and wellness library within *liveandworkwell.com* features more than 12,500 articles, 60 videos and texting programs relating to BH, lifestyle and well-being issues from reliable resources (e.g., Johns Hopkins University). *Liveandworkwell.com* also provides links to the *Recovery Toolkit* that provides specific practical resources for substance use disorder (SUD) recovery and the *Personal Empowerment Kit* that includes self-assessments, goal-setting and useful techniques for self-management. We are providing a link from our secure member portal (*myuhc.com*) for Heritage Health members to *Common Ground*, a Web-based resource that enhances provider-patient

communications and supports BH self-management by enabling the member to create a recovery goal on which to focus his/her BH treatment.

- ***Youth Peer Support Groups:*** We are collaborating with the Youth Emergency Services (YES) to develop a peer support-group program that helps youth who are going through recovery. The program will be developed in rural areas following the pilot.
- ***Mental Health First Aid:*** We will provide Mental Health First Aid, an innovative approach to training that provides individuals with a basic understanding of the warning signs and what to do if they encounter someone who may have mental illness or an SUD, particularly someone who may be in crisis and in need of rapid assessment.
- ***Question, Persuade and Refer (QPR):*** We will provide QPR, an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond effectively to individuals who are exhibiting suicide warning signs and behaviors. The training teaches professionals and others to detect, assess and manage suicide risks for a range of ages in a variety of professional settings.

Foster Children/Youth Support

- ***On My Way:*** We will provide *On My Way*, a tool to guide and support foster youth through the process of "aging-out" of foster care and becoming independent.
- ***Assigned care navigator:*** Foster children will be assigned a care navigator who will work with their assigned caseworker to coordinate medical and BH services with other state services providing a comprehensive and holistic view of care for the child.
- ***Youth Emergency Services (YES) collaboration:*** We are collaborating with YES, an Omaha organization assisting homeless and at-risk youth and young adults. YES provides critical resources to empower these individuals to become self-sufficient, helping with immediate needs for food, shelter, clothing and safety. Our BH peer support specialist, BH care managers and CHWs will be part of the collaborative team working with YES. This collaboration will enable us to influence behavior with educational efforts for foster youth that are aging out of the system.

Closing Gaps in Care

- ***MyMoney Connect:*** The myMoney Connect program provides a reloadable prepaid debit MasterCard® to Medicaid members with an integrated wellness rewards program enabling them to earn incentives for taking steps to improve their health.
- ***Health fairs:*** In collaboration with our partners, we participate in health fairs in Nebraska to bring education to members and other residents to influence their behavior and interest them in adopting healthy behaviors. For example, we participated in Cinco de Mayo health fair events in south Omaha, providing educational materials on pregnancy and nutrition to Latino communities in Spanish and English. Approximately 3,000 Nebraska residents participated in the event.
- ***Impact Pro™ predictive modeling tool:*** Our predictive modeling tool (*Impact Pro*) stratifies members by risk level to determine the level of intervention designed to maintain and improve health from an MSA, care navigator, CHW or care manager. *Impact Pro* also identifies members with BH conditions, including members with co-occurring, mood and psychotic disorders, considers the impacts to a member's risk based upon comorbid conditions and promotes a holistic approach to member care. Providers and care management staff track our members through various touch points to note when members complete checkups and close their gaps in care. On a monthly basis, *Impact Pro* synthesizes member-integrated data and develops individualized risk profiles. This helps our care management team identify a member who is trending toward a higher

or lower level of care, which may prompt a reassessment. Reassessment results may be used, along with other data, to re-stratify a member in a lower or higher level of care and may prompt an interdisciplinary care team to adjust a member's existing plan of care. Supplemental health risk assessments help us channel those with special health needs into care management programs and other targeted services, as needed.

- ***CommunityCare care management platform:*** Our care management collaboration platform, *CommunityCare*, provides PCP information, member Medicaid ID, a record of each service event, appointments, a record of all immunizations, a listing of the member's durable medical equipment (DME) along with the ability to capture notes and store attachments. *CommunityCare* integrates evidence-based medicine gaps in care and hospital admission, discharge and transfer (ADT) messaging for review by the member's care team and allows the care team to input information about interactions with members, such as post-ER discharge follow-up and care. *CommunityCare* facilitates information sharing and communication. *CommunityCare* includes the Population Registry, which offers a comprehensive view of services used by any given care population. Using the member view within Population Registry, providers can view a member's clinical history, while the population view lists members in a provider's practice who need specific follow-up, such as preventive or chronic care services, and processes/steps for specific follow-up. *CommunityCare* also allows the care team to quickly identify a member's gaps in care, including needed EPSDT services.

Chronic Disease Management

- ***2016 Asthma Care Program pilot:*** We will implement an Asthma Care Program pilot in 2016 to improve self-management skills and medication adherence by providing inhaler attachments capable of automatically tracking usage. These sensors can connect to mobile applications, providing asthma education, medication reminders and other self-management tools.
- ***Chronic disease management mailings:*** We send educational mailings to newly identified members diagnosed with chronic conditions, such as diabetes and asthma, with follow-up by telephone or in person by a care navigator to perform an additional assessment and provide further chronic disease management and member support.

Reduction in Obesity

- ***Dr. Health E. Hound® programming:*** We deliver nutritional education to parents and children through our mascot, Dr. Health E. Hound, who promotes fitness and healthy habits.
- ***4-H Food Smart Families programming:*** We support the University of Nebraska Extension for 4-H Food Smart Families Programming, which provides families with nutrition, cooking and budgeting education, in addition to connections with nutrition assistance resources.
- ***KidsHealth website:*** Our online *KidsHealth* program includes health and wellness resources to encourage healthy behaviors among children, teens and parents and provides informational resources on nutrition, exercise and making smart food choices.

Universal Tracking Database

Our Universal Tracking Database (UTD) is a Web-based tool used by our staff to document and track preventive outreach activities to members and providers using HEDIS-specific criteria. The UTD system allows search capability by family link, so that the care manager can educate the entire family on available preventive services, such as EPSDT services, well-child visits, cancer screenings and adult wellness. This system is claims-based, and reporting is available to track and trend those members

receiving education on the different measures as well as to track whether the service was obtained within 60 days of education. UTD uses HEDIS-specific criteria including:

- Lead screening
- Well-child visits
- Lead screenings in children
- Immunizations
- Annual dental exams
- Chlamydia screening for women
- Breast cancer screening
- Cervical cancer screening
- Comprehensive diabetes care
- Use of appropriate medications for individuals with asthma
- Colorectal cancer screening
- Cholesterol screening
- Controlling high blood pressure
- Glaucoma screening

Involvement of the Primary Care Provider

A strong relationship between the member and his/her PCP is beneficial to the member. The member's PCP has a strong influence on member behavior change. Once this important relationship is established, the member is more likely to participate in his/her own health care by scheduling and attending appointments, and following his/her provider's plan of care.

Gaps in Care Notifications

We analyze claims and utilization data on an ongoing basis to detect variances from evidence-based medicine guidelines. When we detect such variances, we send targeted mailings to the member to provide education and recommend PCP visits for gap closure. Providers receive profile reports to demonstrate variances and are offered member-level detailed reports to assist in gap closure. In addition, we offer cobranded letters to our providers as a collaborative effort to outreach to members and close gaps. We also offer telephonic outreach for the member to reinforce the benefits of following evidence-based medicine recommendations in improving overall health over time.

Other Methods

Other methods to influence member behavior include: health and wellness outreach materials and targeted member outreach events; partnerships with community, faith-based and advocacy organizations; promotion of health and wellness through technology (e.g., our member portal, *myuhc.com*, and mobile app, *Health4Me*) HEDIS-related activities promoting screening services and vaccinations and programs focused on conditions prevalent in high-risk members.

34. Describe the processes the MCO will put in place to ensure the MCO does not restrict the choice of providers from whom the member may receive family planning services and supplies. *1 page*

Heritage Health members may self-refer for family planning services without prior authorization or approval from their PCP. We will comply with 42 CFR 431.51(b)(2), Free Choice of Providers, and will not restrict the member's choice in selecting a family planning services provider, even if the provider is not in our network. Likewise, we will honor claims submitted by Medicaid providers for family planning services, even if the provider is not in our network. Our claims system programmatically generates appropriate payments for family planning services and supplies.

"Enrolled female members have freedom of choice of providers of family planning services."

–The language above appears in the Benefits section on page 33 of the existing Nebraska Member Handbook.

We will build on our current robust network in Nebraska for the Heritage Health program, recruiting providers and monitoring our network to confirm access to family planning services for members in all areas of the state, both rural and urban. We have 744 OB/GYN/family practitioners/mid-level providers across the state to meet the family planning needs of our members. We recruit qualified Medicaid providers who promote culturally sensitive environments, and we offer providers the use of our translation services as needed for doctor appointments to promote understandable communication with the member.

We assist and encourage members to make a choice of providers based upon their own individual needs. We recognize the importance of removing barriers to family planning services, such as a pharmacy for periodic refills (e.g., birth control pills). In this case, we will assist members by connecting the member with a local pharmacy.

We educate our staff on family planning services coverage so they are able to provide clear information to our members. Coverage information is available via desktop in the Benefit Summary used by our MSAs, care managers and other staff to provide accurate information. The Benefit Summary provides our staff with covered services and other information related to the member's program. During telephonic or face-to-face interactions with Heritage Health members, we will answer their questions and provide them with sufficient information to allow them to make an informed choice when self-referring to a family planning services provider.

Member, provider and other educational materials contain language and instructions that clearly state the member's freedom of choice and self-referral abilities regarding family planning services.

35. Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the MCO has used for member education.

We have been providing education-related materials to our Nebraska members and their families for nearly 20 years to advance member knowledge of benefits, improvement of physical health, recognition of BH issues, appropriate use of ER services and more. With our current experience, we will leverage best practices to benefit the member and focus special attention on individuals with complex care, BH and special needs. We support our members in accessing community resources such as food, job assistance, housing, financial assistance and more. Education begins with new member onboarding materials, including the **member ID card, welcome card carrier letter** and **welcome packet**. The member ID card includes instructions for emergencies, our toll-free member services number and other numbers for filing grievances and reporting Medicaid fraud. Accompanying the member ID card is our welcome card carrier letter, which provides step-by-step instructions for how to register on our secure member portal, ***myuhc.com***. On the member portal, members have access to extensive health and wellness information, benefit information, a provider search and the *Member Handbook*. The member portal provides links to additional Web-based educational sites including ***KidsHealth***, **OptumRx** and our BH support website, ***liveandworkwell.com.***

Our ***Member Handbook*** delivers education that includes a description of covered services and appropriate utilization; use of emergency services, facilities and transportation; PCP roles and responsibilities; how to prepare for a doctor's visit; well-child services and how to access them; NurseLine functions and access information. To promote ease in understanding for our members, we will offer the *Member Handbook* in an audio format.

We mail our ***HealthTalk*** newsletter, in English or Spanish, to all Nebraska members. It includes relevant health education topics such as, "Have you taken a Health Assessment?" and "In the zone…Your asthma action plan," featured in our fall 2015 issue.

Throughout our response to this question, we reference numerous member education materials, including *HealthTalk*, disease management brochures, our *liveandworkwell.com* website, etc. We have provided examples of educational materials in Attachment 19 Q35 Member Materials.

- Baby Blocks Brochure
- Personal Empowerment Program
- Health Talk – Member Newsletter
- Asthma Mailer
- Asthma Mailer – Spanish
- Diabetes Mailer
- Diabetes Mailer – Spanish
- KidsHealth Flyer
- Multilingual Welcome Card
- Liveandworkwell.com Screen Shots

We have several other disease management brochures, like mailers for CHF and COPD in both English and Spanish.

We have provided English and Spanish versions of our current Nebraska Medicaid *Member Handbook* behind the Attachment 5 Member Handbook tab.

Innovative Methods Used for Member Education

We use innovative methods to provide BH and substance abuse education, such as linking members from our secure member portal to the BH resource and information website, ***liveandworkwell.com***. *Liveandworkwell.com* provides information on a variety of topics including recovery, well-being support and health management. The site delivers an online library that features more than 12,500 articles, 60

videos and texting programs relating to BH, lifestyle and well-being issues from reliable resources (e.g., Johns Hopkins University). *Liveandworkwell.com* also provides links to the **Recovery Toolkit** that provides specific practical resources for SUD recovery and the **Personal Empowerment Kit** that includes self-assessments, goal-setting and useful techniques for self-management. An additional Web resource for BH issues is our ***KidsHealth*** website, which provides parents, teens and children with access to informative videos and articles. To help community members to recognize signs of BH issues and crises, we provide in-person training through **Mental Health First Aid**. To address the importance of BH service, we provide the **Question, Persuade and Refer (QPR)** program, an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond effectively to someone exhibiting suicide warning signs and behaviors. The training teaches professionals and others to detect, assess and manage suicide risks for a range of ages in a variety of professional settings. Mental Health First Aid is another innovative approach to training that provides individuals with a basic understanding of the warning signs and what to do if they encounter someone who may have mental illness or an SUD, particularly someone who may be in crisis and in need of rapid assessment.

We use innovative methods to provide education on preventive care and promote personal responsibility in our members. We implement specialized outreach programs that provide education on care and offer incentives to members for completing important screenings and immunizations. We also employ increased outreach efforts and provider collaborations to educate Nebraska members on the importance of preventive care. For example, to educate members on the importance of breast cancer screenings, we conducted a member incentive program that provided a monetary gift card reward to members in need of a mammogram for completing the screening. We collaborated with our network physicians, providing them with a list of noncompliant members, to remind members to get a mammogram. This program resulted in an **increase in breast cancer screening rates by 8.3 percentage points**.

We provide education on nutrition by collaborating with community-based organizations to conduct outreach events and health fairs. A fun innovation we use to demonstrate physical activity and healthy eating is our "**blender bike**." We bring "blender bikes" to educational events so that participants can ride the bikes and learn how to create healthy smoothies. We deliver nutritional education to parents and children through our mascot for healthy living, **Dr. Health E. Hound**. We have provided $55,000 to support the University of Nebraska Extension to implement **4-H Food Smart Families** programming, which provides families with nutrition, cooking and budgeting education, in addition to connections with nutrition assistance resources. In the past year, we conducted educational sessions on healthy habits, nutrition and physical activity through our Sesame Street® Food for Thought and Healthy Habits for Life programs. We will continue to seek innovative approaches to encourage healthy nutrition and exercise to combat obesity in Nebraska.

We recognize the need for disease management programs to address chronic diseases, especially asthma, diabetes and ADHD. We will address asthma issues with our innovative **Asthma Care Program pilot**. In 2016, we will pilot an intervention to improve asthma care in Omaha where well-identified asthma disparities exist, particularly in the eastern portion of Douglas County. While death rates due to asthma have been decreasing these past 20 years, there continues to be a greater impact in Douglas County, and African-American citizens have an average annual death rate twice as high as Caucasian citizens. Due to these recognized asthma disparities in Omaha, we aim to empower those in most need of assistance. The goals of the pilot are to improve self-management skills and medication adherence by providing inhaler attachments capable of automatically tracking usage. These sensors can connect to mobile applications, providing asthma education, medication reminders and other self-management tools. The primary benefit of the program will be improved asthma control level as measured by increased medication adherence,

reduced rescue inhaler use, and reduced hospitalizations and ER visits. We also pay for smoking cessation programs, which provide members with education on the importance of quitting smoking.

Our **Community Computers Donation Program** enables us to donate computers to groups in need. This initiative improves lives in the communities we serve by providing residents with access to information such as social supports, community resources and important health education.

To educate caregivers, we will provide the **Special Needs Planning Guide**, which delivers resources and information to families of members with special health care needs. This guide is a thorough, easy-to-read resource that gives parents a chronological guide for each stage from birth to adulthood. Caregivers receive comprehensive advice and strategies on how to address financial, legal, governmental, family, support and emotional issues.

Describe how the MCO will provide equitable member education throughout the State.

We understand the health disparities across the various demographics and cultures in Nebraska, including residents of rural areas and Hispanic and Native American populations. We customize our member education materials to provide equitable and meaningful engagement across the state to meet needs related to demographics and language. We provide the ability for members with no access to mobile technology or the Internet to obtain informational resources, by mailing materials and following through on telephone requests. Under the new contract, we will provide **health education kiosks** to be placed in clinics and other MLTC-approved areas in the state to provide health and wellness education to Heritage Health members in Spanish and English.

"UnitedHealthcare has done an outstanding job of answering questions and seeking knowledge about people with I/DD and their families in the state of Nebraska. By looking for new and innovative service systems and asking questions about the current systems, I feel that UnitedHealthcare is ready to move forward with any contract it is awarded."

–Michael J. Chittenden, Executive Director The Arc of Nebraska

Our CHWs also support equitable member education, using their knowledge of the community and its resources to locate and engage members, establish relationships, identify and access local community resources, connect members to a PCP, escalate members to a BH clinician and provide education. CHWs work with community committees, providers and organizations to become an integral part of the community.

We provide community outreach specialists in Nebraska who work to develop strong partnerships with community organizations. For the Heritage Health program, we will add a rural community outreach specialist to extend the reach of education into Nebraska communities, thereby providing new and ongoing opportunities for underserved and potentially overlooked populations. For example, our outreach specialist Alberto Cervantes participated on the planning committee for *The Good Life in My Moccasins*, an annual event focused on connecting Native American families to health care and support services. We provided health care education to 250 attendees this year. We have proactively built relationships with Nebraska's four Native American tribes, particularly upon learning of the issues surrounding youth suicide on the reservations. We are working to assist with youth suicide prevention and education programming for the four tribes.

Provide examples and descriptions of how member education will be used to improve service coordination including:

Integration of physical, behavioral health and pharmacy services.

We provide fully integrated physical and behavioral health services in 21 states across the nation, and we manage pharmacy services in 20 states. Prior to and during service integration, we will conduct

community-based forums throughout the state, such as town hall meetings and one-on-one interactions to engage stakeholders on topics of opportunity, including education about the integration of services. We also will hold interactive member orientations at locations across the state, where information will be provided and individuals can ask questions and voice their concerns. Stakeholder engagement meetings may be held prior to or following member orientations. Our active participation in community partnerships, events and health fairs in the state enable us to provide education and information to the citizens of Nebraska, to further understanding of service integration. Our Member Advisory Committee will focus on education about service integration to facilitate a meaningful exchange of information leading to tangible solutions for improved choices and quality of life.

Because we use one information technology platform to manage the full array of services, we have the unique ability to provide a fully integrated approach to services. For example, our MSAs receive training to recognize both medical and BH issues in members who are calling for assistance. We have developed protocols to assist MSAs with caller referrals to trained clinicians who can provide clinical support or a service referral. Our HIPAA-compliant, cloud-based, population health and care management system, *CommunityCare*, enables integration between authorized users including members, care managers, PCPs and specialty physicians, to support communication of critical, relevant and timely member-specific information that is essential to conducting ongoing care planning and coordination across a continuum of services and settings.

Our Heritage Health *Member Handbook* and secure member portal, *myuhc.com*, will provide members with information explaining one-call access to member services for assistance with physical, behavioral health and pharmacy services. The *Member Handbook* will provide detailed integrated services benefits and coverage. The welcome packet we will send to Heritage Health members will inform them how to request the *I/DD Information Guide, Behavioral Health and Substance Abuse Handbook* and *Special Needs Planning Guide*.

Recognizing that individuals may be hesitant to reach out for BH assistance, we provide tools to assist members with education. We will provide access to Heritage Health members to our BH support website, *liveandworkwell.com*, through a link on our member portal (*myuhc.com*). This comprehensive website provides mental health and well-being information, articles on health conditions, addictions and coping. It also enables members to read articles about managing their health and take self-assessments on a variety of topics.

Children, teens and parents can access the online *KidsHealth* website to view information and articles about mental health including depression, anxiety, phobias and more. *KidsHealth* provides links to resources, such as the National Mental Health Association (NMHA).

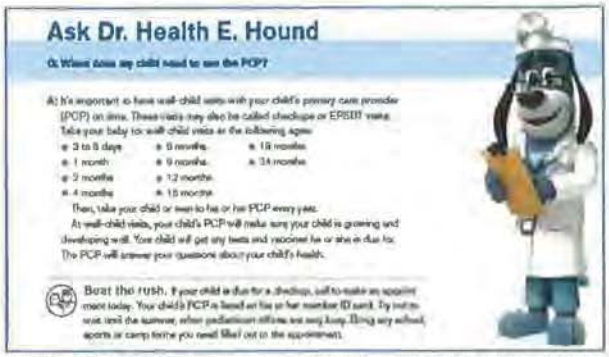
EPSDT compliance.

We are committed to providing our Heritage Health members with education about EPSDT compliance in our efforts toward continued improvement for children and adolescents. For new members, we conduct welcome calls that include an initial health risk screening, allowing us to identify any gaps in the member's care where we can help by providing information, scheduling appointments and arranging transportation.

We partner with select high-volume providers to implement cobranded letter and automated call campaigns to heighten awareness of EPSDT benefits. The cobranded letter and calling campaigns are a collaborative program providing reminders from the member's PCP. The reminder notifies the member that preventive screening services are due and he/she should call to schedule an appointment. These

reminders, mailed three to four times per year, are sent only to members with known gaps. As of October 2015, we have mailed 4,418 cobranded letters to members and their families this year.

We use our website, *myuhc.com*, and member newsletter, Figure IV.F-6, *HealthTalk*, and member mailings such as **birth month postcards** to provide education on EPSDT services. Using monthly member mailings that communicated age-appropriate preventive care screenings, we implemented a successful member incentive program. We achieved the plan-established goal of **increasing the rate of compliance by 3 percent**.


Ask Dr. Health E. Hound

Q: Where does my child need to see the PCP?

A: It's important to have well-child visits with your child's primary care provider (PCP) on time. These visits may also be called checkups or EPSDT visits. Take your baby to well-child visits at the following ages:

- 3 to 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months

Then, take your child or teen to his or her PCP every year.

At well-child visits, your child's PCP will make sure your child is growing and developing well. Your child will get any tests and vaccines he or she is due for. The PCP will answer your questions about your child's health.

Beat the rush. If your child is due for a checkup, call to make an appointment today. Your child's PCP is listed on his or her member ID card. Try not to wait until the summer, when pediatrician offices are very busy. Bring any school, sports or camp forms you need filled out to the appointment.

Figure IV.F-6. We leverage our member newsletter to educate members and their families about EPSDT compliance.

Our Baby Blocks program reminds expectant mothers to attend their prenatal, postpartum and well-baby appointments. Our *Member Handbook* also provides information about available EPSDT services, including eligibility and obtaining assistance with appointments and transportation. The *KidsHealth* website provides several articles for parents about immunizations. Another way we support EPSDT compliance is by conducting health-screening events. We engage local organizations to sponsor screening events and health fairs where we can provide education and literature on annual checkups and other health-related issues. For example, through our partnership with **Completely Kids**, an Omaha-based organization working to educate low-income families, we provided health education to over 300 families at an elementary school event in May of this year.

Appropriate emergency room utilization.

We understand the difficult choices imposed on members when they must make health care decisions while they are sick or injured. We employ numerous methods to educate our members about ER use so that they are prepared and knowledgeable on appropriate reasons to seek ER services, including through our new member welcome call; member portal (*myuhc.com*) and mobile application *Health4Me* available 24 hours a day, seven days a week; our member newsletter *HealthTalk* and the *Member Handbook*. Our *Member Handbook* includes a section titled "Hospitals and Emergencies" that defines reasons to go to the ER. The *Member Handbook* also explains to members who may be having a difficult time deciding whether to go to the ER that there are resources to help them make their decision, such as the following:

- ***Contacting their PCP by phone:*** Network providers are required to be available 24 hours a day, seven days a week. Through this availability, providers can assist members on seeking the appropriate level of care. Our vendor, DialAmerica, and our provider advocate team conduct monitoring of after-hours access to ensure compliance.
- ***Contacting member services/NurseLine:*** Our MSAs provide information to help members make decisions about services they should seek. In addition, NurseLine is available 24 hours a day, seven days a week. The RNs answering the calls can provide information to help members recognize symptoms and choose the right level of care. They also can provide education regarding a member's health condition. Our NurseLine teams are skilled at supporting members to access the appropriate level of care. Nationally, 31 percent of callers reported they used a less urgent and expensive source of care after engaging with NurseLine.

We deliver direct information to members through interactions with care managers and CHWs, who work directly with members to remove underlying barriers to accessing care and close gaps by helping

members adhere to their plan of care. We provide educational materials and newsletters to offer condition-specific information, including recommended routine appointment frequency, necessary testing, monitoring and self-care. We design these materials to empower members with the information they need to understand their conditions. Our CHWs emphasize the importance of obtaining preventive care that reduces inappropriate ER use. CHWs participate in interdisciplinary care planning and help members recognize symptoms of worsening chronic conditions and seek help from their PCP before it reaches crisis level.

We also provide education through **peer support specialists**, with recovery-oriented care that emphasizes self-direction and member empowerment. Peer support specialists meet individually with members and conduct groups to help members identify ways to manage their symptoms and live a healthy and productive life, which is the essence of the recovery philosophy. This may include selecting the right provider or learning how to participate actively in treatment. It also may be encouraging the member to become active in available community activities, take self-management training or find opportunities for education and/or employment.

The use of prenatal services.

Providing expectant mothers with education on healthy behaviors, resources and support is critical for improving pregnancy and child care outcomes in our communities. We deliver information to expectant mothers related to prenatal care, nutrition, prematurity prevention and parenting through programs and community outreach. We provide education via the *Member Handbook*, member portal, automated calls and our newsletter, *HealthTalk*. Our MSAs provide education during welcome calls and other interactions.

A dedicated maternity and child health team manage our maternity care program, **Healthy First Steps** (HFS). Through HFS, we verify that our members receive a comprehensive, coordinated, full spectrum continuum of maternity care and receive education, outreach and coordination of labor and delivery services, treatment of pregnancy-related conditions, nutrition and family planning services.

Figure IV.F-7. Baby Blocks. Our Baby Blocks brochure teaches expectant mothers how to sign up for the program.

Our **Baby Blocks** program uses online tools to remind and reward members for attending appointments during pregnancy and into the first 15 months of their baby's life. More than 2,200 Nebraska members have enrolled in the *Baby Blocks* program since its launch in October 2013 with nearly 700 children completing the program. We provide a Baby Blocks brochure, Figure IV.F-7, to help expectant mothers sign up for the program.

We partner with the National Healthy Mothers, Healthy Babies Coalition to deliver educational cellphone text messages through ***Text4baby***. All members are encouraged to sign up for the no-cost program. Expectant mothers receive text messages until their estimated due date. Members receive postpartum follow-up messages, along with well-baby care/visit reminders up to one year after delivery.

Expectant mothers can follow us on **Twitter, *@UHCPregnantCare***, where our messaging delivers health and wellness information relating to pregnancy, childbirth and general health information applicable to

pregnant women. Our Spanish version, *@UHCEmbarazada*, includes the same content as *@UHCPregnantCare*, but allows our audience the option to choose their preferred language.

Through **community baby showers**, initiated through our community partnerships in Nebraska, we reach pregnant women, new moms and their support systems to provide them with education and awareness about prenatal and postpartum care. Through October 2015, we collaborated with Educare in Omaha and Lincoln and other community partners for seven community baby showers in our service area this year, reaching 158 women.

The use of technological tools, including social media and mobile technology.

Using the Web-Based *Healthify* Tool

Our CHWs, care managers, outreach specialists and MSAs use the Web-based tool *Healthify* to provide Nebraska members with quick referrals to nearby social services, thus going beyond immediate clinical needs to address the needs of the whole person.

Our member portal, *myuhc.com*, enables Nebraska members to log on to a secure member portal, providing a convenient way to access information such as a downloadable *Member Handbook*; searchable list of providers; health care services history and claims; benefits and coverage information; member rights and responsibilities; information on how to file grievances and appeals; and health and wellness information. *Myuhc.com* links members to our Spanish-language website, *uhclatino.com*. This site provides health and wellness information, healthy recipes and more. *Myuhc.com* also links members to the online *KidsHealth* program that includes health and wellness resources for children, young adults and their parents. A vast amount of content is available, including assistance for high-risk members with managing conditions such as diabetes, asthma and stress. Videos, written and spoken articles are accessible through a computer, tablet or smartphone.

Members who use our secure member portal, *myuhc.com*, will appreciate the convenience of our *Health4Me* mobile application for accessing their member ID card and claims information, reviewing health benefits, locating in-network providers, learning about health and wellness, accessing contact information and more.

We furnish health and wellness information related to pregnancy, childbirth and general health information applicable to pregnant women through *Twitter* (*@UHCPregnantCare*). A Spanish version with the same content is available through *@UHCEmbarazada*. Expectant mothers can sign up for the *Text4baby* program to receive informative and educational texts about pregnancy and child care.

For the Heritage Health program, we will provide additional educational Web resources, linked through our secure member portal, such as the ***liveandworkwell.com*** BH support website. It includes mental health and well-being information, articles on health conditions, addictions and coping. It also enables members to take self-assessments on a variety of topics, read articles and locate community resources. *Liveandworkwell.com* provides Spanish translation of content for our Spanish-speaking members. In addition, we are providing a link for Heritage Health members to ***Common Ground***, an interactive Web-based resource that enhances provider-patient communications and supports self-management. *Common Ground* enables the member to create a recovery goal, or power statement, on which to focus his/her treatment, helping him/her to remain motivated during the treatment period. After the recovery goal/power statement is established, the member completes a questionnaire that focuses on his/her current condition, expectations from treatment and any concerns. Information from the questionnaire electronically transfers to the patient's record and is available to the provider prior to, or at the beginning of, the member's first appointment. This enables the provider to understand and assess the issues requiring treatment. The provider also is able to recommend self-help tools and education programs that are available within *Common Ground* to support the member in between appointments.

We currently leverage social media to provide health education and are expanding our initiatives to include ***Facebook***. Members viewing our Facebook page from Nebraska will see localized communications (events and Heritage Health program information) in addition to general interest content (preventive health tips and healthy eating on a budget).

Partnership with community-based organizations for education and outreach. *10 pages*

The purpose of our outreach activities is to educate and empower members and eligible individuals about the importance of preventive health care and disease management, and to promote better health education and access to care. Under the direction of Kim Manning, marketing and community outreach director, our community outreach experience in Nebraska is extensive. We will continue our work with existing partners, in addition to forming new relationships to educate and serve the needs of Medicaid populations in Nebraska.

- ***4-H partnership:*** Our partnership has focused on providing resources for 4-H programs in underserved communities
  where health issues, such as obesity and diabetes, are disproportionately high. We use the **Food Smart Families** program to address the issues of food insecurity and poor nutrition by providing education, cooking and budgeting skills, and connections with nutrition assistance resources in the community. The young people who participate in the program are encouraged to take action for themselves, their families and within their communities to promote healthy living priorities and achieve improved physical, social and emotional well-being. Through our 4-H partnership, we sponsor the **KidzExplore** family festival in the Omaha/Council Bluffs area each year. This year we provided an educational activity with our "exercise blender bikes."
- ***Educational events:*** We have collaborated with numerous partners to attend events and provide health education, including:
  - D.R.E.A.M. (Developing Relationships through Education, Athletics & Mentoring)
  - Completely Kids (assists more than 2,000 children and their families via school and homeless shelter partnerships)
  - Heartland Family Services
  - Butler Gast YMCA
  - Center for People in Need
  - Safe Kids Sarpy County
  - Heart Ministry Center (Summer Pathway classes), El Encuentro de La Mujer Sana (Latina women's health summit), Healthy Women's Summit (health education for Latina women)
  - School Nurses Association Conference
  - Omaha YMCAs
- ***Health fairs:*** Health fairs we have participated in this year include:
  - 17th Annual Black Family Health and Wellness Fair
  - Memorial Health Systems Health Fair in Seward
  - Cinco de Mayo Health Fair
  - The Good Life in My Moccasins Family Health Fair
  - Bridge to Care Refugee Health Fair
  - College of St. Mary Health Fair

Educating Nebraska Fathers

We shared information this past year with an Omaha Healthy Start Initiative created for men, by men, called ***Father's for a Lifetime***. This program promotes responsible parenting by delivering training and resources. We provided health information to these dads, many of whom are unaware of available health care services.

- ***UnitedHealthcare Community Grants℠ program:*** Through our Community Grants Program, we are prioritizing the integration of physical and behavioral health. In September 2015, we hosted community brainstorming sessions in Gering, Kearney and Columbus as seen in Figure IV.F-8, in which 104 community members including representatives from local nonprofits, faith-based organizations, public health and medical facilities discussed the source and impact of the lack of integration of physical and behavioral health, determined goals and values for addressing the issue, and brainstormed strategies to address the issue.

  On October 19 and 20, we released a Request for Proposals with the goal of collaborating with community and health services organizations to better integrate physical and behavioral health care. As of the due date, December 4, we received 20 proposals from local organizations. We plan to award two to four grants to nonprofit agencies and FQHCs in Nebraska. Award notification occurs by April 30 and programs will begin July 2016. Successful proposals will support at least one of the following priorities: focus on prevention, early intervention, and/or screening; promote collaboration, multi-disciplinary teams and blended resources; expand quality and culturally competent community-based services; incorporate community health workers or a peer services model.

Figure IV.F-8. Community Grants Meeting. Community Grants facilitator Allison Rojas leading a session with community members in Columbus, NE.

In addition to our outreach educational efforts, we also work to support community needs in Nebraska as described below:

- ***Sesame Street Reading Corners:*** We place Sesame Street Reading Corners in health care facilities to provide preschool-age children with an engaging area to encourage reading and learning about healthy eating habits. The goal of this initiative is to influence healthy eating habits before children reach school age, directly improving their health and indirectly lessening absenteeism. We delivered 15 reading corners to the following health care facilities in Nebraska this year:
  - Charles Drew Health Center (Omaha)
  - People's Health Center (Lincoln)
  - Nebraska Urban Indian Medical (Lincoln)
  - Community Action Partnership Western Nebraska (Gering)
  - Heartland Health Center (Grand Island)
  - Midtown Health Center (Norfolk)
  - Together, Inc. (Omaha)
  - Heartland Hope Mission (Omaha)
  - The DOVES Program of West Nebraska (Gering)
  - Fred Leroy Health and Wellness Center (Omaha)
  - Northeast Nebraska Community Action Partnership (Pender)
  - Good Neighbor Community Health Center (Columbus)
  - Santee Sioux Health Care Center (Niobrara)

- ***Community Computers program:*** Our Community Computers donation program enables us to donate computers to groups in need. This initiative improves lives in the communities we serve by providing residents with access to information such as social supports, community resources and important health education. Through our community computers initiative, we donated 40 computers this year to 10 community organizations throughout Nebraska, including:
  - Southern Sudanese Community Association (Lincoln and Omaha)
  - Salvation Army (Grand Island)
  - Panhandle Independent Living Services (Scottsbluff)
  - Youth Emergency Services (Omaha)
  - Siena Francis House (Omaha)
  - Carole House of Hope (Papillion)
  - Speak Out (11 counties)
  - Open Door Mission (Omaha)
  - PTI-Nebraska (counties throughout the state)
  - Cirrus House (Scottsbluff).

Supporting Computer Access to Improve Lives in Nebraska

Our Community Computers donation program increases the availability of computers within low-income communities and improves lives by:

- Enabling individuals to generate resumes and initiate
- Providing children and teens with access to learning
- Assisting individuals with health literacy and education through use of the Internet

- ***Sponsorships:*** We support community-based organizations through sponsorships and donations, working with leadership to learn about the populations they serve and their needs. Organizations we supported this year include:
  - Together, Inc. (Omaha homeless prevention organization)
  - DOVES (domestic abuse support in five counties)
  - Omaha Home for Boys (Douglas County residential home for at-risk youth)
  - Heart Ministry Center (Omaha center with programs to combat poverty)
  - Stephens Center (Douglas County homeless shelter)
  - Center for People in Need (Lancaster County support for families dealing with mental health and complex health issues)
  - Lutheran Family Services (support for BH services, foster care and more in 10 counties)
  - Mid-Nebraska Community Action (serves 27 counties providing employment, housing, health and other services)
  - Northeast Nebraska Community Action (provides food/shelter and recovery programs to 14 counties)
  - KVC Nebraska (child welfare and BH care in Lincoln and Omaha)
  - Food Bank of the Heartland (mobile pantry program) Special Olympics Nebraska (Healthy Athletes Program)
  - Autism Center of Nebraska (Art Garden)
  - Tribal Youth Suicide Program (Omaha, Ponca, Winnebago and Santee Sioux tribes)
  - Good Neighbor FQHC's Prenatal program
  - Audrey's Shoes for Kids Foundation (Douglas County)

In December, we delivered backpacks for distribution to foster children and youth across Nebraska. They were donated to Compass Foster Care Services, KVC Behavioral Healthcare Foster Care Services and Foster Care Closet. These backpacks provide children and youth with a place to keep their personal belongings.

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IV.H. Grievances and Appeals

36. Provide a flowchart and comprehensive written description of the MCO's member grievance and appeals process, including the approach for meeting the general requirements and plan to:

Ensure individuals who make decisions about grievances and appeals have the appropriate expertise and were not involved in any previous level of review.

Ensure an expedited process exists when taking the standard time could seriously jeopardize the member's health. As part of this process, explain how the MCO will determine when the expedited process is necessary.

Use data from the grievance and appeals system to improve the MCO's operational performance. *3 pages*

Member Grievances and Appeals Process Description

Under the direction of our medical director/CMO, Dr. Horn, and our grievance systems manager, Lori Caldwell, we use sound and mindful clinical decision-making, proactive information gathering techniques and our Nebraska-specific medical necessity definition, clinical criteria and clinical practice guidelines (CPGs) to guide the most appropriate, individualized decisions about services and supports for our members. Figure IV.H-1 Grievances and Appeals Flowchart illustrates our integrated grievances and appeals process that assures we continue to meet state, federal and contractual requirements for timely responses to grievances and appeals.

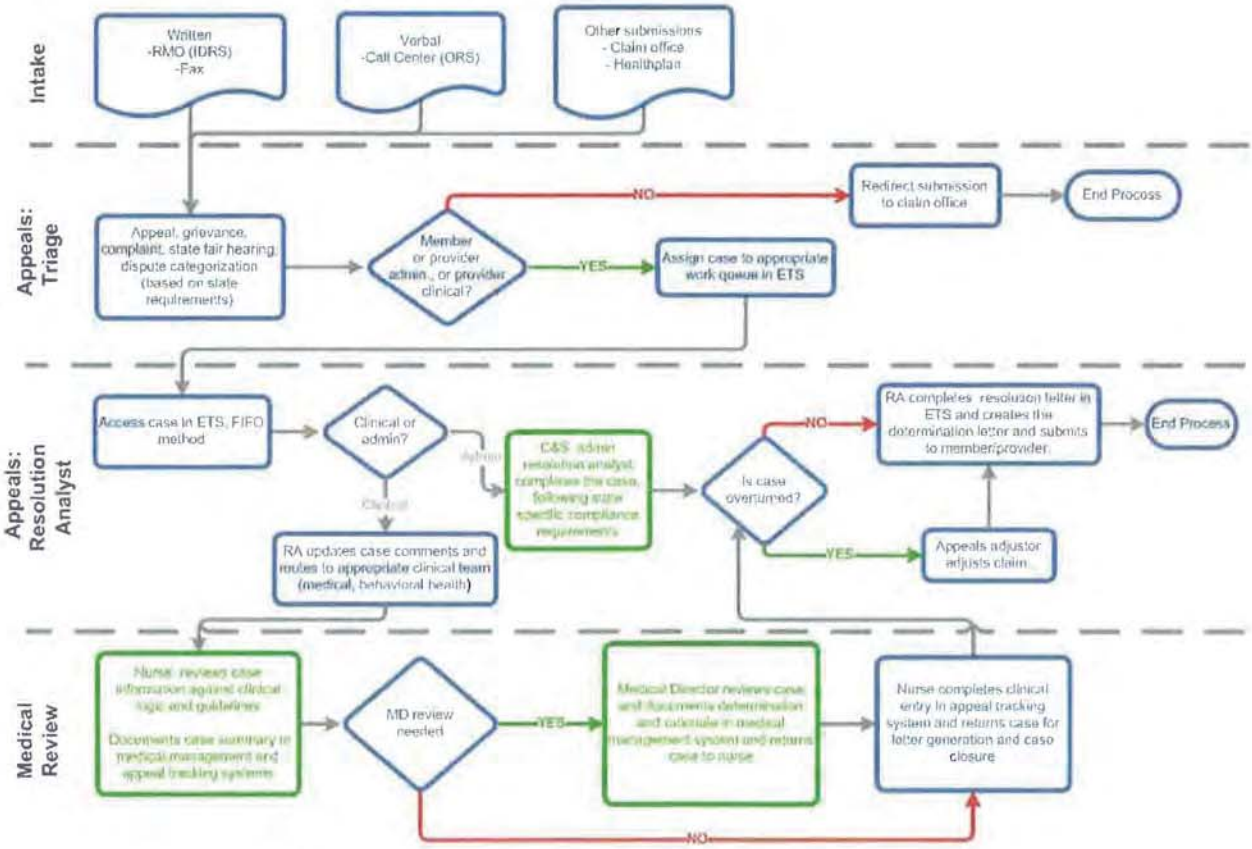

Figure IV.H-1. Grievances and Appeals Flowchart. Our structured member G&A process gives our members recourse to have their concerns resolved in a professional, consistent and timely manner and assures resolution within state, federal and required time frames.

Meeting General Requirements

Since 1996, we have been committed to successfully meeting state, federal and contractual requirements for grievances, appeals and state fair hearings for our members in our Nebraska Medicaid program

through our established processes, policies and procedures for receiving, reviewing, addressing and providing notification of decisions to our members or representatives. ***We have encountered very few grievances due to our person-centered care approach, understanding of system navigation challenges and a "no-wrong-door" philosophy for members to let us know how we are doing.***

Under the direction of Dr. Horn, Ms. Caldwell, our contract compliance coordinator, Tim Langdon, and our Healthcare Quality and Utilization Management (HQUM) committee, we will continue to meet and exceed requirements for our Heritage Health members. We will accomplish this by assuring our processes evolve to address topics including care integration, meeting the needs of complex populations through specialized care such as patient-centered medical homes and trauma-informed care, additional service benefits including behavioral health (BH) and pharmacy as well as new requirements in RFP Section IV.H Grievances and Appeals and 42 CFR 438.226-228.

Our plan includes a comprehensive review and enhancement of our clinical and UM processes and training program for staff that has direct and indirect contact with our members and providers including, but not limited to, the following staff members:

- Member services advocates (MSAs)
- NurseLine clinicians
- Care managers
- Care navigators
- Community health workers (CHWs)
- Grievances and appeals staff
- Utilization management clinicians
- Provider advocates

In the rare event of a grievance, these staff assist members in using the grievances and appeals process in the language of their choice and through user-friendly means such as our interpreter capabilities and telecommunication devices for members with hearing impairments.

Ensuring Appropriate Decision-Making

Our policies, procedures and processes assure our clinicians who make decisions about grievances and appeals have the requisite experience and expertise to make the best decisions for our members. Our board-certified, licensed physician supervises all review decisions and denials. Clinicians involved in any previous review of the request never review denials.

Only licensed clinical staff with the clinical expertise most closely aligned with the member's condition, review member grievances and appeals. This includes our medical director or other licensed staff such as nurse practitioners, RNs, licensed professional nurses and BH clinicians. To further support timely and accurate resolution, we employ skilled resolution analysts (RAs) to gather information and records, investigating all pertinent facts and contacting the member's treating provider as needed. For grievances or appeals that do not involve clinical issues, our RAs research and adjudicate grievances and appeals with support from health plan subject matter experts.

Ensuring Appropriate Expedited Appeals

Our expedited review and resolution of appeals process complies with RFP Section IV.H Grievances and Appeals and upon request by the member, his or her authorized representative or provider, this process includes the following:

- All expedited appeal requests are forwarded to our medical director/CMO, Dr. Horn, to determine if the request meets expedited criteria. This criteria includes life-threatening situations, the unlikelihood of the member's inability to attain, maintain or regain maximum function and reason to believe that the member's condition is of a nature that failure to obtain immediate medical or

BH care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- If Dr. Horn determines the expedited appeal request DOES meet expedited criteria, he will make a decision and provide notice to the member and provider as expeditiously as the member's health requires and no later than 72 hours after receipt of the request. The member may request an extension of up to 14 days or if the health plan needs more information to make a decision.
- If Dr. Horn determines the expedited appeal request DOES NOT meet expedited criteria, we contact the member and provider with verbal notice of our decision within two days. This is followed by a written notice of denial of expedited resolution that explains the transfer of the grievance or appeal to our standard process for resolution within 30 days from the appeal with a possible extension up to 14 days. We also inform the member of his/her right to file a grievance in response to our decision.

Using Data to Improve Operational Performance

Our quality management department collaborates with our compliance department and member services team to track and trend information, conduct analysis of root causes and develop improvement activities based upon findings. We pull aggregate data on a daily, weekly, monthly and ad hoc basis and incorporate data into our decision-making activities to refine our operational processes and enhance the quality of our service delivery. Each quarter, our Quality Assurance and Performance Improvement Committee (QAPIC), Clinical and Provider Advisory, HQUM and Behavioral Health Advisory committees collectively review data analyses to:

- Conduct root-cause analysis and barrier assessments to identify and address contributing factors for gaps or disruptions in care such as social determinants
- Leverage local and national expertise to drive process, policy and procedural improvements that address systemic issues and barriers
- Perform ongoing review of our electronic tracking system to confirm operational changes result in reductions in filed grievances and appeals including identifying individual or group provider trends and issues
- Use year-over-year trend data in our annual program evaluation to drive quality and practice improvement

We also will use this data to identify additional opportunities for us to develop innovative approaches such as members accessing information about, filing and viewing status of a grievance, appeal and/or state fair hearing via our immediately accessible mobile application, *Health4Me*.

During our analysis of complaints in the fourth quarter of the State Fiscal Year 15, we identified a process improvement opportunity related to billing complaints. For balance billing issues, our member services advocates now make two attempts to contact the provider. If they are unable to reach the provider after two attempts, the State-approved cease billing letter is sent. These changes have resulted in a 74 percent decrease in grievances in the fourth quarter—100 percent of our complaints were resolved within the required time frame.

37. Describe the approach the MCO will take to provide members with grievance, appeal, and State fair hearing information. Address how the MCO will ensure the grievance and appeals system policies and procedures, and all notices, will be available in the member's primary language and that reasonable assistance will be given to members to file a grievance or appeal. *2 pages*

Providing Members with Grievance, Appeal and State Fair Hearing Information

Any concern expressed by a member becomes our concern as well. We have served members in our Nebraska Medicaid program for nearly 20 years. Our comprehensive member education approach has successfully provided our members with immediate access to information on our grievances and appeals process and their right to a State fair hearing 24 hours a day, seven days a week through our user-friendly, easily accessible resources and tools including the following in Table IV.H-1:

Table IV.H-1

Resource	Description
Member Handbook	All members receive our *Member Handbook* via mail and have immediate access to our *Member Handbook* 24 hours a day, seven days a week on our secure member website for information on grievances, appeals and State fair hearing including: ▪ Members' rights and responsibilities in their own health care decisions ▪ Who to call when you need information or have questions, comments or concerns ▪ Medical necessity definition and clinical criteria ▪ Services that require prior authorization (PA), including PA processes and time frames ▪ How to file a grievance or appeal and request a State fair hearing, including required time frames ▪ How to ask for help in filing a grievance or appeal or requesting a State fair hearing
Member ID Card	Every member receives a member ID card upon enrollment which identifies a toll-free number he/she can call to get his/her questions answered about and/or obtain assistance in filing a grievance or appeal and his/her right to a State fair hearing.
Advocate4Me	Our integrated member services call center, *Advocate4Me*, is staffed with knowledgeable MSAs who are trained on our grievances and appeals processes as well as our members' right to a State fair hearing. MSAs work with the member to resolve any concerns, issues or complaints the member may have including accessibility and availability of services, help members understand the grievances and appeals process and provide any assistance the member needs in filing a grievance or appeal or requesting a State fair hearing. For clinical concerns, our MSAs connect our members to our NurseLine clinicians through a warm transfer to assure our members' needs are met by the most appropriate and qualified staff.
NurseLine	Members have access to our NurseLine 24 hours a day, seven days a week. Our NurseLine is staffed with licensed clinicians who are trained on our grievances and appeals process as well as our members' right to a State fair hearing. NurseLine clinicians assist members in resolving any concerns, issues or complaints about the services they need or have received, accessibility and availability challenges, understanding the grievances and appeals process and provide any assistance the member needs in filing a grievance or appeal or requesting a State fair hearing.
myuhc.com	Our secure member website, *myuhc.com*, is the hub for member information including our medical necessity definition, criteria for approving requested services, a listing of services requiring prior authorization, our prior authorization, grievances and appeals processes and the member's right to a State fair hearing. Our website also includes information on how our members can obtain assistance by calling our member services call center, NurseLine, or their assigned care manager, care navigator or CHW and instantly access *myuhc.com* 24 hours a day, seven days a week through a computer, tablet and mobile device by downloading our free mobile application, *Health4Me*.

Table IV.H-1 Resource	Description
Notice of Action	Once our clinical team makes a decision to deny a service request, we send timely notification letters to our members to advise them of our decision, the reason for the decision, supporting research and authorities, the processes to follow should they disagree with our decision including requisite time frames, and how to obtain assistance in filing a grievance or appeal or request a State fair hearing within time frames. We also include information on expedited appeals as well as how they may continue their benefits during the appeals process including how to request this and the possibility of the member being held liable for provided services if the denial is upheld.
Written Reminders	Our members receive annual written reminders about our grievances and appeals process and the member's right to a State fair hearing about the services that have been reduced, limited or denied. In addition, we notify our members upon changes to our grievances and appeals process based upon state, federal or contractual updates.

Our Member Advisory Committee provides ongoing feedback to us on our educational materials to assure we continue to provide information on our grievances and appeals process and the member's right to a State fair hearing in an understandable way.

Over the years, we have welcomed feedback from NCQA and EQRO that resulted in improving our grievance and appeals process. For example, based upon feedback from the EQRO, we made revisions to our member notification letters to assure the provision of clear, understandable language regarding the grievances and appeals process including applicable time frames. Since our updates, we have received favorable feedback from both EQRO and NCQA.

Providing Information in Our Members' Preferred Language

Our written member materials are provided in English and Spanish, at a reading level no higher than a 6.9 grade level and can be translated in our members' language of choice upon request through our MSAs, care managers, CHWs or other health plan staff with whom they have contact. Members calling our member services call center, *Advocate4Me*, have access to MSAs who are bilingual in English and Spanish as well as free-of-charge interpretive services 24 hours a day, seven days a week for more than 200 languages. Members with hearing challenges have access to our toll-free telecommunications relay service and those with impaired vision can request large-print materials or have an MSA read the materials aloud.

Assisting Members in Filing a Grievance or Appeal

As described above, we encourage our members to call *Advocate4Me*, NurseLine or their assigned care manager, care navigator or CHW for assistance with any concerns, issues or complaints. These staff members work closely with our members to resolve the issue to the member's satisfaction or assist them in completing and submitting a verbal or written grievance or appeal. The receiving staff member submits the formal grievance or appeal to Dr. Horn for immediate initiation of our process including clinical review and determination.

We remain a consistent resource for our members throughout the resolution process to provide answers to questions, information, direction and support to achieve the best possible outcome and to identify opportunities to improve our processes.

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IV.I. Provider Network Requirements

38. Describe the MCO's proposed provider network outreach approach and recruitment strategy. Provide a detailed work plan for developing an adequate network within the time frame described in Section IV.I. Describe the method the MCO plans to use on an ongoing basis to assess and ensure that MLTC's network standards are maintained, including standards related to:

Distance.
Appointment access.
Cultural competency.
After-hours access.
Inclusion of PCPs.
Inclusion of behavioral health providers.
Inclusion of high volume specialists.
Inclusion of FQHCs and RHCs.
Inclusion of urgent care centers.
Inclusion of pharmacies.
Inclusion of hospitals. *6 pages, excluding plan for developing an adequate network*

We understand the importance of a comprehensive and easily accessible network in promoting member health and satisfaction and we have been offering a fully compliant network to meet these needs in Nebraska for nearly 20 years. This experience, coupled with nationwide expertise in Medicaid Managed Care, creates a deep pool of knowledge, resources and innovations when it comes to building and maintaining provider networks that are both high-quality and affordable. Backed by the vast experience of our national network contracting team, and led by a longtime Nebraska resident Jeremy Sand, provider services manager, we have built upon the strength of our current, fully compliant 10-county Medicaid network. This includes decades of existing local provider relationships in commercial, Medicare and TRICARE, to deliver a fully contracted statewide network for new Heritage Health offerings that is inclusive of out-of-state providers. This provider network delivers access to person-centered care across the full range of covered services, including physical and behavioral health, pharmacy and services for individuals with special health care needs (SHCNs) including the intellectual and/or developmental disabilities (I/DD) community.

Through innovations such as telehealth and technology and rural access coordination teams, we will address access challenges and critical health issues unique to Nebraska. We will enhance our already deep relationships with providers through local engagement and advisory groups to make certain their voices are heard as we maintain network adequacy and access to high-quality care for all members. Our recruitment strategy has focused on obtaining signed contracts rather than receiving letters of intent to contract. Our currently compliant and comprehensive statewide network and relationships with providers make us uniquely qualified to support MLTC with their goal to improve access to quality health care at an affordable price. Table IV.I-1 summarizes our network completeness. We continue to meet and work with the providers to finalize all outstanding contracts, specifically focusing on BH providers.

Table IV.I-1

Provider Type	Percent of providers contracted for Medicaid in Nebraska compared to state provider file
PCPs (including extenders)	99%
High-Volume Specialists	99%
Hospitals	94%
Urgent Care and Convenient Care	91%
Pharmacy	95%
BH	56%

Table IV.I-1	
Provider Type	**Percent of providers contracted for Medicaid in Nebraska compared to state provider file**
RHC	94%
FQHC	100%
Vision	95%

Outreach Approach and Recruitment Strategy

Our network development team is proud to have successfully recruited, retained and supported quality providers in Nebraska for nearly 20 years to positively impact health outcomes for our members and simplify administrative responsibilities to promote provider satisfaction. Under the direction of Mr. Sand, we have developed and implemented a robust network approach and successful recruitment strategy to grow our network for the expansion of services and geography, which includes value-based purchasing (VBP), patient-centered medical homes (PCMHs) and telehealth solutions. Our network strategy goes above and beyond simply recruitment by including processes to evaluate performance compliance. Our network strategy includes a detailed work plan for developing an adequate network within the time frame described in Section IV.I. has been included as a separate attachment in Section c. Proposal Deliverables as Listed in Attachment 5 – Policies, Procedures and Plans.

Developing Recruitment Work Plans

Our detailed work plan to develop an adequate network capitalizes on our existing statewide network. We used GeoAccess Analysis, Strenuus Network 360 Competitive Analysis, State File Review, Community Outreach and Referral patterns to further develop our network plan. In addition, the work plan was updated to pursue those remaining providers that have agreed to contract with us at the time of award as well as any additional providers that meet access needs for members according to State requirements and internal assessments. Our network currently meets MLTC access standards, identified in Attachment 2, for over 90 percent of eligible Medicaid enrollees. Our statewide network includes behavioral health (BH) providers that currently represent 56 percent of the State provider file and pharmacy services that meet over 90 percent of the pharmacies on the State provider file.

Carrying Out Recruitment Efforts

Our network development team proactively implemented a recruitment strategy that has delivered a statewide contracted Medicaid network that is currently in place. Our network development plan identifies those remaining providers that we have targeted for recruitment that have agreed to contract at the time of award, have been identified from the State provider file, or meet a gap-fill strategy based upon applications of specified work plan elements. While recruitment implementation is an ongoing effort, we use the information gathered through analysis efforts to guide the process. Our network management team meets regularly with the health-plan leadership team to review provider recruitment activity and to collaborate on ensuring gaps related to access are considered throughout the recruitment process. We also use our existing relationships that we have across the state through provider visits, town hall meetings and Joint Operating Committees to receive feedback from providers on access concerns, as well as for us to better understand their patient referral patterns and confirm that our network is adequate. The network development team works from the recruitment work plan, conducting mail, telephone and face-to-face outreach with targeted providers to bring them into the network.

Assessing and Ensuring Network Standards

We have applied in-depth processes to evaluate and measure the adequacy, accessibility and compliance of our current network for nearly 20 years. We will expand on this work for our expanded Heritage Health network. This network continues to be enhanced, using our experience building, monitoring and

maintaining provider networks, and using tools like GeoAccess software, member, provider and community feedback and other sources to evaluate and certify network adequacy. Obtaining direct and frequent feedback from the provider community has helped us to identify emerging trends early. We also use feedback from our member services center such as an increase in calls related to finding a provider, which allows us to quickly address the issue to verify proper access to care. We will continue to monitor, maintain and enhance our provider network to verify access and adequacy for all covered Heritage Health members.

Maintaining the Network

We use an integrated, cross-functional team approach to develop, maintain and monitor our provider network. Our provider advocates frequently outreach to the network to receive feedback and provide support. These individuals will be supplemented by a new **BH provider liaison**. We consider the process of maintaining the network a critical activity that is a health-plan-wide endeavor. This endeavor integrates through interdepartmental collaboration, monitoring processes and activities, business systems accessibility and oversight committees structured with representatives from across the health plan. We maintain the network by providing superior provider services and tools, engaging provider advocates in the market, analyzing provider satisfaction and taking action on provider feedback. Our feedback comes through collaborating with providers and the medical associations, hosting town hall webinars, presenting educational sessions, and analyzing provider appeals and grievances.

Monitoring Network Adequacy

Our network and operation teams conduct routine analysis to make certain that our network has sufficient numbers and types of practitioners (clinicians) and providers (facilities) to serve members. We assess the geographic availability, numeric availability, panel size, timely appointment access, wait times and after-hours access, in comparison to availability standards outlined in Attachment 2. Based upon results, we identify and prioritize opportunities for improvement, take action to address opportunities and evaluate the effectiveness of actions taken. Our network team also assesses the cultural, ethnic, racial and linguistic composition of the network against the needs and preferences of enrollees. In our current service area, **our quarterly reporting has demonstrated our ability to monitor and deliver a network that consistently has met the required Access Standards for geographical distance access, timely appointment access and PCP access.** When necessary, we use single case agreements to make certain that members receive medically necessary covered services that are needed. Our Quality Assurance and Performance Improvement Committee (QAPIC) monitors network performance and addresses opportunities for improvement. We use several analysis tools to assess the strength and depth of our provider network, as well as our ability to maintain compliance with contract requirements. This analysis provides insight into the number of providers, by type, as well as the location of the required specialties, to meet contracted access standards. It includes review of out-of-network referrals too.

Distance

We use GeoAccess mapping software to assess network compliance with travel time and distance standards. At least quarterly, we evaluate the entire network for adequate coverage and compliance with access standards using GeoAccess mapping, which enables us to identify and analyze potential gaps in coverage by location, specialty and provider type. Initial review occurs at the department level and any identified trends are reported to the QAPIC, which is responsible for monitoring all aspects of compliance with access standards. We will serve the needs of Heritage Health members throughout Nebraska by continuing our network development efforts throughout Nebraska and leveraging our existing provider relationships to meet or exceed the minimum network requirements. We have the network knowledge and tools to maintain and monitor our provider network in compliance with MLTC's requirements and an

excellent record recruiting and retaining local providers, all of which will support Heritage Health members in a Medicaid program. Table IV.I-2 shows the results of GeoAccess mapping in our current service area for SFY 2015:

Table IV.I-2: % Member Access by Quarter (SFY 2015)					
Quarter	**Hospitals**	**Urgent Care**	**FQHC & RHCs**	**PCPs**	**High-Volume Specialists**
Quarter 1	100%	100%	100%	100%	100%
Quarter 2	100%	100%	100%	100%	100%
Quarter 3	100%	100%	100%	100%	100%
Quarter 4	100%	100%	100%	100%	100%

Appointment Access

We monitor timely access to contracted providers through a standardized review process that includes member feedback through our care management team, quarterly service availability surveys and geographic access and availability studies. We require our network PCPs to comply with appointment standards as specified in Attachment 2 – Access Standards as a condition of their contractual agreement with us. We communicate these standards to providers through the *Provider Administrative Guide*, provider newsletters, new provider orientation, or provider training through our provider advocate program, including a BH provider liaison. To evaluate provider compliance with availability requirements, we currently contract with DialAmerica, a vendor with expertise in conducting phone surveys, to perform a quarterly audit of compliance with availability standards. When this research indicates availability standards are not met, provider advocates conduct outreach and education to providers to reinforce standards compliance. A review of appointment availability annually for SFY 2015 reveals that our network is above the target of 95 percent for every specialty type and is at or near 100 percent in most specialties. Table IV.I-3 below is a summary for results for the State Fiscal Year 2015:

Table IV.I-3			
Provider Type	**Appointment Type**	**Availability Standard**	**Standard Met**
PCP	Emergency	24 hours/day, 7 days/week	98%
PCP	Urgent care	2 calendar days	100%
PCP	Routine	14 working days	99%
High-volume specialist	Routine	30 working days	96%
Prenatal	First trimester	14 working days	100%
Prenatal	Initial second trimester	7 working days	99%
Prenatal	High-risk	3 working days	100%

Cultural Competency

We integrate cultural competency into our provider recruitment efforts, including plans that focus on fulfillment of member needs (e.g., awareness of health disparities, language barriers and patient preferences) from a broad range, including lesbian, gay, bisexual and transgender (LGBT), veterans, migrant farm workers, and people with disabilities to provide members with a responsive provider network. Disability competency is included in the broader approach to cultural competency and is considered in our overall provider recruitment strategy. We will expand our recruitment strategies through work with the disability advocacy community for specific strategies in provider recruitment, training and outreach. In a report of our current 10-county network, we analyzed whether members have access to a multi-lingual PCP by comparing members whose primary language is non-English and to their location to the location of multi-lingual PCPs. We found that all members had continued access to more than one PCP that is multi-lingual and our network continues to meet the access standards for a multi-cultural network.

After-Hours Access

To supplement our medical provider network, we have a network of freestanding urgent care centers and access to ER, to assist members after-hours. In addition, we require our contracted providers to provide after-hours coverage via after-hours calls, after-hours referral or on-call coverage referral.

Inclusion of Primary Care Providers

We have a very strong presence among PCPs in Nebraska with longstanding relationships and current contracts with more than 2,800 PCPs throughout the state for our Medicaid program. Based upon Addendum 3, PCPs include provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners and physician assistants. Our current Nebraska Medicaid managed care PCP network meets access standards for 100 percent of members enrolled in the managed care plan in the 10 county service areas, and nearly 100 percent in the statewide expansion areas. A strong PCP network is essential for establishing Accountable Care Communities (ACCs) which optimize the use of a PCP as the medical home in a patient-centered service delivery model. During the next contract period, we plan to identify practices with which we will pursue contracts in which they will act as ACCs, providing case management and health interventions for their high-risk members and populations. This aligns with the MLTC's and our goal to reduce the rate of avoidable hospital stays and readmissions and advances our efforts to drive member engagement and improve health care quality and outcomes. Our ACC model encourages PCPs to own the leadership role on the member's care team as an integral part of a person-centered approach to comprehensive health care. We monitor PCP capacity on an ongoing basis and will comply with the requirement that PCP to member ratio not exceed 1:1500 for PCPs. We will meet or exceed the access standards for PCPs by plan readiness review.

Inclusion of Behavioral Health Providers

Nationally, we have more than 27 years of experience administering mental health and substance abuse services and are recognized as a pioneer in the development of advancements that dramatically improve the clinical impact and delivery of BH services. We are the largest provider of Medicaid BH services in the country, supporting more than 62 million lives nationwide, with customers that include individuals, small businesses, Fortune 500 companies, commercial health plans and public sector entities including federal, state, local and the TRICARE populations. We partner with more than 130,000 clinicians and 5,000 facility locations nationwide and in Nebraska, we have approximately 1,030 clinicians (MD, MSW, PhD and APRN combined) and seven acute facility locations. Our network is one of the largest managed BH organization networks available in Nebraska and includes providers with experience in treating the BH conditions listed in I.h of this RFP. We have collaborated with the DHHS Division of Behavioral Health and State BH regions in establishing our network.

Inclusion of High-Volume Specialists

Our comprehensive network includes approximately 3,500 contracted specialists for Heritage Health. We are in active discussions with the entire pool of those contracted specialists to solicit their participation in our Heritage Health network, including high-volume specialties, which are defined as cardiology, neurology, hematology/oncology, obstetrics and gynecology, and orthopedic physicians to meet MLTC member needs.

Inclusion of Federally Qualified Health Centers and Rural Health Clinics

We have contracts with 100 percent of all FQHCs and 94 percent of RHCs statewide. We continue to have active contract discussions with the remaining RHCs and have commitments from them to work with us upon contract award. We operate a mixed care model with hospital-based, multi-specialty and

individual providers complemented by a strong network of safety net providers featuring FQHCs and RHCs that will be contracted for both physical and behavioral health and pharmacy services, as applicable. Our partnerships with the FQHCs and RHCs provide members with easy access to care and services, as well as information and awareness about important developments in the Medicaid program. We recognize the value of these close affiliations and as a result, have been sponsoring and collaborating with their organizations for many years.

Inclusion of Urgent Care Centers

We are contracted with 49 of 54 identified Urgent Care and Quick Sick Clinics statewide. We will continue to identify and contract with any freestanding urgent care centers in the statewide expansion areas that provide care to Heritage Health members. Additionally, we will make use of extended physician offices hours and walk-in clinics where available.

Inclusion of Pharmacies

We will maintain a comprehensive network of pharmacies and certify they are available and geographically accessible to all Heritage Health members. OptumRx has provided innovative pharmacy benefit management (PBM) services for more than 20 years. First formed in 1989, OptumRx operates as a subsidiary of UnitedHealth Group, managing benefits for more than 27 million members and processing more than 500 million claims per year in 67,000 national pharmacies. We will perform a gap analysis using pharmacy claims data and the State provider file to identify non-contracted pharmacy providers including independent pharmacies that are crucial to serving our members in rural and frontier areas and will solicit participation from these identified providers in our pharmacy network. For example, understanding the importance of meeting the needs of our members with I/DD, we have identified local, independent pharmacies that work closely with rural I/DD providers and deliver medications 24 hours a day, seven days a week. To enhance access, we will implement our NCQA-accredited mail order program.

Inclusion of Hospitals

We have completed contract negotiations with 94 percent of the hospitals in the state. We have 100 percent of the frontier hospitals contracted. We have commitments from the remaining six facilities to complete negotiations upon successful award.

Cross-Border Providers

When developing the network in rural areas where there may be a lack of providers, we target the available network within the regional area, which may include Border States and counties as represented in Table IV.I-4.

Table IV.I-4

Border State	Contracted Provider Examples
Colorado	Valley Medical Clinic RHC – Julesburg, Banner Health Physicians
Iowa	Methodist Jennie Edmundson Hospital – Council Bluffs, Mercy Hospital – Sioux City, All Care Health Center – Council Bluffs
Kansas/Missouri	Memorial Community Hospital & Physicians – Marysville
South Dakota	Avera Health System
Wyoming	Cheyenne Regional Medical Center, Banner Health Physicians – Torrington and Wheatland

39. Describe the MCO's required PCP responsibilities and how the MCO will verify PCPs are performing them. *2 pages*

We believe the PCP is critical to the overall management of members' health care as well as the coordination of services and specialty care referrals. Our PCP network comprises experienced health care professionals who appreciate their role in achieving cultural competency. They are skilled at treating members with functional and developmental disabilities and addressing BH and women's health care needs. The PCP plays a vital, primary role improving health care delivery in four critical areas—access, coordination, continuity and prevention. Our networks of PCPs are required by contract to enroll with Nebraska Medicaid and agree to comply with all requirements of this participation agreement, including responsibilities of a PCP. Our *Provider Administrative Guide* explains the responsibilities of the PCP and all providers in our network. We require our PCPs understand the member rights and responsibilities listed in our *Provider Administrative Guide*. Some of the significant PCP requirements include but are not limited to:

- Serve as the enrollee's PCP, coordinating and integrating all care provided to the enrollee including specialty care, BH and pharmacy care needs of members to assure that all medically necessary services are made available in a timely manner.
- Collaborate with BH providers and care management policy and procedures including appropriate referrals to BH specialists when serious mental illness is identified.
- Consult with other appropriate health care professionals to assess and develop individualized treatment plans for members.
- Make certain that necessary health care services are available to members 24 hours a day, seven days a week. When the PCP is unavailable to provide care for a member, the PCP must arrange for another network PCP to cover and provide appropriate care and services.
- Follow up with coordination of care ensuring that notes are entered in the patient's chart, proper actions are taken and follow-up care is provided.
- Notify us of services that require prior authorization as outlined in the *Provider Administrative Guide* and our provider portal.
- Maintain a current medical record for the member and provide copies to the member upon request at no charge.
- Provide preventive care and physical examinations, conduct a baseline examination during the member's first appointment, and proactively reach out to members who have not received their annual physical.
- Adhere to the EPSDT periodicity schedule for enrollees under age 21. Members are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and that tracking or follow-up occurs to verify all necessary services are provided to all of the MCO's eligible Medicaid children and young adults.
- Conform to the guidelines of the Americans with Disabilities Act (ADA), and provide services that are culturally diverse and sensitive as well as providing a clean and structurally sound office that meets ADA requirements.
- Adhere to MLTC Timely Access Standards for appointment availability, hours of operation, wait times and after-hours care.
- Participate in our quality programs for assessment and improvement activities, close gaps in care and comply with clinical guidelines, member safety efforts and data confidentiality procedures.

- Consult with other appropriate health care professionals to assess and develop individualized treatment plans for enrollees with SHCNs.
- Notify the MCO of members who meet SHCNs as soon as possible after identification and develop individual treatment plans for SHCNs members.

Verifying PCP Compliance with Stated Responsibilities

We use a variety of tools and processes to verify compliance with PCPs' stated responsibilities including:

Assessing Variation in Practice Patterns

We monitor our participating PCPs against established clinical practice guidelines for acute, chronic and preventive care. Using our robust databases, we compare individual provider performance on quality process and outcome indicators. Specifically, HEDIS measures can be applied to the individual provider or practice level to ascertain whether there are variations from expected performance (e.g., fewer pediatric preventive care visits than would be expected for a pediatrician). This data is reviewed by our quality management and performance department and shared with medical director/CMO Michael Horn M.D. When opportunities are identified, our clinical practice consultants (CPCs) and field-based RNs meet with the provider and their office staff to review performance and the associated clinical practice guidelines to identify opportunities to improve the practice's systems and compliance.

Provider Profiling

We use several methods to profile the performance of our contracted health care providers. We have written policies, procedures and proven processes in place to conduct provider profiling, which includes profiling for network PCPs, ER use and hospital admissions. We conduct annual provider profiling for high-volume PCPs (defined as providers serving 50 or more members), and use the results to verify that providers are complying with responsibilities and care management.

Fraud, Waste and Abuse Review

A primary responsibility of providers is to code and bill accurately for services rendered. Failure to do so leads to fraud, waste, abuse or erroneous payments (FWAE) and can result in termination from our network and federal and state health care programs. We emphasize FWAE prevention by analyzing all claims prospectively using multiple and evolving data analytics programs and algorithms that look for potential FWAE issues, such as when a provider attempts to bill an impossible number of hours in a given day. We detect issues through these methods and through referrals from members, staff, the public and the provider communities, and a service verification program. We then conduct thorough investigations and implement remediation activities, such as provider education, to ensure responsibilities flowing from provider agreements, the State Medicaid participation agreement, federal and state regulations, and other applicable guidelines are met.

Consumer Assessment of Healthcare Providers and Systems®

We are able to monitor the performance of PCPs' compliance through feedback from members and identify areas for improvement. The Member Satisfaction Survey using CAHPS is conducted and monitors the satisfaction of members' experience that includes feedback on the experience with their PCP, appointment availability, access to care, after-hours care and cultural competency.

Member Grievance and Appeals

Member grievances are tracked and trended by the appeals and grievances unit and used by staff to identify and address incidences or trends where a PCP is not compliant with their responsibilities. Follow-up is provided to the PCP on all grievances and to re-enforce the PCP responsibilities.

40. Describe innovative strategies the MCO's intends to use to identify specialty types for which member access is limited. Describe the MCO's intended initiatives for increasing the number of specialists within those specialty types that participate in the MCO's network.

Identify potential challenges the MCO anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the MCO will mitigate those challenges. *3 pages*

Innovative Strategies to Identify Specialty Access Needs

We have developed an understanding of the unique challenges to accessing specialty care in certain areas of Nebraska, from dozens of in-person meetings, rigorous data analysis, and nearly 20 years of working with Nebraska providers. Our innovative strategies for identifying specialty types for which member access is limited include:

Rural Access Coordination Team (RACT): A specialized, multi-disciplinary team focused on resolution of access to care challenges from lack of available providers or other circumstance unique to the area or the member. The team includes a care manager, provider relations and a community outreach representative that serves to document and expedite effective solutions for rural provider access.

State Transportation Vendor Collaboration: We will work with the State transportation vendor, IntelliRide to identify areas of the state that IntelliRide is providing transportation for members to appointments that are outside distance requirements for specialist services.

Technology and Reporting Capabilities: We leverage multiple technologies and reporting tools that we currently use today in proactively managing our provider network to improve limited access and improve choice of providers to members to a specialty provider. These include: ***Geographic Availability:*** **GeoAccess™** geographical mapping to identify distance gaps, ***Numeric Availability:*** Provider-to-member ratio reports provide insight into provider capacity, ***Timely Access Monitoring:*** Monitoring assesses capacity concerns with specialty providers, ***Utilization Review:*** Monitor utilization trends that identify limited access.

Membership & Community Feedback: We seek to include member feedback as a tool to identify specialty types for which member access is limited. We obtain feedback through a variety of sources that include: member's involvement in the Member Advisory Committee (MAC), MSAs, **CAHPS** member survey responses, member grievances related to access, and input from community organizations.

Provider Partnerships: As an existing MCO in Nebraska, we have developed partnerships with providers across the state and have demonstrated that we have worked with providers to meet the needs of Nebraska members. We collaborate with our Clinical and Provider Advisory Committee (CPAC), Statewide Provider Associations, Regional Health Systems and independent providers to quantify access concerns. We receive feedback in several ways that include Individual Provider and Town Hall meetings, our PRISM provider service program, provider satisfaction survey results related to access, and provider grievances.

Initiatives to Increase Access to Specialists

When limited access to specialists is identified, we evaluate opportunities to meet the specialty provider need in the local community through several initiatives that include:

Contracting with Non-par Specialists: We will increase providers in our network by reviewing providers not enrolled with MLTC and approach them for participation.

Specialty Clinics: The majority of the critical access hospitals maintain a specialty clinic where specialty providers from larger health systems rotate on a weekly or monthly basis to provide appointments for

members. We would seek to collaborate with the Critical Access Hospital to increase the amount of specialties offered and improve communication for members.

Telemedicine for Specialty Services: When a needed specialist is not available within the required distance from the member's residence, we will leverage telemedicine and telepsychiatry technology to close specialty-service delivery gaps as deemed appropriate by the specialty providers. Using telemedicine and telepsychiatry, the member's specialty providers can explore the use of a real-time audio-video connection to the appropriate specialist with the member and PCP at the presentation site and the consulting specialty provider located elsewhere. In addition to improving access to the needed services, use of telemedicine and telepsychiatry decreases the burden on the member and the member's family.

Mobile Health Service: We are exploring a pilot to leverage mobile health services that is equipped with clinical resources to facilitate and provide health services to members in the home setting. Mobile health services can be used to coordinate visits with members after discharge from a hospital to lower readmission rates; set up telehealth to assist members with telepsychiatry, eliminating excessive travel for individuals with I/DD and/or BH needs; and provide assessment services for individuals that lack mobility or access to care. The assessment services would include lab work, medication checks, social barrier and safety assessments.

Accommodation for members: Members with complex care needs may need to travel across state to obtain necessary services. Lodging and meals are provided for our Heritage Health members when traveling to obtain their needed care. We work with Ronald McDonald houses and various hotels to provide lodging and hospitals to provide meal vouchers.

Providing Access to Non-par Specialists: When network specialists cannot meet member needs, we take immediate steps to address the gap so their care is not compromised and continuity of care is assured. If a contracted provider is not available to meet member access and availability needs, we enter into a single case agreement (SCA) with the out-of-network provider to make certain the member is able to receive needed care.

Cross-Border Providers: When developing the network in rural areas where there may be a lack of providers, we target the available network within the region area, which may include Border States as represented in Table IV.I-5.

Table IV.I-5

Border State	Contracted Provider Examples
Colorado	Valley Medical Clinic RHC – Julesburg, Banner Health Physicians
Iowa	Methodist Jennie Edmundson Hospital – Council Bluffs, Mercy Hospital – Sioux City, All Care Health Center – Council Bluffs
Kansas/Missouri	Memorial Community Hospital & Physicians – Marysville
South Dakota	Avera Health System
Wyoming	Cheyenne Regional Medical Center, Banner Health Physicians – Torrington and Wheatland

Anticipated Challenges to Specialty Provider Access and Solutions to Mitigate

Our experience in Nebraska allows us to understand potential challenges that members face in receiving appropriate care for specialties where access concerns exist. In building a statewide network in Nebraska, we know that there are particular specialty providers that are not available to members in frontier and rural counties within the access requirements. We know that there are limited providers for pediatric specialties, some examples include: pediatric cardiology, neurology and endocrinology. In other specialties like gastroenterology, for example, we know that our network meets the access standard for 97

percent of Medicaid enrollees, however, there is still a gap in 20 counties that fall outside the access standard and that this is true for other specialties as well. We know there are specialty facilities that are not available in every community. For example, there are only eight cities in Nebraska that have access to a rehab hospital enrolled with MLTC and every community does not have access to an urgent care clinic which forces many members to use hospital ER services. Our strategies to mitigate these challenges are to approach the member from a patient-centered perspective to evaluate the needs of the individual and adjust our services to meet those needs. We will deploy initiatives to increase access to specialists, outlined above, which include access and contracting with non-par specialists, collaborating with hospitals to improve specialty clinics, leveraging telemedicine technology, exploring mobile health services, providing accommodations for members, and cross-border state specialists.

In addition to limited amounts of specialty providers, other factors impact a member's access to a specialist. We know that in frontier counties, members lack access to transportation providers and face the challenge of attending their appointments. Our solution is to leverage existing relationship with MLTC's transportation vendor, IntelliRide, to coordinate their services to our members statewide and assist them in identifying gaps to expand transportation providers. In addition, we would work to mitigate transportation concerns by bringing providers to the member's community through innovative strategies including telemedicine, specialty clinic strategy and exploring mobile health services.

We know culturally competent providers are not always available in rural communities. Members who speak a non-English language may not have available providers in their community. To meet this need, we have already developed several strategies that include a language line for interpreter services, implementation of a Cultural Competency Pilot Training Program, leveraging our existing partnership with the Refugee Task Force and working with State Tribal Nations. We seek to bring access to culturally competent providers through telemedicine, specialty clinic and home-health strategies.

We recognize that access to BH services can be a challenge in many parts of Nebraska. In our conversations with stakeholders, statewide access issues were cited to services ranging from medication management to secure residential treatment. In addition to telemedicine, RACT, border state contracting and other strategies we will be using to expand access to physical health care specialties, we will implement focused efforts to expand access that include:

- We will encourage PCPs to create stronger linkages with behavioral health specialists, whether by hiring them, or sharing staff with a BH agency
- We will encourage behavioral health providers to review the success of Region 1, Community Alliance and other agencies that have hired APRNs
- We will work closely with the Behavioral Health Regions as well as ongoing community groups—such as the Panhandle Partnership—to expand training and recruitment efforts for behavioral health professionals across Nebraska
- We will review our medical necessity criteria and our UM policies to make certain that we are not limiting access to appropriate 24-hour treatment settings
- We will support efforts of the Regions and the Behavioral Health Education Center of Nebraska (BHECN) to train providers in ways to improve their overall efficiency by implementing same-day appointments and similar strategies
- We are implementing a pilot with Region 3 to provide peer support services to our members in Kearney and we are doing a UnitedHealthcare pilot in Regions 4 and 5. We will consider expanding the pilot to other regions and explore a pilot program to expand access to peer services, including contracting for a statewide peer-run warm line.

41. Describe the MCO's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times. *2 pages*

We understand that timely access to care is essential for our members and their families, and we have programs in place to verify that members can access a contracted provider as quickly as required to meet their health care needs. Providers are contractually obligated to comply with appointment and wait time standards as specified in RFP Section 10, Appointment Availability and Referral Access Standards of the IV. Project Description and Scope of Work and Attachment 2 – Access Standards. We also communicate this information in ongoing training and education such as the *Provider Administrative Guide* (our provider handbook), available on our provider portal. Currently, we monitor provider compliance with appointment availability requirements and wait time standards, according to state-specific and NCQA accreditation requirements. We use member complaints and grievances, feedback through our care management team, member satisfaction surveys, quarterly service availability surveys and geographic access and availability studies.

Monitoring Provider Adherence

To further evaluate provider compliance with availability requirements, we contract with an external vendor, DialAmerica, who brings expertise in conducting phone surveys to monitor provider compliance with availability standards. We customize the surveys conducted to meet the needs of our regulators and membership, and to comply with NCQA requirements for accreditation. We are able to perform surveys as often as needed and can target portions of the network for survey based upon specific criteria. As part of our work monitoring provider adherence, we will continue to:

- Conduct appointment availability surveys and "secret shopper" calls through DialAmerica, on a quarterly basis to our provider network or more frequently if access concerns are identified, including PCPs, high-volume specialty care providers, pediatricians and prenatal providers. During these calls, we have ascertained the availability of appointments based upon need, including routine care, sick care and urgent/emergent care needs, specialty and prenatal availability. We also use this opportunity to collect information regarding provider demographic changes such as addresses/locations, phone numbers, website and panel status. Currently providers are monitored at least once annually. If a provider fails to meet standards, they receive follow-up and are included in the next survey for reassessment.
- In compliance with the requirements in Attachment 2, we also will use these survey calls to assess member wait times. We will ask the practice staff to assess their wait time at the time of the call, based upon whether members are presenting for a pre-scheduled appointment or as a walk-in. Additionally, these metrics will be monitored through real-time observation by our clinical practice consultants, clinical transformation consultants, provider advocates, and a BH provider liaison. Beyond this, our staff frequently visits participating providers' practices to provide support and education. When they are there in the office, they will be able to do a time check with the office staff regarding appointment wait times and determine whether the practice is providing updates to waiting members if they are running behind.

A part of our plan to improve accuracy with appointment availability is to monitor the "third next available" appointment. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

In our current service area, we demonstrate our ability to meet this requirement with our current network provider appointment availability for State Fiscal Year 2015 at or near 100 percent. See Table IV.I-6:

Table IV.I-6

Provider Type	Appointment Type	Availability Standard	Standard Met
PCP	Emergency	24 hours/day, 7 days/week	98%
PCP	Urgent Care	2 calendar days	100%
PCP	Routine	14 working days	99%
High-Volume Specialist	Routine	30 working days	96%
Prenatal	First Trimester	14 working days	100%
Prenatal	Initial Second Trimester	7 working days	99%
Prenatal	High-Risk	3 working days	100%

Ensuring Provider Compliance

We take corrective action to remediate instances of identified noncompliance with the required standards and report all noncompliance to MLTC through Timely Access reports submitted quarterly. We use a collaborative approach to working with providers to identify solutions that have resulted in improved access for members. Provider compliance results are measured against state requirements and in accordance with our internal appointment and access policy. These results allow us to verify provider adherence with contract requirements and provide a foundation for understanding where we need additional educational efforts, network development efforts or both. When the provider office responds to the survey with timely access, wait times, or hours of operation outside the requirements, our provider relations group outreaches to the provider to discuss what may be leading to noncompliance and reinforce the standards. The noncompliant provider is added to a list for reassessment in the following quarter. If the provider office remains noncompliant a second time, then a provider advocate or behavioral health liaison will reach out to the office to work with the provider to understand barriers and implement an action plan. The provider office remains on the list for the following quarter, where upon any further noncompliance will lead to network contracting evaluation and is included in our narrative in our quarterly reports to MLTC and the provider may be subject to further disciplinary action such as the closing of panels to new members.

High-Volume Specialist Physician Group Did Not Meet the Access Standard for a Routine Visit

During the SFY2015 2nd Quarter and SFY2015 3rd Quarter, a provider group in Omaha, Nebraska, was found to be noncompliant for two consecutive quarters. In this situation, the office manager indicated due to a sudden increase of patient demand, they were having difficulty meeting the standard. Our provider services team worked with the clinic to put together an action plan. The clinic initiated a process of hiring more doctors and adding capacity so they could meet the standard. To verify future compliance, this provider group was surveyed again during the SFY2015 4th Quarter and was compliant.

Comprehensive Review of Access and Availability

In addition to quarterly availability and wait time survey efforts, we have a supporting mix of monitoring techniques to verify that our network meets required appointment availability and wait times access standards, discussed above. Data sources include PCP-to-member ratio reports, provider panel-size reports, member and provider-satisfaction survey results, trends from member services, medical records reviews, clinical team feedback, provider on-site reviews, HEDIS data, member satisfaction through CAHPS, provider grievance and appeal communication, and claims data surveys.

At least annually, we incorporate data from these assessments into an overall report. Results are presented to the QAPIC for review along with proposed interventions and potentially, corrective action planning. This report is presented by Jeremy Sand, provider services manager, who is integrally involved in monitoring and providing feedback to the QAPIC for system-wide actions, if needed.

42. Describe the MCO's approach to promoting and facilitating the capacity of its providers to provide:

Patient-centered care.

Improved health outcomes.

Member compliance.

Member satisfaction.

Discuss the MCO's successes with patient-centeredness in other Medicaid programs, what lessons have been learned, and the MCO's planned approach in Nebraska. *3 pages*

We recognize supporting providers in using a patient-centered care model can lead to improved member outcomes, compliance and satisfaction. We have and will continue to engage in this effort in Nebraska while promoting patient-centered care in the Heritage Health program.

Patient-Centered Care

Our holistic, person-centered, recovery-oriented model of care provides cost-effective, quality care through a model that empowers members to actively participate and drive their care in meaningful ways and facilitates integrated physical, behavioral, environmental, and social care and services. To promote and facilitate the capacity of providers to provide patient-centered care, we have engaged in partnership and collaboration with our providers and communities across the country to support transformation to a PCMH model. Based upon sound population-health management practices, our data-driven care management processes, programs and technologies, we identify our highest risk, most vulnerable members and provide integrated, whole-person care coordination. Since 2008, we have proactively engaged our primary care practices in partnerships to improve care, with PCMH initiatives spanning all populations on a national basis. Nationally, we have been recognized as an innovator and leader in this arena, **winning the National Business Coalition on Health eValue8 Innovations Award** in 2009. Our experience includes participation in CMS' CPCi multi-payer collaborative in several states. In addition to clinical and process support to the PCMH practices, we have provided financial incentives in the form of PMPM care coordination fees, bonuses for quality and efficiency, rewards for achieving industry PCMH recognition and value-based financial arrangements. We have experience providing direct provider supports by hosting local learning collaborative meetings to promote best practices and to facilitate sharing of experiences among providers. Another tool used to promote and facilitate the capacity of providers to provider person-centered care is the implementation of CommunityCare. With CommunityCare, we support integrated, community-based, person-centered care for members. It is an HIPAA compliant, secure, health care record and information sharing system. It integrates a member's acute care, preventive care, chronic disease management, medical, behavioral, social and long-term care services into a comprehensive electronic record.

Offering Resources for Nebraska Providers on Person-Centered Care

We will offer network providers a course in the recovery-oriented, person-centered approach to treatment. The training will be led by Dr. Neil Adams and Diane Grieder, authors of the highly recommended book on person-centered planning, Treatment Planning for Person-Centered Care; The Road to Mental Health and Addiction Recovery. We will bring the authors to Nebraska and also provide lunch for participants and a copy of the book. For two days, these experts will work with our network providers using case studies brought by the providers to apply the lessons. One month later, Dr. Adams and Ms. Grieder will return and work with providers on challenges they may be experiencing in putting the techniques into practice. The Adams-Grieder training has provided a very positive foundation for revitalizing recovery-oriented practice in other states in which we have offered it.

Improved Health Outcomes

To assist in promoting and facilitating the capacity of our providers to deliver improved health outcomes, our Clinical Practice Consultant (CPC) Program assists providers in delivering timely and effective health services through analysis and monitoring of quality outcomes. CPCs work with PCPs and FQHCs to provide education regarding well visits/periodicity schedule, and the ability to provide well-visit services at a sick visit if the member is well enough. Additionally, CPCs and RNs with clinical practice experience periodically deliver Members In Need of Services (MINS) reports, which provide a detailed listing of members with gaps in care by provider for critical measures. CPCs can then work with provider practices to target specific measures when needed. We also facilitate regularly scheduled Joint Operating Committee (JOC) meetings with providers to further educate and review available benefits and services, consult on complex member cases, and review data on population health and outcome measures. In these meetings, we also work with the provider groups regarding decreasing ER visits, unnecessary hospitalizations and readmissions as well as quality performance measures.

Member Compliance

To promote and facilitate the capacity of providers to provide member compliance, we partner with them in a variety of ways to empower members to take an active role in their health. Upon enrollment, our highly trained member services advocates (MSAs) contact new members within 15 days to welcome them to the program (Welcome Call) and to answer questions about their benefits. The MSAs have the ability to view a member's gaps in care through *Advocate4Me*, inclusive of the member's EPSDT schedules for themselves and their family members. Our MSAs take every opportunity to encourage adherence to EPSDT periodicity schedules when communicating with members. Our MSAs can schedule a member's appointment while speaking to a parent or guardian as well as assist in arranging transportation.

Our CHWs provide care management for high-risk members with primarily non-clinical needs. The CHWs promote member compliance through direct contact by working in the community where they live and engaging members, removing barriers to care, coordinating services and community resources, and connecting members to their PCP. CHWs consult with high-risk case managers (HRCMs) regarding member care. If the CHW finds that the member has challenging medical or behavioral needs or is unable to resolve a member's gaps in care, the CHW refers the member to a care manager. An HRCM manages the care of our highest risk, most complex members based upon the member's primary area of need (medical or behavioral). In addition, transformation consultants monitor member interactions with the health care delivery system at the member and provider levels to promote compliance. They identify members who have not been seen by a practice and those who have disengaged from a practice. Transformation consultants share this information with providers and then help develop outreach solutions (e.g., inpatient or ER discharge notifications to PCP for follow-up visits) to re-engage members.

Member Satisfaction

To promote and facilitate the capacity of our providers to promote member satisfaction, we deliver support through our award-winning *Advocate4Me* program, a complete re-thinking of the traditional member service experience. Our team is prepared to connect with doctors, social workers and a myriad of specialty resources to help that member in navigating through the system and getting his/her needed care. Annually, we conduct an NCQA-certified CAHPS survey to assess overall member satisfaction and to identify and prioritize opportunities for improvement. In addition, we participate in clinical studies and use CAHPS survey results to assess the quality and appropriateness of care provided to members.

Successes and Lessons Learned

In New Mexico, we have deployed a holistic, whole patient-centered model of care to great success in terms of member engagement, improved health outcomes and member satisfaction. Throughout the state, we deployed 24 care coordination teams comprising individuals with varying backgrounds, including nursing, behavioral and clinical social workers, counseling, sociology and criminology. These individuals live in the communities they serve and are fully aware of the socioeconomic and health care needs of the resident members. Each member is assigned a care coordinator—their single point of contact—for engagement and continuity in addressing their holistic care needs. They are assigned based upon risk stratification data and consideration of member preferences such as ethnicity, primary language, preferred gender, and care coordinator expertise. Providers can access members' comprehensive care plans at any time, enabling them to direct proper care to those that need it most, and track member progress and outcomes.

In Louisiana, to promote member outcomes and compliance, we introduced a Population Registry tool for all Louisiana Medicaid PCPs, including providers participating in ACC practices. This tool offers a population view that offers a high-level perspective on trends and utilization and a patient view that provides a member's three-year clinical history showing pharmacy, lab results, outpatient visits, hospitalizations and ER use. Providers were able to make use of this data, with assistance from UnitedHealthcare staff, to target efforts to close gaps in care, promote appropriate service utilization, and improve member outcomes. Through these innovations, Louisiana experienced a reduction of greater than 30 percent in inpatient admission and ER utilization and an 11 percent drop in hospital utilization.

Planned Approach in Nebraska

Our planned approach in Nebraska is to continue the programs we have in place in the current 10-county service area while implementing successful practices learned nationally for our new populations and services. For example, we will expand the current use of CPCs to include new counties served, including providers and FQHCs in these areas. The CPCs will work with these new groups to promote and facilitate their capacity to provide patient-centered care, and improved outcomes, compliance and satisfaction. Additionally, CommunityCare will be available to these groups and as needed and appropriate, education regarding patient-centered care will be provided.

Our planned approach also includes the rollout of innovations and lessons learned in other states, including an increased focus on ACC communities and the *Advocate4Me* care model discussed above.

Accountable Care Communities help to align resources and payment structures to drive increase provider capacity and improved member outcomes. Transformation consultants are an integral part of ACCs and assist providers in accessing resources and information, including using our Population Registry tool. This tool, as highlighted in the New Mexico example, gives providers both population and member-level data to guide where to focus efforts. Data is updated in the Population Registry daily and the tool has other functionalities, such as automatic notification of members newly discharged from an inpatient stay. Through the ACC model, and use of associated resources, Nebraska providers will be able to, at a minimum, take action on access to care issues, help drive a reduction in avoidable ER use, reduce inpatient utilization and improve high-risk patient care.

43. Describe how the MCO's network development plan will establish patient-centered medical homes consistent with the requirements included in Section IV.I Provider Network Requirements. The description must address requirements in the RFP including:

Promoting and facilitating provider capacity to meet PCMH standards.

Maintaining contact with members throughout their interactions with the health care system.

Managing referrals.

Illness and disease prevention.

Encouraging active participation of the member or family/guardian/authorized representative in health care decision-making

Encouraging the use of specialty services and supports.

Providing access to care outside normal business hours.

Facilitating open scheduling and same-day appointments where possible. *5 pages*

Establishing Patient-Centered Medical Homes

At the heart of our clinical transformation strategy is our work to enable primary care practices to become more patient-centered and proactive through building high-performance, physician-led care teams. A core part of our strategy involves helping the practice integrate information from across the continuum of care, to enable a "whole person" view of patient clinical history. This integration effort typically includes reviewing care team roles, revising workflows and adding new care coordination activities. We have a specific and proactive strategy to engage provider practices on the journey to achieving PCMH recognition. This strategy includes our accountable care programs team, led by Cory Melvin, central region director, as our national support to a local focus with a dedicated, Omaha-based transformation consultant. Dr. Horn and our transformation consultant have been collaborating with Nebraska practices, such as Nebraska Urban Indian, Charles Drew, People's Health Center and OneWorld to further PCMH goals. In Nebraska in our current 10-county service area, **33 percent of PCPs are practicing in a PCMH-recognized or PCMH-like clinic.**

Nationally, we have a long history of collaboration with our delivery system, promoting and supporting transformation to a PCMH model in our communities. Our ACC program builds on a PCMH's capability over time to operate as a Medicaid accountable care organization (ACO), becoming accountable for the total costs of care of assigned members. In 2015, we executed 97 new ACO value-based contracts nationwide with PCMH practices, and we expect to have activated clinical partnerships with more than 250 active Medicaid ACOs in 20 states by the end of 2015.

To achieve coordinated care for Heritage Health members and to promote consistent, ongoing contact with members throughout their interactions with the health care system, we will partner with primary care practices in five focused areas consistent with PCMH recognition and population health management:

- Improving convenient access to care
- Reducing avoidable ER use
- Reducing avoidable inpatient admissions
- Improving high-risk patient care processes with team-based care
- Improving quality by closing gaps in care.

Our team assists in meeting members' holistic needs through strengthened collaboration with PCPs, service providers, inpatient hospital providers and peer providers. Timely and actionable clinical data are

available to the PCMH team using our secure Web-based Accountable Care Population Registry, enabling access to three years of clinical history on all assigned patients.

No later than 90 calendar days after contract award, we will provide to MLTC a final PCMH Implementation Plan that fully describes our methodology. The combination of our strategies will drive an increase in the number of PCMHs available for Heritage Health members. These strategies will align with MLTC's CMS-approved quality strategy/quality plan. Our solutions encourage providers to attain NCQA PCMH recognition, consistent with Section IV.I Provider Network Requirements, through the following innovative, market-tested strategies:

- Leveraging our national PCMH experience, including NCQA PCMH recognition
- Providing training and best practices through transformation consultants
- Providing technical assistance by enabling technology and data sharing
- Promoting a payment methodology whereby we provide financial incentives
- Implementing a community-based learning collaborative
- Partnering with the Primary Care Association and local provider organizations with a focus on FQHCs and rural health centers (RHCs)
- Evaluating provider participation levels and health outcomes achieved using a common evaluation methodology developed through collaboration with MLTC

Our PCMH model meets Nebraska's mandatory requirements and enhances a provider's capability by providing technology solutions and evidenced-based information in real time at the provider's location. We connect PCMHs to our population management tools, such as our secure Web-based Accountable Care Population Registry. This tool provides a portal for receiving notifications of inpatient and ER discharges, tracking high-risk population management, and viewing claims information and open care opportunities for members assigned to a PCMH.

By partnering with provider organizations, including FQHCs and RHCs, we can grow the number of Heritage Health members in medical homes, facilitating broad program impact. As illustrated in the Figure IV.I-1, in anticipation of the new statewide contract, we have conducted an analysis of Nebraska's FQHCs and RHCs as part of our PCMH outreach activities to target these entities as key PCMH delivery system partners.

Figure IV.I-1. By partnering with large practices, we can quickly grow the number of members served by PCMHs. Green dots and Xs indicate contracted RHCs and the blue dots and Xs indicate contracted FQHCs.

Promoting and Facilitating Provider Capacity to Meet PCMH Standards

Improving clinical efficiency and expanding provider capacity are among the many benefits of PCMHs. We offer a technical assistance approach (includes education, training tools and relevant clinical data) that maintains a strong focus on supporting the practice-level operational changes necessary to meet PCMH standards. These include:

Direct supports via practice coaching: We deploy transformation consultants to offer technical assistance to primary care practices at the heart of each ACC. We will deploy transformation consultants in

Nebraska in communities working toward PCMH recognition. In Nebraska, our transformation consultants lead clinical transformation initiatives and help provider practices team achieve the PCMH vision. Transformation consultants work directly with leadership and engage primary practice teams in rapid cycle improvement efforts to successfully integrate PCMH practice components. This includes helping practices build capacity to work with technology tools and data, conduct risk stratification, and develop blueprint processes of care and workflows integrating team roles and evidence-based practices. The transformation consultants analyze practice population data and hospital data to measure, monitor and manage member care and to present results/outcomes to the practice's executive leadership. The transformation consultants provide practices with a risk stratification of their practice population and identify specific evidence-based care opportunities for each member in their practice (e.g., PCMH screening for BH conditions resulting in either treatment or referral to a BH practitioner through coordinated care). The transformation consultants support process reengineering, operationalizing practice transformation and the goals mentioned above.

Support for performance measurement and quality improvement: Performance measurement and improvement strategies include collaboration with quality teams and providers to address gaps in care and drive quality improvement. During JOC meetings with PCMHs, our staff reviews a PCMH's progress on initiatives and identifies opportunities to collaborate more effectively. Initiatives may include identifying gaps in process or actionable data needed by a practice. A plan-do-study-act (PDSA) view of results is essential to achieving desired efficiencies and quality outcomes. Key elements are access to care and performance tracking (e.g., ER, and readmits), which become components for incentive payments and NCQA PCMH recognition.

Data sharing: An essential component for all of our ACC initiatives, the transformation consultants train practices to use and realize the benefits of the technology tools we provide. Data sharing supports continuity of care and care management. With a comprehensive view of our member's encounters in the health care system, we help practices facilitate care coordination with specialists, pharmacies and labs. Health IT offers a structure to help PCMHs improve access to care, information sharing, communication and teamwork. Data sharing can have a positive impact as part of the care transition process, especially after an inpatient admission discharge. When these events occur, providing that signal to the member's PCP for their outreach and follow-up can have a significant impact on reducing risk of hospital readmission.

Training and Technology Tools Facilitate Provider Capacity to Meet PCMH Standards

We developed the Population Registry and supplied it to the PCMHs **at no cost** to address the gap in population management and data limitations. Our transformation consultants will continue to work with PCMH staff to promote this tool and to provide training to other interested Nebraska PCMHs. The Population Registry supports a PCMH's ability to deliver the CMS Triple Aim of improved patient care, reduced costs and improvement in population health. This tool connects the local hospitals and practices so they operate across the continuum of care. The Population Registry establishes core processes, enabling a practice to meet NCQA PCMH recognition and providing a bridge for practices, hospitals and carriers to exchange real-time data while their electronic medical records (EMRs) and the health information exchange (HIE) expand in capability. Predictive modeling uses claims, lab and pharmacy data to risk stratify our members for each PCMH, and evidence-based guidelines are used to generate care opportunities for high-risk members. Care opportunities are based upon HEDIS measures and well-established clinical practice guidelines. Examples include member visits every three months to their PCP, regular measurements of cholesterol (LDL) for members with diabetes and heart disease, HgbA1c for diabetics and flu shots.

The performance view of the Population Registry shows practice goals and performance relative to goals. A PDSA view of results is essential to achieving the desired efficiencies and quality outcomes. In today's clinical model, practices often operate reactively, delivering care to members who have scheduled an appointment, seeing members in 15-minute time slots. In this model there are critical gaps—clinicians may know individual members but are unaware of the relative risk of their member population as a whole. Typically, practices do not know when their members are seen in the ER, when other providers see them or when they are admitted to the hospital. Electronic medical records do not have population management capabilities—population risk stratification and episode of care analyses of cost trends by service line (e.g., inpatient, ER and pharmacy) or give clinicians visibility to care delivered outside of their own practice. UnitedHealthcare, in partnership with practices and community hospitals, supports the transition from this reactive care to a proactive model of population management using information technology and HIE to support the development of effective PCMHs. We are working with NeHII to develop a pilot to help identify barriers and solutions to expanding the community investment in information technology.

Maintaining Contact with Members throughout Interactions with the Health Care System

We know the "patient-centered" part of a medical home depends on having activated, engaged patients. Transformation consultants monitor member interactions with the health care delivery system at the member and provider levels. They identify members who have not been seen by a practice and those who have disengaged with a practice. With PCMH staff, the transformation consultant reviews claims and utilization reports to understand a member's interactions with the health care system with the goal of helping PCMHs maintain contact and engage with our members. Transformation consultants share outreach solutions (e.g., inpatient or ER discharge notifications to PCP for follow-up visits) to re-engage members for their care needs and help PCMHs implement those solutions.

Managing Referrals

The PCMH acts as the hub for primary care services and a gateway to the larger health care system should an individual's needs (including social and environmental needs) extend beyond the primary care setting. Referral management is an important PCMH function, which is complemented by our care coordination program. In Nebraska, we are in the process of sharing the *Healthify* tool with FQHCs to help them connect individuals to *Healthify's* database of culturally matched community-based organizations to help remove barriers to care. *Healthify* aggregates information found on public sites and includes services that are offered, contact information, intake requirements, service hours and languages spoken for the resource and service centers listed in the database. All service listings are telephonically validated and staff are encouraged to provide edits and new information as it is available.

Illness and Disease Prevention

We expect PCMHs to coordinate and facilitate access to disease prevention and health promotion services to prevent illness. The transformation consultant helps PCMHs support a continuous quality improvement program and makes sure PCMHs collect and report on data that permits an evaluation of increased coordination of care and chronic care management on individual and population-based clinical and cost outcomes, experience of care and quality of care outcomes. The Population Registry provides information about an individual's care opportunities (based upon HEDIS measures) for providers to review and act upon.

Encouraging Active Participation in Health Care Decision-Making

We recognize members and their families/guardians/representatives have competencies, capabilities and personal goals that should be recognized, supported and encouraged during care planning. Further, services should be provided in an individualized manner, consistent with a member's unique priorities

strengths, resources and concerns. We will continue to promote inclusion of the member and his/her natural supports in health care decision-making, care planning team meetings and developing a member's plan of care. We support providers who hire peer support specialists and can offer our own recovery/resiliency director to help the BH provider network to integrate with other programs and services (e.g., anonymous recovery programs) that promote our members' recovery, empowerment and use of member strengths to achieve a member's clinical goals and health outcomes. Our care management and member services staff work with members to help them schedule appointments or arrange transportation.

Encouraging the Use of Specialty Services and Supports

Referrals from PCPs to specialty services and supports represent an opportunity for improved care coordination. Our national ACC/PCMH model focuses on collaboration and information sharing (e.g., via Population Registry and *Healthify*) with our strategic network partners, such as FQHCs and RHCs. This model integrates hospitals, PCMH practices and specialists into a common local community of care for attributed populations. Cross-functional teams drive medical home integration at the practice level in support of "communities of care," extending beyond the traditional medical home four walls to include the hospital teams, specialists, transformation consultants, CPCs, BH advocates and CHWs.

Care Outside Normal Business Hours, Open Scheduling and Same-Day Appointments

Convenient access to care is a critical foundation for every medical home. Each practice is held accountable for improving access to care, which means they should be providing after-hours care, increasing the percentage of same-day visits and reducing the percentage of no-show appointments. After-hours care coordinated with a member's usual PCP is facilitated in the context of member demand, provider capacity, a shared electronic health record, systematic notification procedures and a broader practice approach to improving access and continuity of care. Practices may need to revamp scheduling processes/workflows and to adopt new technologies; therefore, we support them to promote enhanced customer service. We encourage them to offer telephone consultations by clinicians during evenings and weekend hours.

We require contracted providers to provide after-hours coverage via one of these methods:

- ***After-Hours Calls:*** Providers must have an answering service respond to after-hours calls. The answering service must contact the PCP (or another designated medical provider) and return calls to the member and his/her family within 30 minutes of the initial call.
- ***After-Hours Referral:*** Providers must have a voicemail recording directing members and families to call another number to reach the PCP or other PCP-designated provider.
- ***On-Call Coverage Referral:*** Providers must forward their office telephones so that it transfers directly to another location, where someone answers the telephone and can contact the PCP (or other practitioner) who will then return the call within 30 minutes.

Measuring, monitoring and managing access to care information is supported by the transformation consultant in partnership with the practice leadership. We monitor provider compliance with appointment availability requirements and wait time standards, in accordance with state-specific requirements or NCQA accreditation requirements, whichever is more stringent, using member complaints and grievances, feedback from our care management team, member satisfaction surveys, quarterly service availability surveys and geographic access and availability studies. We contract with external vendors with expertise in conducting phone surveys to monitor provider compliance with availability standards.

44. Describe how the MCO would respond to the network termination or loss of a large-scale provider group or health system. Take the following areas into consideration in the response:

Notification to MLTC.

Coordination with the PBM.

The automated systems and membership supports used to assist affected members with provider transitions.

Systems and policies used for continuity of care of members experiencing provider transitions.

Impact if the loss is in a geographic area where other providers of the same provider type are not available and the MCO's response to that impact. *3 pages*

Under the direction of our Nebraska leadership team, we have extensive, existing policies and processes to make certain our provider network remains stable. The role of our provider advocate team is to be in frequent contact with providers and the larger health community. This level of engagement means that if there are concerns, they are addressed in a timely manner to avoid termination due to performance. Our teams are prepared to respond in the event a provider leaves a practice or a large-scale provider group or health system terminates and no longer is able to provide services. It is our responsibility to provide our members with access to providers and services. If we receive a notice of termination, it is communicated to Sean Jones, chief operating officer (COO), who, in coordination with leadership and functional leads, will conduct outreach to the provider to better understand the cause for the termination, the potential impact of a termination and take ownership to develop a plan of action. This plan of action includes notifying MLTC, coordinating with our PBM and other subcontractors, addressing automated systems and membership supports to assist members and providers, arranging for continuity of care, and addressing access related to the geographic area impacted.

In the event of a loss due to a natural disaster, Mr. Jones also will coordinate with Enterprise Resiliency & Response and the local Business Continuity Planning and Emergency Coordinator to activate the local Nebraska business continuity plan. During disasters, we encourage members and providers to use the toll-free numbers we have already provided to them to help make certain their calls are routed appropriately. We recognize that in the confusion of evacuation and the aftermath of a disaster, people may not have these numbers readily at hand, so we have created single entry points into our customer care organization, which we publish in press releases associated with our event response. Each disaster is unique and our response is customized based upon need and the services we provide to members in the impacted area. The following are potential activities that may be included as part of our overall efforts:

- Medical benefits may be temporarily modified to assist members preparing for, or responding to, the disaster to ease access to health care. These actions may include but are not limited to removing PA/notification requirements or easing restrictions on use of out-of-network providers.
- A Crisis Counseling line may be made available to the community as a whole to provide mental health support to those who may need it. This is free of charge and open to anyone impacted by the event.
- Our local clinical directors collaborate to identify members currently hospitalized or at long-term care facilities and those with SHCNs, evaluate the provider capacity within the geographic area, and where appropriate, identify reassignments and communicate this information to members and providers.
- Our medical directors review care coordination and disease management files to identify members at most risk due to disease severity or fragility. These members are a priority to contact to arrange for care continuity and determine if they need evacuation assistance.

- Our hospice patients are identified, and our care managers verify adequate supplies and prescription medications are available. In the event the member is to be evacuated, appropriate sites and resources are identified to meet the transportation and ongoing needs of the individual.

Our compliance team proactively searches for any regulatory orders related to the event, such as state-level executive orders, Department of Insurance Orders or U.S. Department of Health and Human Services' or Centers for Medicare and Medicaid Services' orders, to make sure we are addressing all regulatory requirements.

Disaster Recovery Efforts

In 2013 and again in 2014, UnitedHealth Group acted to support people in Iowa, Illinois and Nebraska affected by tornadoes and floods. Our support included a free emotional-support line to help people in the affected communities, early refills of prescription medications and assistance to health plan participants who were affected and needed to make alternate arrangements to verify continuity of care. We also supported the efforts of the American Red Cross Disaster Relief Fund, which helped people in the affected communities.

Notification to MLTC

In the event of a network termination or loss of a large-scale provider group or health system, we will take steps to notify MLTC as soon as we have substantive information to share. This communication will be part of our comprehensive strategy to verify continued network adequacy. We will communicate with MLTC a summary of the circumstance surrounding the loss of a large-scale provider as well as actions taken to make certain members have access to care.

Coordination with the Pharmacy Benefit Manager

We will immediately conduct outreach to the PBM to notify them of the status of the network. Working with the PBM, we will initiate measures to facilitate continuity of care such as removing PA/notification requirements, allowing early refills of prescription medication, and providing early replacement of durable medical equipment.

Automated Systems and Membership Supports

When reassignment of members is required because of the loss of a contracted provider, group or a clinic site, MSAs use telephonic outreach to affected members to make certain they are notified by phone, or in writing within 15 calendar days of the receipt of the termination notice from the provider. In addition, in the event of the loss of a large-scale provider or natural disaster, we would use our Business Continuity Plan to activate our Technology Command Center and event management team to leverage national support to aid us in the identification of members that need continuation of services.

Systems and Policies Used for Continuity of Care

Members affected by the termination or loss of a provider are assigned to care managers to help them through the transition of care process. Our defined policies and procedures help guide care managers as they coordinate the plan of care with the new provider, member and other identified care team members to verify a complete transition from one provider to another provider. When a provider is no longer available through our network, we allow members, who are undergoing an active course of treatment, to access services from non-contracted providers or remain with their current provider for an additional 90 calendar days to make certain of continuity of care. Our care management, network strategy and provider relations teams immediately assess the availability of other providers in the community. The preferred strategy is to refer the member to another qualified, contracted provider. If a contracted provider is not available, short-term interventions will include continuing services with the terminated provider until the acute treatment

period ends, referring the member to a non-contracted provider, recruiting a new provider, or arranging for a member to see a provider outside the member's community.

If a Particular Provider Type is Not Available in That Area

Because we understand the need to preserve the physician-patient relationship whenever possible, we always exhaust all options to avoid the loss of a provider. When a contracted provider is not available, the following interventions are taken:

- ***Referral of a member to a provider outside the member's community:*** If a provider is not available in the member's immediate community, we arrange for the member to temporarily receive care from a provider located in another community. This solution is generally used until an appropriate provider is available within the member's immediate community.
- ***Provide services using providers through telemedicine:*** We provide technical, operational support for contracted providers outside the community to deliver clinical services to members using telemedicine. In addition to improving access to the needed services, use of telemedicine decreases the burden on the member and the member's family. This is a valuable service that improves access and reduces transportation needed for enrollees in areas where there are shortages for certain physician specialties. By using telemedicine, providers are able to bring the service to the member even if there is no other network provider of a specific specialty that is available to the member.

In September of 2013, UnitedHealthcare's five-year agreement with DaVita, a national dialysis provider, expired. Several proactive measures were put into place well in advance of the termination date to verify that member access to care would be maintained in the event the contract was not renewed. First, using our technology, we identified all members receiving care through DaVita to determine that service was readily available through other network providers. Then we conducted a general network analysis to assess the capacity available through other contracted dialysis providers. We notified MLTC of the potential termination and our action plan. MLTC provided approval of our member notification letters. Members and providers were notified in writing of the upcoming change, and transition plans were implemented in collaboration with UnitedHealthcare Clinical Coverage Review (CCR) teams and Kidney Resource Services (KRS). Outreach was conducted to DaVita patients to make certain they were informed of DaVita's changing status to an out-of-network provider, and to assist them in transitioning to another network provider. We established a process with CCR and KRS to provide hands-on assistance and management of continuity of care requests. To minimize disruption and assist member transition, a business decision was made to approve all continuity of care requests for a minimum of 90 days. Finally, our own health plan care management nurses placed calls to our impacted members to reinforce understanding of the change, and to further assist with transitions to other dialysis provider options. We credit the successful transition to our proactive approach and our commitment to placing our members' care needs first.

45. Describe the MCO's credentialing and re-credentialing process including:

Ensuring that providers are enrolled in Medicaid and have a valid identification number.

Obtaining information on ownership and control.

Identifying excluded providers and persons convicted of crimes searches.

Using quality and utilization measures in the recredentialing process. *3 pages*

As credentialing and recredentialing processes verify physician qualifications and practice histories, we understand that these processes serve as a critical component in assuring our members' access to quality health care. Our current Medicaid network in Nebraska meets the credentialing and recredentialing requirements. Encompassing and complying with Section IV.J.14, UnitedHealthcare has established minimum provider credentialing requirements, licensure requirements and a rigorous credentialing/recredentialing review and approval process to confirm contracted providers are qualified to provide member health care services. We will submit our credentialing and recredentialing policies to MLTC for approval upon request.

Our material affiliates and subcontractors are delegated to perform their own credentialing, and must comply with both MLTC's and our credentialing policies. We employ stringent quality standards and mechanisms to oversee their credentialing performance, including executing an agreement that clearly defines specific duties, responsibilities and activities. In addition, we review the potential delegate's credentialing policies and procedures and, if necessary, perform a file audit of their credentialing processes. As required, we will obtain MLTC approval of our subcontractors and credentialing process, including delegated service components.

If, at any time, we deny or terminate provider participation in our network due to adverse member quality of care actions, we will promptly communicate these decisions to the proper authorities (e.g., MLTC, DHHS Division of Behavioral Health and DHHS Division of Public Health). We currently submit a monthly provider termination report to the MLTC.

Ensuring Provider Medicaid Enrollment and Identification

UnitedHealthcare requires all network providers to be enrolled in the Nebraska Medicaid program and to provide their Medicaid ID numbers during the contracting process. Contracted nurse practitioners acting as PCPs are held to the same requirements and standards as physicians acting as PCPs. We also use the MMIS-provided file, with current provider information, to confirm enrollment and the presence of a valid identification number. Providers that have not obtained a Medicaid ID will not be credentialed.

Obtaining Information on Ownership and Control

We have established procedures for collecting Ownership and Financial Disclosure statements from participating network providers, in addition to all our employees and subcontractors. During contracting, all newly enrolled providers must submit disclosure forms, which we collect in accordance with federal regulations. Providers must not be ineligible, excluded or debarred from participation in Medicare/Medicaid and related state and federal programs. In addition, providers must disclose any criminal information on these statements. We make certain that our providers submit full disclosures of all owners with a control interest of 5 percent or greater; certain business transactions as described in 42 CFR §455.104; and the identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity. All providers and identified individuals with an ownership or control interest in the provider entity are screened against the List of Excluded Individual and Entities (LEIE), maintained by the Office of Inspector General (OIG) and System for Awards Management (SAM) by the General Services Administration (GSA); Social Security

Administration's Death Master File; the National Plan & Provider Enumeration System (NPPES) Registry and the Nebraska Medicaid Excluded Providers List. Should our provider screening include an adverse result (e.g., criminal conviction, disbarment, sanction), we forward the disclosure to MLTC and adhere to its direction on whether to allow the practitioner to become a Nebraska network provider. If a provider does not submit a disclosure form to us, we use disciplinary actions, such as halting claims payment, until the form is completed and submitted.

Identifying Excluded Providers and Persons

We identify excluded providers and persons during our credentialing and recredentialing processes' primary source verification step; our comprehensive processes are described below.

Medical and Behavioral Health Provider Network Credentialing

- ***Initial Provider Application:*** To initiate a new credentialing application, providers are required to contact our credentialing center. The credentialing specialist sends the provider a Council for Affordable Quality Healthcare (CAQH) identification number with instructions for completion of the Universal Credentialing application. Using their CAQH number, providers or their staff input their credentialing application information once, online or by fax, in a secure, state-of-the-art data center. We also will accept any standardized credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.
- ***Primary Source Verification:*** Completed applications are extracted from CAQH on a daily basis by our contracted Credentials Verification Organization (CVO) for primary source verification, which includes the NCQA-required elements noted below. Using an external certified CVO is the primary quality control mechanism we use to confirm the veracity of submitted provider information.
  - Verification of current medical license
  - No revocation, moratorium or suspension of state medical license
  - Professional liability claims history and malpractice coverage
  - Medicare/Medicaid imposed sanctions
  - Five years' work history
  - Education, training, board-certification
  - Hospital privileges or admitting arrangement, if applicable
  - Valid Drug Enforcement Administration (DEA) certificate or Controlled Dangerous Substances (CDS), if applicable

  Behavioral health agencies and substance abuse services are credentialed at the program-level or level of care and must meet regulatory requirements and level of care criteria. Non-accredited programs must participate in an environmental site visit review.
- ***Review of Credentialing Materials:*** Once verifications are completed, the provider's credentialing file is presented to our Credentialing Committee. The committee considers all credentialing program criteria and renders a decision, which is documented and submitted to our local CPAC. If the committee approves the credentialing application, the decision is sent to our network management team for provider contracting.
- ***Building a Responsive Network:*** Providers receive a letter notifying them of the approval decision or denial of network acceptance. Denial letters inform providers of appeal rights.

Credentialing Provisionally Licensed Behavioral Health Providers

To support BH workforce expansion, we credential provisionally licensed clinicians who are functioning under a provisional state license and operating under required supervision protocols. Credentialing these providers increases member access and enables recent graduates to become active, productive members of the BH community—particularly important to our providers in rural and frontier Nebraska counties where there is limited BH practitioner access.

Pharmacy Network Credentialing

All contracted pharmacies must pass an initial credentialing process. Our network contracts are "evergreen," featuring an automatic, yearly renewal, and are recredentialed every three years, as new contract amendments are made or as required by law. Our contracting strategy incorporates rigorous credentialing criteria, including maintaining adequate hours of operation, agreeing to on-site audits and maintaining sufficient professional and general liability insurance. To meet minimum requirements, chain and independent pharmacies must provide us with a copy of their valid state pharmacy-board license and permit, and undergo a national database query search and verification. They must also submit a completed provider credentials form, which includes: federal tax identification; state license verification and ownership history; DEA license information; Proof of Liability; most recent board of pharmacy inspection date; and a signed attestation related to prior disciplinary actions, convictions and restrictions.

Recredentialing

The recredentialing process mirrors the credentialing process for all network provider types and facilities and begins six months prior to the three-year anniversary of the original credentialing or last recredentialing date. It also considers historical data, including but not limited to grievances, quality review results, member satisfaction survey results and utilization management information.

We will completely process credentialing applications from all provider types within 30 calendar days of receiving a completed application. Our credentialing and recredentialing processes meet NCQA standards, as well as other applicable regulations.

Using Quality and Utilization Measures in Recredentialing

Our credentialing and recredentialing process falls under the purview of our QAPIC, chaired by Dr. Horn. Reporting to the QAPIC and in partnership with the BHAC, the CPAC performs peer review activities, including credentialing review and disposition of concerns about the quality of clinical care for members.

Our national Quality of Care (QOC) department records all quality of care issues from member complaints and other referral sources in a database for tracking and trending. The QOC notifies our Credentialing Committee of all moderate or serious quality concerns identifying credentialed providers. Our QOC also performs ongoing monitoring for any potential provider trends every six months and evaluates at the CPAC to determine if any additional actions are warranted. The following quality-related criteria and stipulations are reviewed when considering network pharmacies for recredentialing: offering of 100 percent point-of-service capability; compliance with all of drug utilization review (DUR) and plan design parameters; maintenance of verifiable record of authorization for refills; and record of not charging a member more than the contracted amount.

While provider utilization is continuously tracked and promptly acted upon if an issue arises, our health services team also provides our Credentialing Committee and HQUM Committee with provider utilization data at the time of recredentialing. These committees will review the reported list of providers and their data to identify providers with utilization issues and factor their performance into our network recredentialing decision and processes.

46. Explain the process the MCO will put in place to maintain the provider file with detailed information on each provider sufficient to support provider payment, including issuance of IRS 1099 forms, meeting all federal and MLTC reporting requirements, and cross referencing State and Federal identification numbers to ensure excluded providers are identified. *2 pages*

Process to Maintain the Provider File

We have an existing, comprehensive process in place to maintain a provider file from MLTC that contains sufficient information to successfully support provider payment, including issuing Internal Revenue Service 1099 forms and meeting all federal and MLTC reporting requirements and cross-referencing state and federal identification numbers to ensure excluded providers are identified. We confirm all our contracted providers and subcontractors screen their employees for exclusions and understand MLTC will not reimburse us for services rendered by an excluded provider. MLTC currently sends us a weekly provider file that represents information for the full provider network. We retrieve the file and analyze it to identify any discrepancies or changes to provider information, generating discrepancy reports that are verified through provider outreach and submitted to our data loading teams and used to update our provider information. This analysis helps to certify we are handling MLTC's dollars responsibly, reimbursing only eligible providers and maintaining consistent and current provider payment data. We recognize the importance of submitting accurate and complete provider data to MLTC and the need for MLTC to use our provider data for other reporting and editing purposes. We use a rigorous, multi-step process to efficiently load and verify provider contract data according to MLTC business rules.

When contracting with providers, the first step of the process is for the provider to complete a credentialing application. Upon receipt of credentialing application, our Credentialing Committee credentialing specialists review applications for completeness, telephoning providers who submit incomplete applications to gather missing information. National Credentialing Committee staff members conduct primary source verification data provided via the credentialing applications. Data verified include, but are not limited to National Provider Identifier (NPI), validity of license, education, board certification and Sanctions including site survey results when applicable. Upon receipt of all required application data, credentialing specialists enter data into our Universal Credentialing Database application, which uploads into our Network Data Base (NDB). Provider data in the NDB is electronically loaded and updated on a daily basis into CSP, our core transaction system. Our system tests all new contract data to make certain that provider contracts are set to pay according to the benefit design and eligibility and reimbursement policies. Once testing confirms provider contracts are set up in the system correctly, the contract is tagged as claim ready. We understand the frustration that providers feel and the administrative burdens placed on providers as a result of errors in our data or if the provider is mistakenly excluded. That is why we prioritize data accuracy and have enhanced our process with our new PRISM provider service model to make sure that providers are not affected by errors. If errors are made within our provider enterprise system, including mistakenly identifying a provider as excluded, errors are prioritized for remediation and quickly corrected within the system as well as within the MLTC provider files to prevent any further negative impact to the provider's relationship with enrolled members or claims payment process.

Issuing IRS 1099 Forms

Annually, after year-end processing, our finance team extracts 1099 data out of the CSP claims platform. The data is validated against our general ledger, creating a list of providers that show discrepancies in data, such as conflicts with NPI numbers. Our provider administration team researches and resolves discrepancies, then forwards the final data to our corporate tax area where the 1099 forms are generated and distributed to providers no later than Jan. 31.

Meet all Federal and MLTC Reporting Requirements

Our claims platform, CSP, is configured to comply with all federal and MLTC reporting requirements. Our Provider Affiliation File is produced weekly and contains a complete listing of our provider network and includes, but is not limited to, the following data elements in support of accurate provider payment:

- National Provider Identifier (NPI)
- Taxpayer Identification Number
- Effective date of provider's contract with us

Data quality is determined using an internal error report to identify provider records not in the appropriate format. Our provider file information is then reconciled with MLTC provider file to verify data accuracy and alignment. Our business intelligence and compliance teams support executive leadership's efforts to meet all federal and MLTC reporting requirements, based upon each report's scheduled production and our compliance team tracks each report production cycle to verify we are meeting reporting requirements.

Cross-Referencing to State and Federal Identification Numbers

As part of our credentialing process, we cross-reference provider identification numbers, such as tax identification and NPI for each provider with the following databases: United States Department of Health and Human Services – Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded providers. We understand that this is a federal requirement that helps prevent fraud and abuse in federal and state health care programs. State agencies use the information to help ensure that providers/facilities providing care within the state's Medicaid system are compliant with the federal regulations. This cross-referencing process helps ensure providers have not been unfairly barred from providing services or do not have relationships with individuals or entities that have been excluded or terminated from participating in any federal health care program.

We understand the importance of making certain that provider file information is complete, and that MLTC members do not receive service from any excluded providers. As a part of our process, we include copies of all queries in the provider's credentialing files. As we identify excluded providers from any sources previously mentioned or State sources, they are given an adverse credentialing determination when identified during credentialing, or are terminated from our network when identified during the recredentialing or monitoring processes. In between the provider's credentialing and recredentialing process, our fraud, waste and abuse teams cross-reference these lists through ongoing monitoring processes. Although identified excluded providers are not granted a contract with us, we still maintain a provider record where they are tagged as excluded. As claims are loaded into CSP for processing, any claim coming from a provider flagged as excluded is sent to our Special Investigations Unit (SIU) for manual review. SIU associates review these claims to confirm the excluded status of the submitting provider. If it is determined that the provider is excluded, we do not pay the claim and send it back to the provider with a remittance advice/adverse determination. When we determine the provider is not excluded, the claim is sent back to the claims team for processing and payment.

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IV.J. Provider Services

47. Provide a description of the MCO's provider services program/department and how the MCO intends to partner with the provider community to deliver covered services. Include:

Information available in the provider handbook or other media.

Description of any committees the MCO will form for providers to offer input regarding issues such as the MCO's service delivery, MCO/provider interactions, and potential opportunities/ innovations for improved health outcomes.

Description of how the MCO will develop, establish and maintain its provider advisory committee, with representation as identified in this RFP.

Sample provider outreach methods. *4 pages*

In compliance with all requirements from Section J of the IV. Project Description and Scope of Work, our Nebraska-based provider relations team, led by provider services manager Jeremy Sand, has partnered with providers for almost 20 years. We supply providers with the information and support needed to deliver covered services to Nebraska Medicaid members. We designed our provider services program to be innovative, adaptable and promote continuous improvement for all providers. The Nebraska program encompasses the following elements:

Provider services call center: Described in detail in our response to Q48, provider phone representatives (PPRs) in our provider services call center respond quickly to provider inquiries. With the planned 2016 implementation of a **Nebraska-based provider services center,** our call center will be open and staffed in accordance with the requirements of Section IV. J, including the availability of clinical pharmacists. Providers can obtain assistance on a variety of topics, from covered services to member eligibility verification to claims payment and more.

After-hours support: After-hours calls to our provider services center are answered by our interactive voice response (IVR) system, which provides automated eligibility verification and benefits information. Additionally, our secure provider portal, *Link*, provides 24 hours a day, seven days a week access to interactive features, such as claims submission, prior authorization (PA) and eligibility verification. Providers can submit questions and comments to us through either of these resources and receive responses to inquiries within one business day of receipt.

Dedicated provider services staff: Our dedicated Nebraska provider services team actively supports Medicaid providers. Our provider services manager, Jeremy Sand, has ownership to ensure our providers receive the support they need. They answer questions, promptly resolve issues and conduct outreach and education about UnitedHealthcare. The team includes:

- ***Provider advocates, including a BH provider liaison*** who conduct provider outreach and education. We currently have six Nebraska-based provider advocates, disbursed statewide, who support physical health providers; these staff are assisted by telecommuting network managers. As we expand our Nebraska service coverage, we will correspondingly add new Nebraska-based provider advocates to ensure sufficient provider support, including a focus on BH services.
- ***Clinical practice consultants (CPCs)*** are field-based RNs who meet with targeted providers and their office staff to review performance, the associated clinical practice guidelines and to identify opportunities to improve the practice's systems to improve compliance. We currently have two locally based CPCs to support Nebraska providers; and will be adding CPCs in appropriate regions of the state to support the new Nebraska Heritage Health contract.

- ***Market service agents in our PRISM team*** work on end-to-end provider claim and call quality, enhance the provider portal and other provider tools, and develop provider training and education. Our Nebraska market service agent is dedicated solely to supporting our local service center.
- ***Claims adjustment representatives*** research provider claims questions, engage other UnitedHealthcare departments to resolve claims and adjust claims, as appropriate.
- ***Claim project managers*** provide end-to-end management of provider-based claim projects to resolve concerns impacting providers with claims. Our ***claims research team*** supports the claim project managers by adjusting claims, providing claims reports and investigating defects.
- Our ***provider claims educator***, Candace White, has expertise related to our grievance, claims processing and provider services systems. Ms. White will facilitate the exchange of information between these resources and our Nebraska providers.

Information Available in Our Provider Handbook

We maintain a Nebraska provider handbook, our *Provider Administrative Guide,* specifically addressing the requirements, policies, covered benefits and goals of the Nebraska Medicaid program. Our current Nebraska handbook is comprehensive and compliant to MLTC requirements. We will update and enhance the manual to include all new topics and information stated in Section IV.J.3—submitting the updated handbook to MLTC for review and approval a minimum of 90 calendar days prior to contract start date, and posting it for online access via our provider portal (*Link*) applications within 10 calendar days of MLTC approval. Available in electronic or in hard copy format, the *Provider Administrative Guide* is updated periodically (at a minimum, bi-annually) based upon feedback we receive from providers. Providers are alerted to modifications in the handbook and to changes in provider requirements via a posting on our provider website or via email. Our *Provider Administrative Guide* is a comprehensive resource for physicians, other health care professionals, ancillary providers and facility staff. The handbook includes prior authorization telephone numbers for all services, including BH. An extensive section of the handbook addresses a PCP's role in continuity and coordination of care, emphasizing BH screening opportunities. The handbook reinforces our expectations that all providers involved in a member's care will coordinate care, including communicating significant findings and recommendations.

In addition to our handbook, we use a variety of educational and communication mechanisms designed to support providers, including:

Provider Newsletter and Service Bulletins: We create and distribute a monthly newsletter for both physical and behavioral health providers. Our provider newsletters (see Figure IV.J-1) contain program updates, claims guidelines, policy and procedure information, cultural competency information, clinical practice guidelines, articles on pertinent health topics and more. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements. Service bulletins are also listed on the provider portal and recapped in our provider newsletters, accessible via our provider portal.

Figure IV.J-1. *Practice Matters*, our newsletter for physical health providers

Provider Portal: Described in our Q49 response, our secure provider portal supports Nebraska providers through many innovative features, applications and tools, and is integrated with our critical systems and provider website. The portal enables providers to electronically determine member eligibility, submit claims and ascertain claims status. It also contains links to online versions of our *Provider Administrative Guide, Provider Directory*, clinical practice guidelines (e.g., our I/DD

Toolkit), quality and utilization requirements and educational materials. We also post notifications, regulations and alerts.

On-Site Provider Visits: Our provider advocates visit high-volume hospitals, FQHCs, physician practices and specialists on a regular basis. We assign each provider advocate a geographic area to deliver face-to-face support to providers, with the ability to supplement with webinars or teleconference calls as needed. A BH provider liaison will conduct similar visits with BH providers. We document all material provider outreaches in a central repository to allow tracking, trending and reporting. The prioritization and frequency of provider office visits is determined based upon a variety of factors, including assigned or attributed membership, geography or type of education/training need.

Establishing and Maintaining Collaborative Provider Committees

We use a variety of ways to give providers opportunities to be heard about the effectiveness of our provider support and provider relations. Provider input is solicited through outreach efforts including:

Clinical and Provider Advisory Committee (CPAC): Critical to our Quality Assurance and Performance Improvement (QAPI) Program is the information we solicit from physicians through our CPAC, which meets quarterly (at a minimum). Composed of network PCPs and representatives from major Nebraska specialty provider organizations, including BH and pharmacy providers; the CPAC serves as a forum for physician input on clinical improvement initiatives, clinical guidelines, data analysis, drivers of member and provider satisfaction, credentialing and quality of care and services monitoring. Chaired by our medical director/CMO, Michael Horn, M.D., and attended by provider services manager Jeremy Sand (serving in the role of provider network liaison), BH clinical director Dr. Charles Freed and other plan leaders, this committee provides input into all policies, procedures, and practices associated with care and utilization management functions. Additional responsibilities of the CPAC include peer review of network providers, review and disposition of concerns about quality of clinical care provided to members, and evaluating and monitoring the quality, continuity, accessibility, availability, utilization and cost of the medical care rendered within our network.

Behavioral Health Advisory Committee (BHAC): The BHAC is a forum for BH providers to provide recommendations, input and prioritization of initiatives or issues. The BHAC is responsible for providing input to the CPAC on network development and management strategies and policies for the provision of BH services. At a minimum, BHAC members consider provider input and expertise relative to clinical issues, including policy development, service planning/evaluation, performance improvement projects and training plans. The BHAC allows us to gather valuable feedback, input and advice for enhancements to systems and changes to procedures in the provisioning of integrated BH services throughout Nebraska. We will ask the Nebraska Association of Behavioral Health Organizations (NABHO) to recommend participation on the BHAC, as well as a psychiatrist (M.D.) to sit on the CPAC.

Administrative Advisory Committee (AAC): With implementation planned for Nebraska in 2016, we created the AAC as a formal method to capture provider feedback. During triannual AAC meetings, we present various administrative topics that allow committee members to provide input on strategic direction and feedback regarding their daily experience with us. AAC members encompass influential practice and/or hospital administrators, health-care-related national societies, health care leaders from multiple provider administrative and medical specialties and our market leadership.

Focus Groups: In 2016, we will begin holding Nebraska provider focus group sessions, starting with key FQHCs and RHCs across the state to continue partnership efforts with these critical practices and ensure their issues are heard and resolved.

Joint Operating Committee (JOC) Meetings: We conduct JOC meetings with key provider groups and facilities to address strategic, contractual, clinical performance and operational issues, including education needs. Provider advocates schedule meetings with hospitals, primary care practices and high-volume specialists across Nebraska to ensure critical policies and procedures are reviewed, access/availability information is gathered and to discuss pertinent issues. As we expand our collaboration with BH providers, a BH provider liaison will conduct similar outreach. Dr. Horn holds JOC meetings with the clinical leadership of larger health systems to review their utilization data for all of UnitedHealthcare's Nebraska products (Commercial, Medicare and Medicaid); we use this information to compare peers and to drive improvement discussions.

"Through the roundtable discussion... we were able to share our concerns related to UnitedHealthcare and get answers and solutions. I appreciate the ICD-10 updates at each meeting. It was at these discussions that the new website was introduced. I was excited to learn about the new website and thrilled to be working with it now that it has launched. I look forward to these meetings in the future."

–Angela Collins, CPC, CMOM
Practice Manager

Provider Roundtable Meetings: We currently conduct semiannual roundtable meetings in Lincoln with 12 provider office managers. Meetings focus on operational updates and seeking direct feedback on our provider support, overall performance and program quality. We share this feedback with our executives and staff. Topics covered during roundtable meetings include: 1) an ICD-10 overview of our online resources as well as the Physician ICD-10 Coding Practice Tool and 2) an overview of our provider value-based contracting programs.

Sample Provider Outreach Methods

We know that provider outreach, education and training play an important role in member satisfaction and health outcomes, which is why our Nebraska provider outreach strategy includes multiple methods of engagement (e.g., committees, forums, marketing and community outreach, lunch-n-learn sessions, town halls, seminars, etc.). Examples that we have used and we will continue to employ and enhance for Nebraska include the following; provider training and education solutions are described in detail in our response to Q50.

- 2015 Nebraska *Provider Administrative Guide* (Attachment 19 Q47-1 NE Provider Handbook), a comprehensive administrative resource for all Nebraska physicians, health care professionals, ancillary providers and facility staff.
- Provider Education Town Hall Session Presentation (Attachment 19 Q47-2 NE Provider Town Hall Session Presentation), a monthly presentation that covers topics useful to providers, as well as offers an open forum for the provider community to ask questions.
- Provider Quick Reference Grid (Attachment 19 Q47-3 NE 2015 Provider Quick Reference Guide), a one-page provider reference table highlighting key and commonly used information.
- New Provider Welcome Kit (Attachment 19 Q47-4 NE 2015 Provider Welcome Kit), a kit sent to each new network provider that contains valuable information about important contacts, policies, procedures and services.
- Provider Network and Education, Provider Advocate Presentation (Attachment 19 Q47-5 2015 NE Provider Advocate Presentation), a presentation used to introduce Nebraska providers to their assigned provider advocate, as well as instruct providers on working with our provider advocates.
- BH Provider Brochure (Attachment 19 Q47-6 2015 BH Provider Example), a guidance brochure that covers the eight important things BH providers need to know about the ICD-10 transition.

48. Describe the MCO's Provider Services toll-free telephone line, including:

How the MCO will provide a fully-staffed line between the hours of 7:00 a.m. and 8:00 p.m. CST. Monday through Friday, to address non-emergency issues and how the MCO will provide a clinical pharmacist staffed at all times during the hours of 8:00 a.m. and 8:00 p.m. CST Monday through Friday.

How the MCO will ensure that provider calls are acknowledged and resolved within three business days of receipt.

The location of operations, and if out of state, describe how the MCO will accommodate services for Nebraska.

How the MCO will measure and monitor the accuracy of responses provided by call center staff, as well as caller satisfaction. *3 pages*

Integrated and Compliant Provider Services Center

In the past year, our established provider services center has handled 37,689 Nebraska provider calls with:

- An average hold time of four seconds
- An average speed of answer (ASA) of 26.77 seconds
- An abandonment rate of 1.8 percent
- A timely response to inquiries rate of 98.2 percent
- An accurate response rate of 98 percent or higher

Nebraska medical and BH providers can use our established toll-free telephone line at 866-331-2243 to reach our provider services call center. Pharmacies use the dedicated toll-free line at 800-310-6826 to reach our pharmacy benefits management (PBM) specialists, staffed with clinical pharmacists, and available Monday through Friday 8 a.m. to 8 p.m. Pharmacies needing claims assistance may call our dedicated pharmacy claims department at 877-305-8952 Monday through Friday 8 a.m. to 8 p.m. The provider services call center will comply with the required hours and be staffed with live agents Monday through Friday, 7 a.m. to 8 p.m. CST, excluding State-approved holidays. Each time a provider calls during staffed hours, he/she is routed to the appropriate inquiry focus area and speaks with a dedicated PPR who has been thoroughly trained in provider services processes and the expected needs of most callers. Through our call center, providers can obtain assistance on a wide variety of topics such as: covered services, fee schedules and member eligibility verification; PA and referral procedures; provider credentialing/recredentialing status; filing provider complaints, grievances and appeals; claims payment and dispute procedures; verifying member assignment to the provider's panel; referrals to the fraud and abuse hotline as necessary; pharmacy formularies/Preferred Drug List (PDL); and coordinating the administration of out-of-network services.

Our Nebraska provider services center staffing model includes pharmacy and BH specialists to meet provider needs and comply with MLTC requirements. Physicians with pharmacy-related questions can call our provider services center during live staffing hours and, through a warm transfer, be promptly connected to a clinical pharmacist. Additionally, our center will have a full-time BH integrated care model (ICM) liaison to train PPRs and address BH-related calls requiring further assistance.

After-Hours Calls and Support

After-hours and weekend calls to our provider services center, as well as those on State-approved holidays, are answered by our IVR system. Depending upon the reason for the call and the options selected by the calling provider, our IVR system seamlessly routes calls to the applicable service information (e.g., medical, BH or pharmacy). Our IVR provides information regarding normal business hours, automated member eligibility verification instructions, benefits information and more. Providers may also use our secure provider portal, *Link*, to access claims management, claims reconsideration, eligibility and benefits, prior authorization and provider data-management information during and after business. Both the IVR and provider portal offer options for eligibility verification 24 hours a day, seven days a week on behalf of a member who may need immediate treatment for an urgent or emergent

condition. The IVR also allows callers to leave a message, with a return call from our PPRs within 24 business hours.

Workforce Management and Forecasting

We use a dynamic workforce management and forecasting model that factors for hours of operation, anticipated call volumes, average handle times and Heritage Health contract requirements. Although our provider services center is primarily serviced by our Nebraska PPRs, we integrate our provider services center functionality with our centralized National Operations Center (NOC), which facilitates our ability to manage unexpectedly high call volumes, regardless of the reason. Using sophisticated technologies, the NOC acts as a central source of information for identifying trends across all operations; this allows us to forecast and plan for local provider services centers, as well as appropriately staff them to meet required performance levels and contractual requirements. The NOC maintains real-time reports on call queues, enabling us to shift necessary resources to provide optimal member service and meet or exceed performance standards.

Workforce management and forecasting includes the following: monitor and make real-time adjustments based upon intraday delivery of call volume; monitor real-time staff schedule adherence; manage and maintain metric reporting (e.g., forecast to actual staffing, occupancy); maintain historical data for reporting; monitor the system that tracks PPR performance metrics; manage scheduling software used to confirm appropriate staffing; meet with site leadership team weekly to discuss the staffing plan adjustments; and determine capacity plans.

Acknowledging and Resolving Provider Calls

Provider calls are considered acknowledged at the point of live PPR contact, meaning the time of the call. Providers are also able to reach our PPRs through our IVR system. These calls are then tracked in several reporting areas: 1) through our MIS reporting tool that identifies volume, ASA, hold times and service levels; and 2) through our CSP and MACES systems, which are available for PPRs to see previously collected applicable notes and call information to aid in resolution. Provider calls are considered resolved once the call to our provider services center is ended. When PPRs must route a service request to another internal department for resolution, we provide turnaround times to the provider (not exceeding 30 business days).

Location of Operations

Meeting all contractual requirements, Nebraska provider calls are currently answered by PPRs located in our existing Texas center. However, in alignment with our commitment to Nebraska, we are pleased to **establish a Nebraska-based provider services center as part of our 2016 implementation plan.** In choosing the location, we will collaborate with the Nebraska Department of Economic Development to consider Nebraska areas and communities that will benefit most from the economic growth and improvement related to a call center installation. We look forward to expanding our current footprint of employees in Nebraska that includes over 270 staff serving more than 425,000 members throughout Nebraska. In either scenario, Nebraska providers have a direct toll-free line to reach our dedicated PPR team. We will make certain this team has all the training needed to handle calls regarding specific Nebraska requirements, including additional training for calls related to the new benefits and covered member populations.

Measuring and Monitoring Response Accuracy and Caller Satisfaction

The following describes the comprehensive methods we use to measure PPR performance.

Monitoring the Provider Services Line: The provider services center management team monitors our call response rate using applications, such as scheduling software, and generates specialized reports to identify peak call times and quantify individual PPR productivity. They also measure the longest caller wait time by monitoring the number of calls holding in queue.

Live Call Monitoring: We use a call monitoring system to conduct provider services monitoring activities. These activities include playing recordings, performing record on demand (instant recording), live monitoring and performing evaluations. Supervisors access the call monitoring system to review their team's quality evaluation details and scores. We record 100 percent of calls, randomly select PPRs for monthly quality reviews, and monitor no less than 3 percent of calls for compliance with customer care guidelines. Our evaluation of service quality includes, but is not limited to, the following components to confirm positive provider engagement:

- ***Phone Technique:*** Use a professional greeting with the provider, apply hold courtesy skills, apply call control skills, follow redirection procedures and use a professional closing at call end.
- ***Building Trust:*** Identify provider's inquiry/issue, demonstrate full attention, deliver response with confidence, communicate clearly and connect with the provider.
- ***Accuracy and Completeness:*** Provide accurate, complete information to the provider.
- ***First-Call Resolution:*** Assure that call documentation matches the call content, route or close documentation correctly, make outbound call if necessary to resolve issue and send out requested information.
- ***Call Calibration Meetings:*** Call center management meets monthly with our Nebraska leadership teams to listen to recorded calls and provide input regarding call conduct.
- ***Call Feedback to PPRs:*** We provide feedback to PPRs through our behavioral analytics program used to assist them in matching their communication style to the personality of the caller. Behavioral analytics uses language-based algorithms to predict caller dissatisfaction (rating the provider's level of distress or satisfaction). A key program feature is the provision of data available at our local health plan, program, provider and PPR level. All recorded calls are available to review and analyze through our analytics capabilities and, as a result, the overall provider services experience has improved.
- ***Post-Call Surveys:*** Each caller is invited to participate in our United Experience Survey (UES), a brief post-call satisfaction survey. Providers opting to complete the survey are asked to provide ratings on four questions and give informal feedback about the PPR's service. Individual issues and concerns are reported out for action as appropriate, and aggregated survey information is used to trend provider services center satisfaction and formulate topics for ongoing PPR training. **Recent UES survey results indicate 97 percent provider satisfaction with service quality.**

Recent Nebraska providers calling our provider services center have told us the following via our UES survey:

"The rep was very knowledgeable and very good."

"I'm calling on behalf of the Regional Health Center. I wanted to say that the rep was excellent today. She went above and beyond to assist."

"I appreciated that Keisha solved the problem for us today and that she's doing it in-house instead of telling us we have to do paperwork to fix the problem."

49. Provide an overview of the MCO's proposed provider website, including examples of information that will be available on the website and on portals for providers.

Include proposed resources and tools that will be of use to providers. Please provide a description of technology that will be used to enhance the provider website. *5 pages excluding sample resources, tools and materials*

All Nebraska network providers have access to *Link*, our enhanced, secure provider portal and dashboard that relies upon cloud-based technology; the portal is our common site across all UnitedHealthcare lines of business (e.g., Commercial, Medicare & Retirement, OptumRx, OptumHealth and more). We use *Link* as our primary online site to connect providers to current, accurate, compliant and searchable information and documents. We will use our *Link* portal to meet all MLTC requirements from Section IV.J.4. Section 508 of the Americans with Disabilities Act requirements are incorporated into our *Link* requirements and usability design, and our QA teams are trained to identify and report Section 508 compliance issues for remediation. Portal content applicable to the Heritage Health program will be reviewed, determined and approved in collaboration with MLTC (at a minimum, 90 calendar days prior to the contract start date). Sample resources, tools and materials available for providers via *Link* are included in our response as Attachment 19 Q47-1,Attachment 19 Q47-4, and Attachment 19 Q49-1-8.

Link offers providers access to critical applications and tools such as *unitedhealthcareonline.com* and *uhccommunityplan.com*. Our provider-based online sites and tools enable health care professionals to connect and collaborate in easily accessible ways that improve the cost structure and quality of their practices. We will use applications on the *Link* dashboard to provide access to MLTC's website, our corporate website and other related key websites, as required.

Secure Provider Portal (*Link*)

Our secure provider portal, *Link*, has numerous applications in a dashboard format to distribute key Nebraska-specific program elements for providers, provide easily accessible and referable provider training and education materials and simplify care via enabling better provider and payer work flow processes. *Link* allows for easy use of health applications, information and communications in one place. **By logging in once to a single and secure portal, providers can access all current online resources, plus new solutions aimed at streamlining and simplifying interactions.** In the *Link* dashboard Figure IV.J-2, please note the application tiles for *uhccommunityplan.com*, *unitedhealthcareonline.com* and Optum Behavioral Health— all integrated and easily accessible via our *Link* portal and dashboard. Although not shown, providers could also choose to add tiles for our pharmacy-focused application, *OptumRx.com*, or a link to our single application for all PAs.

Figure IV.J-2. Sample *Link* Provider Dashboard. Much like the dashboard on a smartphone, each individual network provider can customize their *Link* dashboard based upon preference, applicable applications and authorization.

Through *Link*, we add new features and functionality in the form of different provider applications for physicians and health care professionals. The portal is currently available to approximately 5,000

Nebraska users (e.g., providers and provider administrative staff), representing the majority of our provider offices across the state. Our goal is to provide a single provider platform with *Link* as the foundation; our vision brings together multiple websites and incorporates new applications to improve efficiencies for our providers. *Link* technology offers providers the convenience to conduct business with us 24 hours a day, seven days a week (except for minimal scheduled maintenance downtime).

Figure IV.J-3. CommunityCare Platform, Available via Link. CommunityCare enables providers to quickly and efficiently locate the type of member information they need to coordinate primary, acute, chronic, specialty, behavioral health/substance abuse disorder, social support and long-term care services. CommunityCare seeks to redress health disparities by providing real-time coordination among multiple providers in different physical and BH care settings (e.g., social and family support for the specific populations).

More than 600,000 health care professionals across the United States are now using *Link*. The cloud-based platform has enabled health care professionals to connect and collaborate in ways that improve the cost structure and quality of their practices. A perfect example of this is our CommunityCare platform, shown in Figure IV.J-3, which is one of the applications accessible via *Link*. CommunityCare is an HIPAA-compliant, secure, cloud-based health care record and information sharing system that provides comprehensive support for the continuum of integrated, person-centered care coordination. The platform provides a mechanism to share the critical, relevant and timely member information essential to conducting ongoing care planning, management and coordination across a continuum of services and settings, such as:

- Interventions and previous medical documentation (e.g., medical history, physician orders, diagnosis, medications, dosages and any known drug contraindications, service dates and outcomes, progress notes and case conference notes) across all encounters, including the authorizing provider's name, and any servicing providers (if different), and contact information
- Emergency contact information, prior authorizations, physician orders, documentation of contacts with family members and persons giving informal support can be accessed
- Reports about the member's involvement with community agencies that are not part of the provider network, including any services provided
- Member priorities, goals and important concerns

Link Tools for Provider Self-Service

Via *Link*, providers have access to applications supporting self-service eligibility, claims management, electronic payments and statements, secure communications, prior authorizations, panel rosters, provider changes and clinical data exchange. These self-service features are described below.

- ***Collaborative Clinical Applications:*** Our real-time collaborative clinical applications such as CommunityCare, Automated Care Transition, Community Health Record and Health Information Service Provider (HISP)/Direct are contained in *Link*'s dashboard with single sign-on access. Clinical data is available in CommunityCare, accessed from the portal, allowing providers to view health risk screening results and provide feedback on member care plans.

- ***Eligibility and Benefits:*** This tool eliminates the need for calls by giving providers greater flexibility in member search features and looking up member's eligibility and benefits online; allowing providers to view deductible, out-of-pocket, copayment and coinsurance information; and giving providers tools to determine coordination of benefits. The tool also highlights any open HEDIS gaps in care that may need to be filled in an upcoming visit. UnitedHealthcare remains compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing any member eligibility or identification information via *Link*.
- ***Remittance Advices:*** Enhanced provider portal functionality includes access to images of electronic and paper remittance advices within one business day of when payment is made for querying and viewing.
- ***Electronic Payments:*** The portal is integrated with CSP, our claims processing system, and gives providers access to a variety of comprehensive plan and member-specific information including the ability to enroll in an electronic payment program. Electronic funds transfer (EFT) is our preferred method of provider payment.
- ***Claims Management and Administration:*** Providers are able to manage their accounts receivable with greater ease due to more detailed information being provided with increased granularity. Easy access to information decreases claim inquiries and resubmissions. *Link*'s capabilities allow providers to submit claims online and view claim status. Claims administrative tools include the following:
  - *Claim Status Inquiry:* Look up the payment status of individual claims or a batch of claims
  - *Claim Adjustment Requests:* Request a single or multiple claim adjustments (prior to formal dispute)
  - *Display Recovery Projects:* View a list of the claims where we are recovering funds
  - *Claim Trends:* View claim trends and summary information
  - *Display Authorizations:* View UnitedHealthcare care authorizations and service accumulators
  - *Claims Error Validation:* Integration with our CSP transaction processing tables allowing for instant error validation.

  Features include claims search detail (payment/check information, edits, codes, line level payment); clear claim status remark codes; and additional reporting features to assist in account reconciliation.
- ***Claims Reconsiderations:*** Registered users of *Link* are able to submit claim reconsiderations with attachments, which saves time and money and provides seamless visibility to each reconsideration submission by providing confirmation of receipt and real-time tracking capabilities.
- ***Prior Authorizations:*** *Link*'s clinical self-service capabilities allows providers to submit, view and manage PAs. Providers can perform a quick-check of whether or not PA is required, and communicate electronically with our clinical staff. One of the exciting capabilities of our online technology allows providers to be notified for specific clinical information needed when submitting a procedure for medical necessity review, and allows electronic attachment of required clinical information at the time of online PA submissions. It also confirms that clinical information has successfully been attached to the request once the clinical information is uploaded by the provider. Finally, *Link* provides the ability to track the status of the request as it goes through the various steps of medical necessity review.
- ***Provider Demographic Changes:*** Through *Link*'s applications, providers can submit changes to their demographic information.

- ***OptumRx/RxClaim:*** *Link* connects to *OptumRx.com* and the RxClaim system, which holds pharmacy claims history and allows providers to submit, view and manage pharmacy PAs. Also accessible is our formulary (list of covered medications) and the Nebraska PDL. MLTC-approved formulary changes and PA requirements, clinical criteria and revisions will be submitted a minimum of 30 calendar days prior to the effective date of the requirement or revision.
- ***Referral Search:*** We maintain an online, searchable provider directory with the most up-to-date information on participating providers and facilities. The provider search capabilities interface with our network provider database. Users are able to customize their provider search using parameters such as location, name, clinical specialty, race/ethnicity, languages spoken, disciplines or condition and will have the ability to print a list of providers. Provider location mapping is available, in addition to "step-by-step" directions to the provider's office.
- ***Other Administrative and Clinical Resources:*** Other links include performance measure results, HEDIS compliance reporting and evidence-based guidelines.

Technology Used to Enhance the Provider Portal

We devote significant corporate resources and IT investment to monitoring capability and system enhancements to our already robust websites—offering the best technology solution possible for our provider services model. We are enhancing our provider portal with real-time technologies allowing providers to submit inquiries and receive a response via "click to chat" functionality. Click to chat will significantly reduce the providers' administrative burden by allowing them to submit real-time questions, and receive responses, without placing a phone call.

In 2016, we will build the ability to submit, edit (only if original submission is in an electronic format) and rebill claims as a new feature on *Link*.

Requests for administrative simplicity were among the most frequent recommendations we have received from Nebraska providers. Providers told us they wanted a better, more intuitive, way to get the information they needed with less clicking and entering repetitive data. *Link* launched on October 19, 2015, as scheduled (replacing the former *Optum Cloud*) and offers an improved interface and a better platform to house and upgrade the applications the providers use to perform their daily tasks.

We continue to pursue innovative solutions to streamline and simplify our providers' administrative experiences, while maintaining strict data security. *Link* enhancements to date include:

- Implementing greater identity management and convenient single sign-on capabilities
- Establishing new links to key internally and externally hosted applications
- Developing data management applications for master patient and provider indexes, with search/identity matching capabilities against the master indexes
- Creating hosted applications, with public and private cloud partitions
- Establishing links to public and private health information exchanges, as applicable

Additional applications may be easily added to our portal dashboard and attached to our identity management/single sign-on capabilities. Allowing us to grow our catalog of Application Program Interfaces (APIs) and search services as needed.

We also will use *Link* enhancements as a flexible, dynamic provider resource to help transform care delivery. For example, by the new contract start date, Nebraska BH providers and PCPs will be able to access and use *Common Ground* via *Link*, an interactive Web-based resource that enhances provider-patient communications, supports improved adherence to medication and builds member activation, engagement and self-care. *Common Ground* enables the member to create a recovery goal, or power

statement, on which to focus his/her BH treatment, helping him/her to remain motivated during the treatment period and helping the provider frame treatment. After the recovery goal is established, the member completes a questionnaire that focuses on his/her current condition, expectations from treatment and any concerns. Information from the questionnaire electronically transfers to the patient's record and is available to the provider prior to, or at the beginning of, the member's first appointment. This enables the provider to understand and assess the BH issues requiring treatment. The provider also is able to recommend self-help tools and education programs that are available within *Common Ground* to support the member in-between appointments.

Link Provider Education and Training Resources

Through *Link,* providers can also navigate to *uhccommunityplan.com* and other sites to access a broad range of provider education and training resources and connectivity that helps support the member in every aspect of his/her care. The portal provides links to a downloadable PDF repository of all applicable Nebraska provider forms and key educational and training materials such as cultural competency information, newsletters, recent MLTC and UnitedHealthcare bulletins and other provider information. We also post notifications regarding legal changes, regulations, upcoming provider trainings and alerts.

Physician Cultural Education Library: This library provides links to numerous training tools/reference materials to help enhance awareness of socio-cultural influences on health beliefs and behaviors and to better understand population-specific disease prevalence and outcomes. Some of the resources available include cultural competency practices, educational decks, provider manuals and self-paced cultural competency training, including courses with continuing education credits (CEU) and continuing medical education (CME) requirements.

Network Standards and Training: Our network standards for medical providers are published in our provider handbook, the *Provider Administrative Guide*, which is available to each of our contracted providers before the start of the program. The Heritage Health *Provider Administrative Guide* will include, in addition to many other critical content items, information about our provider and member grievance system; limitations on provider marketing; instructions regarding how and whom to contact for questions about filling prescriptions; our updated Maximum Allowable Cost (MAC) pricing; and information on how to contact our provider services staff.

Provider Screening Tools: We use our portal as one way to educate providers and provide them with the tools they need related to medical and behavioral diagnoses within geographic areas (e.g., depression) or the specific populations they serve. For example, we find PCPs diagnose and treat depression more often than by specialized BH providers. As a result, efforts to educate PCPs and educational officials about depression and to develop sound connections between these "first responders" and BH specialists can yield significant quality improvement for the members we serve. We include free depression screening tools and information in the *Behavioral Health Toolkit for the Health Care Professional*, offer psychiatric consultation and additional education on our provider and member secure websites.

I/DD Toolkit: Another resource available to clinicians is the I/DD Toolkit from the Vanderbilt Kennedy Center for Excellence. The focus of the toolkit is to address the disparities in primary care services for individuals with intellectual and/or developmental disabilities (I/DD) in comparison to the general population. It includes information regarding the unique medical and behavioral needs of an individual living with I/DD, as well as resources and supports for the individual, family and caregivers. The Toolkit is divided into four categories: General Issues, Physical Health Issues, Health Watch Tables, and Behavioral and Mental Health Issues.

50. Describe the MCO's proposed provider education and training program, including:

A description of the training program.

A work plan that outlines education and training activities, including frequency of office visits to conduct activities.

A listing of the types of materials and content the MCO will distribute (include three samples of materials).

How the MCO will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions. *5 pages, excluding sample materials*

Under the direction of Jeremy Sand, provider services manager, we have had a well-developed provider training program that has been in place in Nebraska for many years, which includes educational mailings, online seminars, individual on-site provider visits and group trainings. For all Heritage Health providers, provider training **prior to the start of operations** under this contract will cover a number of subjects that address MLTC requirements and that we know from experience are necessary to include in a training program for providers serving our Medicaid members. In addition to billing requirements, it includes such topics as cultural competency and how to obtain culturally relevant materials, how to use interpreter services for non-English-speaking members, and how to obtain materials in alternate formats. We also address integration of physical and behavioral health care, as is coordination for other services such as dental, home and community-based services and transportation.

Initial Provider Training

One of the ways we build and maintain a high-performing network of providers is through our initial and ongoing training. The health care system is undergoing a tremendous amount of change and we adapt training programs to meet the demands of this change. We consult, we educate and we collaborate with providers based upon *where they are*—to create a training program that meets their busy personal and professional lives and in terms of where they are in the learning curve. We require each new provider to complete our online or in-person *UnitedHealthcare 101* orientation within 30 days of the contract effective date. New provider training topics and requirements may include, but are not limited to:

- Billing
- Claims
- Service Authorization
- Network Management
- COB
- Fraud, Waste and Abuse
- National Provider Identification HIPAA
- Cultural Competency
- Enrollment/Eligibility
- Administrative
- Prenatal Care
- Telemedicine
- Care Management
- Behavioral Health
- Electronic Data Interface
- Quality Management
- Special Programs

We also will provide education to all participating providers on the quality metrics that MLTC has identified relative to its membership, and any additional areas of quality performance improvement that we have identified. This will include written explanation of how the quality metrics are calculated. We will continue to reinforce this education during regularly scheduled or ad hoc meetings with network providers and their staff.

Ongoing Provider Education

Ongoing training to providers and their staff is essential as we transform the health care delivery system. We conduct provider education and trainings through face-to-face meetings, group sessions, town halls, mailings and fax. We have been proactive and industry leading in developing specific ICD-10 training. Finally, we provide a dedicated EDI hotline as a convenient method for providers to receive electronic claims support through our EDI support team. After the initial provider training, our provider relations team remains in frequent communication with our providers through mail, phone and fax to update them

Provider Roundtables
UnitedHealthcare currently conducts provider roundtable meetings in Lincoln, Nebraska, on a semiannual basis with 12 provider office managers. The focus of the meetings are to provide operational updates and to seek direct and honest feedback from providers on their perception of UnitedHealthcare related to provider servicing and overall performance and quality of programs. We share feedback of the group with our executives and staff. Recent topics included an overview of ICD-10 online resources, and introductions to value-based contracting.

on program changes, answer their questions and maintain current provider contact information for the *Provider Directory* (e.g., office hours, location, contact information and panel status). Live instructor-led webinars are held monthly, and self-directed online training is available at any time. In addition, provider relations staff meets with providers one-on-one as needed to offer training refreshers or additional training. We educate providers on the importance of making us aware of changes and provide them with the network, resource-team contact number to report changes. We also remind providers about access and availability requirements. In addition to regularly scheduled meetings, our staff meets with providers one-on-one to provide focused training that addresses any concerns and issues related to outlier data and potential noncompliance. For example, we proactively identify outlier billing and coding trends and follow up with providers to offer guidance and support. We send all network providers, including those who have attended these training sessions, an educational packet and instructions related to pursuing additional provider training opportunities.

Education and Training Work Plan

We created and customized the provider training and education work plan, Table IV.J-1, to suit the unique needs and requirements of Nebraska providers with input from Nebraska providers and provider associations:

Table IV.J-1

Education Type	Targeted Providers/Focus of Education	Frequency	Method
UnitedHealthcare101	***Newly Contracted Providers:*** Full UnitedHealthcare or line of business overview.	Within 30 days of contract effective date	Face-to-face or webinar, and a link to materials on provider express
On-Site Visit	***Core/Level 1 Providers (based upon a variety of factors)/participating providers:*** Frequent engagement to foster relationships, maximize performance, issue resolution, promote tools/programs, administrative efficiencies.	≥ Quarterly with core groups (includes monthly telephonic) and as needed or requested for all other participating groups, including BH	Face-to-face or webinar
Teleconference	***All participating providers:*** Topical in nature, associated with an outreach initiative or structured meeting. Core providers receive monthly telephonic structured meeting.	Monthly for core groups and as needed or requested for all other participating groups including BH	Telephonic or webinar
Town Halls	***All participating providers:*** Multipractice forum designed to educate en masse on multiple or targeted topics at various locations throughout the state. Sample topics include UnitedHealthcare 101 orientation, follow-up training, changes in prior	Quarterly for post go-live or ad hoc	Face-to-face

Table IV.J-1			
Education Type	**Targeted Providers/Focus of Education**	**Frequency**	**Method**
	authorization processes, and claims submission and provider payment.		
Webinars	***All participating providers:*** Multipractice forum designed to educate en masse on multiple topics. Can be focused on specific agenda item (e.g., new protocol deployment, reference tool). Topics may include Webinar UnitedHealthcare 101, demonstrating how to navigate online resources, specialized quarterly webinars addressing identified needs; and online on-demand training modules.	Monthly and ad hoc	Teleconference with visual presentation
Provider Information Expo	***All participating providers:*** Education event that assembles multiple UnitedHealthcare business units, material subcontractors and external partners in one venue.	One time per market per year	Face-to-face
Lunch and Learns	***All participating providers or specific specialties:*** Primarily focused on appropriate coding for treatment associated with HEDIS measures.	Quarterly and ad hoc	Webinar
Operational Meetings/JOCs	***Select provider groups:*** Operations meeting focused on operational performance and improvement strategies that ease administrative burdens. JOCs include leadership engagement focused on business strategies, accounts receivable management and relationship management.	Operations – Monthly JOCs – Quarterly	Face-to-face or telephonic
Administrative Advisory Council	***Selected panel of practice leadership:*** Formal mechanism for UnitedHealthcare to inform medical practices of the development and improvement of local and administrative policies in an advisory capacity.	Three times per year per market	On-site at local market and includes telephonic participation

Types of Materials Distributed and Training Provided

Modes of training and training materials vary upon the method and location of training provided:

Provider Administrative Guide: All network providers will receive a printed copy of the provider training manual upon request. We will post the *Provider Administrative Guide* on our provider portal. The *Provider Administrative Guide* includes information about the Nebraska program benefits and our policies and procedures, and information regarding payment terms and utilization review.

Provider Newsletter (Practice Matters) and Service Bulletins: Also included in training and educational information is our monthly provider newsletter. *Practice Matters* contains program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives and articles regarding health topics of importance to members.

Link: Our cloud-based provider portal will support providers through many innovative features and tools and is integrated with our critical systems. Our interactive website enables providers to electronically determine member eligibility, submit claims and ascertain the status of claims. Response to Q49 contains more information on *Link*.

Field-based provider training: Field-based training is an important component of our continuous quality improvement efforts. We schedule routine trainings and educational forums to touch our providers and facilities. The provider advocate team holds at least monthly meetings with high-volume providers to present regular updates and refresher trainings. Additionally, our BH provider liaison will conduct regular outreach to provide field-based training. We hold JOC meetings with key facilities to address operational issues, including training needs.

Biopsychosocial Assessments: We provide mental health and substance abuse assessment tools to medical practitioners to incorporate in their practices for the purpose of assessing members. Regardless of the type of clinician they present to, this ensures that the member's medical and BH needs/conditions are identified and addressed through direct treatment by the provider or referral to a specialty provider with care coordination.

Person-Centered Care: We will offer network providers a course in the recovery-oriented, person-centered approach to treatment. The training will be led by Dr. Neil Adams and Diane Grieder, authors of the highly recommended book on person-centered planning, *Treatment Planning for Person-Centered Care; The Road to Mental Health and Addiction Recovery.* We will bring the authors to Nebraska and also provide lunch for participants and a copy of the book. For two days, these experts will work with our network providers using case studies brought by the providers to apply the lessons. One month later, Dr. Adams and Ms. Grieder will return and work with providers on challenges they may be experiencing in putting the techniques into practice. The Adams-Grieder training has provided a very positive foundation for revitalizing recovery-oriented practice in other states in which we have offered it.

Behavioral Health Toolkit for the Health Care Professional: Available to providers on our secure provider portal, the Toolkit was designed with the recognition that more than half of BH issues, including substance abuse, are treated in primary care or other non-BH settings. The Toolkit offers a convenient resource for health care professionals to guide them to our BH clinical practice guidelines and evidence-based approaches.

I/DD Toolkit: The I/DD Toolkit developed by Vanderbilt Kennedy Center for Research on Human Development is available on *unitedhealthcareonline.com* as a resource to assist physicians with the transition of individuals with intellectual and/or developmental disabilities (I/DD) from the pediatric system of care to adult medicine. Using claims-based data, we targeted physicians and other health care professionals currently serving individuals with I/DD as the audience for external awareness and education initiatives.

Webinars: We offer a full slate of monthly interactive webinars, all conducted in real-time by a live facilitator. Online copies of the training are available after the conclusion of the training. New "on-demand" webinars now available on UHC On-Air enable providers to watch educational webinars that have already aired (Acts as an educational DVR); topics may vary. On Demand seeks to reinforce and capture upcoming and ongoing educational needs, while preventing gaps in participation.

Town Halls: Materials distributed at Town Halls include *Provider Administrative Guide*, Notification/Prior Authorization Quick Reference Guide, Provider Demographic Change Form, Claim Reconsideration Request Form, ID Card Samples, Radiology Notification and Authorization Quick Reference Guides.

Interactive or (E-) Technology: Provide innovative, cutting-edge applications "apps" and virtual programs using several internally approved programs, applications and visual presentations. This

education is interactive and requires provider input and participation. We offer the power of the technology and innovation using real tools our clients and members will use (iPads, cellphones, etc.). This was proven by the tremendously positive customer response during our provider visits throughout Nebraska in introducing examples such as Health4Me and *Healthify*.

Online Materials: Providers have access 24 hours a day, seven days a week to a vast library of materials, including webinar instructional decks and all written material including the *Provider Administrative Guide* and the *Behavioral Health Toolkit.* We have included the required education samples as Attachment 19 Q47-3 NE 2015 Provider Quick Reference Guide, Attachment 19 Q47-4 NE 2015 Provider Welcome Kit and Attachment 19 Q47-6 2015 BH Provider Example.

Evaluating the Usefulness of Education

We collect post-session surveys following all large group trainings. Participants rate elements of the session (e.g., satisfaction with written materials) and give open-ended responses to questions about what attendees liked most, liked least and what they recommend for future training topics. We also evaluate the effectiveness of our training efforts through our provider services center using call tracking tools, to track and trend the reasons for provider calls and inquiries. The provider relations team uses this data to pinpoint providers who require further training or attention and to develop or modify future training opportunities. Through provider complaints, staff feedback, trended claims data, associations and provider advisory councils, we identify common topics or opportunities for retraining and specific providers for focused retraining. We monitor to ensure effectiveness and provide additional education when we identify common issues of interest. We communicate to all providers on relevant training topics and update our training curriculum on an ongoing basis to better communicate information especially on common issues such as billing and eligibility verification. As referenced in our town hall description, we listen to providers and adapt our training based upon their feedback and the usefulness of the information we present.

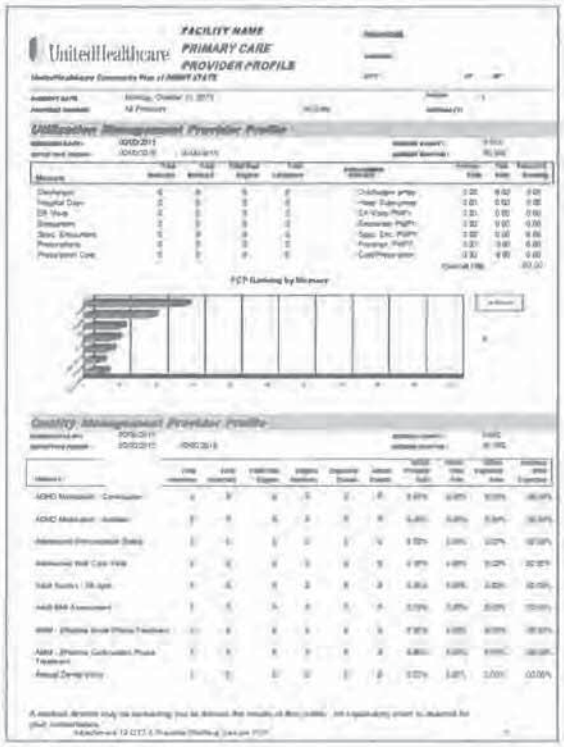

Figure IV.J-4.

Provider profiling allows us to identify those quality providers to be retained and rewarded, as well as identify opportunities for additional training and education. This proactive approach to provider management allows us to manage providers through identification of high and low performers and provide best practices for improvement. Annual PCP utilization and quality profiles are designed for us by our national quality-management department and are seen here in Figure IV.J-4 They summarize utilization history on five utilization and nine quality indicators for PCPs, with sufficient data to generate statistically significant profiles. Individual provider scores are compared to network peer scores. The utilization indicators include encounters and visits to ERs and hospitals. Quality indicators include visits by age range for children, immunizations by age range and screenings for cervical and breast cancer screening. Our CMO, Dr. Mike Horn, visits with providers when results appear to have opportunities for additional training or education.

51. Describe the MCO's proposed approach to promoting communication between providers and the MCO. Include a discussion of how the MCO will work with providers to improve administrative efficiencies, and engage providers in developing and monitoring clinical policies and operational issues. Discuss how the provider network liaison will work with the Provider Advisory Committee to respond to provider concerns, develop provider trainings, and enhance MCO-provider communication strategies. Provide examples of how the MCO has successfully collaborated with providers to identify necessary changes and how these changes have been implemented. *2 pages*

Approach to Promoting Communication with Providers

We understand and value the importance of strong, collaborative provider relationships. Our communication strategy is designed to proactively target medical and behavioral practitioners, health care facilities and pharmacies to create awareness of our programs and help providers collaborate with us and our members. Today in Nebraska, we go beyond basic communication strategies, such as telephonic outreach and mailings, and use many other meaningful facets of interaction such as technology and personal interaction. We have developed a standing relationship with our network providers so that communication is open and a partnership is developed to foster a collaborative approach to improve health care and open doors to innovations to enrollees. In addition to building trusted relationships through direct communication with our provider relations team and provider participation in key committees, we will leverage several tools and technology to communicate with providers including:

- Newsletters and Electronic Notices
- Provider Website
- Provider Administrative Guide
- BH Provider Liaison
- Video/WebEx Conferencing
- Town Halls
- Tribal Network Liaison

Improving Administrative Efficiencies and Engaging with Providers

Our current, dedicated provider relations team in Nebraska is readily available and actively supports providers in our statewide network. This locally based team, including a BH provider liaison, is available to collaborate with the providers and address any immediate needs including but not limited to claims payment consultation, program changes, policy and procedural updates, provider trainings and is a dedicated resource to act as a single point of contact for escalated service issues and operational concerns. Another available resource for improving efficiencies is our single provider platform, *Link*, which brings together multiple websites and incorporates new applications to improve efficiencies for our providers. *Link* technology offers providers the convenience to conduct business with us 24 hours a day, seven days a week (except for minimal scheduled maintenance downtime).The Provider Services Program focuses on end-to-end root cause analysis as well as appropriate and complete issue resolution.

Clinical Provider Advisory Committees and Provider Network Liaison

We have a long history of leveraging our existing Clinical and Provider Advisory Committee (CPAC) as a forum for discussing health issues across a population, coordination of care and services and provider best practices. We embrace the opportunity to expand our support to the providers across the state by generating forums to hear concerns and receive feedback. The provider network liaison will work collaboratively with the CPAC to establish the process for responding to provider concerns, develop provider trainings in response to identified needs or changes in protocols, and will enhance MCO-provider communication strategies. In our existing service area, Jeremy Sand, provider services manager performs this role. He currently serves on the CPAC and has developed collaborative relationships with physicians on the committee and already has a process in place to discuss provider concerns, trainings and communication strategies. For example, Mr. Sand presents results of the Provider Satisfaction Survey to the committee for feedback and uses input received on opportunities for improvement to enhance the

Provider Satisfaction Improvement Plan. As we continue to enhance the CPAC to add statewide representation and integration of pharmacy and BH providers, we will further demonstrate our commitment to strengthening our partnerships and engaging in productive dialogue with our network providers. All clinical policies and procedures are presented to members of the CPAC for review, feedback and approval. The CPAC provides a forum for provider engagement to develop and monitor our clinical policies. We use a variety of committees and methods to give providers opportunities to be heard regarding the effectiveness of our provider support and provider relations elements. As described in detail in Question 47, provider input is solicited through outreach efforts aimed at providers including:

- Clinical and Provider Advisory Committee (CPAC)
- Administrative Advisory Committee (AAC)
- Focus Groups
- Community Grant Meetings
- Joint Operating Committee (JOC) Meetings
- Nebraska Medical Associations
- National Advisory Groups

Successful Collaboration with Providers

Examples of successful collaboration include:

- Working with providers to prepare for the recent release of ICD-10: We collaborated with providers to launch an initiative to sponsor ICD-10 seminars in Omaha, Lincoln, Kearney and Scottsbluff by a national UnitedHealthcare ICD-10 program lead. Across the state, 299 attendees completed a post-session survey and rated the speaker's knowledge, helpfulness of the survey, usefulness of the information, the material met expectations and relationship with our local health plan as a 3, 4 or 5 on a five-point scale. In fact, for all six areas evaluated, 84 percent of the respondents rated the areas as a 4 or 5. Most importantly, attendees believed it benefitted them.
- Working proactively with providers to develop operational efficiencies: At the beginning of January 1, 2013, attested PCPs who provided primary care services to enrollees became eligible to be paid an enhanced primary care rate. We worked with MLTC to receive the attested provider file and with providers to communicate the process for attestation and change in payment successfully.
- Enhancing our Radiology Prior Authorization Program process: As a result of feedback received from providers, implementing intermediate reconsideration and additional review steps, allowing providers to simply supply the missing information to resolve the case and avoid direct appeal measures. Through our enhancements, we have reduced the Nebraska radiology PA appeal volume from 30 in 2013 to three in 2015.
- Proactively building relationships with Nebraska's four Native American tribes: Particularly upon learning of the issues surrounding youth suicide on the reservations, we are working to assist with youth suicide prevention and education programming for the four tribes and providing additional information on billing and claims services.

52. Provide a description of the MCO's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as time frames in which the MCO will acknowledge and resolve inquiries and grievances. Explain how the MCO will track provider complaints and how the MCO will use this type of information to improve provider services. Include a description of any type of internal reporting the MCO will perform, and how the MCO will use reporting information to influence the activities of the MCO's provider services representatives. *3 pages*

We maintain a comprehensive, integrated process to resolve provider inquiries, complaints and grievances and facilitate a fair and timely resolution. Under the direction of grievance system manager Lori Caldwell, who is our key staff member designated to oversee receipt and processing of provider complaints, we will continue to operate a provider complaint-management approach that complies with all MLTC requirements outlined in Section IV.J.8. We also hold our delegated subcontractors (e.g., Superior Vision) to the same requirements and standards. They are required to provide us with reporting on their received provider complaints, appeals and grievances; the status of these receipts; and attend quarterly meetings with our local health plan staff to review compliance with MLTC requirements.

All associated policies and procedures are reviewed at least annually to verify adherence to program standards. Our Nebraska *Provider Administrative Guide*, available online or via hard copy, includes a specific section on UnitedHealthcare's provider-dispute system policies and procedures, including high-level instructions on how to contact us to file a provider dispute and which individuals have authority to review provider disputes. For out-of-network providers, we communicate our policies and procedures with the remittance advice.

Approach to Handling Provider Complaints

While Nebraska provider complaints can be communicated to and logged by our staff during any provider interaction, our provider services call center is mainly responsible for handling both in- and out-of-network provider complaints—which are typically more informal or of a less serious nature. Complaints might be inquiries, misunderstandings or misinformation and can be promptly resolved by providing accurate information or support right away. Providers must submit complaints within 30 calendar days of the event causing dissatisfaction. Our goal is to resolve all complaints within one business day of receipt. Any complaint not resolved within one business day is treated as a formal complaint/grievance and routed, along with all associated information received and logged to date, to our A&G team for resolution. Regardless of the purpose of the Nebraska provider call, all calls are logged and documented in our centralized provider services call center information system for tracking and reporting purposes.

Essential to confirming providers receive high-quality service and timely responses to concerns is our staff's ability to distinguish between a complaint and a grievance. We provide staff training on how to differentiate between a complaint and a grievance, as well as the steps needed to ensure the issue is addressed with the appropriate process and established timelines.

Correspondence, Time Frames and Processes Used for Resolution

As outlined in Section IV.J.8, we currently comply and meet the Nebraska time frame standards for resolving all provider type formal complaints, grievances and appeals, as shown in Table IV.J-2 below:

Table IV.J-2	Provider Complaint	Provider Administrative Appeal	Provider Clinical Appeal	Provider Appeal (Overpayment Refund)	State Fair Hearing*
Timely Filing	30 calendar days	12 months	90 days	30 calendar days	Within 90 calendar days from initial denial/final appeal
Acknowledgement Letter TAT	N/A	3 working days	3 working days	3 working days	N/A
Closure TAT	N/A	Pre-service 30 calendar days; Post-service 45 calendar days	Pre-service 30 calendar days; Post-service 45 calendar days	Pre-service 30 calendar days; Post-service 45 calendar days	N/A
** Providers may be required to complete the internal appeals dispute process before requesting a State Fair Hearing on behalf of a member.*					

Our resolution process, which includes personnel with corrective action authority, comprises:

- Our regional mail operations receives written provider complaint, grievances or appeals, date-stamps, scans and routes them to our A&G triage team. Alternatively, a provider may also contact a PPR to file a formal complaint. All providers have the ability to submit appeals via *Link*.
- The A&G triage team enters the complaint, grievance or appeal into our tracking and reporting system on the date of receipt and creates a case file; generates an acknowledgement letter, which is sent to the provider within three days of receipt; and triages to make sure it is identified, investigated, resolved, tracked and filed.
- Once we have triaged, our system queues the formal complaint, grievance or appeal to A&G for investigation and resolution. We thoroughly investigate each provider dispute using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying our written policies and procedures. A&G also engages other internal departments, such as our BH and pharmacy specialists, as necessary for resolution.
- A&G gives each provider a reasonable opportunity to present evidence and allegations of fact or law; date stamps and incorporates into the case file any information received during the resolution process; and gives providers an opportunity to examine the file.
- Upon resolution, A&G issues a system-generated written Notice of Adverse Action (for complaints/grievances) or Notice of Appeal Resolution (for appeals) providing notice of our decision to the provider. For expedited requests on a member's behalf, A&G provides a verbal decision notice as expeditiously as the member's health condition requires.

Tracking Provider Complaints while Improving Provider Services

We have many channels to understand, track and analyze the experience of our providers, and use them to improve provider services. Using our robust systems, we maintain, record and store all complaint, grievance and appeals activity; system capabilities provide standard management reports to track our resolution time frames and ad hoc query functionality. We adhere to federal- and state-specific requirements when maintaining system data to document the entire lifecycle.

We use a monthly multi-departmental analysis meeting of system data to trend the reasons for provider complaints, enabling our local management team to evaluate the need for policy and procedural changes or quality improvement. Below is just one Nebraska improvement example.

Example: Nebraska Provider Administrative Guide Update

Based upon annual provider-satisfaction survey results, we recently made significant enhancements to our provider handbook, the *Provider Administrative Guide*. The 2014 survey results related to the helpfulness of our Nebraska *Provider Administrative Guide* were below our national UnitedHealthcare averages—indicating that Nebraska providers were not satisfied with the resource. As a result of this feedback, we took action and assembled a multidisciplinary internal team that included staff from our provider network, quality, operations, health services and member services departments to review the existing *Provider Administrative Guide* and recommend improvements. The team evaluated comments made by providers as well as feedback received from the CPAC. They additionally reviewed several *Provider Administrative Guides* from other UnitedHealthcare state health plans to identify best practices. We used the team's findings and recommendations to revise our Nebraska *Provider Administrative Guide*, improving the layout and documented information. These enhancements will improve administrative efficiencies for providers so they can better focus on patient care.

We also will use our recently implemented, enhanced Provider Relationship, Insight and Service Model (PRISM) to identify, track and rapidly resolve Nebraska provider problem areas. PRISM, with its single intake portal, offers a streamlined approach to issue resolution and includes analytics and root cause analysis for proactive issue prevention and detection. PRISM integrates information from claims, enrollment, clinical episodes of care, and utilization history; identifies gaps in care and compliance with clinical guidelines; and provides clear escalation protocol for a rapid response to critical provider issues. Based upon the success of this model in other states, we anticipate increased Nebraska provider satisfaction, a reduced number of repeat issues, and fewer service issue/complaint intakes.

Finally, we use two types of provider surveys to determine provider satisfaction and accordingly, when complaints are noted, improve our provider services: 1) an annual provider survey, which is a part of our quality process, and 2) surveys extended to providers at the end of calls to our provider services center.

Internal Reporting

Our systems maintain, record and store all provider complaint, grievance and appeal activity. We have significant flexibility in developing reports based upon multiple data elements, filters and sorting options. Our system allows us to track provider issues by type or status; identify resolution of all cases; track staffing resolution time frames; track referrals to pertinent internal departments; and develop customized reporting and inquiry capabilities on multiple data elements. To engage internal controls and deliver positive impact to provider relations, issues are reviewed, reported and remediated in a daily inventory call for: capacity planning, inventory control, correct issue categorization, performance-guarantee status checks. We also proactively identify if additional training is required to resolve common provider complaints (e.g., re-training for our PPR staff, or network provider training by our provider advocates or BH provider liaison). Our A&G staff also develops daily and monthly managerial reports that track key metrics used to evaluate compliance with contract requirements and service to providers.

We also incorporate provider services center and A&G reported data in decision-making activities to refine our operational process and enhance the quality of our service delivery. Each quarter, our QAPIC, CPAC and HQUM review the analyses to: establish quality metrics, goals and performance thresholds; conduct root cause analysis and barrier assessments; develop and implement both proactive and reactive action plans; and identify contributing factors and procedure changes/interventions to address systemic issues, barriers or other opportunities to improve processes, outcomes and provider satisfaction. In addition, we analyze trend data in our annual program evaluation, which drives quality improvement recommendations in various operational areas based upon year-over-year data.

53. Describe the MCO's plans and ability to support network providers' "meaningful use" of electronic health records and current/future Federal IT requirements. *1 page*

We actively leverage our resources in the states we serve to support Medicaid providers in practical and targeted ways to make progress toward meeting state and federal health information technology (HIT) and health information exchange (HIE) requirements. We have active value-based contracts in Nebraska for commercial products that have incentives for meaningful use electronic health records (EHRs). The new Heritage Health contract provides a valuable opportunity for us, working with Medicaid EHR staff, Nebraska Health Information Initiative (NeHII) and HIT stakeholders, to strengthen HIT and HIE meaningful use capacity as required for comprehensive care management, especially among smaller providers in outlying areas of the state. Leveraging our demonstrated results with these strategies in other states, our action steps will include:

- Deploying and continuing to make available our next generation platform CommunityCare, which is currently live in Nebraska and supports meaningful use technology and workflows. Providers will be able to use this platform to share clinical summaries; use secure messaging with DIRECT; benefit from timely engagement with members in care transitions using admission, discharge and transfer (ADT) integration to both provider facilities and NeHII, exchange Consolidated-Clinical Document Architectures (C-CDAs); communicate with members via an integrated member and caregiver portal and mobile tool; and collaborate across care teams.
- Enabling providers with both technology, such as CommunityCare, and practice transformation assistance using onsite or webinar-based sessions to help providers meet current meaningful use stages or prepare for Stage 3 meaningful use.
- Supplying BH providers with CommunityCare, which enables collaboration across care teams, including PCPs and specialists, in real-time.
- Working with NeHII to develop a pilot proposal that will ultimately incorporate a value-based contract with a significant provider organization/partner that will support health care transformation through the creation of a secure, Web-based HIE that serves Heritage Health members. The pilot will help identify barriers and solutions to expanding the investment in NeHII and meaningful use EHRs.

Aligning with Future State and Federal IT Requirements

UnitedHealthcare's commitment to Medicaid programs across the country includes close monitoring and engagement at a state and federal level to understand and influence the development of HIT strategies within the states we serve. Stage 3 meaningful use targets continue to push providers toward more robust EHR and HIE capacity. We support these capabilities by provisioning CommunityCare to our accountable care communities and integrating the use of NeHII to help providers confirm their workflows include consistent sharing and use of patient information from an expanded array of available and relevant sources, such as the community-based providers that Nebraska envisions being part of comprehensive primary care planning and care coordination.

Across the United States, we observe states adopting and implementing all-payer claims databases to improve transparency and analytics across their populations. In several markets, we have had early discussions about how all-payer claims databases can serve as a foundation for a virtual EHR on NeHII, and ultimately provide the data source for clinical analytics to perform risk stratification and identify care opportunities.

54. Discuss how the MCO will engage and educate PCPs about their role in the provision of behavioral health services and the coordination of co-existing conditions. *2 pages*

Our experience shows that BH problems are more common in members with chronic illnesses. Left untreated, BH conditions, especially those associated with co-existing physical health conditions, can result in further poor health outcomes that complicate physical health problems and increase costs. We also realize that many of these BH-related issues are most effectively treated in the primary care setting, either by the PCP or by a readily available BH provider. The PCP plays a vital role in the screening, treating or referring of members as well as providing ongoing management and coordination of a member's person-centered care plan. We strongly support the full integration of physical and BH care in arrangements that create the best outcomes for members and offer the most efficient and effective approach for the treating professionals. The foundation of our integrated clinical model will improve the overall health of members. It is built upon the core belief that a successful coordinated system of care certifies access to BH and substance use disorder (SUD) services and individuals with these conditions can and do get better, they do recover and they do become more resilient to future challenges through their recovery. Our interactions with members and their families, as well as our *Provider Administrative Guide* and provider trainings, focus on these basic tenets of recovery and resiliency.

Under the leadership of our BH clinical director and manager and with the assistance of a BH provider liaison, we will offer PCPs a curriculum focused on the integration of BH evidence-based practices into person-centered care plans. Integrated care is supported by our integrated, community-based care teams, comprising an RN and licensed BH clinician, who consult with one another to address the needs of members with comorbid conditions. For example, individuals with BH or comorbid conditions may be well served by CHWs working under the guidance of the licensed clinician. The CHW provides continuous, supportive care beyond the clinic encounter. They assist the member in navigating community support systems, engage family and relationship support systems and facilitate appropriate access to physical and BH services. We will support and advocate for the philosophy of a recovery-based care model throughout our provider network, especially with our PCPs. It is critical that we share a common understanding of the nature of BH conditions and the importance of the PCP in the member's overall recovery process. Locating a BH professional in the PCP office provides immediate access to assessment and treatment. In other instances, PCPs and BH providers work out priority referral arrangements, ensuring quick access to services when required. Some BH providers have hired advanced registered nurse practitioners or other PCPs to provide primary care for members they serve. We will work with MLTC, the Division of BH and Nebraska's other MCOs to support existing integrated care designs and also to create further opportunities for integrating BH services in the primary care setting.

One of our most important initiatives in the new contract period is to work with FQHCs and other PCPs who serve a large number of Medicaid members to implement our Accountable Care Communities (ACCs), a PCMH-type program that promotes integrated care, shared care coordination responsibilities and shared savings. In other states, we have found this to be one of the most effective ways to support a fully integrated, person-centered approach to serving Medicaid beneficiaries, especially those with chronic or complex needs. Providing initial and ongoing education on BH is critical to the success of an integrated recovery-based model.

Educational Materials for the Provision of Behavioral Health Care Services

We will provide proactive education, training and consultation to PCPs to support the provision of basic BH services in a primary care setting and coordinate referrals with integrated BH specialists when working with members identified to have complex BH and SUD needs. Provider advocates and a BH provider liaison specializing in BH and SUDs deliver initial orientations and ongoing training to primary

care practices. Through OptumHealth Education (*optumhealtheducation.com*), PCPs, the pharmacy network clinicians and other licensed providers receive free online education units on BH conditions as well as access to webinars, group trainings, provider newsletters and the *Provider Administrative Guide*. We will share materials we have developed to assist providers in expanding their understanding and knowledge of behavioral health and substance use treatment issues as well as their willingness to handle routine BH issues. Educational materials and training topics may include but are not limited to:

- Person-Centered Care
- Cognitive Behavioral Strategies
- Substance Use Disorders
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Screening for and identifying BH disorders, how to refer members for specialty BH services, quality initiatives and best practices for coordination and treatment
- Brief solution-focused interventions
- Trauma-Informed Care
- Motivational Interviewing
- Other Evidenced-Based Treatments
- Recovery-Based and Recovery-Oriented Systems of Care
- Methods to deliver psychosocial interventions

Tools for Coordination of Co-existing Physical and Behavioral Health Conditions

The PCPs will have training on the tools we provide to assist in the coordination of members with co-existing physical and BH conditions. We provide PCPs with BH and SUD print materials that they can distribute during office visits.

CommunityCare: Recognizing the importance of ongoing collaboration between all providers serving our members, we will provide PCPs with training and access to CommunityCare, our clinical record platform that will include the member's plan of care, which will include a comprehensive, person-centered plan outlining the member's goals and services being offered by all treating providers. CommunityCare also allows for communication between treating providers and the member, creating a virtual treatment team environment.

Consultation Line: We will establish and maintain a PCP consultation line, a phone number for PCPs to access our BH clinical director, a psychiatrist that provides consultation on BH conditions, psychotropic medications, treatment interventions, and to answer any other questions the PCP might have. Our Nebraska-based BH clinical team also will be available to respond to questions from local PCPs and other practitioners.

Behavioral Health Toolkit (Toolkit) for the Healthcare Professional: We designed our *Toolkit* to provide the non-BH practitioner with helpful links to important information about common BH conditions and treatment, such as depression screening. The *Toolkit* also assists providers in linking members to treatment, including clinical practice guidelines for prevalent BH and childhood disorders such as attention deficit hyperactivity disorder (ADHD), and explains and promotes the use of BH screening tools such as the PHQ-9 and the AUDIT-C alcohol screener.

Mental Health First Aid: Our Mental Health First Aid program helps both providers and laypersons identify and assist someone experiencing a mental-health-related crisis. In the Mental Health First Aid course, participants learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations and where to turn for help.

55. Describe the approach the MCO will take to assess provider satisfaction, including tools the MCO plans to use, frequency of assessment, and responsible parties. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes. *5 pages*

The voice of the provider community and their input and satisfaction are crucial components of providing high-quality, affordable care to our members. Our approach to assessing their satisfaction is to use multiple methods and opportunities to obtain this information. These methods include direct provider interaction, regular surveys and various other communication forms.

Provider relations works directly with network physicians, ancillary, BH, pharmacies and hospitals serving our Commercial, Medicare and Medicaid members. Provider relations is staffed by physician, hospital and facility advocates and will include a BH provider liaison, all of whom act as ambassadors of the company and aim to establish themselves as trusted advisors with their clients on industry solutions for problems facing medical practices and hospitals. The hospital-focused advocates increased our outreach and the focus of the program to include 75 percent of our hospital systems. The advocates are actively focused on opportunities to move beyond basic accounts receivable management to proactive education and mutual administrative simplifications.

Developing meaningful, personal relationships in this way cultivates trust, reliability and partnership. We aim to reduce administrative burden in all our actions to become the easiest organization to do business with. We offer responsive, collaborative communication by providing timely, respectful, informative, clear and concise communications. We hold ourselves accountable to measure (and ultimately achieve industry-leading) improvements in satisfaction; to back our actions with relevant, industry-supported data; to be transparent in our clinical programs, policies, communications and service performance; and in deploying technology solutions that work for everyone. As part of our continuous quality improvement efforts, we conduct ongoing assessments of provider satisfaction using the following strategies:

- An annual network provider satisfaction survey (partially shown in Figure IV.J-5) is conducted for us by an independent firm to obtain performance feedback from our Medicaid PCPs and specialists from our 10-county service area; areas assessed include utilization management (UM) processes, claims processing, reimbursement, administrative processing and practice service support. A random sample of providers is selected from network rosters and the surveys are offered to provider offices via fax and online completion. We send follow-up reminders to non-respondents based upon a pre-established protocol. We compile the results and present them to our leaders via a customized scorecard and report. Our material affiliates and ancillary subcontractors also conduct annual provider satisfaction surveys and share the results with us for review.
- Network hospital satisfaction is determined during discussions at our JOC meetings, which we conduct quarterly with key Nebraska hospitals. JOC meetings also provide an opportunity to identify potential UnitedHealthcare process and policy improvement areas, which may ultimately impact provider satisfaction. We also determine hospital satisfaction levels via our ongoing provider advocate activities.
- Our provider services center is the primary point of contact for network provider inquiries, questions and grievances. Providers with questions or issues use a toll-free number to contact our trained PPRs. We offer each caller the opportunity to participate in our United Experience Survey (UES), a brief post-call satisfaction survey, seen in Figure IV.J-6 Providers opting to complete the survey are asked to provide ratings on six questions and give informal feedback about the PPR's service. **Recent UES survey results indicate 97 percent provider satisfaction with service quality.**

- Our Nebraska provider relations team members regularly visit key practices to educate, discuss provider issues and assess provider satisfaction.
- Our Clinical and Provider Advisory Committee (CPAC), Behavioral Health Advisory Committee (BHAC) and Health Care Quality and Utilization Management (HQUM) Committee meet monthly. They provide a forum to solicit provider input on quality management, clinical outcomes and improvement activities, data analyses, drivers of member and provider satisfaction, overutilization and underutilization monitoring, provider profiling, credentialing and quality of care and services monitoring.

Processes to Address Low Provider Satisfaction

While our processes to address low provider satisfaction are dependent upon the information source (e.g., annual survey, UES survey or feedback from face-to-face interactions), all resolution and improvement activities are incorporated into our quality management (QM)/ UM work plan in collaboration with other operational teams. Our QAPIC review all assessments and approve applicable policy updates. We continuously track action plans to confirm the areas causing low provider satisfaction are successfully resolved.

Low annual satisfaction survey score resolution. Final provider-satisfaction survey scores are compared to our national averages, as well as our performance in previous years. If low provider satisfaction rates are identified during our review, our Nebraska staff determines the top actionable items, reviews internal processes for mitigation opportunities and develops custom action plans with targeted improvement tasks and completion dates.

Low UES survey score resolution. If low provider satisfaction scores are entered on the UES about our provider services center, individual issues and concerns are reported out for action as appropriate (e.g., immediate PPR coaching), and aggregated information gathered during these surveys is used to trend provider services center satisfaction and formulate topics for ongoing PPR training.

Resolution of low provider satisfaction identified via meetings. If low provider satisfaction is communicated or identified during any of our face-to-face interactions with network providers, we document the issue on our monitored and tracked action plan for resolution.

Integration of Provider Satisfaction into Ongoing Network Management

We understand attracting and retaining high-quality providers is essential to sustaining an adequate provider network, and we use an integrated, cross-functional approach in developing, maintaining and managing our network. Beyond the annual survey noted above and corresponding resolution activities prompted by low scores, we continuously improve our provider network management and information dissemination practices based upon provider feedback, suggestions and complaints.

Our Nebraska providers have told us they like and want more self-service options for administrative and research tasks, as well as education and training. This has prompted us to **continuously enhance** our provider portal (*Link*), applications, online resources and self-service training/webinars—providing transparency and access to policies, procedures and resources 24 hours a day, seven days a week, anytime it is convenient for the provider. Recent provider services model initiatives and enhancements for *Link* focused on our claims resolution model and prior authorization, intake model integration.

We also know from provider feedback that getting critical new information distributed to our providers is vital; therefore, we continuously update and improve our network dissemination methods and educational materials. For example, in 2014, CMS released and implemented new reimbursement policies applicable

to home health and we promptly developed a supportive training program for our providers. CMS has revised billing policies for hospice providers this year, and we are offering similar provider training. We also provide an online monthly provider bulletin, the *Medical Policy Update Bulletin*, as another form of ongoing communication about code updates, policy and procedural changes, state requirement reminders and more. Nebraska providers receive an email alert when new bulletins are posted.

Recent Provider Network Satisfaction Examples

During August – October 2014, we conducted our annual provider satisfaction survey across all active Nebraska service areas. January 2015 survey **results received indicated that overall satisfaction results increased by 25 percent in the category of Satisfied (6–10 range), and increased by 45 percent for the category of Very Satisfied (8–10 range).** In response to the annual survey results, UnitedHealthcare, through our Nebraska provider relations team, creates and executes specific work plans to address areas rated as primary and secondary improvement targets. In the interest of achieving a higher level of operational consistency and provider satisfaction, key improvement strategies initiated in the past year include, but are not limited to, the following areas:

- ***Implementation of formalized review process for provider manual and updates.*** As a result of the 2014 provider satisfaction survey, there was a decline in satisfaction related to the helpfulness of the *Provider Administrative Guide*. The health plan developed a multidisciplinary team to review the *Provider Administrative Guide* and include feedback from providers to improve the layout, format and enhance information to help providers. Updates were made to the 2015 *Provider Administrative Guide*.
- ***Implementation of our Provider Relationship, Insight and Service Model (PRISM) in Nebraska.*** In 2015, PRISM, with its single intake portal, was implemented in Nebraska as an improved operating model for prevention, detection and resolution of issues with a market-level focus, including analytics and root cause analysis for issue prevention. PRISM provides information from claims, enrollment, clinical episodes of care and utilization history. It identifies gaps in care and compliance with clinical guidelines. Based upon the success of this model in other states, we anticipate increased provider satisfaction, a reduced number of repeat issues, less provider advocate involvement and fewer service issue intake.
- ***Creating a more integrated end-to-end provider issue detection, prevention and resolution process (Provider Early Warning System).*** Our provider services team, working in collaboration with other cross-functional teams, is now responsible for gathering, evaluating and trending provider input; prioritizing provider-identified issues; and developing effective intervention strategies to address provider performance issues. These multiple data points of provider information represent a clearinghouse and an early warning system to identify issues as soon as possible and avoid the need for escalation.
- ***Continuing enhancement of tactical provider service areas.*** We continue to enhance the tactical areas of: secure provider portal and dashboard capabilities; first pass claims payment accuracy and turnaround time; reconsideration claim accuracy and turnaround time; appeal determination accuracy and turnaround time; first call resolution rate; customer service transfer rate; and notification turnaround time to increase provider satisfaction.
- ***Enhancing key provider administrative processes based upon observed inefficiencies.*** In Nebraska, we noted a significant increase in provider appeals related to radiology service prior authorizations. We conducted a root cause analysis and determined that our radiology PA processes needed restructuring to provide an intermediary step between denial and direct appeal.

Originally, radiology PAs denied due to missing substantiating documentation (e.g., X-ray) would have no option but to undergo a direct appeal, starting the entire process over from the beginning. In 2014, we enhanced our process by implementing intermediate reconsideration and additional review steps, allowing providers to simply supply the missing information to resolve the case and avoid direct appeal measures. Through our enhancements, we have reduced the Nebraska radiology PA appeal volume from 30 in 2013 to three in 2015. Our program enhancement efforts resulted in radiology PAs being processed more efficiently—thus improving provider satisfaction with UnitedHealthcare, while simultaneously reducing provider administrative burden.

Visiting and Engaging Providers to Assess Satisfaction and Capture Concerns

We create and customize provider visitation and engagement plans to suit the unique needs and requirements of Nebraska Medicaid providers and MLTC. During these outreach engagements, we directly evaluate provider satisfaction and capture provider issues/concerns for documentation, tracking and resolution as described in Table IV.J-3 below:

Table IV.J-3

Visitation Type	Targeted Providers/Focus of Visit	Frequency
On-Site, Regular Visits to Key Providers	Core participating providers (based upon a variety of factors) are visited to foster relationships, maximize performance, issue resolution, promote tools/programs and administrative efficiencies. Provider advocates, our BH provider liaison and CPCs provide enhanced outreach and support for these high-volume provider sites via telephonic/WebEx or face-to-face meetings. We connect with the PCP or staff to identify any issues that require attention or improvement, and put in place appropriate action plans.	≥ Quarterly, with ad hoc visits for community-based events, requested outreach reporting and individual requests
Clinical Practice Consultant (CPC) Visits	CPCs visit high-volume PCPs whose panel sizes fall within the top 50 percent of a Plan's total panel sizes and have members who are noncompliant in HEDIS measures. They also coordinate activities with provider advocates, provider relations, marketing and community outreach teams to provide education and support.	Continuous
Operational Meetings/Joint Operating Committee (JOC)	For select provider groups (e.g., larger physician organizations and targeted hospital systems and FQHCs), we hold face-to-face or telephonic/WebEx operations meetings focused on operational performance and improvement strategies that ease administrative burdens. JOCs include leadership engagement focused on business strategies, accounts receivable management and relationship management.	Operations – Monthly JOCs – Quarterly
Clinical and Provider Advisory Committee Meeting	The CPAC is a peer-review committee with local community and hospital-based network clinicians from a variety of specialties (e.g., pediatrician, family practice, BH, surgeon, pharmacy, etc.) across the state that support our efforts to improve quality of care and UM across the care continuum. Because our network spans the entire state, meetings are held via WebEx conference calls.	Monthly
Behavioral Health Advisory Committee Meeting	The BHAC is a forum for BH providers to provide recommendations, input and prioritization of initiatives or issues. The BHAC is responsible for providing input to the CPAC on network development and management strategies and policies for the provision of BH services. At a minimum, BHAC members consider provider input and expertise relative to clinical issues, including policy development, service planning/evaluation, performance improvement projects and training plans. The BHAC allows us to gather valuable feedback, input and advice for enhancements to systems and changes to procedures in the provisioning of integrated BH services throughout Nebraska.	Monthly
Ancillary Provider Interactions	Dedicated provider relations staff interacts with Nebraska ancillary providers (e.g., home health, home infusion, hospice, durable medical	Continuous

Table IV.J-3		
Visitation Type	**Targeted Providers/Focus of Visit**	**Frequency**
	equipment/O&P, sleep centers, transportation, surgery centers, freestanding labs, freestanding radiology, dialysis) via phone, WebEx and email to answer questions, resolve issues and provide information/education.	
ACO JOCs	Our ACO JOC meetings provide a forum for UnitedHealthcare leadership and key staff members and the leadership of the ACO to review monthly processes, outcomes, discuss improvement opportunities, successes and barriers, identify joint action items and evaluate the quality of services to our members. The focus is on the five pillars of our ACO program, which include: access to care, reduction in avoidable ER visits, reduction in inpatient admissions and high-risk cohort population or complex cases that are at risk for admissions.	Quarterly

IV.K. Subcontracting Requirements

56. For each subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following:

The date the company was formed, established or created.

Ownership structure (whether public, partnership, subsidiary, or specified other).

Organizational chart.

Total number of employees.

Whether the subcontractor is currently providing services for the MCO in other states and the subcontractor's location. *1 page per subcontracting organization*

Subcontractors

We are committed to providing the highest quality services to the Heritage Health membership. While we deliver the majority of our services to our members and providers through our own employees, we subcontract certain services when the subcontractor has a particular expertise and experience in furnishing those services. For these, we maintain complete accountability and oversight for each subcontractor's performance. While bringing the best of UnitedHealthcare to Nebraska, we chose subcontractors—affiliates and other partners—most of whom we have had prior experience. We are confident they will provide the highest quality of care, services and support to our members; and they will meet or exceed all contractual requirements. Through performance-based contracting and close oversight of direct and subcontracted functions, we are committed to affording high-quality health care and services to your members.

Affiliate Subcontractors:

UnitedHealth Group, Inc. owns the affiliate subcontractor companies in this section; they are affiliates of UnitedHealthcare. On the following pages, we identify our affiliate subcontractors and provide detailed information, as requested:

- ***FiServ, Inc.:*** Identity card processing
- ***OptumHealth Care Solutions, Inc.:*** Chiropractic care; physical, occupational and speech therapy; and complementary alternative medicine
- ***OptumInsight, Inc.:*** Data analytics, technology and operational services, including fraud, waste and abuse; subrogation and payment integrity services
- ***OptumRx, Inc.:*** Sophisticated array of high-quality, integrated pharmacy benefits management services, including retail pharmacy network claims processing, mail order pharmaceuticals, specialty pharmaceutical management and clinical programs
- ***United Behavioral Health, Inc. d.b.a. Optum Behavioral Solutions:*** Behavioral health management services
- ***United HealthCare Services, Inc.:*** Administrative management services, including employees, contracting, claims payment, data management and other administrative functions

FiServ, Inc.	
Description of services	FiServ will process identity cards for Heritage Health. FiServ offers award-winning solutions for mobile and online banking, payments, risk management, data analytics and core account processing, including identification cards and leading global provider of financial services technology. They provide electronic payments processing products and services, internet and mobile banking systems, and related services. FiServ serves approximately 14,500 clients worldwide, including banks, thrifts, credit unions, investment management firms, leasing and finance companies, retailers and merchants.
Date company formed, established or created	FiServ was incorporated in the State of Delaware in 1984, and it was reincorporated as a Wisconsin corporation in 1992.
Ownership structure	For-profit and a publicly traded corporation FiServ Inc. is a for-profit corporation and a publicly traded company.
Organizational chart	See Figure IV.K.56a. Organizational Chart – FiServ.
Total number of employees	They employ more than 21,000 employees.
Date operations began	Operations began in 1984.
Services provided in other states and physical location	Services include financial technology and printed materials to over 16,000 clients throughout the United States. FiServ is headquartered in Brookfield, WI.

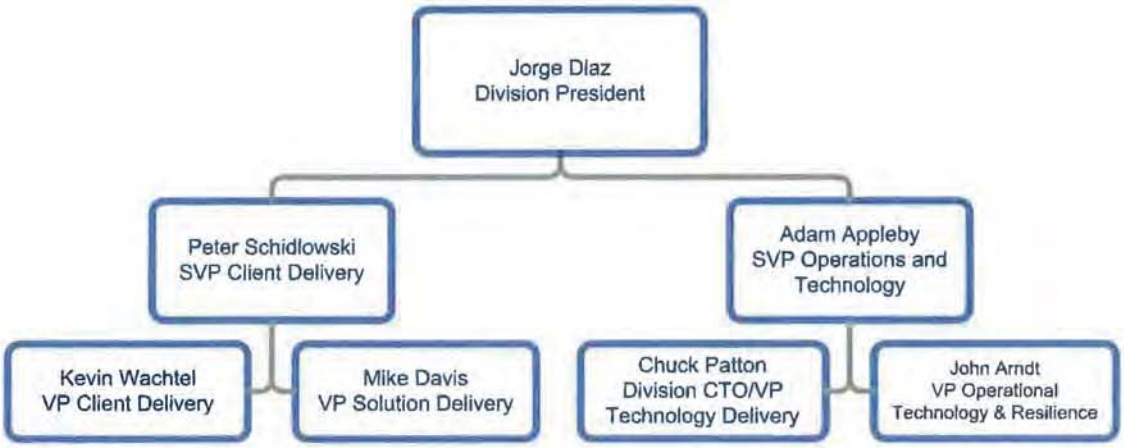

Figure IV.K.56a. Organizational Chart – FiServ.

OptumHealth Care Solutions, Inc. (OHCS)	
Description of services	OptumHealth Care Solutions, Inc. (OHCS) will provide chiropractic and therapy network and credentialing services for Heritage Health. OHCS offers access to chiropractic care; physical, occupational and speech therapy; and complementary alternative medicine. Its programs help manage cost by assisting individuals with their therapy-based health care and delivering a quality network of providers.
Date company formed, established or created	OptumHealth Care Solutions was originally American Chiropractic Network, formed in July 1987. The name changed to OptumHealth Care Solutions, Inc., in August 2010.
Ownership structure	The ultimate parent organization of OHCS is UnitedHealth Group. OHCS is a wholly owned subsidiary of OptumHealth Holdings, LLC, which is a wholly owned subsidiary of Optum, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which in turn is a wholly owned subsidiary of UnitedHealth Group Incorporated.
Organizational chart	See Figure IV.K.56b. Organizational Chart – OHCS.
Total number of employees	OHCS employs 280 full-time employees.
Date operations began	Operations began in 1987.
Services provided in other states and physical location	Currently, OHCS extends benefits to 23 million members located throughout the United States for numerous programs, many of which include public sector programs in Nebraska, Arizona, Florida, Hawaii, Iowa, Kansas, Maryland, Michigan, Mississippi, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas and Washington. OHCS serves more than 360,000 members in Nebraska through various public sector and commercially based programs. OHCS' corporate offices are at: 11000 Optum Circle, Eden Prairie, MN 55344—closely located to its ultimate parent company's location at: 9900 Bren Road, Minnetonka, MN 55343. Other operational sites are located in Kingston, NY; Rockville, MD; San Diego, CA and Eden Prairie, MN.

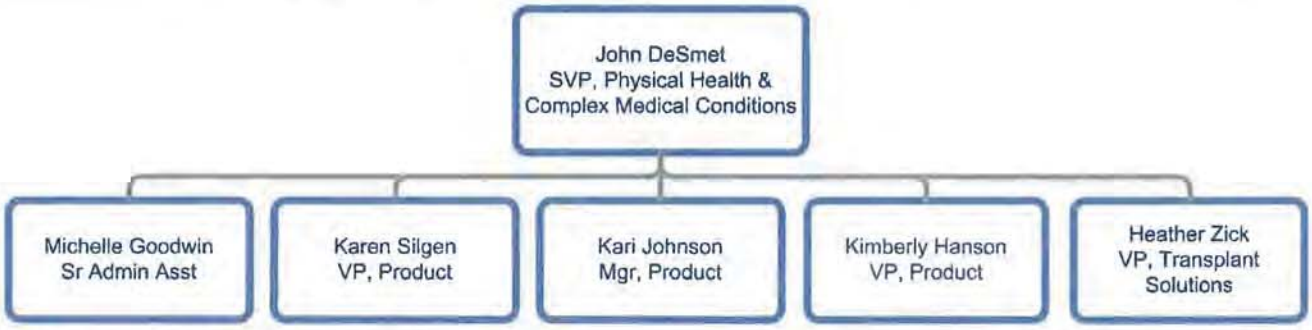

Figure IV.K.56b. Organizational Chart – OHCS.

OptumInsight, Inc.	
Description of services	OptumInsight is providing and will continue to provide fraud, waste and abuse; subrogation and payment integrity services. OptumInsight is one of the largest health care information, technology, operational services and consulting companies in the world, providing technology and services to more than 125 customers. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations depend on OptumInsight to help them reduce costs, meet compliance mandates, improve clinical performance and adapt to the health system landscape. For example, due to our subrogation and third party liability processes and procedures, nationally, we reported provider savings of $981,521 in 2014 and $1,232,353 in 2015; we reported total subrogation recoveries including vendor recoveries of $283,041 in 2014 and $107,874 through 2015. In Nebraska, we reported subrogation recoveries including vendor recoveries of $328,154 in 2014 and $369,125 YTD in 2015.
Date company formed, established or created	OptumInsight was established in 2011. OptumInsight, Inc., has been incorporated in Delaware since 1993; it is licensed to do business in 49 states and the District of Columbia.
Ownership structure	The ultimate parent organization of OptumInsight, Inc., is UnitedHealth Group. OptumInsight is a wholly owned subsidiary of OptumHealth Holdings, LLC, which is a wholly owned subsidiary of Optum, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which in turn is a wholly owned subsidiary of UnitedHealth Group Incorporated.
Organizational chart	See Figure IV.K.56c. Organizational Chart – OptumInsight.
Total number of employees	OptumInsight has 15,425 employees worldwide.
Date operations began	Operations began in 2011.
Services provided in other states and physical location	OptumInsight, Inc., has been incorporated in Delaware since 1993; it is licensed to do business in and is offering services in 49 states and the District of Columbia. OptumInsight supports public sector programs in 37 states, including Nebraska. Optum Insight's corporate offices are at: 11000 Optum Circle, Eden Prairie, MN 55344.

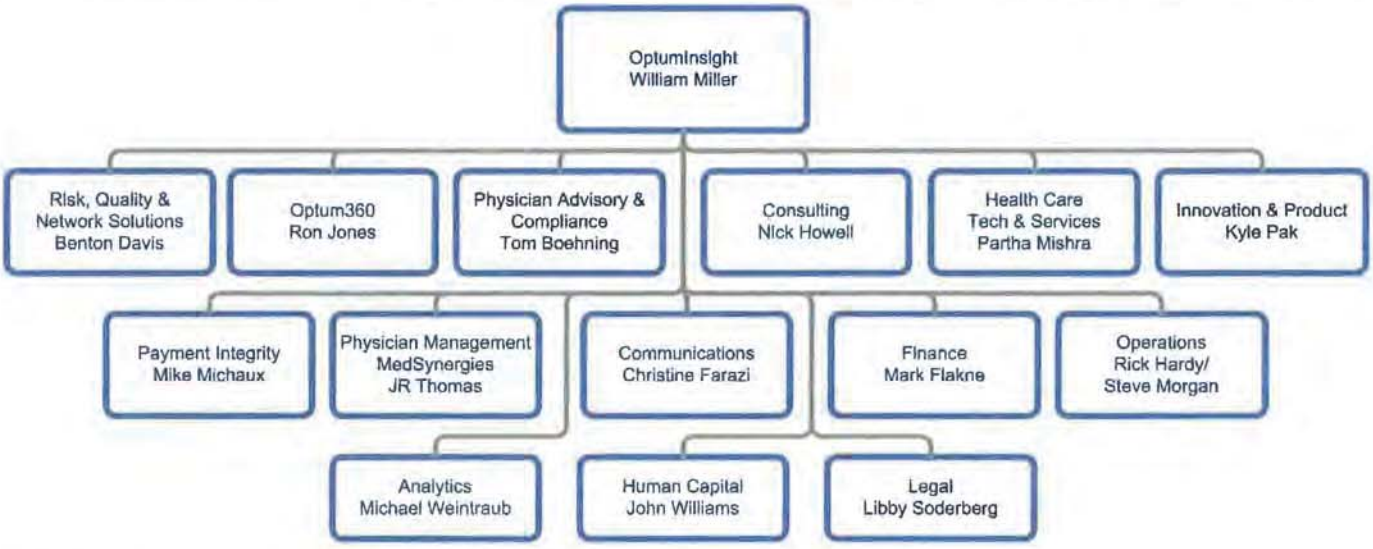

Figure IV.K.56c. Organizational Chart – OptumInsight.

OptumRx, Inc.	
Description of services	OptumRx offers pharmacy benefit management and other related services (e.g., retail pharmacy network, specialty pharmaceutical management, claims processing, clinical programs and a home-delivery pharmacy program). OptumRx's customers consist of numerous organizations, including public and government entities, MCOs, Medicare and Medicaid plan sponsors, employer and union groups, and third-party administrators. OptumRx has extensive experience managing Medicaid, CHIP, public sector and commercial plans. Providing pharmacy benefit services to more than 65 million members nationwide and with 66,000 pharmacy access points, OptumRx handles more than 1 billion prescriptions each year (about one in every four prescription claims in the United States), which results in approximately $74 billion in managed drug spend. In Nebraska, OptumRx has 36 commercial customers with approximately 18,066 members and a public sector customer supporting more than 200 members.
Date company formed, established or created	OptumRx was established in 1989.
Ownership structure	OptumRx is a wholly owned subsidiary of Optum, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated (UnitedHealth Group). UnitedHealth Group is a for-profit, publicly traded Fortune 50 corporation trading on the New York Stock Exchange under the ticker symbol UNH.
Organizational chart	See Figure IV.K.56d. Organizational Chart – OptumRx.
Total number of employees	OptumRx employs over 12,000 dedicated employees, with 278 employees supporting local commercial and public sector programs.
Date operations began	OptumRx's operations began in 1989. UnitedHealth Group acquired OptumRx in 2005. Services have been offered in Nebraska since January 1, 2008.
Services provided in other states and physical location	Currently, OptumRx delivers pharmacy benefit-management services to public sector members across the United States in 20 states, including Nebraska. Corporate headquarters are at: 2300 Main Street, Irvine, CA 92614. OptumRx maintains several satellite offices. Home delivery pharmacy facilities are located in Carlsbad, CA, and Overland Park, KS. Internal specialty pharmacy facilities are located in Carlsbad, CA; Jeffersonville, IN; Las Vegas, NV and Overland Park, KS.

Figure IV.K.56d. Organizational Chart – OptumRx.

United Behavioral Health, Inc. d.b.a. Optum Behavioral Solutions	
Description of services	United Behavioral Health Inc. d.b.a. Optum Behavioral Solutions provides and will continue to provide post-hospitalization planning and follow-up; BH outpatient case management, UM for covered BH services; BH quality management; BH network management and development; BH call center services and BH claims processing and payment. Optum Behavioral Solutions supports a full range of Medicaid, Medicare, and state and federally funded BH services. With 27 years of experience administering mental health and substance abuse services, they hold URAC and NCQA accreditation. Partnering with more than 130,000 clinicians and 3,500 care facilities nationwide, Optum Behavioral Solutions offers one of the largest managed BH organization networks available. They extend benefits to 33.1 million Americans located throughout the United States for numerous programs, many of which include public sector programs in 24 states. In these states, they serve 5.7 million Medicaid, dual eligible, CHIP and uninsured members.
Date company formed, established or created	Optum Behavioral Solutions is a brand name of United Behavioral Health (UBH), which began as a provider of Employee Assistance Program (EAP) services in 1979 and expanded into managed BH services in 1988. The brand name changed to Optum Behavioral Solutions in 2011.
Ownership structure	Optum Behavioral Solutions is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group, Inc., a Minnesota corporation and a publicly held company (NYSE: UNH).
Organizational chart	See Figure IV.K.56e. Organizational Chart – Optum Behavioral Solutions.
Total number of employees	As of 2013, Optum Behavioral Solutions employed 2,432 full-time employees.
Date operations began	Managed care operations began in 1988.
Services provided in other states and physical location	United Behavioral Health is incorporated in California and domiciled in California. It is qualified to do business as a foreign corporation (with the Secretaries of State) in 49 states and the District of Columbia and Puerto Rico. Corporate offices are located at 425 Market Street, 14th Floor, San Francisco, CA 94105. Other sites are in Idaho; New Mexico; Pierce County, Washington; Salt Lake County, Utah and San Diego County, California.

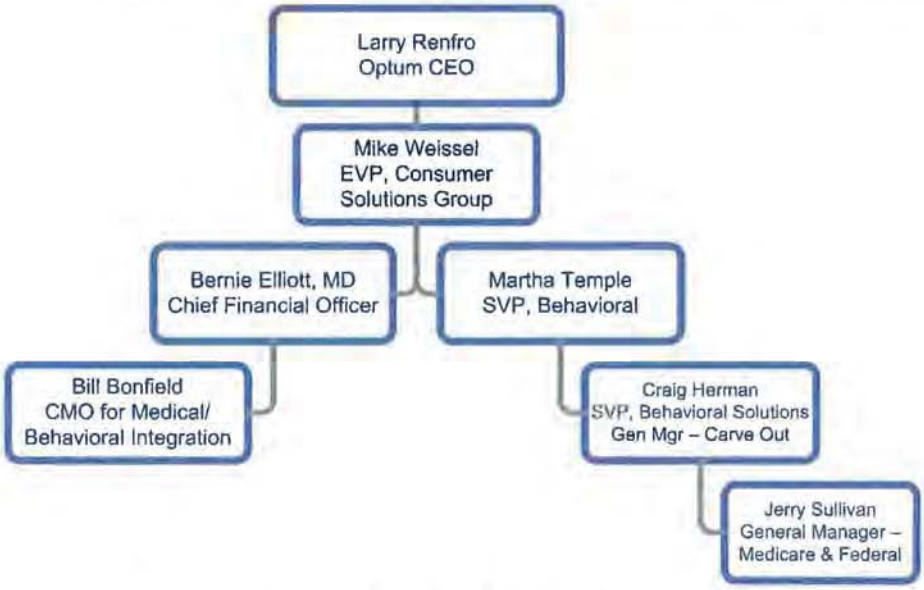

Figure IV.K.56e. Organizational Chart – Optum Behavioral Solutions.

United HealthCare Services, Inc.	
Description of services	United HealthCare Services is the management services company for all UnitedHealth Group companies and provides many services, to include management, employees, contracting, claims payment, data management and other administrative functions. It is licensed in many states across the nation—as a third party administrator in 43 states and a utilization and medical necessity review agent in 30 states.
Date company formed, established or created	United HealthCare Services was established in 1974.
Ownership structure	Wholly owned subsidiary United HealthCare Services is a wholly owned subsidiary of UnitedHealth Group, Inc.
Organizational chart	See Figure IV.K.56f. Organizational Chart – United HealthCare Services.
Total number of employees	United HealthCare Services employs approximately 57,900 employees, including more than 150 employees in Nebraska. Its estimated annual revenues are approximately $3.9 billion—the vast majority of which derive from providing services to affiliates and subsidiaries.
Date operations began	Operations began in 1974.
Services provided in other states and physical location	United HealthCare Services is domiciled in Minnesota and authorized to do business in all states and the District of Columbia, plus several U.S. territories with offices in multiple locations. Its corporate headquarters are at 9900 Bren Rd, Minnetonka, MN 55343.

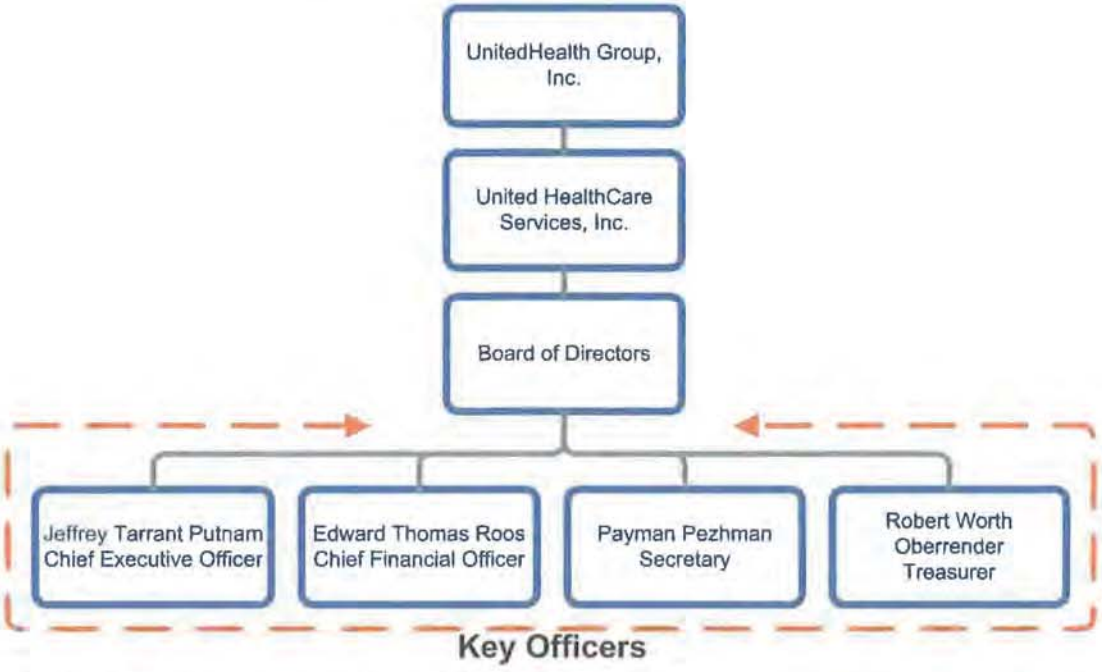

Figure IV.K.56f. Organizational Chart – United HealthCare Services.

Non-affiliate Subcontractors:

UnitedHealth Group, Inc. does not own non-affiliate subcontractor companies. Below, we list our chosen non-affiliate subcontractors and provide detailed information, as requested:

- ***BIWORLDWIDE:*** Baby Blocks member outreach with mailings or limited ad hoc calls
- ***Burke, Inc.:*** Care management member satisfaction surveys
- ***Decision Support Systems Research:*** CAHPS consulting and support services
- ***DialAmerica, Inc.:*** Access and availability services
- ***EviCore (CareCore National, LLC d.b.a. eviCore):*** Management services for outpatient advanced radiology and cardiology benefits
- ***IntelliRide (Transdev North America, Inc. d.b.a. IntelliRide):*** Transportation
- ***Johnson Anderson and Associates:*** Envelopes
- ***LanguageLine Solutions, Inc.:*** Language interpretation
- ***Market Strategies International:*** Provider satisfaction surveys
- ***MedReview, Inc.:*** Fraud, waste and abuse services for DRG review
- ***Mirixa Corporation:*** Medication therapy management services
- ***RR Donnelley & Sons Company:*** Mail services
- ***Silverlink Communications, Inc.:*** Member incentive outreach – automated and personal
- ***Superior Vision Benefit Management, Inc.:*** Vision services

BIWORLDWIDE (BIW)	
Description of services	BIW is our chosen subcontractor for Baby Blocks' member outreach with mailings or limited ad hoc calls for Heritage Health. Baby Blocks is a custom website designed to engage pregnant mothers on Medicaid. BIW provides a holistic approach to engagement strategies (e.g., communications, technology, rewards and measurement) managed in-house. BIW manages Community Rewards, Scavenger Hunt, Medicare and Retirement member learning, and several digital solutions for UnitedHealthcare. BIW is a full-service performance improvement company offering a comprehensive range of strategic and tactical marketing services to help clients initiate and sustain customer engagement, while optimizing revenue potential through efficient lifecycle management and enhanced perceptions of brand relevance. BIW is a multi-national company serving Global 2000 corporations in over 125 countries.
Date company formed, established or created	BIW was formed in 1950.
Ownership structure	BIW is a privately held company.
Organizational chart	See Figure IV.K.56g. Organizational Chart – BIW.
Total number of employees	BIW employs over 1,200 people with approximately 860 in the United States.
Date operations began	Initial operations began in 1950.
Services provided in other states and physical location	Services include strategy and account planning; strategic insights and analytics; interactive marketing; social media; creative, production and technology services, recognition services and account management. They are present in 16 states and the District of Columbia. National headquarters for BIW are located at 7630 Bush Lake Road, Minneapolis, MN 55439-2810.

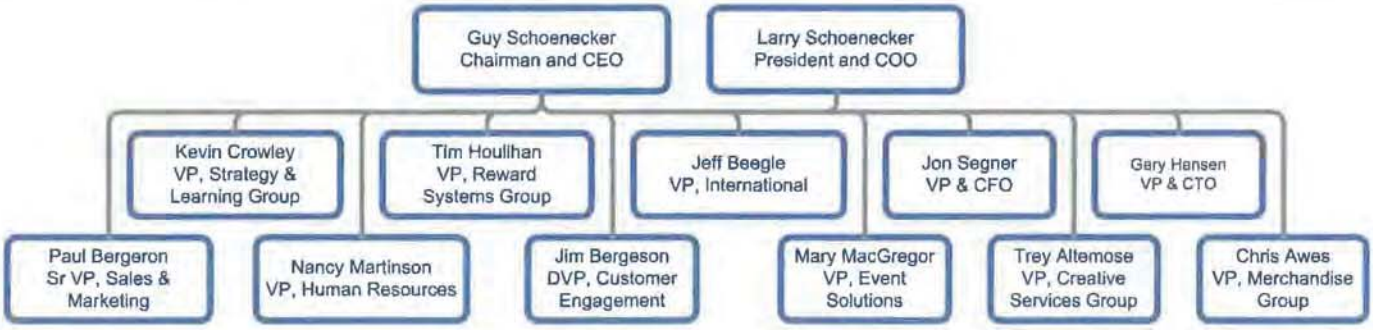

Figure IV.K.56g. Organizational Chart – BIW.

Burke, Inc.	
Description of services	Burke, Inc., is our chosen subcontractor for care-management member-satisfaction surveys for Heritage Health. Burke is an independent, full-service market research and decision support company. Burke capitalizes on its state-of-the-art research execution, advanced analytical techniques and leading-edge technology to provide decision support solutions to companies across all major industry sectors. Burke is the industry leader in market research and consumer insights education through The Burke Institute, which has trained more than 85,000 participants from 10,000 companies, through more than 4,000 public and in-house customized market research seminars in 40 different countries.
Date company formed, established or created	Burke was founded in 1931.
Ownership structure	Burke is 100 percent employee owned. In 2004, Burke formed an ESOP (Employee Stock Ownership Plan), so all employees are able to participate in stock ownership and help to contribute to the company's success. The ESOP, representing broad-based employee ownership across all positions of the company, has owned 100 percent of the shares of Burke since January 2008.
Organizational chart	See Figure IV.K.56h. Organizational Chart – Burke.
Total number of employees	342 employees, to include 252 full time and 90 part time; 70 interviewers
Date operations began	Operations began in 1931. Burke began working with UnitedHealthcare in October 2014.
Services provided in other states and physical location	Services include health care call center and consumer research operations. They are provided throughout the United States in California, Colorado, Florida, Georgia, Indiana, Massachusetts, Maryland, Michigan, Nevada, New Jersey, North Carolina, Tennessee and Texas. Their corporate headquarters are at 500 West 7th Street, Cincinnati, OH 45203.

Figure IV.K.56h. Organizational Chart – Burke.

Decision Support Systems Research	
Description of services	Decision Support Systems Research (DSS Research) is our chosen subcontractor for CAHPS consulting and support services for Heritage Health. DSS Research is a fully qualified, professional and well-respected company dedicated to developing and organizing information that enables clients to better understand and serve members. They have been fulfilling the broad research needs of the health insurance industry for over 30 years and have been a major player in most all CAHPS programs since their inception—obtaining and maintaining all the necessary certifications and approvals. DSS Research is a certified survey vendor with both CMS and NCQA. National in scope, DSS Research serves all of UnitedHealthcare Community & State plans required to administer CAHPS surveys.
Date company formed, established or created	DSS Research was founded in 1982.
Ownership structure	DSS Research is a privately owned company.
Organizational chart	See Figure IV.K.56i. Organizational Chart – Decision Support Systems Research.
Total number of employees	DSS Research employs more than 100 full-time and nearly 400 part-time employees.
Date operations began	Operations began in 1982.
Services provided in other states and physical location	Services include administration, operations, analytics and CAHPS survey reporting. They are offered nationwide. Regional offices are located in Washington D.C. and a call center/data center is located in Texas. Corporate headquarters are at 4150 International Plaza, Suite 900, Fort Worth, TX 76109.

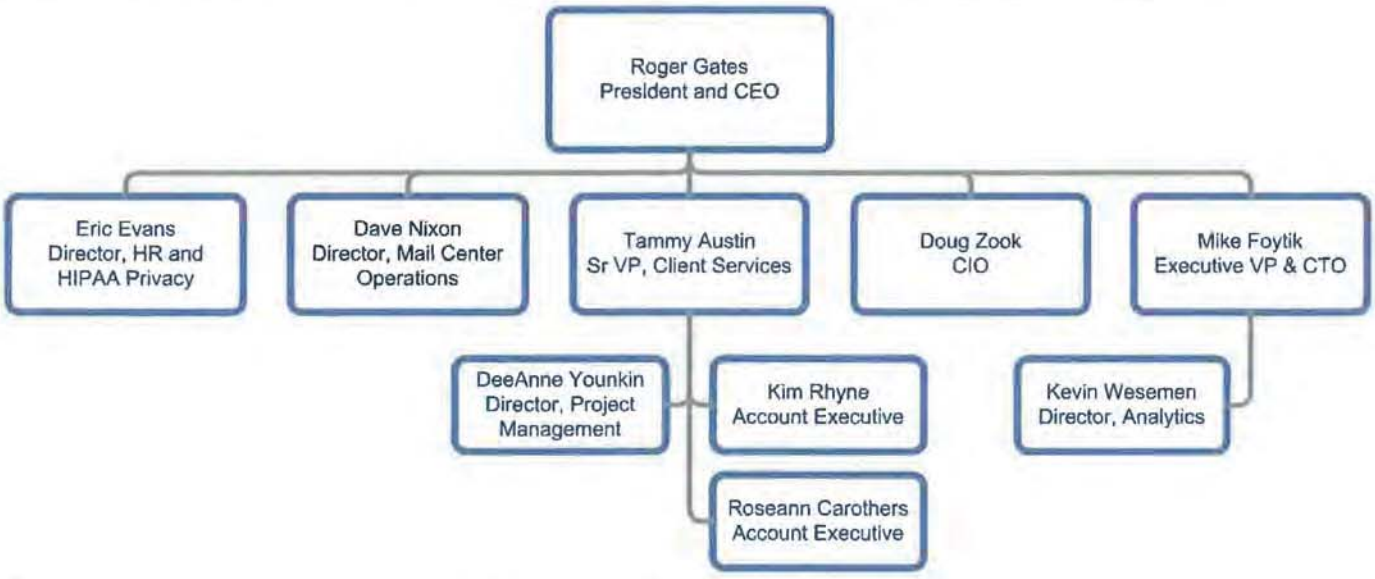

Figure IV.K.56i. Organizational Chart – Decision Support Systems Research.

DialAmerica, Inc.	
Description of services	DialAmerica, Inc., is our chosen subcontractor for access and availability services for Heritage Health. DialAmerica has been providing services to UnitedHealthcare in Nebraska since March 2011. Committed to high quality standards and a "zero error" quality environment, DialAmerica is dedicated to following all local, state, and federal telemarketing laws and regulations. For the Heritage Health program, all calling will be handled in the Knoxville, TN location.
Date company formed, established or created	DialAmerica was established in 1957.
Ownership structure	DialAmerica is a privately owned corporation.
Organizational chart	See Figure IV.K.56j. Organizational Chart – DialAmerica.
Total number of employees	DialAmerica employs approximately 5,000 personnel. Currently, for Heritage Health, DialAmerica has 11 employees conducting UnitedHealthcare access and availability survey calls.
Date operations began	Operations began in 1957. DialAmerica has conducted surveys for UnitedHealthcare since March 2011 and for the state of Nebraska since December 2011.
Services provided in other states and physical location	Services include access, availability and call center services, and they are provided in Arizona, Florida, Georgia, Illinois, Indiana, Nebraska, New Jersey, New York, Ohio, Pennsylvania, South Carolina, Tennessee and Texas. Corporate headquarters are at 960 Macarthur Boulevard, Mahwah, NJ 07495.

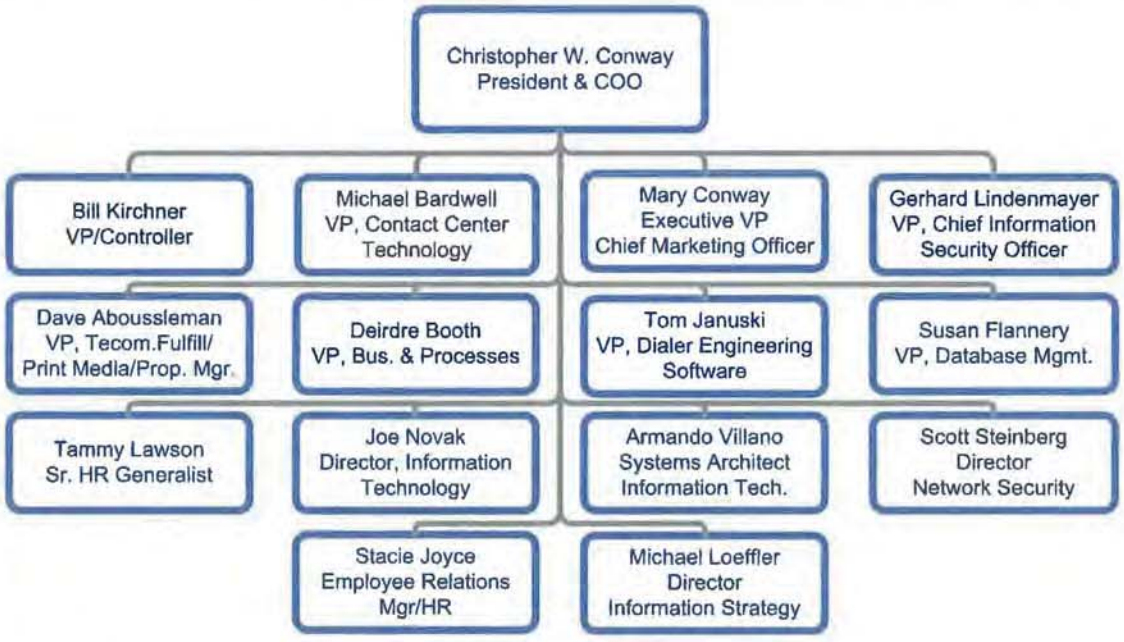

Figure IV.K.56j. Organizational Chart – DialAmerica.

eviCore (CareCore National, LLC d.b.a. eviCore)	
Description of services	eviCore, our chosen subcontractor for outpatient advanced radiology benefits for Heritage Health, offers advanced radiology modalities (e.g., magnetic resonance imaging [MRI], magnetic resonance angiogram [MRA], computed tomography [CT]—including contrast and three-dimensional identity (3DI), positron emission topography [PET] and nuclear medicine).
Date company formed, established or created	eviCore (CareCore) was established in 1994.
Ownership structure	Privately owned, limited liability company CareCore National, LLC d.b.a. eviCore is a privately owned, limited liability company that does not have a parent organization. CareCore National, LLC is wholly owned by CareCore National Intermediate Holdings, LLC. CareCore National Intermediate Holdings, LLC is wholly owned by CareCore National Holdings, LLC. 71 percent of the ownership interest CareCore National Holdings, LLC is held by General Atlantic (CC), LLC. General Atlantic (CC), LLC is wholly owned by General Atlantic (CC) Holdco, LP. General Atlantic Partners 93, LP, a limited partner in General Atlantic (CC) Holdco, LP, indirectly owns 65.81 percent of CareCore National, LLC.
Organizational chart	See Figure IV.K.56k. Organizational Chart – eviCore.
Total number of employees	They employ more than 1,570 employees, with two remote employees based in Nebraska.
Date operations began	Operations began in 1994. They have managed radiology and cardiology services for UnitedHealthcare since 1999. Services have been offered in Nebraska since 2010.
Services provided in other states and physical location	Incorporated in New York and domiciled in South Carolina, CareCore National, LLC d.b.a. eviCore is licensed to do business in all states, except for California. Nationally, eviCore manages specialty benefits for 63 million members for advanced imaging services. Through their relationship with UnitedHealthcare, eviCore provides health care management services to more than 5 million managed Medicaid members from 12 different health plans. They support 155,000 members in Nebraska, with 60,000 members in public sector programs. Its corporate headquarters are at 400 Buckwalker Place Boulevard, Bluffton, SC 29910. eviCore has a fully integrated call center in Colorado Springs, CO.

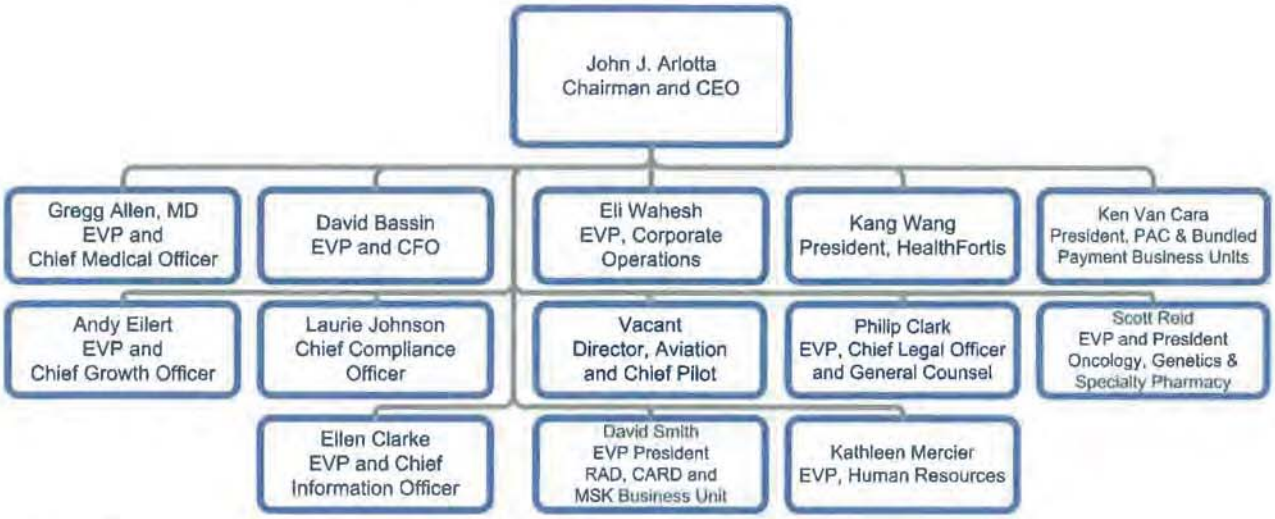

Figure IV.K.56k. Organizational Chart – eviCore.

IntelliRide (Transdev North America, Inc. d.b.a. IntelliRide)	
Description of services	IntelliRide is our chosen subcontractor for prior authorization, scheduling, and dispatch services for UnitedHealthcare members who need non-emergency transportation to received approved services. IntelliRide, a division of Transdev North America, focuses on using next generation mobility management to improve quality while containing costs of paratransit and other human services transportation. The flexibility and customization capabilities within IntelliRide allows for tailoring technology and business processes to integrate with clients' existing systems and address their unique needs.
Date company formed, established or created	IntelliRide Nebraska was established in April 2014. IntelliRide was established in February 2013. Transdev North America was established in December 1986.
Ownership structure	IntelliRide Nebraska is owned by Transdev North America, Inc., which is a privately owned company.
Organizational chart	See Figure IV.K.56I. Organizational Chart – IntelliRide.
Total number of employees	Currently, IntelliRide Nebraska has 35 employees and the IntelliRide Division of Transdev has 160 employees.
Date operations began	IntelliRide Nebraska began operating in May 2014.
Services provided in other states and physical location	The local Nebraska IntelliRide office for non-emergent medical transportation is at 2222 Cuming Street, Omaha, NE 68102. The corporate office is at 720 E Butterfield Rd, Suite 300, Lombard, IL 60148. Other IntelliRide locations and services offered are at the following: NE NEMT – Brokerage office/dispatch for Medicaid CA East Bay BART – Brokerage office/dispatch of paratransit transportation CA San Francisco (SFMTA) – Brokerage office/dispatch of paratransit transportation CA AVTA – Brokerage office/dispatch of paratransit transportation DC WMATA – Manages and administers taxi services PA ACCESS – Manages NEMT for PA Transdev North America has locations worldwide.

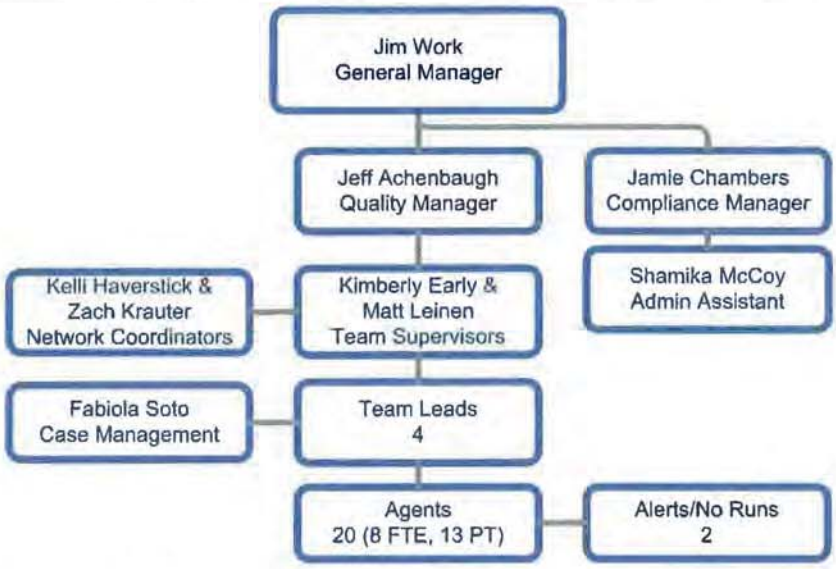

Figure IV.K.56I. Organizational Chart – IntelliRide.

Johnson Anderson	
Description of services	Johnson Anderson is our chosen subcontractor for envelopes for Heritage Health. They are a full-service envelope manufacturer. They recognize each job is unique and their employees make sure your project is on time, on budget and with the highest of quality. Johnson Anderson has G7 Master status, which is granted to physical facilities qualified to use the G7 Proof-to-Print Process and organizations that use the most modern technology, techniques and press controls to produce a close visual match from proof to print.
Date company formed, established or created	Johnson Anderson was established in September 1983.
Ownership structure	Johnson Anderson is an S-Corporation.
Organizational chart	See Figure IV.K.56m. Organizational Chart – Johnson Anderson.
Total number of employees	Johnson Anderson has 116 employees.
Date operations began	Operations began in September 1983.
Services provided in other states and physical location	Services include printing and paper products, which are produced at a site in Shakopee, Minnesota. Its address is 5010 Valley Industrial Blvd., South Shakopee, MN 55379

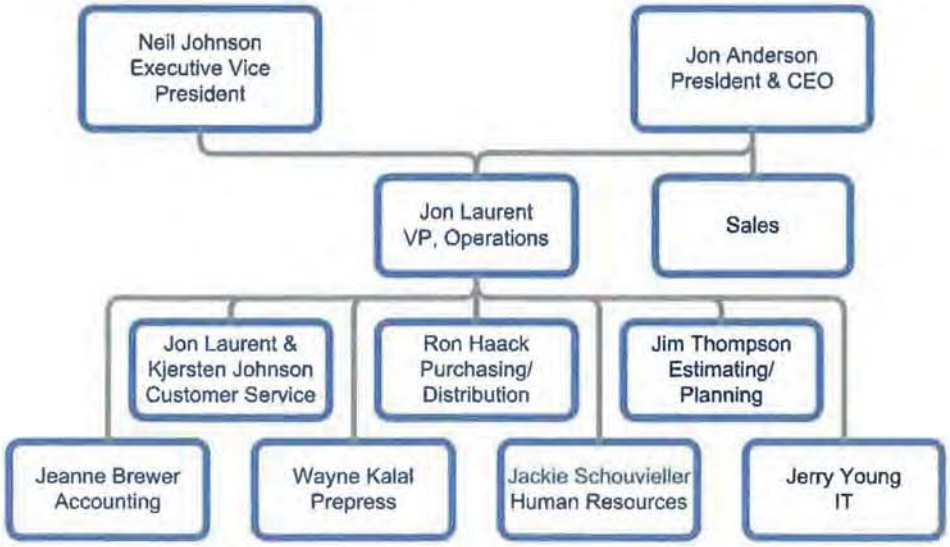

Figure IV.K.56m. Organizational Chart – Johnson Anderson.

LanguageLine Solutions, Inc.	
Description of services	LanguageLine is our chosen subcontractor for translation services for Heritage Health. LanguageLine provides language interpretation and document translation services worldwide for health care organizations, law enforcement, legal courts and businesses in over 200 languages. They handle the majority of over-the-phone interpretations for 911 emergency calls nationwide. LanguageLine is the largest interpretation services provider in the world. They employ approximately 5,000 interpreters and support staff globally who answer 40 million calls each year.
Date company formed, established or created	LanguageLine was established in 1982.
Ownership structure	LanguageLine Solutions is a privately owned corporation.
Organizational chart	See Figure IV.K.56n. Organizational Chart – LanguageLine.
Total number of employees	Currently, LanguageLine has 6,500 employees, with five employees based in Nebraska.
Date operations began	Operations began in 1982.
Services provided in other states and physical location	Services include interpretation and document translation services. They are offered in various locations throughout all 50 states.

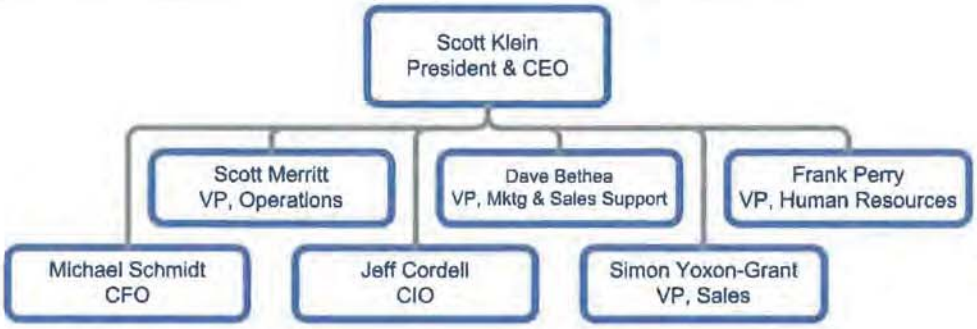

Figure IV.K.56n. Organizational Chart – LanguageLine.

Market Strategies International	
Description of services	Market Strategies International is our chosen subcontractor for primary, custom market research, consulting services and syndicated research. They provide research specialties in satisfaction/stakeholder experience, brand, communications, product development and segmentation. With industry expertise that spans across health care, telecommunications, financial services, technology, consumer and retail, and energy, Market Strategies International offers these industries solutions in quantitative, qualitative, marketing and data sciences and information design.
Date company formed, established or created	Market Strategies International was formed in 1989.
Ownership structure	Market Strategies International is a privately owned company.
Organizational chart	See Figure IV.K.56o. Organizational Chart – Market Strategies International.
Total number of employees	Market Strategies International has 890, both full- and part-time employees.
Date operations began	Operations began in 1989.
Services provided in other states and physical location	Services include primary, custom market research, consulting services and syndicated research. Market Strategies International has sites in the following states: Arkansas, Georgia, Massachusetts, Oregon and Philadelphia, with the corporate office located at 17430 College Parkway, Livonia, MI 48152.

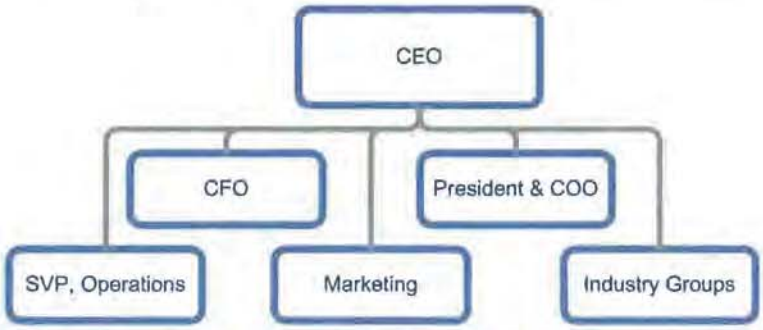

Figure IV.K.56o. Organizational Chart – Market Strategies International.

MedReview, Inc.	
Description of services	MedReview is our chosen subcontractor for fraud, waste and abuse services for DRG review for Heritage Health. MedReview, one of the first organizations registered as a certified Utilization Review (UR) agent in New York when UR registration began in 1997, offers utilization management and analysis services for labor organizations, corporations, insurance companies and managed care organizations. MedReview uses medical professionals, licensed and registered in their specific disciplines. Over the past 20 years, MedReview has conducted over 2 million peer reviews to evaluate clinical decisions and services rendered by medical practitioners on all levels of the health care continuum. MedReview maintains a physician review panel of more than 100 clinicians, in 74 specialties and subspecialties. MedReview is accredited by URAC as an Independent Review Organization (IRO) and as a Health Utilization Management (HUM) organization.
Date company formed, established or created	MedReview, Inc., was formed in April 1984.
Ownership structure	MedReview, Inc., is a wholly owned subsidiary of New York County Health Services Review Organization (NYCHSRO), and a for-profit corporation, formed in 1984 to offer utilization management and analysis services to the private sector, including labor organizations, corporations, insurance companies and managed care organizations. NYCHSRO was founded as a 501(c)(3) not-for-profit corporation in 1974 under the Federal Law mandating Professional Standards Review Organizations (PSROs) for Medicare and Medicaid review.
Organizational chart	See Figure IV.K.56p. Organizational Chart – MedReview.
Total number of employees	MedReview's main office in New York has approximately 200 employees.
Date operations began	Operations began in April 1984.
Services provided in other states and physical location	Services include DRG validation and cost outlier audits. Presently, MedReview has its headquarters in New York City, with a new office recently established in Massachusetts. Additional offices will be established to facilitate provision of services to new local markets.

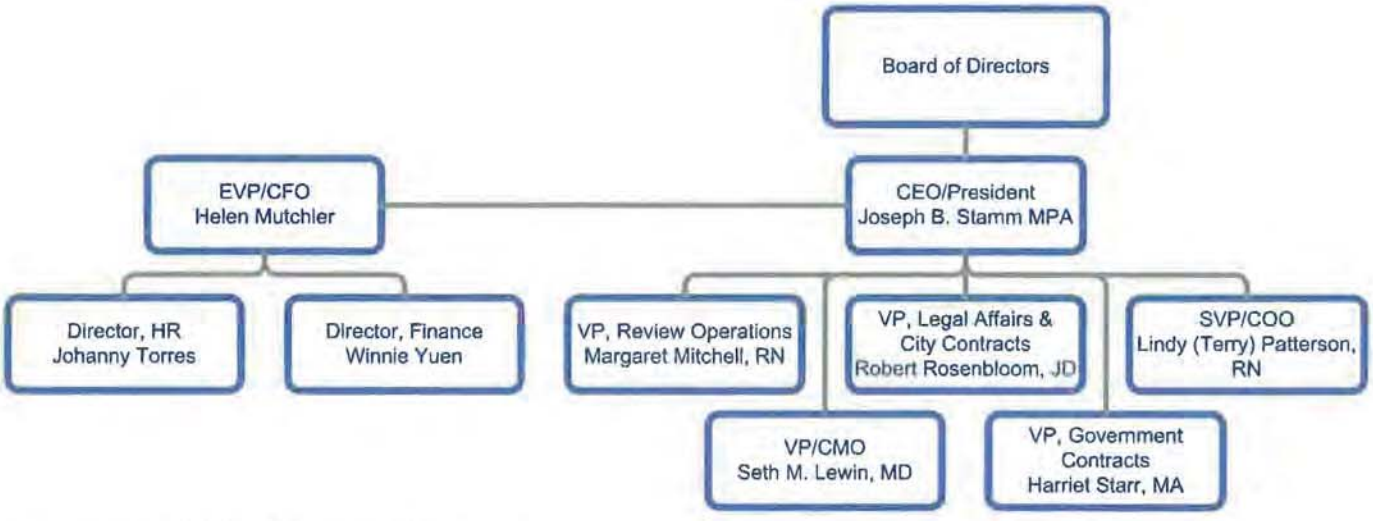

Figure IV.K.56p. Organizational Chart – MedReview.

Mirixa Corporation	
Description of services	Mirixa Corporation is our chosen subcontractor for medication therapy-management services for Heritage Health. Mirixa facilitates valuable interaction between health plans and their members through community pharmacists. Building on the fundamental elements of medical therapy management (MTM), they help improve health outcomes; evaluate the safety, appropriateness and efficacy of medication treatment plans; benchmark against quality standards and eliminate costly inefficiencies. Mirixa serves customers representing over 125 Medicare and Medicaid contracts and commercial plans. These plans represent an excess of 9 million (9,000,000) covered lives.
Date company formed, established or created	Mirixa was established in 2005.
Ownership structure	Mirixa Corporation is a privately held Delaware corporation, founded and owned by the National Community Pharmacist Association (NCPA).
Organizational chart	See Figure IV.K.56q. Organizational Chart – Mirixa Corporation.
Total number of employees	Mirixa employs approximately 65 staff members in addition to a number of independent contractors and consultants.
Date operations began	Mirixa operations began in 2006.
Services provided in other states and physical location	Mirixa provides MTM services for Part D, Medicaid and commercial plans. Mirixa's contracted retail network consists of nearly 55,000 retail pharmacy locations across the United States. Mirixa offers call center services performed from approximately four locations around the country: Burbank, California; Melville, New York; Pittsburgh, Pennsylvania and Reston, Virginia. Mirixa's corporate office is located in Reston, VA, and the Mirixa Technology Center is located in Emeryville, CA.

Figure IV.K.56q. Organizational Chart – Mirixa Corporation.

RR Donnelley & Sons Company	
Description of services	RR Donnelley & Sons Company is our chosen subcontractor for commercial print, fulfillment and ordering portals—among other services and across all UnitedHealthcare business segments. They provide individual program support and do other types of ad hoc work, as requested.
Date company formed, established or created	RR Donnelley was founded in 1864.
Ownership structure	RR Donnelley has been a publicly held company since 1956. The common stock is listed on the NASDAQ Stock Market under the symbol RRD.
Organizational chart	See Figure IV.K.56r. Organizational Chart – RR Donnelley.
Total number of employees	RR Donnelley has approximately 65,000 employees.
Date operations began	Operations began in 1864.
Services provided in other states and physical location	RR Donnelley provides commercial print, in-line, fulfillment and ordering portals across all business segments. They are certified to handle PHI/PII/data in the following states: California, Connecticut, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, Utah and Wisconsin. Corporate offices are located at 35 West Wacker Drive, Chicago, IL 60601.

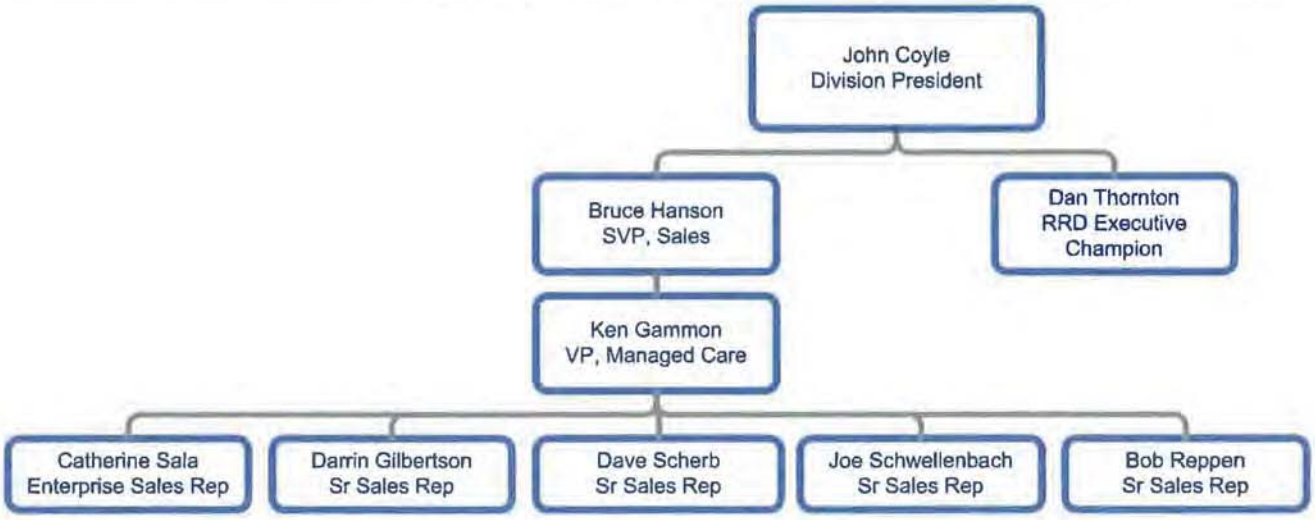

Figure IV.K.56r. Organizational Chart – RR Donnelley.

Silverlink Communications, Inc.	
Description of services	Silverlink Communications is our chosen subcontractor for member incentive outreach via personal (e.g., person to person) and automated for Heritage Health. Currently, Silverlink Communications provides services to many of the largest health care companies in the country, including public sector customers. It continues to enhance its communication platform to support voice, web, mail, SMS text, email and fax channels—bringing innovative campaign functionality to serve UnitedHealthcare's member communications initiatives. Silverlink continues to invest in data analytics to enhance its segmentation and optimization efforts.
Date company formed, established or created	Silverlink Communications was established in 2002.
Ownership structure	Silverlink Communications is a privately owned company.
Organizational chart	See Figure IV.K.56s. Organizational Chart – Silverlink Communications.
Total number of employees	Silverlink has 115 full-time employees.
Date operations began	Operations began in 2002.
Services provided in other states and physical location	Services include communications platforms to support voice, web, mail, SMS text, email and fax channels. All services are provided from Burlington, Massachusetts. Corporate offices are located at 67 South Bedford Street, Suite 300E, Burlington, MA 01803.

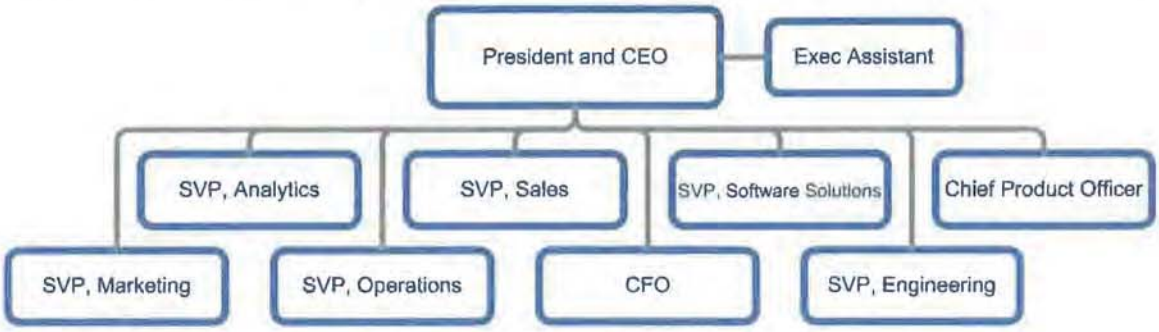

Figure IV.K.56s. Organizational Chart – Silverlink Communications.

Superior Vision Benefit Management Inc.	
Description of services	Superior Vision Benefit Management is our chosen subcontractor for the management of vision and eye care benefits. Superior manages vision and eye health benefits for managed care organizations and third-party payers. Superior has extensive experience with government-sponsored programs (e.g., Medicaid, Medicare, CHIP, Health Insurance Exchanges) in the areas of compliance, data reporting, cultural competence and in providing thoughtful assistance for special needs members.
Date company formed, established or created	Superior Vision Benefit Management, Inc., formerly known as Block Vision, Inc., was incorporated on January 5, 1984.
Ownership structure	Superior Vision Benefit Management, Inc., is a privately held corporation.
Organizational chart	See Figure IV.K.56t. Organizational Chart – Superior Vision Benefit Management, Inc.
Total number of employees	Superior Vision Benefit Management has 148 employees.
Date operations began	Operations began in January 1984.
Services provided in other states and physical location	Superior Vision Benefit Management provides services in the following states: Arizona, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia and West Virginia, plus the District of Columbia. Kansas and Missouri will be added in January 2016. Main physical location from where Superior Vision Benefit Management conducts operations: 939 Elkridge Landing Road, Suite 200, Linthicum, MD 21090.

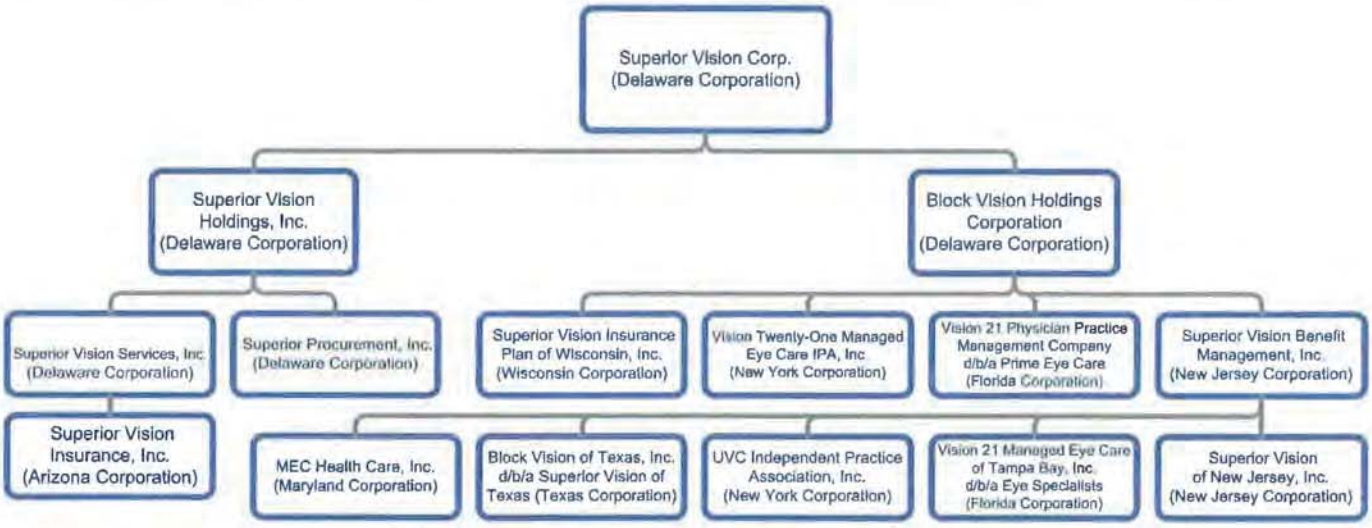

Figure IV.K.56t. Organizational Chart – Superior Vision Benefit Management, Inc.

57. For subcontracted roles included in the proposal, describe the MCO's process for monitoring and evaluating performance and compliance, including but not limited to how the MCO will:

- Ensure receipt of all required data including encounter data.
- Ensure that utilization of health care services is at an appropriate level.
- Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP.
- Ensure adherence to required grievance policies and procedures.
- Ensure that subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service unless a request has been submitted to and approved by MLTC. *8 pages*

For Heritage Health, UnitedHealthcare will assure Nebraska-specific standards are met through oversight and subcontractor monitoring, while meeting provisions of service excellence in accordance with state and federal regulations—and MLTC's contractual needs.

We acknowledge and will adhere to K. Subcontracting Requirements, Items 1-3, to include 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2) and (3). We will implement and adhere to the requests from MLTC, as noted above in IV.K. Subcontracting Requirements #57.

Monitoring Performance and Ensuring Compliance of Subcontractors

We have extensive experience managing subcontractors and evaluating performance and compliance in Nebraska, while administering programs and services to meet MLTC's requirements. For over a decade at the national level, we have garnered a substantial amount of information on working with subcontractors and integrating their services into our programs—and we have learned how to do this successfully. With each experience, we become more educated on what works and what does not. We have taken this knowledge and sought to improve our subcontractor processes continually to strengthen our programs and to offer seamless, well-integrated services for our clients, providers and members.

Our programs focus on achieving high-quality outcomes that address health care affordability and innovative delivery. To achieve this, we work alongside internal affiliate subcontractors and external partners with whom we have strong, well-established relationships. The longevity of our subcontractor relationships has allowed us to build strong oversight programs, understand contractual requirements and apply compliance protocols effectively for both medical and non-medical areas (e.g., behavioral health [BH], claims, fraud, pharmacy, printing, transportation, vision, etc.).

Both subcontractor types—internal affiliates and external partners—have proven their ability to successfully perform delegated activities for Medicaid services and other public sector programs. Over the years, we have applied quantitative and qualitative methodologies in the public sector to assess affiliates and partners, and their abilities to perform delegated services. We have facilitated subcontractor meetings regularly to monitor network operations for BH, vision, transportation and other specialty areas and to discuss and review performance metrics for all subcontractors. Our established oversight and compliance programs have further improved subcontractor performance by identifying any deficiencies and addressing action plans. Our subcontractors are evaluated against criteria, such as national and NCQA credentialing requirements, federal compliance program regulations and established claims processing protocols. Through these approaches, our subcontractor relationships have strengthened and our program processes have aligned, allowing us to provide superior health care services—easily accessible to provider and member.

With our extensive and lengthy experience working with many subcontractors for many service types and adhering to the needs of Heritage Health to ensure efficient and effective subcontractor monitoring, we will offer MLTC an integrated and well-developed Medicaid program.

For Heritage Health, we will assure Nebraska-specific standards are met through oversight and subcontractor monitoring, while meeting provisions of service excellence in accordance with state and federal regulations—and MLTC's contractual needs. UnitedHealthcare will implement and adhere to the requests from MLTC, as noted in IV.K Subcontracting Requirements #57.

To address this, we will apply protocols to address monitoring and subcontractor performance, in accordance with RFP standards, to include but not limited to:

Receipt of All Required Data, including Encounter Data

For subcontractors, we ensure receipt of required data through the use of secure file transfer methods, including but not limited to encrypted emails and Secure File Transfer Protocols. Currently, in Nebraska, encounter data is processed without a subcontractor relationship.

Appropriate Use of Health Care Services

For any subcontracted services involving utilization of health care services at an appropriate level, we will conduct regular medical reviews involving clinical staff with necessary expertise, apply data analytics to review utilization trends, and conduct targeted reviews as needed. For example, we will review, monitor and stratify claims data to identify and respond to inappropriate or unsafe prescribing patterns, medication prescribing and usage trends, and whether prescribers make changes following intervention. We will analyze utilization data and present system solutions to build a plan for managing costs and outcomes in support of the total plan goals. We will provide detailed trend reports tracking drug trends monthly, quarterly and annually.

Delivery of Administrative and Health Care Services

Currently, we assure our administrative services meet or exceed our internal standards and the standards of our current contract through a system of oversight meetings, internal reporting, auditing and accompanying remediation, including the use of corrective action plans (CAPs). We will continue to do this, and we will expand these efforts for the new Heritage Health program to encompass new services. For subcontracted health care services, we assure internal and contractual standards are met through the same methods, with additional clinical measurements and reports.

Adherence to Required Grievance Policies and Procedures

For subcontracted services, we ensure adherence to required grievance policies and procedures through internal monitoring of compliance with required, including contractual, metrics. One method we have used to monitor grievance performance and compliance, and will continue to build upon, is the use of an internal appeals and grievances dashboard. This dashboard allows for tracking and trending of performance and issues, allowing us to target improvements as needed.

Subcontractor Reimbursement Rates

We take steps to ensure that subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid fee-for-service (FFS) rate in effect on the date of service, including educating those involved in soliciting these contracts of this requirement. If a situation arises where a subcontract could contain rates that are less than the published Medicaid FFS rate in effect on the date of service, we will submit the required information for review and approval to MLTC prior to contract execution.

Commitment to High-Quality Services

Our subcontractor oversight process, described herein, is coordinated and transparent. It is designed to enhance lines of communication, accountability and authority, and to provide visibility for senior leadership about performance and regulatory issues, including regularly scheduled meetings with appropriate documentation to demonstrate that our programs are effective. We will construct a similar program to meet MLTC's expectations and to facilitate efficient auditing and monitoring methodologies.

Selecting a Suitable Subcontractor

Over the years, we have matured to become a cautious and educated purchaser of subcontractor support from our UnitedHealth Group affiliates and external organizations. Oversight for our programs begins before a subcontractor is selected. We select only subcontractors who support us in improving the effectiveness and efficiency of service delivery and have a strong reputation for administrative excellence. In accordance with the HIPAA, we enter into business associate agreements with all subcontracted partners to ensure compliance with privacy and security regulations. On selection of a vendor, we mutually agree with our State clients on a method for reporting and measuring performance, based upon state contractual requirements. If a subcontracted partner handles member data or has direct connectivity to our systems, we conduct a thorough data security assessment to ensure full integration with our internal systems and processes.

UnitedHealthcare and its affiliated subcontractors will not enter into a contract with any vendor excluded from participation in a program funded by Medicare or Medicaid, or that has been excluded, sanctioned or debarred from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued by Executive Orders.

For the Heritage Health program, all subcontracts will be supported by a written agreement that specifies the delegated activities and reporting responsibilities, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. Its contents will ensure all contract requirements are met and filed, as required by MLTC.

Tools Used to Monitor and Evaluate Performance and Compliance

We monitor, manage and evaluate subcontractor performance and compliance through several mechanisms to facilitate oversight and to adhere to state contractual requirements. Unless otherwise requested, we will use these approaches for our affiliated entities and for our external subcontractors.

Operating Arrangements

The operating document incorporates the following:

- Description of the required functions and service levels
- Process by which we assess performance
- Recourse we have if service standards or expectations are not met—including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate
- Authority of chief executive officer Kathleen Mallatt and the executive team to drive change

Relationships are constructed, formalized and managed with the consent of MLTC, the subcontractor and UnitedHealthcare. For the Heritage Health program, MLTC has the right to review and approve or disapprove all subcontracts for the services provided under this contract. All operating agreements will conform to the terms and conditions in accordance with this RFP—to include that subcontracts will not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service, unless a request has been submitted to and approved by MLTC.

Signoff Authority

Notifications of any changes to a subcontract that materially affect the subcontract are approved by Ms. Mallatt and presented to MLTC. For this RFP, Ms. Mallatt will provide MLTC with contract documents and amendments for review and approval prior to their execution, in accordance with this RFP.

Monitoring and Governance

We assign local executives as vendor relationship owners (VROs). The VROs hold regular meetings with our subcontractors. Functional area leaders, quality and compliance committees, and executive leadership, together with the subcontractors' staff who perform the services, conduct local monitoring activities regularly. For the Heritage Health program, we will assign our Nebraska executives as VROs for governance purposes.

This regular governance oversight helps to verify that performance metrics are being met and ensures subcontractors' staff, policies and resources are appropriate to meet the requirements of their agreement. Results of these monitoring activities are reported in functional area committee and compliance committee meetings, which include executive leadership reviews. If there are performance issues, these committees recommend actions for the subcontractor to remedy operational issues and maintain compliance with the contract. This may include a corrective action plan, or if necessary, revocation of the delegation agreement.

Regular Operations Meetings

We have regular operations meetings with our subcontractors to promote understanding of interdependencies of each functional area. During these meetings, we provide direction to make sure subcontractors meet quality and effectiveness requirements. Local functional area business owners report on subcontractor performance and measurements. Operations meetings include:

- Feedback and oversight
- Review of policies and procedures
- Training and education
- Key performance indicators monitoring
- Effective lines of communication
- Responding to issues/escalating, as necessary

Performance Oversight Workgroup

The Performance Oversight Workgroup acts as an oversight group that focuses on the qualifications and performance of delegated vendors who provide coordination of BH, physical health, vision and other specialty benefits. The committee consists of the vendor management team, business and account representatives from the vendors and any additional functional members, as necessary. In addition to reviewing the relationship between vendors and UnitedHealthcare, committee responsibilities include:

- Reviewing clinical, quality and operational performance metrics of delegated activities against plan-level targets as outlined by established service level agreements. Areas of review include provider network adequacy, claim and call center operations.
- Discussing any necessary or ongoing corrective action plans, remedial actions or areas for opportunity.
- Discussing any ongoing, open or significant issues related to member challenges.
- Collaborating on opportunities for new strategic initiatives and new clinical programs that can improve capabilities and consistency in all of our vendors' markets where we have agreements.

- Documenting output from committee meetings in written minutes. The workgroup reports vendor issues to Ms. Mallatt, who works with the vendor management and local leadership team, and the subcontractor through resolution of any identified issues.

Medicaid Delegate Oversight Committee

On a quarterly basis, the Performance Oversight Workgroup reports to the executive Medicaid Delegate Oversight Committee (MDOC). MDOC oversees the development and implementation of an effective and efficient delegate oversight program that meets and exceeds our regulatory and contractual obligations to our key stakeholders. These responsibilities include monitoring the integrity of the procurement processes of UnitedHealthcare, with a specific focus on the qualifications and performance of the delegates, the performance of internal contracting procedures, and the compliance with legal and regulatory requirements in the contracting process. The Committee consists of individuals who have responsibilities in the business, clinical, legal, finance and compliance areas.

Quality Review

Minutes, reviews and any corrective actions from these meetings navigate upward through our health plan quality assurance/performance improvement committee structure, to include the Healthcare Quality and Utilization Management Committee (HQUM), and Quality Assurance and Performance Improvement Committee (QAPIC).

Establishing and Enforcing Written Policies and Procedures for Subcontractors

We have many mechanisms and processes in place that encourage and steer exemplary subcontractor performance. Through our work, we developed a formalized process and established policies and procedures—including grievance policies—for auditing and monitoring subcontractors that address their performance, their data and their data submissions. We adapt these policies and procedures to meet each state's individualized needs.

Prior to customization, our policies outline that we measure compliance and performance of all delegated relationships, and we take appropriate action for noncompliant and/or underperforming relationships. They state that "we know and can demonstrate that our vendors and delegated entities are delivering products and services to the same standards, and with the same level of compliance, as if we were delivering the products and services ourselves." Our policies cover regulatory, financial and legal requirements; service level agreement reviews; time frames; timely reporting; audits; subcontractor trends; risk assessment and process improvement. We address auditing and monitoring of subcontractors' performance in our policies, and included in a stringent compliance program, as described below:

Using a proven "Medicaid Delegated Entity Compliance & Oversight Toolkit," the following compliance program elements are included:

- ***Written Policies and Procedures:*** articulates our commitment to comply with all applicable federal and state standards
- ***Designation of a Program Integrity Officer and a Compliance Committee:*** designates a program integrity officer and compliance committee accountable to senior management
- ***Conduct Effective Training and Education:*** conducts effective training and education for employees
- ***Developing Effective Lines of Communication:*** establishes effective lines of communication between the program integrity officer and the organization's employees, and the entities, as appropriate

- ***Enforcement of Standards:*** enforces standards through well-publicized disciplinary guidelines
- ***Auditing and Monitoring:*** establishes an effective system for routine monitoring and identification of compliance risks, including internal monitoring and auditing
- ***Responding to Detected Offenses and Developing Corrective Action Plans:*** sets procedures in place to ensure prompt response to detected offenses and to develop corrective action initiatives in relation to the organization's delegated contract

Risk assessment and quality management oversight duties are written into the policies.

Customizing and Developing Policies for Heritage Health

We will customize and develop procedures and additional policies, as requested by and in adherence with MLTC's requirements.

Policies and Procedures for Non-performance

We hold our subcontractors—both affiliates and external partners—to required performance levels using contracts, internally set standards, incentives, penalties, and established policies and procedures; to include enforcement for non-performance. Our protocols note that if non-performance issues become apparent, the VROs, through their committee work, recommend next steps to the subcontractor to remedy operational issues and maintain compliance with the contract. Formal corrective action plans within set time frames will be implemented, as appropriate, or revocation of the delegation agreement will be enforced should non-performance occur. Examples from our enforcement policies for non-performance include recommendations, contract modifications, penalties and liquidated damages, sanctions, corrective action plans and contract terminations.

Minutes, reviews, related documentation, any actions and/or corrective actions that culminate from noncompliance issues are communicated to the various committees. These items are reported upward through our health plan committee structure, as we reference above.

Monitoring Internal Subcontractors for Compliance

Just as we monitor our internal groups to ensure compliance with laws, regulations and contract requirements, we will use similar processes to monitor both affiliate and non-affiliate subcontractors. These internal control processes allow us to measure our own effectiveness and the performance of our subcontractors.

Audits performed by compliance, business functional areas, plan personnel or other organizational areas are aimed at identifying, preventing and correcting regulatory risk for the organization. Monitoring activities are intended to provide verification that the compliance program is effective and drives routine feedback on organizational performance and compliance with applicable laws, regulations and company policies. Under the leadership of our Nebraska program integrity officer, Timothy Langdon, our compliance infrastructure will expand monitoring activities to meet the expectations of the Nebraska Heritage Health program. They can include internal audits and reviews, internal operational and functional area reporting of key compliance metrics and implementing appropriate corrective action where necessary. Results of those activities are tracked, trended and reported.

We will employ appropriate internal monitoring programs to test compliance with key state and federal requirements, audit performance and report results through the Compliance Committee structure. The monitoring program will:

- Collect, report and compare monitoring results and findings
- Analyze results to identify risk areas
- Conduct focused reviews, where applicable
- Submit reports, as required and requested by MLTC

Results and information of monitoring will be used to identify risk areas and opportunities for improvement. Business units and functions will develop corrective action plans to cure deficiencies identified through the monitoring process, as needed.

The internal audit management team centrally manages, supports, reports and tracks audits and corrective actions for regulatory compliance audits or studies conducted by federal agencies, including but not limited to CMS, Office of Inspector General (OIG) and General Services Office. Audit management tracks, reports and provides support to regulatory compliance audits conducted by state regulatory agencies and state-contracted entities, such as an External Quality Review Organization (EQRO).

This process ensures high-level oversight and accountability for the accuracy and integrity of all reporting and data submissions to MLTC.

Integrated Subcontracting—Seamless Experience for Members

All of our affiliated subcontractors belong to the UnitedHealth Group family. We share the same infrastructure. We provide a seamless experience for our members. Our selected non-affiliate subcontractors work alongside our affiliates and address other necessary and required functions (e.g., identification cards, transportation, etc.), providing full health care benefit services and a comprehensive program.

For Nebraska, our local leadership team, led by Ms. Mallatt, will oversee internal affiliates and external non-affiliates, providing MLTC with one partner who draws from local experience and who leverages UnitedHealthcare's broad range of capabilities. Placing an established resident team and an identified leader over all subcontractor functionality and activity allows for centralized communications and reciprocal information exchanges that promote smooth program operations; and address issues. This provides heightened integration and smoother subcontractor relationship patterns, and a user-friendly health care experience.

In sum, we offer a locally based program with an entirely integrated group of affiliates and non-affiliates, while accountability and compliance are held at the local level with local leadership and local oversight.

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IV.L. Care Management

58. Provide a comprehensive discussion of the MCO's care management program, including:

- Coordination of services using person-centered strategies.
- Interventions focused on the whole person.
- Management of co-morbidities.
- Incorporation of best practices for behavioral health.
- Member engagement in self-management strategies.
- Social determinants of health, including risk and protective factors for behavioral health concerns.
- Identification and tracking of members whose clinical conditions or social factors place them at an increased risk for circumstances necessitating a higher level of care management services.

Provide case studies and experience from other states illustrating the MCO's ability to successfully address community differences in its care management approach.

UnitedHealthcare Care Management Program

Person-Centered Care Management
Our care management program personalizes engagement, drives coordinated interventions and enables monitoring and measurement—and the whole approach is built on a foundation of data and analytics designed to understand and address the needs of the whole person.

The current health care delivery system in Nebraska must transform from one that responds to the acute needs of our members to one that anticipates and shapes patterns of care for specific populations, including the new populations and services (behavioral health [BH] and pharmacy) being carved into the Heritage Health program. As part of this evolution, we are implementing, innovating and evolving our care management program through partnerships with our members, providers and MLTC. We are actively drawing upon UnitedHealthcare's nationwide commitment of experts and resources to develop enhanced care models and tools that accelerate the re-orientation of the delivery system around an integrated, holistic approach to care and services.

Our integrated, **whole-person centered approach** to care management intensifies our efforts to engage and empower our Nebraska members at every opportunity and touch point. With oversight from our medical director/chief medical officer Michael Horn, M.D., our care management program led by case management administrator Ms. Barbara Palmer, RN, MHA, BH clinical director Dr. Charles Freed and BH manager Mr. Von Grubbs along with our pharmacy department, led by pharmacy director Jeanne Cavanaugh, Pharm.D., will provide a comprehensive suite of care and services to members enrolled in the Heritage Health program. We assign resources based upon member **whole-person needs and self-management opportunities** to improve health outcomes and reduce disparities in health outcomes among different subgroups of the Nebraska population. We have already expanded our statewide capacity for meaningful integration of and access to physical and behavioral health care services. Based upon members' individual profiles of health risks, social factors and health goals, we wrap appropriate levels and scope of care management services, education and resources around each member to engage and empower them toward positive health behaviors and outcomes. Our Heritage Health care management program will incorporate BH (includes resilience and recovery) and pharmacy services in addition to physical health/wellness and environmental, social, family and community services and supports. Our program embraces and respects spiritual/cultural beliefs and resources.

Our data-driven care management program focuses on coordination and collaboration across many groups, including members and their families, PCPs, specialty providers, BH clinicians, various state agencies (and their case managers), stakeholders, other MCOs and community-based organizations. A collaborative approach assures a seamless and coordinated care experience for members, with a focus on the diversity of care settings, on the member/family's role in care, management of **chronic conditions and comorbidities**, and on health maintenance. Integrated care management, utilization management (UM) and quality improvement promote standardization using best practice, vigorous data analysis and data sharing (for example, through scorecards and reports) to drive cost-effective care, improved member outcomes and enhanced member satisfaction.

Our health information technology (HIT) and decision support tools (DST) provide a structure for our provider partners (includes Accountable Care Communities [ACC]/patient-centered medical homes [PCMHs]) and for us to improve access to care; improve communication and information sharing; support continuity of care, care transitions and discharge planning; and enhance collaboration and teamwork. We use system-wide, integrated processes to systematically gather, analyze and share data, enabling internal staff and external providers to identify care opportunities by member and provider. Data review leads to care coordination initiatives and activities, including direct interventions and actions with members and providers to address care opportunities, resulting in improved outcomes and costs.

CommunityCare, our care management platform, integrates a member's acute care; preventive care; chronic disease management; and medical, behavioral, environmental and social needs into a comprehensive electronic record. It is the central hub of communication, connecting providers and the member's care team with member data. CommunityCare gives providers a full view at the population and member level and identifies evidence-based gaps in care. Data analysis related to social determinants allows us to quickly assist members and develop population health-based programs, such as those targeting employment or housing, and interventions based upon a community's needs.

Coordination of Services Using Person-Centered Strategies

Our model of care is person-centered, comprehensive, coordinated, accessible and focused on integration of physical, behavioral, environmental and social needs through comprehensive care management, UM and quality improvement. We empower our network providers and our staff to adopt and implement those philosophies and strategies. Our framework supports each of the key components of our person-centered care model as shown in the following Table IV.L-1:

Table IV.L-1: Care Management Strategies

Person-Centeredness
In the context of care management, person-centeredness means: ▪ The member/family has autonomy to direct care and services. ▪ The member's wishes and preferences are sought and respected, including the individual in the member's natural supports or community who should be included in care planning. ▪ Goal-oriented, person-centered counseling assists members in making decisions about their care and identifying member-specific goals. ▪ Discussions promote a collaborative, interactive exchange of information that include options, risks and benefits and discovery of a member/family's preferences, personal and social circumstances, values and goals. MSAs, CHWs, BH specialists, care navigators and care managers are trained to use motivational interviewing to develop member goals based upon the aspirations, preferences and cultural background of a member/family—understanding that our member is the best guide for identifying his/her goals. Motivational interviewing is an evidence-based approach that works on facilitating and engaging the inherent motivation within an individual to change his/her behavior. It is a conversational approach designed to meet individuals where they are on the

Table IV.L-1: Care Management Strategies

continuum of readiness for change and to help them identify their readiness, willingness and ability to change and to make use of their own change-talk and commit to meaningful outcomes.

- A member's plan of care becomes a living document of personalized and coordinated care as well as support and services that recognize the strengths and abilities of the member, enabling him/her to live a fuller life. It is housed in CommunityCare and includes **interventions that focus on the whole person** and that increase a member's access to preferred care settings, activities and community.
- Health risk screening and assessment strategies produce a significant understanding of an individual's strengths, preferences and communication capabilities.
- HIT facilitates person-centeredness by enhancing communication, information exchange and shared decision-making. With member consent, all care team members have access to the member's centralized record, including assessment results and the plan of care.

Comprehensive and Integrated Care

Comprehensive, integrated care includes **best practices** for physical health, BH, social and environmental needs.

- Care team members use **medical and BH evidence-based practices** and leverage other best practices gained through experience. They use **decision support tools** (DSTs) to create custom and ad hoc reporting and use data analytics to monitor and track member outcomes, gaps in care and **members whose clinical conditions or social factors place them at an increased risk for needing a higher level of care management services**. HIT facilitates automated notifications to members (schedule follow-up appointment) and providers (member admitted to ER or inpatient).
- In Nebraska, we use an Access to Care assessment to assess member risk related to **social determinants to address whole health needs**. We are developing and will deploy in the future a second-generation assessment, which will provide robust data analytics on social determinants.
- By integrating **pharmacy benefit management**, we anticipate achieving cost savings while at the same time providing highly integrated care to maintain the health of Heritage Health members. As needed, we will engage a pharmacist on a member's integrated care team and conduct medication reconciliation, as needed, to avoid medication errors such as omissions, duplications, dosing errors or drug interactions.
- We use *Healthify* and our staff's knowledge of local community-based resources to **help members with unmet social needs connect to local community resources**. In Nebraska, we are in the process of sharing the *Healthify* tool with FQHCs and community-based organizations, which help them connect individuals to a database of culturally matched community support and community-based organizations to help remove barriers to care. Members have the ability to search for resources through the community resource directory on *liveandworkwell.com* and through the Network of Care website (offered by the DHHS Division of Behavioral Health) for BH resources related to prevention, treatment, support groups and advocacy tools.
- Unmanaged stress and burnout can negatively affect the care provider/member relationship, impairing their ability to remain calm, to be fully present and attuned to an individual's needs, and may negatively impact decision-making. We will offer our **Mindfulness for Caregivers and Social Workers program**, a unique program proven to lower stress, enhance well-being, build resilience and promote therapeutic effectiveness. The Moment Health Portal supports program delivery with access to course materials and resources to support a mindfulness practice.
- Poor financial health can contribute to poor physical health. **UnitedHealthcare myMoney Connect™** is an innovative mobile app and online solution that provides a reloadable prepaid debit MasterCard to Medicaid members with an integrated wellness rewards program, enabling them to earn incentives for taking steps to improve their health. By helping to motivate positive health behaviors and closing gaps in care, myMoney Connect is an innovative payment program that improves health outcomes and enables state Medicaid programs to reduce costs. This program provides an important resource to help people improve their overall health by enhancing their financial health.

- We are collaborating with the **Youth Emergency Services (YES)** program, one of the leading Omaha organizations assisting homeless and at-risk youth and young adults. YES provides street outreach, emergency shelter, transitional housing and maternity housing for runaway and homeless youth that need access to services. YES provides critical resources to empower these individuals to

Table IV.L-1: Care Management Strategies

become self-sufficient, helping with immediate needs for food, shelter, clothing and safety. Our BH peer support specialist, BH care managers and CHWs will be part of the collaborative team working with YES. This collaboration will enable us to influence behavior with educational efforts for foster youth who are aging out of the system. By collaborating with YES, we can reach a vulnerable population and ensure needs well beyond clinical are met. We are committed to providing YES with educational resources (such as UnitedHealthcare On My Way™) to teach youth aging out of foster care how to navigate the complex social support systems, including health care.

Accessible

Access to care/services is crucial to a member's improved health and well-being. Key strategies are:

- Robust provider network, including contracts with FQHCs, RHCs and ACC/PCMHs
- Member access to same-day or after-hours appointments/clinical consultation call back
- 24 hours a day, seven days a week NurseLine℠ (includes online Nurse Chat) and BH crisis line
- Support expansion of telehealth, including telepsychiatry, particularly in the rural and frontier areas (includes tribal populations) to eliminate health disparities caused by access to care issues
- Availability and promotion of member portals and member engagement apps

Coordinated

- Care is coordinated across the health care delivery system, including providers, specialty care, ACC/PCMH, hospital, residential treatment centers, community-based organizations, schools and state agencies and spans multiple programs, such as Medicare, foster care and home and community-based services (HCBS) waiver.
- We use **multiple data points to stratify member populations** to identify individuals who can benefit most from care management. This includes members needing minimal support (healthy kids) to medium support (pregnant moms) to members with the highest cost/utilization, such as members with complex health care needs, those with special health care needs and high-risk members participating in multiple programs and needing help navigating the health care delivery system.
- Our **predictive modeling tool (Impact Pro)** stratifies members by risk level to determine the level of intervention designed to maintain and improve health from a member services advocate (MSA), care navigator, community health worker (CHW) or care manager. Impact Pro also identifies members with BH conditions, including members with co-occurring, mood and psychotic disorders, considers the impacts to a member's risk based upon comorbid conditions and promotes a holistic approach to member care. Providers and care management staff track our members through various touch points to note when members complete checkups and close their gaps in care. On a monthly basis, Impact Pro synthesizes member-integrated data and develops individualized risk profiles. This helps our care management team identify a member who is trending toward a higher or lower level of care, which may prompt a reassessment. Reassessment results may be used, along with other data, to re-stratify a member in a lower or higher level of care and may prompt an interdisciplinary care team to adjust a member's existing plan of care. Supplemental health risk assessments help us channel those with special health needs into care management programs and other targeted services, as needed.
- Person-centered, whole-person **interventions have defined durations** (for example, 30 days) that will be completed by the member, the care manager, another member of the care management team or a member of the interdisciplinary care team (e.g., PCP, BH provider). For example, an intervention to be completed by the member might be *"I will discuss medications and diet to lower my blood sugar,"* or an intervention to be completed by the care manager might be *"Educate member on importance of adhering to diabetes medication and avoiding high-sugar foods."*
- Application of **evidence-based guidelines** to integrated data sets to identify preventive and chronic care opportunities, reduce variations in care and to promote the delivery of high-quality, **evidence-based** health outcomes.

Integrated Care Management, Utilization Management and Quality Improvement

- Our clinically integrated health system focuses on a **holistic care experience** with a focus on care transitions, care advocacy, high-risk care management, **comorbidities** and chronic disease management to address the full spectrum of care. We manage a member's conditions and comorbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues. Care managers provide chronic care/disease-

Table IV.L-1: Care Management Strategies

specific education to members for all comorbidities, based upon identification of needs through population-health risk stratification.

- Integration promotes standardization using **best practice, vigorous data analysis and data sharing** (e.g., through scorecards) to drive cost-effective care, improved member outcomes and enhanced member satisfaction.
- **CommunityCare,** our care management collaboration platform, provides PCP information, member Medicaid ID, a record of each service event, appointments, a record of all immunizations, a listing of the member's durable medical equipment (DME) along with the ability to capture notes and store attachments. CommunityCare integrates evidence-based medicine gaps in care and hospital admission, discharge and transfer (ADT) messaging for review by the member's care team. It allows providers to input information about interactions with members, such as post-ER discharge follow-up and care. CommunityCare facilitates information sharing and communication. CommunityCare includes the Accountable Care Population Registry, which offers a comprehensive view of services used by any given care population. Using the member view within Population Registry, providers can view a member's clinical history, while the population view lists members in a provider's practice who need specific follow-up (e.g., preventive or chronic care services) and processes/steps for specific follow-up. Using CommunityCare, the care team can identify a member's gaps in care, including needed EPSDT services.
- Through our UM program, we gather quality measures, prior authorizations, clinical and claims data, and data from providers and subcontractors. Using reporting, dashboards and scorecards developed from data gathered and analyzed by our SMART data warehouse, our staff monitors and manages overutilization and underutilization of services, gaps in care and medication adherence.
- Evidence-based decision support tools and data analytics support analysis and performance monitoring through scorecards and reports. After implementing person-centered interventions, we rely on tracking and monitoring processes to measure the impact of the care management interventions. Our leadership team uses the results of performance measures, member satisfaction surveys and a broad range of clinical and non-clinical data to attain our overall quality improvement goals and performance.

We address person-centered member needs through integrated care management teams. Beginning with the welcome call for new members, our MSAs administer the health risk screening process for members who have not already completed this screening online. The care team uses screening results to determine a member's initial risk level and to begin early identification of member needs and barriers to care. We have learned the value of providing members/families with a primary point of contact that has the appropriate skills and expertise to support a positive member experience. Our care management team includes MSAs, PCPs, CHWs, care navigators, care managers and peer supports who assist our members through the care continuum by:

- ***Primary care providers*** provide comprehensive primary care for our members as part of an integrated delivery system that includes care coordination, use of HIT/DST and a team approach to care. The member's PCP is an active participant on a collaborative interdisciplinary care team, which also includes the member/family, care manager, specialists and others. PCPs offer member/family education, referrals to specialty care and clinical consultation to the care team.
- ***Advocate4Me MSAs*** are key participants in member education. They answer our members' non-clinical questions efficiently and accurately. Our MSAs will receive training on Heritage Health benefits and priorities, including the new BH and pharmacy benefits and requirements as well as the unique new populations we serve. Frequent reinforcement of that training keeps those objectives top of mind for every MSA. For example, we train MSAs to know that achieving compliance in EPSDT screenings is a primary goal, therefore, in each interaction with the member, MSAs verify:
    - EPSDT-eligible members have a PCP

- The member has seen his/her PCP to receive all EPSDT-related preventive care, such as well-checkups and immunizations

The MSAs support closing gaps in care and eliminating barriers to care by assisting with scheduling member appointments with a PCP while the parent/guardian is on the phone.

- ***Community health workers/BH specialists*** are non-clinical staff who collaborate with care managers and care navigators to locate and engage difficult-to-find members, conduct an Access to Care screening and provide targeted health education for members who may have challenges interacting with the health delivery system due to language or cultural barriers. On a system level, they extend the reach of providers and care teams into underserved communities by facilitating a means for culturally appropriate, back-and-forth communication. BH specialists are CHWs who have BH experience and work with members having BH conditions, including **comorbidities**. Through personal and face-to face-engagement with our members, CHWs leverage their local knowledge of the community and follow up with community organizations, providers (including pharmacists and transportation providers) and community groups to get updated contact information for our members. They use the Access to Care assessment results to understand a member's social determinants of health and barriers to care, such as housing, access to food, transportation, employment assistance, energy (e.g., assistance with power bills), support groups, childcare, clothing or safety. They use *Healthify*, a highly effective and proven Web-based tool that enables real-time access to local community resources to support our members. They can access *Healthify* by mobile phone or tablet. Once identified, CHWs document member-specific issues in a member's centralized record and helps the member to overcome barriers to health. CHWs and BH specialists help members develop *"I will statements"* for members who have needs but who are not high-risk. A care manager develops a plan of care and an interdisciplinary care team for members who are high-risk and have intensive needs. Our CHWs operate under the supervision of our care managers and actively participate in the care planning process.
- ***Care Navigators*** are a part of our population-focused, person-centered care model. Located in communities across Nebraska, they coordinate services for our specialized populations who need additional support, including members participating in an HCBS waiver program, members eligible to participate in Medicare and Medicaid, and special needs populations, such as the aged, blind and disabled (ABD), intellectual and/or developmental disabilities (I/DD), foster care kids and Katie Beckett.

  Care navigators will outreach to new members who have been identified as having special needs through the enrollment file or through other information, such as health risk screening or predictive profiling. Care navigators engage with, advocate for, coordinate and collaborate with members/families, care teams, treating providers and others involved in a member's care. They provide care coordination services including completing an assessment that uses best practice techniques, such as motivational interviewing, to solicit member/family input and identify unmet physical/behavioral needs. They refer members to the most appropriate provider(s) for their condition and coordinate care in a holistic manner. They actively coordinate services with state-managed services such as foster care case managers and LTSS case managers to ensure holistic support of these individuals.
- ***Complex Care Managers*** provide care management for members with high-risk/high-utilization for **complex care needs, comorbidities and co-occurring conditions.** Based in Nebraska, field-based care managers will work directly with members/families to provide person-centered care for those who have complex needs. Care managers engage with, advocate for, coordinate and

collaborate with members/families, care teams, treating providers and others involved in a member's care (e.g., caregivers). They assist members, families/representatives with referrals to BH, physical health, environmental, and social supports and services. Care managers provide proactive follow-up and condition-specific education, along with monitoring a member/family's needs and the effectiveness of the plan of care. As necessary, they schedule aftercare appointments, attend appointments with families at facility/provider offices and in the home to assure attendance at scheduled appointments. They coordinate with physical and BH providers, assist in the development of a plan of care and educate the member/family on treatment/medication issues and adherence. With member/family consent, they facilitate information exchange between PCPs, specialists and other providers (e.g., substance abuse services and social services).

Interventions Focused on the Whole Person

Population segmentation, early identification and risk stratification allows individuals to be placed into care models best suited for each population and the individual's risk level. Care management activities are driven by the member's risk level and complexity. Person-centered care comprises a set of interventions focused on the whole person. It is designed to maintain and improve health at the member level from low-risk, healthy members receiving guidance on wellness and preventive care to moderate-risk with members having one chronic condition receiving disease specific information/support to high-risk members with special health care needs or chronic, complex or co-occurring physical or behavioral health conditions receiving high-touch interventions for their needs. We have established processes to recognize and support members whose condition necessitates a move from one risk level to another. Members in all risk levels and populations are entitled to basic/low-risk care management services.

High-Risk Level – Complex Care Management. We provide high-risk care management and intensive supports for members with comorbid and complex conditions. Interventions are based upon Heritage Health program requirements and designed to improve health outcomes. This approach integrates medical, BH, social and environmental supports and services and provides intensive supports to members with comorbid and complex conditions, including depression, cognitive deficits, physical limitations and psychosocial issues. High-risk care management provides integrated care management through a care team that includes a high-risk care manager (RN or BH clinician), CHWs and care navigators depending on the member need. Care managers consult with one another to address specific member needs related to comorbid conditions. They follow established processes to coordinate BH care with medically necessary services, facilitate communication and information sharing between a member's PCP and BH service provider and promote best practices for delivering BH services in a primary care setting.

Medium-Risk Care Management. The first point of contact for a member at moderate risk may be a field-based CHW. Residing in the community served, CHWs provide high-touch, in-person interactions with members, acting as a liaison to assure a member accesses appropriate care. They conduct social assessments and member education. Clinical consultation with an RN or behavioral clinician care manager is available to CHWs as a part of our interdisciplinary care team approach. Members demonstrating an increased risk of transitioning to a higher care management level may be referred to a high-risk RN or BH care manager, depending on the member's primary area of need (physical or behavioral).

Basic/Low-Risk Care Management. All members are entitled to receive basic care management services, including:

- Access to the UnitedHealthcare Healthy First Steps® maternity program

- *Advocate4Me*, NurseLine (includes Nurse Chat, see Figure IV.L-1) and BH crisis line
- Post-hospital transition and discharge management
- Connections to community-based services and supports via *Healthify*
- Provider access and/or identification
- Assistance with transportation and appointment scheduling
- Medical and BH utilization management and written materials
- Mobile applications and online resources that promote health and wellness education
- Member-engagement and **self-management** (e.g., UnitedHealthcare Baby Blocks™, *KidsHealth*, *UnitedHealthcare Health4Me™* and *liveandworkwell.com*)
- Activities that identify and close gaps in care or eliminate access to care issues

Figure IV.L-1.

Care Management for Special Populations. Members who need additional support, including individuals who are medically fragile, individuals with special needs (including the ABD, I/DD, dual-eligible, foster care and Katie Beckett populations) and may be participating in multiple state programs and may have a state-assigned case manager. A care navigator will contact these members, complete a health risk screening and identify additional needs including coordinating with their state-assigned case manager to ensure holistic management of the individual. Care navigators have training and knowledge of the needs of special populations and their covered benefits, including Medicare and HCBS waiver benefits. By building a relationship with the member, they can help members and their families/caregivers navigate program benefits and assist members with questions across all the programs (e.g., HCBS, Medicare, foster care) that support their care. Care navigators become the member's contact with the health plan. They can explain processes to members, for example, how to get a new ID card. Care navigators, like care managers, adhere to established performance standards for calling back members and conducting screening or assessments on a timely basis. Care navigators will collaborate with BH clinicians and work with our delivery system to support complex medical or behavioral needs.

Figure IV.L-2 illustrates our Nebraska care management framework and workflow.

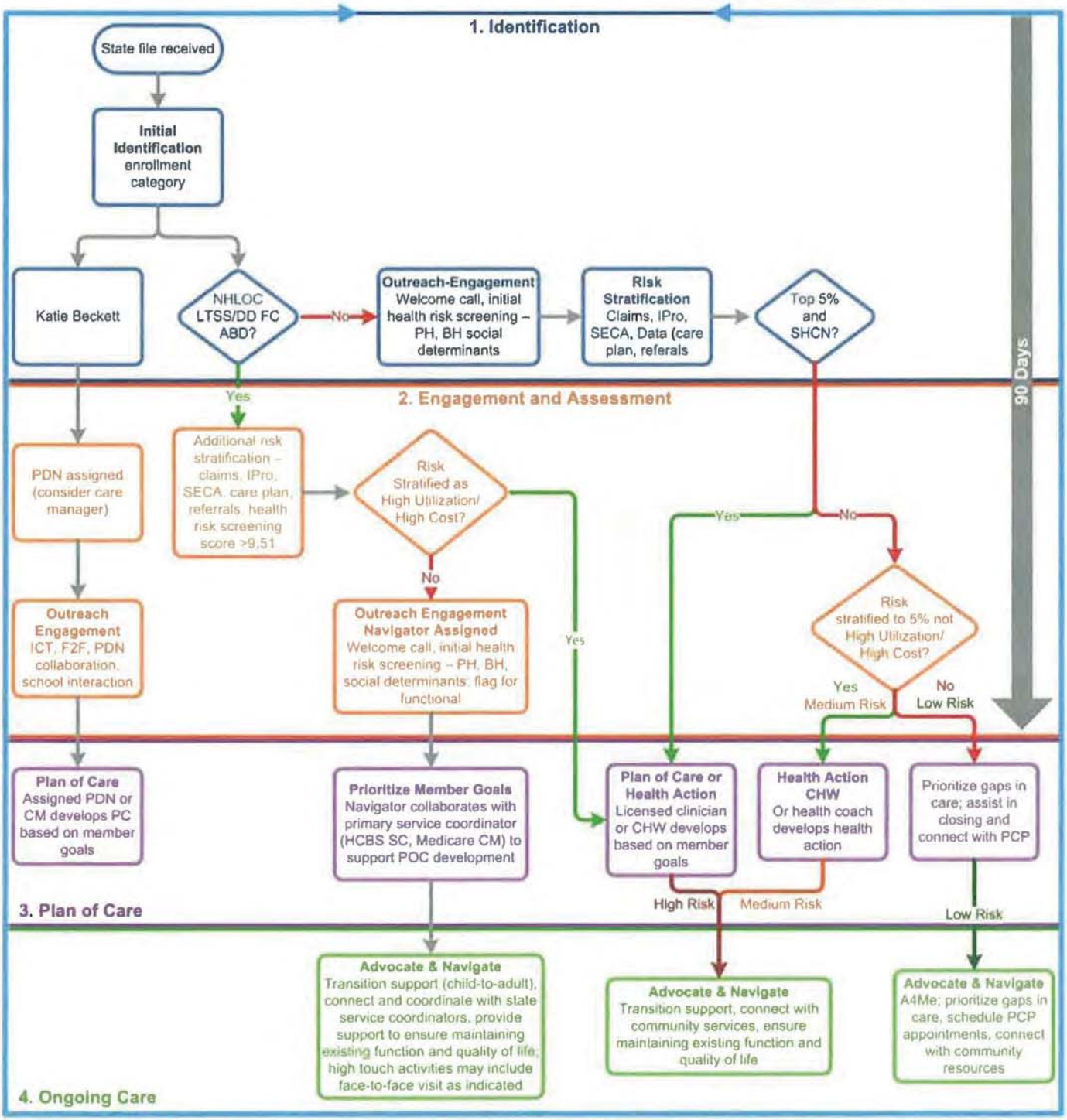


Figure IV.L-2. Nebraska Care Management Framework and Workflow

Management of Comorbidities – Maximizing Delivery of Integrated Services

Nationally, we serve approximately 62 million people through mental health/substance use disorders programs and global well-being solutions that address the emotional health needs of consumers. Our programs span BH conditions ranging from comorbid depression/chronic illness to complex serious

mental illness, substance use disorder (SUD) and co-occurring disorders. We offer integrated Medicaid programs in 21 states. These programs include members with complex care needs and include dual-eligible members; long-term care; ABD; adults, children and adolescents with developmental disabilities; high-risk maternity with SUD and members with serious mental illness (SMI). Our programs integrate person-centered planning, predictive modeling, evidence-based clinical outcomes management, care coordination, family and peer support, and access to the nation's largest network of BH providers.

We know from experience that many individuals with the most complex conditions suffer from both medical and BH conditions and an integrated approach to coordinating and delivering health care services is critical to management of their health. Key features of our approach to maximizing physical and BH integration include:

- An integrated (physical and behavioral), whole person care coordination model and an integrated UM program that is member-focused and facilitates appropriate access to physical and BH services.
- Coordinating care through our integrated, community-based care teams, comprising an RN and licensed BH clinician, who consult with one another to address the needs of members with comorbid conditions.
- For individuals with BH conditions who could be well-served by community-based BH integration, CHWs provide continuous, supportive care beyond the clinic encounter, navigating community support systems and engaging family and relationship support systems.
- Implementing tools, such as Impact Pro, which identify individuals with behavioral or comorbid (medical/behavioral) health conditions.

A unique feature of our predictive modeling system, Impact Pro, is its ability to identify specific diagnoses and risk categories and synthesize multiple comorbidities, including BH issues and demographic information, to provide a more accurate risk analysis. Impact Pro considers the impacts to member risk based upon comorbid (medical/behavioral) health conditions. Impact Pro predicts BH risks and expected costs separately, ensuring BH risks are not masked or eclipsed by more costly physical health comorbidities during population risk analysis, which promotes a holistic care approach. Impact Pro looks for service utilization patterns and characteristics that allow us to identify members with BH conditions, including members with co-occurring, mood and substance use disorders. We can customize Impact Pro reports for specific cohorts (e.g., under 18 years) and certain diagnoses, allowing us to target BH interventions for a given group.

Recognizing that more than half of BH issues are treated in primary care or other non-BH settings, we give health care professionals our *Behavioral Health Toolkit for Health Care Professionals*. It guides health care professionals to our BH clinical practice guidelines and evidence-based approaches, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), and provides access to our BH advocates for help accessing care for members who screen positive for a BH condition.

Incorporation of Best Practices for Behavioral Health

Incorporation of best practices for BH promotes recovery and resiliency. Under the direction of Dr. Horn, Dr. Freed and Mr. Von Grubbs will execute the goals of our integrated approach to medical, behavioral and pharmacy care and services. They will actively participate on our medical management team and assist Dr. Horn with clinical and policy decision-making. The BH clinical director will oversee and manage the BH clinical program, BH UM protocols, implementation of BH level of care guidelines, and BH-related care coordination activities. Our new, **in-state recovery/resiliency manager** will work with

providers, advocacy groups and member organizations, our staff and others to shape care. Our BH staff also will include **two peer support specialists.**

Best practices for BH include peer support services and *liveandworkwell.com* (available through *myuhc.com,* see Figure IV.L-3), our award-winning online BH resource and information member website. Evidence-based training for members, their families/support systems and providers includes **Mental Health First Aid** training to give individuals a basic understanding of the warning signs and what to do if the individual encounters someone who may have mental health issues, including SUD comorbidity. Since 2010, we have provided more than 83 Mental Health First Aid trainings nationwide. We will offer **Question, Persuade and Refer (QPR)** suicide prevention training (with training modules customized for Native American populations). **Seeking Safety** courses will deliver coping-skill therapy to help children, youth and adults attain safety from trauma or substance abuse. Our care managers and peer support specialists will assist members to complete personalized **Wellness Recovery Action Plans (WRAPs)** and crisis plans.

Figure IV.L-3.

Care managers and members will have access to other resources that promote recovery/resilience with members through the *liveandworkwell.com* portal, including recovery toolkits, activation tools, the Recovery Library, peer Just Diagnosed videos, the REACH Grid, self-paced cognitive behavioral therapy for prevalent BH disorders, and the Recovery Planning Tool. Recognizing the rising rates of suicide and depression among teens, the portal offers teen resources, such as the Teen Happiness Center (a strengths-based teen-specific site, focused on positive emotions and relationships) that has health and wellness information specifically targeted to teens. Members can track their recovery progress in CommunityCare with the Maryland Assessment of Recovery Scale (MARS)-12, a 12-question recovery measurement tool that with their provider, caregiver or our staff, a member can assess how he/she is progressing in his/her own BH recovery.

As an innovation, we will provide a link for Heritage Health members to **Common Ground**, an interactive Web-based resource that enhances provider-member communications and supports BH **self-management**. Common Ground enables the member to create a recovery goal or power statement, on which to focus their BH treatment, helping him/her to remain motivated during the treatment period. After establishing a recovery goal/power statement, the member completes a questionnaire that focuses on his/her condition, treatment expectations and any concerns. Information from the questionnaire electronically transfers to the member's record and is available to the provider prior to, or at the beginning of, the member's first appointment. This helps the provider understand and assess BH issues requiring treatment. The provider can recommend self-help tools and education programs available within Common Ground to support the member between appointments.

Member Engagement in Self-Management Strategies

Our integrated, person-centered approach calls for us to assist our Heritage Health members with their self-management skills and education and to promote other strategies that empower and engage members to manage their own care. We fully recognize the benefits of promoting personal responsibility and self-management skills and support this effort with a progressive, strategic approach. We have partnered with Nebraska's communities for almost 20 years and applaud the MLTC's efforts to nurture and promote

personal responsibility. Our approach starts with building trust and empowering members to make informed decisions. We provide:

- ***Empowerment through Education:*** We promote responsibility and self-management through education. Our strategy begins with educational opportunities that address member needs with proven solutions, such as understanding their benefits, accepting their preferences and offering care decision support data and information about their preventive care needs (or gaps in care) and chronic conditions. We guide our members during onboarding through welcome calls, printed materials, and member and community outreach activities. We facilitate communication with a member's care team and personalize preventive services, disease management programs and notifications about their coverage. Educational strategies include direct contact, chronic disease self-management, dynamic plan of care, recovery-oriented WRAP plans, prevention and wellness programs, educational brochures/newsletters.
- ***Engagement through Incentives:*** We create and implement incentive programs to help members engage in healthy behaviors and develop/practice self-management skills. Incentives include those available through Baby Blocks and, in Nebraska, we offer a mammography screening $25 gift card incentive pilot program to increase breast cancer screenings, which has increased screenings by 8 percent after offering this incentive.
- ***A Supportive Digital Member Experience:*** Our ever-evolving digital technology serves as a common thread across our programs and initiatives to facilitate access and personal responsibility wherever and whenever it is needed. This includes tailored digital communications, mobile and Web-based tools that provide easy access to member support through digital channels, and through shared access to data, empowering our members to make informed and confident choices. Our digital member experience includes *Health4Me*, On My Way™, *myuhc.com*, *KidsHealth.org*, *liveandworkwell.com*, *Connect4health* health and wellness text program and Twitter for pregnancy health/wellness information.

Self-management strategies help members to develop the knowledge, skills and confidence they need to make informed decisions, take appropriate action and manage circumstances that impact their health and empower them to take charge of their health.

Social Determinants of Health/Risk and Protective Factors for Behavioral Health Concerns

Members' health care needs are often complicated by factors that are not health-related. These factors, often broadly referred to as social determinants, create barriers to achieving optimal care. Addressing these factors, as shown in Figure IV.L-4, is often key to ensuring improved quality and outcomes, and experience for our members. We identify our members' needs, help them address those needs and incorporate this knowledge in care plan development. Addressing things like access to healthy food and safe housing become cornerstone to improving the health for many of our members. Our care managers and CHWs use innovative solutions, such as *Healthify*, to identify available resources within a member's community. By hiring CHWs from the communities in

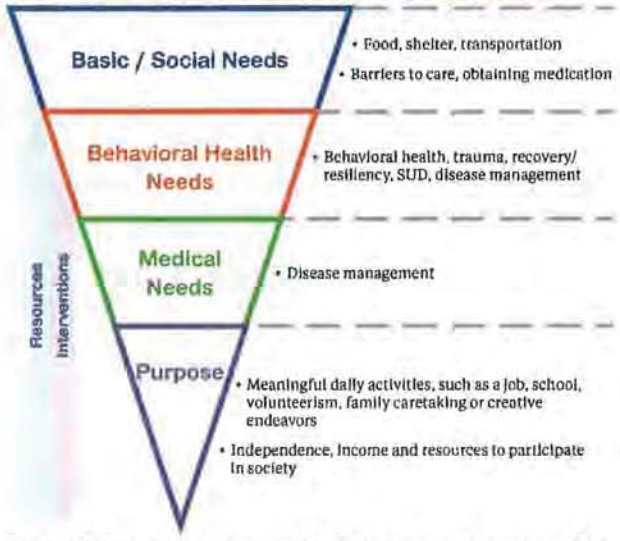


Figure IV.L-4. Inverted pyramid. By helping our members find ways to meet their basic/social needs, we improve their ability to focus on their health and overall well-being.

which our members live, they further support the alignment of services to address social needs. Our care managers also understand the unique challenges social determinants can create for individuals with BH concerns. Addressing safety and security and basic needs allows members to focus on addressing their behavioral health.

Our health risk assessment process provides a holistic and detailed view of the member, including his/her physical and BH risk and protective factors. Risk factors can increase an individual's chances for substance use, while protective factors can reduce the risk. The assessment process captures information about risk factors, such as medical risk factors or genetic vulnerability; gender; physical or emotional trauma; pregnancy and birth complications; educational level; environmental triggers; smoking; family burden; low socioeconomic status; serious behavioral and emotional problems in childhood; social dysfunction; substance use; caregiver burden; and psychosocial risk factors.

We have significant success in improving health outcomes and quality, however we know there is much more to be done to support our members' social needs. In support of this, we developed **myConnections,** which is specifically **focused on addressing social determinants** to improve our members' health as well as the health of their communities. As part of our myConnections solution, we have customized a pilot to address the unique needs of Nebraskans living in rural parts of the state. We will **deploy a mobile myCommunity Connect** to be a resource center for our members. At myCommunity Connect, members will be able to be assessed for services for which they are eligible—outside of Medicaid—and will be referred to those services in their own community or as close by as available. This unique rural solution will bridge gaps for our members that are far more difficult to overcome in rural areas of the state.

myCommunity Connect will be key to supporting the BH in rural areas of Nebraska where access to services is more limited. By bringing myCommunity Connect to communities, we will leverage the strengths of our CHW model and establish a robust approach to address the behavioral health needs of our members. This unique pilot will enable us to identify all available services, link those services to needs as well as identify gaps in social services that may exist that stand as barriers to addressing whole person health—including BH. **myCommunity Connect will be supported by a robust data tool known as myData**. myData allows us to evaluate programs for which an individual consumer is eligible and make referrals to ensure that he/she is supported in a holistic fashion. The ability to help identify programs for which a member is eligible is combined with the capabilities of *Healthify* in myData to create a comprehensive referral system. We are also able to track referrals to determine efficacy of the services. This referral and efficacy information can also be shared with community service providers to help them understand the needs of individuals within their service area and how to better align resources with needs.

Identifying and Tracking Members Who Need a Higher Level of Care Management Services
We identify, monitor and track members whose clinical conditions and/or social factors place them at risk for needing a high level of care management.

We engage members whose health risk screening results indicate possible barriers to care, conduct additional assessments to understand their social determinants of health and barriers to care, such as housing, access to food, transportation (e.g., to the provider, pharmacy or WIC office) or safety and then connect the member to needed services and supports.

We focus on the health outcomes within a group of individuals with a goal of eliminating health disparities caused by social determinants of health and affected by socioeconomic factors. This empowers our staff and network providers to identify and connect individuals to community-based organizations that provide assistance with social services, such as food (WIC, SNAP and food pantries), shelter,

employment and wellness programs and support groups targeting specific diseases or conditions, empowering members to manage their health care. Such groups of include:

- Heritage Health rural/frontier members (removing barriers and improving access)
- Members identified as pregnant (prenatal care and supports for women with high-risk pregnancies)
- Children with EPSDT gaps in care (promoting well checkups)
- Native American tribal population (overcoming trust issues and access to care challenges and educating tribal leaders about MCO processes)

Care management summary for Marion:

- Health risk screening identified Marion for the HFS program based upon health risk screening
- A CHW assigned to outreach and engage Marion in HFS
- Face-to-face meeting resulted in Marion agreeing to participate in HFS and Baby Blocks
- Coordination with community-based agencies for social needs
- Follow-up support and ongoing monitoring through HFS

Case Studies Illustrate How We Address Community Differences

The following case studies illustrate our care management approach, which is flexible to address and adapt to community differences. The case studies feature real UnitedHealthcare members; however, we changed member names to protect their privacy.

Marion, a Member Who Is Pregnant and Living in Omaha

In 2015, our CHW, Angi, visited Marion at her home in Omaha. Based upon health risk screening and the **Healthy First Steps** (HFS) assessment results, Marion qualified to participate in the HFS program; however, she had not enrolled thus far. Angi was assigned to outreach and engage Marion in the HFS program. Although they had never met, Angi lived in the same community as Marion. Before Marion agreed to let Angi into her home, upon learning the purpose of the visit, Marion's initial reaction was to say "no" she did not want to participate in the HFS program. Then, she had second thoughts and asked Angi if saying "no" meant that Marion would be cut off from her Medicaid benefits.

Angi reassured Marion that declining HFS participation would not disenroll her from the Medicaid program; however, Marion might miss out on community resources like a free car seat that Angi could connect facilitate. This sparked Marion's interest. Marion invited Angi into her home, but she let Angi know this did not mean she was willing to commit to participating in anything. Through their interaction, Angi learned that Marion was married, was an independent woman, felt embarrassed about needing Medicaid and was afraid of taking resources away from someone else. Angi shared with Marion that prior to working for UnitedHealthcare, she used to be a Medicaid enrollee when she was a single mom with young children and had no other option for health insurance. Angi also described her community-service activities in their community related to helping teen moms—many of whom also needed Medicaid program benefits just like Marion and Angi. Marion related to Angi who helped her see the benefits of programs, such as Baby Blocks and NurseLine.

According to Angi, it was as if a light bulb came on when Marion said, "*I really do need this. This just sounds like everything we could use right now and I had no idea anything like this existed. You changed my mind. Thanks for telling me about your story. You don't look like someone who was on Medicaid. I guess I do want to sign up.*" Angi enrolled Marion into the HFS program and Baby Blocks that afternoon. Angi used her motivational interviewing skills to recognize where Marion was on the health care continuum and to understand that although Marion wanted information, she was cautious and proud. In addition, Angi connected Marion to several community-based agencies that could help Marion with other

needs. Before Angi left, Marion gave her a hug. Angi left her contact information and told Marion she could call her or the phone numbers on her ID card for member services or the NurseLine if she needed help.

John, a Member with Complex Care Conditions and Barriers to Care in Urban Tennessee

Care management summary for John:

- Use of data analytics to identify overutilization and underutilization of services
- Referral to a CHW to identify barriers to care and assist with establishing member health goals
- Consultative support available from an RN care manager and medical director
- Interventions included linkage to providers, a specialist and community-based services/supports using Healthify
- Education and support to increase self-management skills
- Follow-up support and monitoring

John, age 42, is a city of Memphis resident. He lives alone and has had significant challenges managing HIV, hypertension, asthma, hepatitis and, most recently, an open wound. In the past, he visited a health clinic to get medications for HIV, leaving his other conditions largely undertreated. Based upon a review of data analytics identifying significant gaps in John's care, underutilization of services and a significant risk for needing ER or inpatient services, John was referred to our high-risk care management program. Kelsey, John's RN care manager, asked Taylor, a CHW, to outreach and engage John to help him understand the importance of getting treatment for his medical conditions. Taylor lives in John's community, is knowledgeable about the local providers and community-based resources and understands the challenges and barriers to care that exist there. Taylor met John at his home and through motivational interviewing, she identified John's barriers to seeking the care and services he needed and was able to understand what he wanted. Because John did not have a telephone, Taylor helped John schedule an appointment with a PCP and arranged transportation. During the face-to-face visit, John allowed Taylor to call our medical director who then spoke with John and convinced him to get a consultation with a specialist for his open wound. Taylor offered to accompany John to some of his appointments because he mentioned he had no natural supports. John is fortunate to live in Memphis where there are many options for community-based services and support. Taylor used *Healthify* to connect John to resources in his neighborhood, including a food pantry and a faith-based HIV support group.

Taylor continues to maintain an ongoing relationship with John to help him stay on the right track to addressing his medical and social service needs. John is completing regular appointments with his PCP who assessed John for depression. With Taylor's help, John's self-management skills have improved. John asked Taylor to connect him to a free cellphone program. After receiving his new phone, Taylor helped John input important phone numbers, just in case he needed to reach his PCP, his care manager Kelsey, Taylor, member services, NurseLine or 911. John is adhering to his new treatment regimen, including taking his prescriptions. John's open wound healed after the appointment with a wound care specialist.

Mateo, a Hispanic Member with Comorbid Conditions Living in Texas

Mateo, an 18-year-old Hispanic male, was admitted to a Texas inpatient psychiatric facility in 2012 due to out-of-control aggression with family members. He was diagnosed with bipolar disorder, most recent episode mixed, severe without psychotic features and alcohol abuse. Comorbid medical issues identified included hypertension and obesity. Mateo had not seen an outpatient BH provider in six months and his behavioral condition worsened during this time. A care manager with BH expertise reviewed the case with the facility and escalated his case to interdisciplinary complex care rounds.

Care management summary for Mateo:

- Use of data analytics to identify this member at significant risk for decreased functioning and possible incarceration and/or mortality
- Assessment of physical, behavioral and social needs
- Referral to a Spanish-speaking BH field care manager who identified barriers to care and helped the member establish personal health goals
- Referral to a Hispanic peer support specialist with lived experience with alcohol abuse
- Consultative support available from an RN care manager and interdisciplinary care team
- Culturally sensitive interventions that included linkage to providers, transportation and (using *Healthify*) community-based services and supports
- Education and support to increase self-management skills and improve wellness, including diet and exercise
- Follow-up support and monitoring

The outcome of interdisciplinary complex care rounds resulted in the assignment of care management staff with expertise and experience working with people with conditions similar to Mateo's. Marian, an RN care manager, worked with Denise, a Spanish-speaking BH field care manager who was assigned as Mateo's primary care manager to connect Mateo to interventions to improve his health and meet his whole health goals. Denise connected Mateo to a PCP to address Mateo's medical conditions (hypertension and obesity), including exercise and dietary assistance. Denise scheduled an appointment with a new BH provider who could provide timely follow-up BH services after discharge from the facility. Denise arranged transportation to Mateo's appointments to help him access care. Using *Healthify*, Denise located community-based services, including rental support, post-high-school financial assistance, financial planning assistance and a support group for families dealing with alcohol-related issues.

Denise engaged and coordinated with child protective services staff who worked with Mateo and his family to increase their self-management skills and strengthen healthy family relationships. This combination of services helped Mateo improve health outcomes. For several years, Mateo has not required inpatient psychiatric services. He remains alcohol free and, he has decreased his waist size by three inches. A peer support specialist contacts the family and helps Mateo stay on track with his self-defined recovery and resiliency goals.

Jimmy – African-American Community in Florida

Based upon predictive modeling and health risk screening, a licensed care manager with BH expertise was assigned to work with new member, Jimmy, a 10-year-old African-American, adopted male with multiple psychiatric diagnoses. Prior to becoming our member, Jimmy's care coordination had been largely managed through the school system. Jimmy's medical history included fetal alcohol syndrome, oppositional defiant disorder (ODD) and attention deficit hyperactivity disorder (ADHD). Malinda, a care manager with BH expertise, asked Nina, a CHW, to conduct a field visit with Jimmy's mom, Tamika, to engage her, gather more information and identify any barriers to connecting Jimmy to care and services. During the visit, Tamika explained she adopted Jimmy when he was just three

Care management summary for Jimmy:

- Use of data analytics to identify BH conditions that had the potential to delay development
- Referral to a CHW to identify barriers to care
- Referral to a care manager to assess physical, BH, environmental and social needs
- Helped member/family establish member health goals
- Engagement with an interdisciplinary care team that included a pharmacist and referral for a medication reconciliation
- Collaboration with school-based services and supports
- Consultative support available from an RN care manager and interdisciplinary care team
- Culturally sensitive interventions that included linkage to providers, transportation and (using *Healthify*) community-based services and supports
- Education to increase self-management skills and improve wellness, including diet and exercise
- Follow-up support and monitoring

days old and was told that he was born with fetal alcohol syndrome and a biological family history of mental illness. She also shared that recently Jimmy was becoming increasingly difficult to control in social environments and that he had been to several counselors with little or no behavioral improvement. Tamika is worried about Jimmy being over-medicated for his ADHD and ODD. Malinda conducted health risk assessments to determine Jimmy's risk level and to identify his holistic needs. Malinda arranged for an interdisciplinary care team meeting that included a BH clinician, pharmacist, Jimmy's mother and a representative from Jimmy's school to discuss next steps for Jimmy's care. Malinda set up a meeting with Jimmy, his mother and the school's disabilities resources personnel to discuss Jimmy's individualized education program (IEP) services, psychiatric care and other available care management resources. This meeting revealed that Jimmy was experiencing gaps in care partially because of transportation issues, including the impact of the school not renewing its subcontracted services for students with specials needs. Malinda worked with the school and several BH agencies to develop a person-centered plan of care consistent with his IEP. The plan of care included measurable goals defined by Jimmy and his mom and self-management strategies, including teaching Jimmy how to use the school library computer to access the *KidsHealth* online resource. *KidsHealth* online provides support on a range of physical, emotional and behavioral issues that affect children and teens, such as nutrition, asthma, stress and coping strategies. With intervention, Jimmy improved his school performance and he attends after-school tutoring. He is currently receiving behavioral modification therapy in school. Malinda connected Jimmy and his family to community resources and social supports to reduce the strain on his family.

Juan, a High-Risk (Event-Driven) Member in a Hispanic Community in Florida

Juan (name changed) is a 17-year-old Hispanic male whose family only speaks Spanish. After being hit by a car, Juan suffered a traumatic brain injury leaving him in a persistent vegetative state. He has a tracheostomy, requires gastrostomy tube feedings and requires 24-hour total care. Because of his multiple health issues, we assigned a transition care manager (Sandy) with experience with traumatic brain injuries. Juan's mother scheduled a home visit with Sandy (who lives in the same community) to identify Juan's needs and gaps in care. After assessing Juan's needs, Sandy coordinated multiple interventions, including:

- Requested reassignment of a Spanish-speaking RN care manager for optimal communication post discharge from the hospital
- Assisted with obtaining multiple DME items, including tracheostomy supplies, gastrostomy tube feeding supplies, diapers, a hospital bed to keep Juan's head elevated while in bed and a custom wheelchair for his mom to be able to transport him to follow-up appointments after discharge from the hospital
- Scheduled intermittent transportation to transport Juan in a stretcher until his customized wheelchair was ordered and delivered
- Arranged for physical and occupational therapy

Care management summary for Juan:

- Use of data analytics to identify a member with an inpatient stay
- Referral to a transition care manager with experience working with members with traumatic brain injuries. Post-discharge assessment to ensure a safe care transition and assistance in establishing member health goals
- Assessment of physical, BH, environmental and social needs
- Use of *Healthify* to identify community-based resources for home modifications
- Culturally sensitive interventions that included linkage to skilled nursing providers who spoke Spanish and transportation that accommodated special needs
- Education and support for the family to help them understand the member's condition, signs the condition is worsening and what to do about it
- Follow-up support and ongoing monitoring

- Engaged 24-hour consistent skilled nursing care in the home
- Referred Juan to specialty physicians for follow-up
- Arranged for home modifications from a community-based organization
- Developed a back-up plan, safety measures and an emergency escape plan for nurses and his family to follow in the event Juan would need to be evacuated quickly; e.g., hurricane
- Educated Juan's mother on caring for her son's complex health care needs, including positioning for feeding, turning and repositioning, monitoring for signs and symptoms of infection, wheelchair use, how to advocate for Juan, and how to navigate the health care system and ask for help when she needs it

Because of these interventions, Juan has had no further hospitalizations and has been without complications. His health is stable, and his family is supported to understand better what services and benefits are available to Juan. His family is happy that Juan is being cared for in his home rather than being in a skilled nursing facility.

Jackie, a Foster Child with Special Health Care Needs from Louisiana

Care management summary for Jackie:

- Enrollment file indicated a child with special health care needs
- Claims analysis indicated a high need for physical health care services
- Referral to an RN care manager
- Assessment of physical, behavioral and social needs
- Interdisciplinary care team inclusive of the foster parents, DME provider and coordination with a state-assigned case manager to avoid duplication of services
- Intervention for assistive technology and physical therapy
- Support for the member's IEP
- Follow-up support and ongoing monitoring

Jackie is a 13-year-old member with special health care needs and is in foster care. Claims analysis showed Jackie had a high need for physical health care services. We assigned an RN care manager, Rosie, to Jackie. During the comprehensive risk assessment process and a discussion with Jackie's foster parents, Rosie found out Jackie is trached/vented with a feeding tube. She requires substantial DME, including a wheelchair, special bed and a ventilator. Jackie also has a state-assigned caseworker.

Rosie convened an interdisciplinary care team meeting to develop a person-centered plan of care for Jackie. Rosie invited Jackie's physicians, a DME representative, her foster parents and Jackie's state caseworker to attend the meeting and to provide active input during care planning. The foster parents told the care team that Jackie may soon need a new wheelchair and that they planned to follow up with the DME company. The team recommended coordination of physical therapy for a stander (assistive technology that can be used by those who rely on a wheelchair for mobility). Rosie requested the DME company send a physical therapist to Jackie's home to measure Jackie for a new stander device.

After the care-planning meeting, Rosie had a follow-up action item to review Jackie's IEP with her foster parents and school personnel. During the IEP meeting, Rosie coordinated with school district personnel for physical therapy because the school system had standers available. Rosie cancelled the DME in-home appointment for a stander measurement. Coordination of care between the DME company and the school avoided duplication of services and costs, yet Jackie received the care she needed.

Joseph, a Member with a Mild Developmental Disability and Other Conditions in Texas

Joseph is a 19-year-old male diagnosed with mild intellectual disability, congenital abnormalities of the heart, pulmonary insufficiency, unspecified mood disorder, obsessive-compulsive disorder, hypothyroid and alopecia. Joseph enrolled in our I/DD care management program two years ago. On an annual basis,

Care management summary for Joseph:

- Reassessment of physical and behavioral needs indicated need for additional services and support
- RN care manager supported by BH field care manager
- Referred member to a new PCP and BH professional in an integrated care setting
- Coordination with state agency case worker and referral to self-directed services
- Follow-up support, ongoing monitoring and reassessment

an RN care manager contacts Joseph and conducts a comprehensive health risk assessment, health risk screening, REL/disability assessment and SF-12 assessment.

After Joseph finished high school, his family relocated to another town. Joseph began taking one class at the community college, but he was struggling with the transition to a new town and having trouble adjusting to community college. Joseph told his parents that he needed help and felt depressed.

The RN care manager worked with a BH care manager to identify and outreach to a PCP that was part of a practice providing integrated physical and behavioral health services. The RN care manager helped Joseph make an appointment with his new PCP. Joseph's new PCP provided Joseph with a two-month supply of a previously prescribed prescription regimen for depression and referred Joseph to a psychiatrist in the provider group. In addition, the RN care manager educated Joseph about the self-directed support services available from the Texas Division of Disability Determination (DDD) Services program. The RN care manager contacted a DDD caseworker who followed up with Joseph and his family. The DDD caseworker explained the process and connected Joseph and his family to the self-directed services.

Nationwide Experience Coordinating Care

Nationally, we have 33 years of Medicaid experience. UnitedHealthcare currently provides managed care services to more than 5.3 million low income and medically fragile members, including D-SNP, in 24 states plus the District of Columbia. As shown Table IV.L-2, we have extensive national experience coordinating care for populations similar to those included in the Heritage Health program.

Table IV.L-2: UnitedHealthcare Community & State – National Experience

		Current Programs/Populations Served		
State	**Origination Date**	**CHIP**	**TANF**	**Other Programs**
Arizona	1982	✓	✓	ABD, D-SNP, LTSS, Adult Expansion, Children's Rehabilitative Services, Developmental Disabilities (DD), Special Needs
Delaware	2007	✓	✓	ABD, LTSS, Adult Expansion
Florida	1987	✓	✓	ABD, D-SNP, LTSS, Dual Eligible, Nursing Home Certifiable
Hawaii	2009	✓	✓	D-SNP, LTSS, Adult Expansion, Nursing Home Certifiable
Iowa	1999	✓	✓	Adult Expansion, HCBS, CSHCN, MEPD, Foster Care, Institutionalized, SSI, Cervical/Breast Cancer (*new contract awarded; anticipated start date 1/1/2016*)
Kansas	2013	✓	✓	ABD, LTSS, Frail Elderly, Physically Disabled and DD/ID
Louisiana	2012	✓	✓	LTSS, HCBS, Foster Care, Cervical/Breast Cancer
Maryland	1997	✓	✓	ABD, Adult Expansion
Massachusetts	2004			FIDESNP, LTSS, LTC, HCBS
Michigan	1996	✓	✓	ABD, Adult Expansion, Children with Special Health Care Needs
Mississippi	2010	✓	✓	ABD, Disabled, Long-Term Illness
Nebraska	1996	✓	✓	ABD, Wards and Children with Severe Disabilities

Table IV.L-2: UnitedHealthcare Community & State – National Experience				
		Current Programs/Populations Served		
State	Origination Date	CHIP	TANF	Other Programs
Nevada	1997	✓	✓	Adult Expansion
New Jersey	1995	✓	✓	ABD, D-SNP, LTSS, Adult Expansion
New Mexico	2008	✓	✓	D-SNP, LTSS, Adult Expansion, Dual Eligible, Disabled/Elderly, Brain Injury, Long-Term Illness
New York	1997	✓	✓	ABD, D-SNP, LTSS, Adult Expansion, Family Health Plan
Ohio	2005	✓	✓	ABD, D-SNP, LTSS, Adult Expansion, MMP
Pennsylvania	1989	✓	✓	D-SNP, Adult Expansion
Rhode Island	1994	✓	✓	ABD, Adult Expansion Adult SSI, Children with Special Health Care Needs
Tennessee	1994	✓	✓	ABD, D-SNP, LTSS
Texas	1998	✓	✓	ABD, D-SNP, LTSS
Washington	2005	✓	✓	ABD, D-SNP, Adult Expansion, Foster Care, COPEs, Nursing Home/HCBS
Wisconsin	2005	✓	✓	Uninsured Adults

59. Describe the MCO's approach for identifying members in need of care management services, including:

- The proposed process for providing a health risk screening to all members upon enrollment to identify and assess members potentially eligible for care management services, including those who have or are likely to experience catastrophic or other high-cost or high-risk conditions.
- A description of the algorithms and methodologies the MCO will use to identify members potentially eligible for care management.
- The proposed process for conducting health risk assessments for members identified as potentially eligible for care management. Submit the proposed health risk assessment template that the MCO plans to use. *5 pages*

Identifying Members in Need of Care Management Services

Our person-centered approach to integrated care management begins with collecting person-specific information about members and using advanced data analytics and assessment results to proactively identify and stratify members who need care management services. Clearly defined processes, dedicated staff and IT/decision support tools enable us to categorize members according to **MLTC's categorized risk levels: low, medium and high risk**. This, in turn, allows us to appropriately focus interventions and resources. We prioritize outreach to members requiring immediate, high-intensity contact and levels of coordination necessary to assure continuity of care and stable functioning, focusing attention on those with special health care needs. Outreach staff and system prompts refer high-risk members to the care management team who contacts the member and conducts applicable health risk assessment(s).

Providing Health Risk Screening upon Enrollment to Identify Member Needs

Online Initial Health Risk Screening Tool
In Tennessee, Washington State and Louisiana, we made the health risk-screening tool available to our members online via myuhc.com and on mobile devices. We will have an online screening option available for Nebraska members via CommunityCare. Providing health risk screening via mobile devices offers members an additional choice for how they engage with us, addressing individuals with differing comfort levels when providing personal information.

While claims data and other enrollment information provide specific demographic and health-related information about our members, many other factors that are not readily apparent contribute to an individual's overall health risks. Initial health risk screening is the first step toward categorizing and prioritizing member health needs and targeting member populations for specific levels and types of care management. Our health risk-screening tool includes a series of questions to collect data from members to create a picture of the member's current situation. This includes social determinants that could affect his/her health care, such as housing, food security, health symptoms and functioning, physical and BH care utilization and other factors related to a member's health and social concerns and priorities. Cultural insights may be gained that are relative to linking the member to appropriate providers and/or care management services. Our multi-faceted, proactive approach allows us to intervene quickly and engage members in preventive care and wellness programs, facilitating a seamless transition to us without disruption of ongoing services and supports.

- We send new member welcome packets within 10 business days of receiving enrollment data from the enrollment file. The welcome packet includes a new member **welcome letter that encourages new members to complete health risk screening** using our online tool, through the member's PCP/PCMH provider or through direct contact with us. The letter encourages members to make an appointment with their PCP for a baseline assessment (physical and BH) and other preventive services, including an assessment or screening of individual's potential risk, if any, for specific diseases or conditions. The new member welcome letter lists contact information for member

services and informs the new member and his/her family how to obtain personalized assistance from an MSA regarding any concerns, such as how to change a PCP, locate a provider and more.

- Members can complete the health risk screening online at their convenience **using a mobile device** or signing into **CommunityCare** or the **member portal**. Our members have told us they like the online screening tool because it allows them to feel comfortable sharing personal information. To optimize member engagement, starting in 2016, the member portal will provide Web-based guidance by using rotating banners that guide the member toward an action after logging in to the portal. Members clicking the **rotating banner** *"Why complete health risk screening?"* will land on a page where they can complete the health risk screening online.
- Our MSAs place outbound welcome calls to new members to welcome them to UnitedHealthcare and to gather information and offer assistance with their current needs. These calls enable new members to ask questions and obtain assistance, such as making an appointment with a PCP. During this call, MSAs conduct health risk screening and encourage members to share health-related information, such as current health status, diagnoses, authorized services, receipt of community-based supports, ER usage and inpatient admissions/readmissions, living arrangement, and social and natural supports that may indicate social and environmental barriers, complex, chronic, co-occurring or comorbid conditions. We train MSAs to understand and anticipate our members' unique needs, including cultural competency, to promote sensitivity to improve the member experience. Training in motivational interviewing helps to promote member engagement and information gathering (such as, pregnancy, barriers to care and unmet needs) to help us provide personalized services. When an MSA identifies a member with special needs during the call, the MSA initiates a referral through a task in CommunityCare to our care management team for additional outreach, screening and health risk assessment(s).
- A care manager may request a CHW or a BH specialist to locate a member who is difficult to find and engage that member in **health risk screening** and the **Access to Care** tool that looks at a member's access to care (primary, specialty and behavioral) and social and environmental barriers and concerns.
- MSRs send a "We Are Trying to Reach You" postcard to encourage members they cannot reach by telephone to call us to complete health risk screening.
- As an innovation, we are working to contract with **Continuum of Care (CoC)** and HUD providers of homelessness services to match homeless management information systems (HMIS) data against our membership data to identify joint members. This will assist us in locating members who are homeless and are using homelessness services. Once matched, we will engage the homelessness service agency to conduct a warm introduction between our member and a CHW or BH specialist who will conduct health risk screening.
- Our new **mobile health services pilot** will provide assessment services for individuals who lack mobility or have barriers to accessing care. Assessment services will include social barrier and safety assessments as well as lab work and medication checks.

In summary, health risk screening data is documented in the member's record. The screening tool is scored and members whose score indicates they are at-risk are referred via our care management system to the care management team for further review and assessments.

Algorithms and Methodologies to Identify Members for Care Management

Our care management program puts data and analysis to use with an unprecedented level of precision, rigor and action-orientation. Our approach supports identification of members potentially eligible for care

management through multiple sources. These sources include **referrals** from members, families, providers, MLTC or other DHHS division staff, community-based organizations (e.g., homeless shelter), internal staff from any department (including Dr. Horn, our pharmacy director, BH clinical director, member services, discharge planners, UM or care management), various **screening tools** (includes health risk screening, BH screeners and EPSDT), **health risk assessments** and **predictive modeling**. Our network providers are a primary resource for identifying members who may benefit from care management. During appointments, providers screen members for symptoms that may indicate potential specialized health care needs and may refer members to our care management program.

Process for Conducting Comprehensive Health Risk Assessments

Health risk screening and health-risk assessment activities are designed to collect critical information needed for an informed understanding and holistic view of a member's overall health state. A care manager—an RN, a licensed BH clinician or a PCMH provider care manager—conducts the health risk assessment process, using tailored supplementary assessments, as needed. We use algorithms and clinical judgment to make care manager assignments based upon capacity, geography and the member's primary area of need. Depending on member need, contact occurs face-to-face or telephonically. We encourage participation from the member/family, caregivers or representatives in the assessment process and schedule the appointment to conduct the assessment at a convenient time when they can actively participate.

Our health risk assessment process identifies key high-risk conditions; family history; health literacy skills; family supports; current and past medical, behavioral and functional history; personal behaviors and lifestyle choices; social history/needs (e.g., housing or employment); spiritual preferences; and environmental risk factors. It can trigger additional, condition-specific assessments based upon our evidenced-based clinical guidelines and the member's individual condition (e.g., diabetes or asthma). Supplemental assessments may target particular health conditions (e.g., diabetes, cardiovascular disease or depression). Members who report certain chronic conditions or who respond positively to BH screening questions are prompted to complete an in-depth review of the particular condition identified. As an example, for members who respond positively to the BH screening questions for depression using the PHQ-2, we conduct PHQ-9 screening. We use the GAD-2/7, the AUDIT-C, and a single item drug-screening question that can lead to further assessment of specific symptoms.

We assess cognitive impairment, including an individual's ability to complete activities of daily living and instrumental activities of daily living, using a functional needs assessment. Our pregnant members receive an HFS OB leveling assessment, which includes a comprehensive review of obstetrical and medical history and a psychosocial assessment. Assessment results combined with other data analytics allow us to place the member into the appropriate care management level (high, medium or low) with a customized, person-centered care plan and personalized resources. Ongoing, care managers conduct routine reassessments based upon an individual's risk profile—with care managers using their clinical judgment to determine a need for expedited assessment time frames. System alerts in CommunityCare can be set as a reminder to schedule and conduct assessments. Care managers and their managers can run reports on the aging and completion status of assessments due.

The care manager documents assessment results in the member's record in CommunityCare, which is used to engage a broad care team in supporting the member by facilitating information sharing between interdisciplinary care team members. Supplemental assessment results assist care managers and the interdisciplinary care team, inclusive of the member's PCP and the member/family, with care planning, plan of care development with interventions targeted to improve outcomes and to educate members on

ways to improve self-management of their conditions. An answer to a question on the health risk assessment may generate an opportunity, goal and subsequent intervention in our member's plan of care, as seen below. ***Assessment question:*** *Does your child's health keep him/her from doing the things he/she wants?* If the member answers "yes," the care manager asks "why?" and updates the plan of care.

- ***Opportunity:*** Parents of a female Katie Beckett member from Lincoln wanted to improve the quality of their daughter's life so she could breathe on her own and speak (2015).
  - ***Goal:*** Resolve barrier through decannulation (tracheostomy tube removal).
    - ***Intervention 1:*** Convene an interdisciplinary care team meeting.
    - ***Intervention 2:*** Arrange for an appointment with a pulmonologist who can develop a plan for decannulation.

Proposed Health Risk Assessment Template

As Attachment 19 Q59 Initial Health Screening Sample, we provide our proposed health risk assessment templates, which are used to collect the RFP-required data listed in Section L. Care Management, Health Risk Screening/Assessment. Table IV.L-3 describes our suite of comprehensive health risk assessments:

Table IV.L-3: Our Suite of Comprehensive Health Risk Assessments
Access to Care Assessment
This 14-question assessment is completed upon initial engagement by a CHW or BH specialist whose role it is to actively engage members in the community. This assessment looks at a member's access to care (primary, specialty and behavioral) and social and environmental barriers and concerns. Assessment results inform a member's initial action plan.
Adult Core Health Risk Assessment
This assessment is completed by an RN/BH clinician within 30 days of engagement. It provides a holistic view (e.g., behavioral, environmental, emotional, social, spiritual, physical, including genetic predisposition and lifestyle choices) of the member's overall health state. It helps determine the need for additional condition-specific screenings and helps to determine health outcomes and encourage member goals and to ultimately provide the inputs into the member's care plan. The assessment identifies key high-risk conditions, family history, family supports, current/past medical history, personal behaviors, social history and environmental risk factors. It triggers condition-specific assessments based upon evidenced-based clinical guidelines and the member's individual condition (e.g., diabetes).
Pediatric Core Assessment
This assessment is completed by an RN/BH clinician within 30 days of engagement. It includes evidence-based screening tools related to trauma, depression, children with special health care needs, caregiver support, self-management skills, medication management, environmental concerns, health equity (e.g., drivers from cultural or spiritual drivers that impact health care), educational needs, healthy behaviors, health literacy and disaster planning.
HFS Initial Leveling Assessment
This assessment is completed upon initial engagement with a pregnant member. We process referrals on an ongoing basis—weekly for certain data pulls and as often as daily for escalated referrals. We proceed with outbound telephonic outreach to all referred members to ascertain risk factors, provide initial risk stratification, identify barriers to care and provide immediate assistance for resolution of barriers. Higher risk members (includes those whose initial barriers cannot be resolved) are transferred to a nurse for clinical assessment, intervention and ongoing case management, if needed.

60. Describe the specific types of services members will receive at each risk level. Provide recommendations for additional innovative care management strategies, if any, MLTC may want to consider. *5 pages*

Through our extensive experience operating care management programs, we have learned the importance of focusing our efforts on members who are most at risk and able to benefit from intervention and specialized care management programs. To improve member outcomes and impact costs, we have designed strategies that target high-risk, high-cost members who need to be managed proactively. Our integrated, person-centered care management program (led by Dr. Horn, Ms. Palmer, Dr. Freed, Mr. Grubbs and our new tribal network liaison) drives the processes, policies, procedures and tools that support our:

- Identification of care management needs through early screening and assessment
- Stratification of members into MLTC-defined risk levels: low, medium and high
- Development of an integrated plan of care, which addresses holistic needs (includes BH and pharmacy) via covered and non-Medicaid covered (community-based) services
- Interdisciplinary care team referrals (includes facilitating access to specialty services), enhanced communication and information/data sharing
- Emphasis on wellness, prevention and chronic condition management
- Care coordination, includes appointment scheduling, arranging transportation, system-generated or direct appointment reminder calls, follow-up to verify appointment completion and service initiation, tracking member progress toward goals and adjusting interventions and services in the plan of care, as needed
- Evaluation, including reviewing, tracking, monitoring and adjusting; data analysis related to health outcomes, quality metrics and performance monitoring/improvement

Identification strategies (health risk screening, data analytics and predictive modeling) assist us in assigning an initial risk score to each member. The score is provided to a care manager who conducts further health risk assessments for those who potentially need care management programs. For example, a member identified as having a high-risk BH condition is referred to a care manager with BH expertise. Members identified as having complex, chronic, co-occurring or comorbid conditions are referred to a care manager with expertise that aligns with the member's primary risk and needs. Upon identification of member needs and risk stratification, our staff (including MSAs, care navigators, care managers, CHWs) or PCMH staff outreach to members to connect them to the services and supports they need to achieve personal health goals, a better experience navigating the health care system and improved health outcomes.

Stratification by Risk Level

Care managers use a systematic approach to identify members who are at risk for poor health outcomes and target specific individuals for care management services. Care managers evaluate members; and our predictive modeling system, Impact Pro, groups members according to specific conditions, disease factors, historical claims history and member-reported information to improve their quality of life through appropriate and efficient use of necessary services and supports with a goal of reducing unnecessary or avoidable services. This grouping, using MLTC-defined risk levels, triggers care management interventions corresponding with member risk level needs, assuring members needing immediate interventions receive the highest priority. Based upon the member's assessment results, the most appropriate care manager, clinical skills and experience is assigned. Members with high-risk/high-utilization and complex needs are assigned to an interdisciplinary care team. Table IV.L-4 shows the

correlation between MLTC-defined risk levels and the characteristics of the populations engaged in each risk level.

Table IV.L-4: Heritage Health Care Management Program Risk Levels and Populations	
Risk Level	**Population Characteristics**
Low Risk	▪ Low use of acute medical/BH services and inpatient care ▪ Minimal to no functional/cognitive impairment ▪ Condition/disease needs managed effectively with self-management skills, provider office care or disease management program ▪ Minimal gaps in care related to prevention, wellness and social determinants of health
Medium Risk	▪ Moderate use of acute medical/BH services and inpatient care ▪ Impairment necessitates supervision with ADLS and/or IADLs ▪ Inadequate self-management and issues adhering to treatment or a care plan ▪ Moderate gaps in care related to prevention, wellness and/or social determinants of health or issues with access to needed care and supports
High Risk	▪ High use of acute medical and BH services, inpatient care and social services ▪ Impairment requiring assistance with ADLs or IADLs ▪ Multiple complex, chronic, co-occurring or comorbid conditions requiring close management, including the transplant and high-risk pregnancy populations ▪ Significant gaps in care related to prevention, wellness and/or social determinants of health or issues with access to needed care and supports

Care Management Program Services by Risk Level

Our model of care is based upon population health and a focus on person-centeredness and personalized engagement by deploying face-to-face, telemedicine, Internet, remote monitoring and other ways to meet the member in the best way possible. Our approach considers the health of groups of individuals with the goal of improving health across the populations rather than focusing on disease states. We will build upon our established care management program to improve population health with the carve in and integration of BH and pharmacy services and the addition of new Heritage Health populations. These populations include rural and frontier populations (includes tribes) in central and western Nebraska; special needs populations, such as I/DD; those dually eligible for Medicare and Medicaid; and those participating in the HCBS waiver program.

Once a member's risk level is identified, the appropriate care management staff outreaches to the member to engage him/her in navigating the health care system including accessing services and supports when needed. For members with special health care needs, such as I/DD, we work with members, their families (or legal guardians), state case manager (if applicable) and their health care providers to develop a seamless package of care. The primary, acute care and specialty service needs are met through a plan of care that is understandable to the member and his/her family or legal guardian. Our staff uses member-engagement strategies to help individuals overcome their fear, anxiety, lack of self-confidence or hesitancy about participating in care management activities; we also use peer support specialists to engage members who are resistant to engage in care services due to their BH symptoms (e.g., psychosis). Our person-centered and member-directed approach engages individuals in achieving their health and independent living goals by meeting them where they are physically, emotionally and socially and by offering opportunities to access services along the continuum of care in a meaningful, impactful way. We do this by using, hiring and training qualified and experienced care management staff; by continually enhancing targeted care management programs; and by helping members connect to community-based

resources. Figure IV.L-5 below illustrates our systematic process for identification, risk stratification and assignment to care management services:

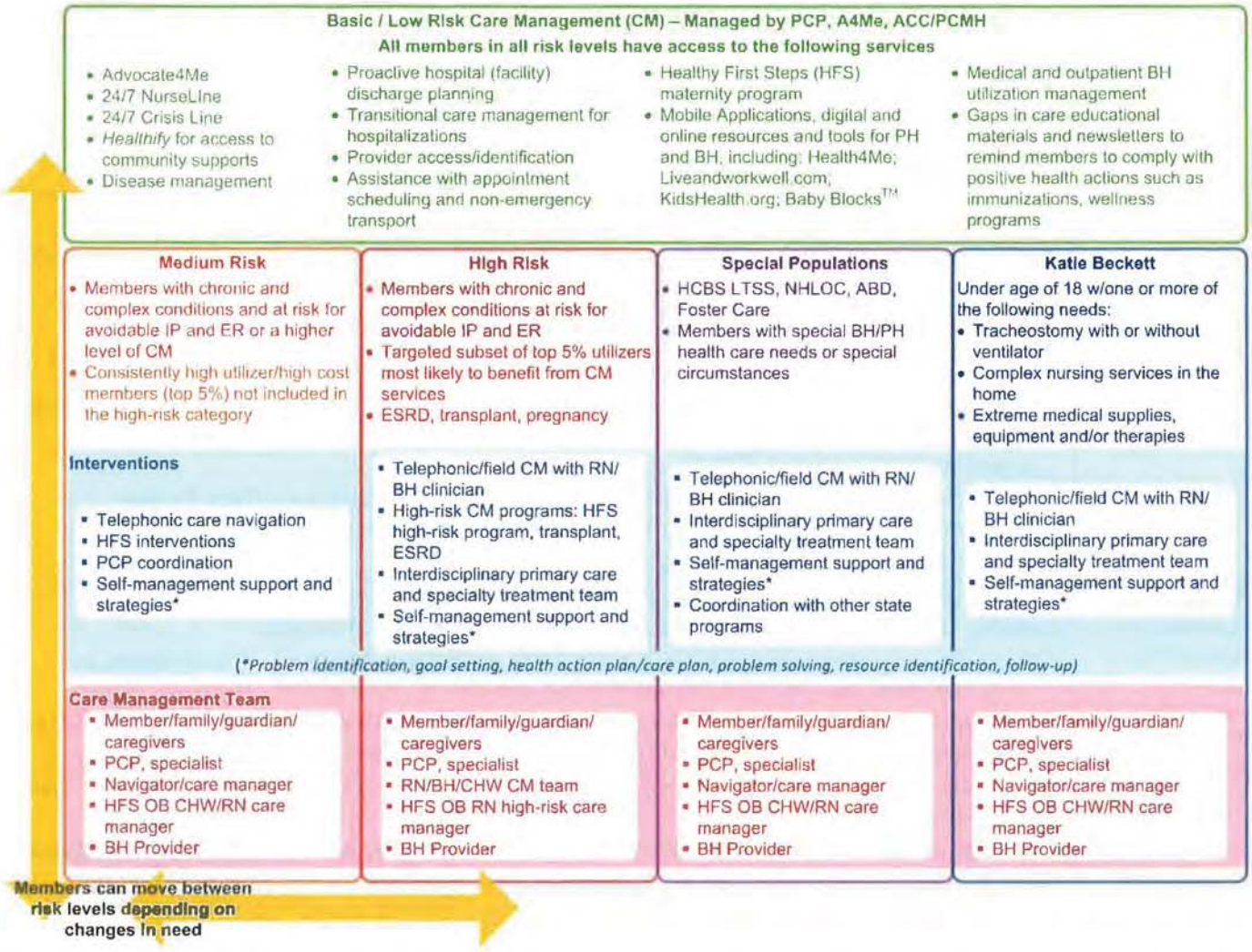


Figure IV.L-5. Process Flow. Members receive basic CM services and receive medium- and high-risk care management services as needed.

Table IV.L-5 shows care management program interventions by member risk level:

Table IV.L-5: Care Management Program Services/Interventions by Risk Level

Risk Level	Services/Interventions
Low Risk (Basic care management services available to all members)	Services and interventions are designed to promote a healthy lifestyle, prevent onset of disease through regular PCP visits, preventive screenings, immunizations and self-management. All members in all risk levels have access to the following basic services: ▪ Assistance with appointment scheduling and identifying network providers ▪ Assistance with care management and accessing primary care, BH, preventive care and specialty care, as needed ▪ Disease management education (e.g., diabetes, asthma, CHF and ADHD) ▪ Care coordination linking a member to providers, medical services or residential, social, community and other support services, as needed ▪ Proactive discharge planning and continuity of care during care transitions from one setting (hospital or facility) to another

Table IV.L-5: Care Management Program Services/Interventions by Risk Level	
Risk Level	**Services/Interventions**
	▪ Collaboration with other providers involved in a member's transition to another level of care, assuring all care team members, including the PCP, are kept informed of a member's treatment needs, changes, progress or problems ▪ Policies and procedures to assure members and network/non-network provider interactions are effective, identifying, addressing and updating P&Ps as needed ▪ Assistance with identification/referral to wellness programs and community resources; e.g., those identified using *Healthify*, including nutrition, housing, legal aid, employment and issues related to physical or sexual abuse ▪ Follow up with members and providers, including but not limited to regular mailings, newsletters and face-to-face meetings, as appropriate ▪ Access to *Advocate4Me* staff ▪ 24 hours a day, seven days a week access to NurseLine (includes Nurse Chat) and the BH crisis line to assist with health concerns, such as deciding how to treat an illness, BH crisis support (mental health/substance use) and self-help. NurseLine staff support member access to the right level of care. Nationally, 31 percent of NurseLine callers report they used a less urgent/expensive source of care ▪ Health/wellness and self-management education and digital tools (e.g., Baby Blocks, *KidsHealth*, Live and Work Well (link from *myuhc.com*) and *Health4Me* ▪ Healthy First Steps Maternity Program
Medium Risk (services in addition to those available through basic care management)	Services and interventions are designed to help members manage disease(s), condition(s), disability and delay/prevent progression via self-management and include: ▪ Facilitation of relapse prevention plans, including education, extra clinic visits or follow-up telephone calls, for members with depression and other BH conditions ▪ Partner with providers having high medication adherence rates to identify their best practices and use this information to support providers with low adherence rates ▪ Education for provider office staff about symptoms of exacerbations and how to communicate with their patients (our members) ▪ Plan for coordination and communication with MLTC staff who are responsible for management of HCBS waivers ▪ Development and dissemination of talking points and triggers for making emergency appointments ▪ Development and maintenance of specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors and unmet needs ▪ Medication reconciliation
High Risk (services in addition to those available through basic and moderate care management)	Services and interventions are designed to prevent further complications/disability using focused care management strategies and intensive self-management support and include: ▪ Organization of care using a person-centered, interdisciplinary primary care and specialty treatment team to assist with development and implementation of individual medical care plans, in accordance with MLTC QI and UM standards ▪ Maintenance of a list of community resources for member referral purposes ▪ Plan for coordination and communication with MLTC staff who are responsible for management of HCBS waivers ▪ Development and maintenance of a process to engage members who do not adhere to treatment/care plans or medication regimens ▪ Development and maintenance of an information-sharing strategy for effective communication with members/families/caregivers as well as key service and support providers and community service agencies (with member consent) ▪ Identification of providers with special accommodations (e.g., sedation dentistry)

Table IV.L-5: Care Management Program Services/Interventions by Risk Level	
Risk Level	**Services/Interventions**
	▪ Formal/ongoing training for staff about the barriers members may experience in making/keeping appointments and the interventions used to remove barriers ▪ Facilitation of group visits to encourage self-management of various physical and BH conditions/diagnoses, such as pregnancy, diabetes or tobacco use ▪ Direct member communication about person-specific gaps/needs to encourage members to obtain baseline and periodic medical evaluations from their PCPs

Additional Innovative Care Management Strategies for Consideration

We manage population health using a data-driven approach of advanced data analytics to inform care management strategies and promote adherence to evidence-based practices. We would like DHHS to consider our use of the following care management strategies:

UnitedHealthcare On My Way™. On My Way (Figure IV.L-6) is a new initiative designed by the UnitedHealthcare Innovation Center of Excellence to help young adults transition to adulthood and independence. Youth in foster care often do not have access to the same kind of support and guidance that other teens their age have. Youth are struggling for independence while trying to make smart life decisions. This requires support and guidance, even for young adults who have grown up in a stable and supportive environment. Our new, interactive mobile and Web-enabled game, which we will make available to our Nebraska foster care transition age youth members, takes the overwhelming transition process and breaks it down into bite-size, manageable steps and connects foster youth with the support/guidance they need and want (e.g., they can easily connect with peer support staff).

Figure IV.L-6. On My Way™.

Mobile health services. In Nebraska, we recognize our responsibility to provide members with accessible services and providers and know there are challenges in the rural/frontier counties. As such, we are exploring a pilot to offer mobile health services through a van equipped with clinical resources to provide health services to members in a home setting to lower costs, improve health outcomes and reduce readmission into a hospital and/or ER visits. Examples of how mobile health services can help our members in rural/frontier counties include:

- Coordinate follow-up visits with members after discharge from an inpatient stay
- Set up a telehealth tool to assist members with telepsychiatry
- Provide screening/assessment services (e.g., lab work, medication checks, safety, social)

Peer support for BH population. Peer support is an evidence-based practice recognized by SAMHSA and complements our person-centered care model. We will leverage peer support specialists and peer support groups to assist members with mental health, co-occurring mental health/substance abuse and comorbid conditions. Members will have the ability to access their peers through On My Way and through use of CommunityCare. Peers promote recovery via their living testimony that emphasizes recovery is possible. They reinforce resilience and self-management while facilitating access to assistance. We will offer a pilot in Region 3 to provide peer support services in addition to our own peer support staff (one of whom will be a Native American peer) in Regions 4 and 5.

61. Describe how the MCO will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover. *2 pages*

In Nebraska (and nationwide), we engage in community partnerships and actively help members connect to community resources that the Medicaid program does not cover. We meet with the community-based organization leadership teams to understand the services they offer, learn about where their gaps are and then collaborate to find ways to close those gaps, especially for our new Heritage Health populations. Today, we support the Autism Center of Nebraska in developing The Art Garden, a retail outlet showing the work of Autism Center artisans, to help them promote work experience and community-based employment. Through a partnership with the National 4-H Council, since 2012 we have provided $137,000 to support healthy living programs in Nebraska. We gave $55,000 to support the University of Nebraska Extension to implement 4-H Food Smart Families programming to empower families with education and connections to community-based nutrition resources. We will be exploring how to expand our relationship with 4-H to Nebraska's rural/frontier counties. We will further expand our efforts to forge community partnerships by leveraging our national experience working with employment providers, supportive housing providers and homelessness service providers.

We forge community partnerships to improve health care by 1) improving care coordination, access and service delivery; 2) strengthening the community and safety-net infrastructure; and 3) preventing illness and reducing disparities. As seen in the Figure IV.L-7, ensuring basic needs is foundational to effective care management. The top of the inverted pyramid shows a member's basic/social needs. Members with high utilization and high costs often face numerous challenges when it comes to addressing their medical and BH needs and interacting with the health care system. Our experience shows even the best interventions may be ineffective at helping members with complex health problems unless we first address their basic and social needs. Some of our members have a history of homelessness, food insecurity, childhood instability and trauma, early loss of parents or other caregivers, histories of sexual and/or physical abuse, gang involvement and early substance abuse. We recognize the ways these needs influence member/family interactions with the health care delivery system and how these factors can become barriers to accessing care.

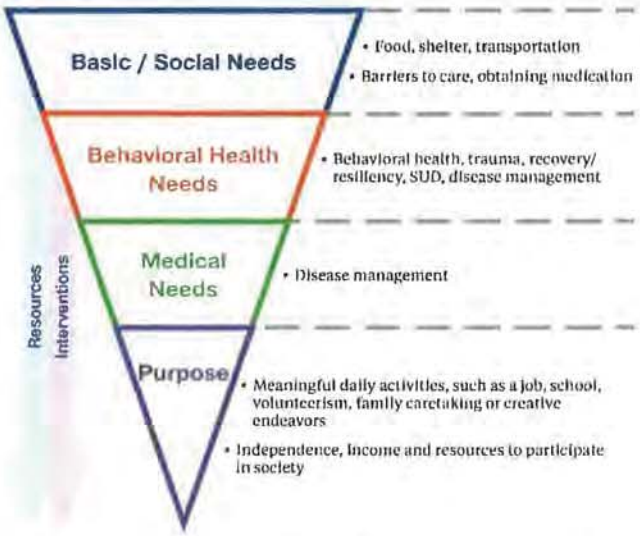


Figure IV.L-7. Inverted pyramid. By helping our members find ways to meet their basic/social needs, we improve their ability to focus on their health and overall well-being.

Our care management program focuses on connecting our members to community resources, enabling them to address barriers to allow them to better take full advantage of covered benefits and services and to promote healthy behaviors and self-care management. By connecting members to community resources, such as food, housing, employment, utility payments and transportation, we can remove barriers so that a member's health care needs become a realistic focus. We will continue to leverage our own and our community partners' expertise and resources to offer education on local key concerns, for example, classes on suicide prevention, parenting and exercise. Our approach to linking members to non-covered resources is shown below in Table IV.L-6:

Table IV.L-6: Approach to Linking Members to Non-Covered Resources

Early identification of needs and interventions

We use health risk screening, health risk assessments, data analytics and direct interaction with members/families, providers and communities to identify person-specific needs, gaps in care and barriers to care. We employ technical tools and commit staff resources, such as MSAs, navigators, CHWs, care managers and peer support specialists, to connect members to community-based services. We identify, monitor and track specific populations, such as dual-eligible members in low-income housing, whose clinical conditions and/or social factors place them at risk for needing a high level of care management. We collaborate with providers to connect our members to early interventions and community resources. Our health plan leadership meets with Native American tribal members to customize our programs to their needs; for example, we will offer youth suicide-prevention education. Our new tribal network liaison will expand our capabilities to identify needs and connect Native American members to culturally appropriate non-Medicaid community resources.

Innovative technology

Healthify is a Web-based, mobile-friendly application that connects individuals to relevant community resources. We are strengthening IT resources currently used by our interdisciplinary care team members by sharing the *Healthify* tool externally with FQHCs and key community-based organizations in Nebraska—the interface will be operational by the end of 2015. *Healthify* users bridge the gap between health care and social needs by using this tool to identify and share information with members/families and interdisciplinary care team members about community-based resources (e.g., food banks). A simple search feature enables *Healthify* users to quickly sort search fields by type of service and preferred location. Every resource includes a map, contact information, eligibility requirements, service hours, languages spoken and other information. *Healthify* users can target cultural, linguistic and educational support for Nebraska's prevalent ethnicities, including Native Americans. The *Healthify* database includes more than 2,890 Nebraska community-based social services, including WIC and food banks/pantries. From August to October 2015, the top four searched services in Nebraska using *Healthify* were housing, food, health education/support groups and financial support. Recently, a Nebraska CHW used *Healthify* to help an Omaha member locate a free source for winter coats and a nearby food pantry.

In addition to *Healthify*, members can search our community resource directory through the member portal, *myuhc.com*, for local resources close to home or the Nebraska Network of Care website for statewide BH resources and information about prevention, treatment support groups and advocacy tools.

Leveraging community resources

Our myCommunity Connect pilot in rural Nebraska has been designed to create a hub in areas of the state where accessing services is more difficult than urban and suburban areas. Linked by myData, the myCommunity Connect will provide ready identification of needs and programs for which individual members are eligible and will actively link them through referrals and follow up. The myCommunity Connect will become an invaluable resource to our rural members as we make the connections necessary to address their needs—particularly those not covered by Medicaid.

Collaboration with providers

We form partnerships with providers that connect members to community resources. For example, Dr. Horn and Ms. Palmer, RN, currently share/discuss member-specific predictive modeling data with key provider partners, such as physician-led UniNet Healthcare Network, to help them better identify and positively impact our medically complex, high-need members through outreach by UniNet staff. We make sure UniNet care managers have the knowledge and tools necessary to connect people to holistic services and support. We have existing relationships with FQHCs, RHCs, school-based clinics and social service entities in rural Nebraska and, we are building relationships with Nebraska's BH regions, which provide an array of BH services that are not covered by Medicaid, such as housing assistance. We are committed to providing targeted BH education, such as Mental Health First Aid, Seeking Safety and QPR, in each region annually.

62. Describe the MCO's strategy to address the unique challenges when coordinating care for dual-eligible individuals who receive their services from both Medicare and Medicaid. *2 pages*

With experience serving dual-eligible members across the country, including those in dual-eligible Special Needs Plans (D-SNPs) in 17 states, we have a deep understanding of the unique challenges inherent in addressing the needs of this vulnerable population. The dual-eligible population tends to require substantial resources. Many of them have complex, chronic illnesses, do not have a natural support system and often need emergent care. Besides being poor, the dual-eligible population, compared with the larger Medicare population, is largely female, part of a minority group (African American or Hispanic) and lives alone. Dual-eligible members often receive a variety of programmatic community-based long-term services and supports—with each program having its own care management structure. Sometimes dual-eligible individuals get confused about coverage or about which of their doctors is in-network and which of them is out-of-network. Our goal is to improve care, promote wellness, lower costs and reduce waste.

Strategies to Address the Needs of the Dual-Eligible Population

Our proposed strategies for coordinating care for the dual-eligible population include:

- ***Proactive Identification of Members with Dual Eligibility:*** We identify these members through the MLTC enrollment file and document this information in the member's record in CommunityCare, our clinical management system. To identify dual-eligible members, we regularly perform retrospective review of secondary claims, as they are indicators of additional coverage. Once identified, we assign members a care navigator who will be their contact with the health plan and who will conduct health risk screening and, if needed, a comprehensive health risk assessment to determine unique member needs, such as a mental health diagnosis, substance abuse or social issues.
- ***Coordination of Medicare and Medicaid Services:*** *Advocate4Me* and care management staff address the individual's full range of integrated health (includes BH and pharmacy) and functional needs by identifying the services and supports required to address the individual's needs and goals, regardless of which program pays for it. Through our integrated, person-centered approach, all dual-eligible members will be assigned to a care navigator who works with members, families, caregivers, Medicare providers, state staff (such as, HCBS or Medicare case managers) and other stakeholders to help members navigate the overall health care system. The goal of this care management strategy helps to identify members who may be declining both medically and functionally and engaging/coordinating options (including community resources) that can support an individual's ability to remain at home longer and avoid nursing facility placement.
- ***Individualized Benefit Navigation Assistance:*** In a traditional Medicare model, members may be contacted telephonically on an as-needed basis by a Medicare care manager or are assisted through a general customer service approach. In our model, members have access to *Advocate4Me* and care management staff with training and knowledge of Medicare and Medicaid benefits. They can help members and their families/caregivers navigate program benefits and assist members with questions. Members, families and caregivers can call the 24 hours a day, seven days a week NurseLine for help, as needed.
- ***Network Services:*** Conflicting payment policies can result in a lack of coordination between providers that are being reimbursed primarily by Medicare versus those paid mostly by Medicaid. We will support our robust provider network, which can meet the needs of individuals with dual eligibility, with training as well as financial incentives and value-based contracting to achieve better health outcomes and lower costs. In Nebraska, ACC/PCMHs, like UniNet, already employ

care managers. Our goal is to expand these provider models and support increased provider involvement in care coordination of this complex population because it will lead to better-integrated service delivery.

- ***Information Sharing:*** To assist with integration between care coordinators and primary care and specialty physicians, for dually eligible members, CommunityCare enables the sharing between interdisciplinary care team members PCP, care manager, member/family, specialists, state-assigned case manager, etc.) of critical, relevant and timely member-specific information essential to conducting ongoing care planning and coordination across a continuum of services and settings. CommunityCare supports collaboration by sharing care continuity documents and progress notes through Health Information Service Provider (HISP)/DIRECT. It supports a multiplicity of assessments that trigger care events in the plan of care and facilitates alerts to other care team members. It also integrates evidence-based medicine gaps in care and hospital ADT messaging (if available).
- ***Targeted Staff Training:*** Targeted training promotes our staff's knowledge and understanding of how Medicare and Medicaid work together and separately. We require mandatory, annual Medicare 101 and quarterly refresher training: The ABC & D's of Medicare and Medicaid, UnitedHealthcare D-SNP and Medicare Advantage Plans. Additional training includes how to determine coverage and eligibility, use assessments to coordinate wraparound services, use comprehensive benefits and services guides (*Medicaremadeclear.com* guides are available to the public and our staff to understand Medicare), and use the *Show Me Guide*, an easy-to-use Medicare reference.

Coordination with Other Payers, Plans and Providers

We successfully coordinate with other payers, plans and providers. We coordinate services with the Medicare payers, Medicare Advantage Plans and Medicare providers, including specialty providers. While eliminating duplication of services, we serve our members to achieve optimal utilization of acute and outpatient services and streamline overall benefit administration. We will ensure services covered and provided under the Heritage Health contract are delivered to dual-eligible members in accordance with state/federal coordination of benefits requirements.

We have the capability to process claims that cross over from Medicare fee-for-service. When a member has Medicare primary coverage, we pay the Medicaid benefit without a second claim. We can follow this standard claims process and automatically coordinate pharmacy claims through our PBM. When a member has Medicare benefits external to UnitedHealthcare, we coordinate service utilization with the Medicare payer to assure Medicaid does not pay services when Medicare is primary.

For non-covered Medicare services, in most cases, the provider must submit a Medicare denial of services as a non-covered benefit to our UM department, which then reviews the request for medical necessity. Some non-covered services, such as LTSS, do not require a Medicare denial and are automatically processed as a benefit to the member to optimize appropriate use of a member's benefits for his/her unique needs.

63. Describe the process for care coordination for members who are Tribal members or are otherwise eligible for care through Indian Health Services. *1 page*

Nebraska has a rich history of Native American culture. We have dedicated time and resources to meeting with tribal leadership to learn about their needs so we can build our care coordination approach around those needs. As illustrated in the following written comment from Jan Henderson, Ponca Hills Health & Wellness Center, (2015): *"UnitedHealthcare has proven they are willing to work with our unique approach to care for our American Indian population and we certainly appreciate their willingness to provide solutions and listen to our concerns."*

According to the 2010 census, Native Americans comprise about 1 percent of Nebraska's population. This population has the option of receiving their care through Indian Health Services (IHS); however, movement between urban Indian clinics (I/T/Us) and non-I//T/U clinics adds a layer of complexity to coordinating the care for this population. Cultural differences and a lack of trust or clarity about MCO processes can magnify the challenges in assisting Native Americans with obtaining appropriate health and social services. This highlights the need for a care model that adapts to fit diverse member needs. We have policies and procedures to coordinate eligibility and service delivery with IHS clinics, tribally operated facilities or programs and I/T/Us as well as for managing tribal member care transitions. The following initiatives help us maximize care coordination to improve physical and behavioral health outcomes, empower members and create cost efficiencies.

- ***Person-centered care model:*** We assign resources based upon member whole-person needs and self-care opportunities to improve health outcomes. This includes physical health and wellness (targeting tribal key concerns like the rise in autism and Asperger's); BH wellness and recovery (targeting tribal concerns like adolescent suicide and access to BH services); social, family and community supports; spiritual and cultural beliefs and resources; and continuity of care for those transitioning to/from IHS or other clinics. To address the needs of rural tribal populations, we will continue to work on building their trust and continue our focus on hiring and assigning care managers, CHWs and peer support specialists with a Native American background or those who have demonstrated skills and cultural sensitivity to work appropriately with this population and their community health representatives (CHRs). Today, we coordinate services for 558 urban Native American members in our service area. We share our Accountable Care Population Registry (identifies gaps in care) and the support of our CPC with the I/T/U in Lincoln.
- ***Tribal network liaison:*** Our new tribal network liaison will serve as a conduit for outreach and problem solving with tribal communities. As a single point of contact, this liaison will advocate for tribal populations with network, care management and member services to assure culturally competent care coordination and service delivery.
- ***Telehealth:*** We will implement telehealth solutions (e.g., technical and operational support for rural tribal clinics) to break down barriers (e.g., transportation) and bridge access to care gaps for all of our members (includes tribal entities) living in rural and frontier communities. We are exploring opportunities to support in Lincoln the Nebraska Urban Indian Health Center's efforts to establish and expand BH services using telehealth technology.
- ***Statewide primary care and BH provider network:*** We have three contracts with IHS clinics (also designated as FQHCs) in Nebraska. We will hold a minimum of quarterly planning sessions to coordinate and facilitate health service delivery and to work on reducing health-related disparities.

64. Describe how the MCO will coordinate service planning, service delivery, and post-discharge care among discharge planners (including State psychiatric hospitals) and home health and other service providers. Include the MCO's approach to care management for youth discharged from residential care. Explain how the MCO will monitor the post-discharge care of members who receive services in remote areas. *4 pages*

Service Planning, Service Delivery and Post-Discharge Care Coordination

Managing care transitions is a critical component of our core services and leads to improved health outcomes, enhanced member satisfaction and cost savings. Today, we coordinate care for our members across a full continuum of care; including the services and supports (e.g., **home health, DME and medications**), our members need upon discharge from an acute care hospital. We have P&Ps in place to coordinate service planning and service delivery with members and their families and caregivers, providers, specialists, hospital (facility) discharge planners, and our UM and care management staff, including inpatient care managers, transition care managers, care managers and CHWs. Our primary discharge-planning goal is to provide a proactive and well-coordinated plan for transitioning a member from an acute inpatient facility or state psychiatric hospital to the most appropriate level of care while focusing on quality, safety and member satisfaction. Another important goal is to engage members in person-centered services, supports and resources that minimize a member's risk for readmission. This includes coordination with the State case manager. As such, assuring timely post-discharge follow-up physician appointments is a key strategy to reducing readmissions. In Nebraska in 2015 year-to-date, we have seen a significant improvement in follow-up physician appointments within seven days post discharge, **representing a 55.5 percent improvement**.

We will coordinate inpatient BH discharges; e.g., from the Lincoln Regional Center, and work with state psychiatric hospital staff. Our clinical leadership team, including Dr. Freed, Mr. Grubbs, Dr. Horn and Ms. Palmer, will meet with psychiatric hospital leaders to establish relationships, points of contact, etc. to facilitate smooth BH discharges. Discharge planning is often the first step in recovery; therefore, we begin planning as close to the point of a BH admission as possible. Our experience indicates a lack of discharge planning among those with high-risk BH conditions often leads to relapse and readmission. A practice we noted during our experience as a New York City BH organization was that adults who engaged with care coordination post-discharge showed **an increase of 35 percent in attending outpatient appointments**.

Effective Transitional Care Management

Health risks are heightened when individuals are transitioning from an in-patient setting to an outpatient, community-based setting. Members can be at high risk for complications and costly but avoidable use of services, resulting in fragmented and less than optimal care when transitions are poorly managed. This can lead to increased ER visits, hospital readmissions within 30 days, stress (for member and caregiver) and a potential for poor quality care outcomes. Therefore, we adopted the evidence-based Coleman Care Transition Model as the basis for transitional care management. Discharge planning and transitional care management address the needs of members experiencing an inpatient admission and provide care coordination and supports that improve a member's experience and outcomes during a care transition. Through these programs, our care teams follow members as they discharge from inpatient care and transition to an appropriate level of care (e.g., the member's home/community or a skilled nursing facility) to assure the outpatient treatment level is appropriate to meet their needs, monitor for recovery and determine their needs for ongoing care coordination. We use a combination of technology and local care coordinators to help ensure effective follow-up for those being discharged. CommunityCare offers automated notifications of care transitions.by engaging a recently discharged member by phone through our interactive voice response (IVR) system, as well as through text and email, as reminders and confirmations. Locally, we rely on established processes and procedures for following up with discharged

members (discussed below) to meaningfully enhance the care transition process and to coordinate service planning and delivery among hospital (facility) discharge planner(s), inpatient care managers, a high-risk member's care manager and an interdisciplinary care team, including the member and his/her family. We emphasize family member involvement and support and use an integrated approach to managing support for the member, with input from relevant providers, information on the home situation and available family support, and a range of community resource options that allow the individual to return to a safe home environment. We know that primary caregivers of members with special needs experience high degrees of stress that may result in their own ill health, impaired parenting and caregiving, and psychiatric and social disturbances. As needed, we connect caregivers to our Mindfulness for Caregivers program. This program teaches mindfulness techniques to improve a caregiver's physical and mental health and well-being and to enhance his/her caregiver role. Research indicates individuals receiving care from caregivers trained in mindfulness are less stressed and happier.

Inpatient Care Managers Work in Partnership with Hospital/Facility Discharge Planners

Proactive discharge planning begins the first day of a member's admission and provides an integrated approach to managing care for a member during his/her inpatient admission. Our inpatient care managers have built face-to-face relationships (and will build relationships with new hospitals/facilities) and collaborate with hospital discharge planners, therapists, social workers, nurses and physicians. They know a hospital's culture and procedures for quick and easy access to member information. They promote an evidence-based approach to discharge and transition planning and work closely with a hospital/facility's discharge planners to facilitate best practices. They connect members to community-based services to assure a safe discharge.

Working closely with hospital staff and hospital/facility discharge planners, our inpatient care managers help prevent unnecessary incidents or readmission by anticipating potential post-discharge issues through a thorough assessment of the member's medical, behavioral, social, environmental and functional needs, problems, capabilities and limitations. They have direct knowledge of a member's treatment plan during the inpatient stay. They also have access to the member's medical team and near-real-time information in the member's hospital medical record. Inpatient care managers may meet with a member/family to understand any issues that may affect the member's successful transition to home/community. By building close working relationships with hospital/facility staff, our inpatient care managers become part of and support their staff, and foster a collaborative environment—ultimately benefitting our members. Our inpatient care managers (and assigned care managers and/or CHWs, if applicable) participate in discharge planning meetings at the hospital/facility, make recommendations for services and supports upon discharge, conduct authorization reviews and help the member/family coordinate follow-up services and appointments. They deploy comprehensive in-home services and supports to meet member discharge needs, working collaboratively with assigned care managers for members who are already participating in our care management program.

Engaging a Care Manager and Initiating Discharge Management

Upon notification of a member's inpatient admission, our inpatient care manager contacts our care management program staff via telephone or uses CommunityCare to send an alert and initiate a task. If a member does not have a care manager and needs intensive, yet short-term support, our complex care team assigns a transition care manager with expertise that aligns with the member's condition(s) or demographic (for example, specialty in pediatrics or BH). The transition care manager initiates discharge planning by contacting the member, the member's providers and (with consent) those involved with a member's care to develop a discharge plan. With active participation from the member/family, the

transition care manager identifies the services/supports needed to transition to and remain safely in the home or preferred setting.

Throughout the discharge process, the transition care manager engages the member/family to help connect the member to his/her PCPs or specialists to assure follow-up care. To achieve a smooth discharge, transition care managers collaborate with hospital discharge planning staff and work with member/families to schedule follow-up appointments and help them arrange transportation, as necessary. Transition care managers conduct medication reconciliation, coordinate wraparound services (**home health**) and social supports (home-delivered meals). They educate member/families/caregivers about specific conditions or disease state(s), helping them understand the member's condition, recognizing a member's condition is worsening and determining what to do about it. Transition care managers coordinate care and services among various treating providers and facilitate communication and information sharing. To assure member safety and well-being, within seven days of discharge, the care manager contacts members/families telephonically or face-to-face (in the member's home, provider's office, depending on a member's risk level) following discharge. This allows the care manager to monitor the member's progress with instructions and person-centered interventions; to verify the member has scheduled/completed post-discharge follow-up appointments; to identify and remediate any gaps in care or barriers to care; monitor member progress following discharge; and work with the interdisciplinary care team to make adjustments in the plan of care, as needed.

During the 30-day engagement period, the transition care manager coordinates a member's care and continually evaluates the member's potential to manage his/her condition after the 30-day transitional care management engagement. At the conclusion of the 30-day intervention, the transition care manager assesses the member's need for additional services and ongoing care management (e.g., high-risk care management). If the member requires ongoing care management, the transition care manager refers the member to the care management team for evaluation and enrollment in the appropriate care management level. Once the member engages with a care manager, we shift member care from a transitional care manager to an assigned care manager. For members already enrolled in care management, the care manager re-evaluates the member's care management level and makes an adjustment based upon change in needs.

Care Management for Youth Discharged from Residential Care

Providing an appropriate continuum of BH services and supports is crucial to achieving a successful transition to home or the community and the best possible outcomes for youth being discharged from residential care. Many of these individuals are adolescents who have diagnoses of co-occurring mental health and substance use disorders. In addition, family courts or the juvenile justice system may have had a key role in the placement of the youth in residential care, mandating a placement as part of the disposition process. Our experience shows this population benefits from integrated care coordination; family-driven care; community-based support; collaboration between residential and community-based providers and government entities; and provider adoption of evidence-based and effective practices.

We use a strengths-based, culturally and linguistically competent approach that recognizes the importance of the family, school and community and addresses an individual's holistic needs. For youth discharged from residential care, we will assign a care manager who works collaboratively with residential and community-based providers and others involved in a member's care. The care manager will seek active engagement of the member and his/her family or support system to plan for and coordinate follow-up community-based care and services that become part of the member's plan of care. This plan lists transitional steps toward recovery and management of co-occurring physical health conditions as well as a

crisis/safety plan. Service planning, service delivery and post-discharge care coordination may include but is not limited to:

- An in-home evaluation of the family or living situation
- Coordinating with government entities for youth transitioning to an adult system of care or youth engaged with the courts, the juvenile justice system or the Department of Children and Family Services
- Coordinating with educational institutions
- Connecting members to peer support groups
- Arranging housing
- Engaging a peer support specialist or a CHW to accompany youth to outpatient or other community services
- Connecting an individual to vocational opportunities

Monitoring Post-Discharge Care of Members Receiving Services in Remote Areas

To monitor post-discharge care for our members who live in remote areas, we will implement:

- ***Rural access coordination team (RACT):*** We will bring our best practice outreach and care coordination initiative, known as RACT, to Nebraska. We have implemented RACT in Kansas and Louisiana to monitor Medicaid members living in remote locations. This initiative responds to local rural/frontier community needs by deploying a RACT to maximize our ability to connect with and respond to care opportunities. The team includes a care manager, provider relations staff and community outreach representatives who serve as a resource to our member services team to document and expedite solutions for rural provider access. By focusing on social health determinants in conjunction with medical complexity needs, the RACT ensures members receive necessary services. The RACT conducts outreach calls to discharged members to ensure home health care and pharmacy needs are met, and members are receiving authorized services. Based upon member needs, the RACT team may conduct face-to-face visits with members.
- ***Community health workers:*** Immediately following discharge, a CHW may be engaged to outreach to a member/family and outpatient provider to confirm a follow-up appointment has been scheduled and completed and assist with other needs, including pharmacy and community resources (e.g., connecting the member/family to a community-based or peer support group) or help remove barriers. To serve our members, CHWs will work in the rural and frontier areas to develop partnerships with PCPs and other providers, community organizations and community health representatives (CHRs) associated with tribal populations. The depth and breadth of these relationships extends the reach of health care and education into rural and frontier communities.
- ***Performance monitoring:*** We use a scorecard process to evaluate all providers on their ability to provide timely post-discharge services and follow-up care. We will use this process to evaluate providers in Nebraska's rural and frontier areas. When monitoring indicates a provider is not meeting expectations, we provide feedback, data, training and support to help them make necessary improvements. We currently have good relationships with rural health organizations and plan to expand and build a proactive partnership with the DHHS Office of Rural Health to explore innovative solutions in the delivery of care and seek guidance from the Rural Health Advisory Committee.

65. Describe how the MCO will use data and evidence-based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies. Discuss how these tools and data and systems will be integrated to implement outcome- and value-oriented payment models. Describe the MCO's experience and specific results. *5 pages*

Using Data and Evidence-Based Decision Support Tools

We power modern health care by combining data and analytics with technology and expertise. With 33 years of Medicaid experience nationally and nearly 20 years in Nebraska, we realize key data analytic and decision support tools (DSTs) are a major component in our overall goal to successfully managing our members to improve their health outcomes and reduce the financial burden of care. From using claims, predictive modeling and assessment data to determine a member's risk level, to monitoring and analyzing utilization data, such as authorizations and gaps in care to drive key business decisions, we rely on data to engage the health care system and to inform our decision-making. The depth of our analytic capabilities and suite of advanced health information tools enables better decision-making at every point along the care continuum.

Internally, under Dr. Horn's leadership, care management (CM) staff currently use data and evidence-based decision support tools (DSTs) to maximize care coordination for our members, resulting in improved outcomes and cost efficiencies. We use system-wide, integrated processes to systematically gather, analyze and share data, along with evidence-based DSTs that enable internal staff and external providers to identify care opportunities by member and provider. Data review leads to care coordination initiatives and activities, including direct interventions and actions with members and providers to address the care opportunities, resulting in improved outcomes and costs. Currently, Dr. Horn and Ms. Palmer, RN, share/discuss member-specific predictive modeling data externally with key provider partners to help them better identify and positively affect our medically complex members. With Heritage Health, this activity also will include Dr. Freed and Mr. Grubbs along with pharmacy director Ms. Jeanne Cavanaugh, Pharm.D., *Link*, our cloud-based platform, is foundational to our goal to provide a single provider platform to bring together multiple websites and incorporate new applications to improve efficiencies, automate connections and enhance information and data sharing. *Link* can be used as a flexible, dynamic provider communication and training tool to help transform care delivery and strengthen reforms with dispersed providers throughout Nebraska. For example, our UHC On-Air Web-based system presents live and on-demand educational content (e.g., PowerPoint presentations) on topics relevant and useful to network providers and our field-based care teams.

Delivery System Reform – Integrating Data and Decision Support Tools

A key component of health care delivery system reform is the use of value-based payment (VBP) models to encourage coordination that is more consistent, better quality and greater efficiency in the health services provided. The use of data and DSTs in value-based care can drive transformative change, manage and track progress, and create accountability for measurable performance for providers, payers and those seeking care. Across UnitedHealthcare in 2015, we will make more than **$43 billion** in annual payments through VBP contracts that span our Medicaid, Medicare and commercial lines of business, impacting more than **11 million of our members**. Nationally, these contracts include performance-based and bundled payments and involve ACCs, PCMHs, accountable care organizations (ACOs) and full capitation arrangements across 55,000 physicians and 800 hospitals.

Using Decision Support Tools and Data to Implement Outcome and Value-Based Payment Models

Locally and nationwide, we recognize that ER and inpatient care is costly and that a reduction of avoidable ER and inpatient use has the most opportunity to reduce cost and improve care. Therefore, we have focused VBP models on reducing avoidable ER and inpatient use along with proactive patient care

for members at highest risk. We reward providers for achieving specific metrics, such as lowering readmissions, decreasing hospital-acquired conditions and improving HEDIS measures. **In Nebraska,** we executed four basic quality model contracts and a unique shared savings model/risk sharing arrangement with UniNet Healthcare Network, which covers 26 percent of our membership. These agreements account for 32 percent of PCPs in our Nebraska service area. We provide toolkits for providers to use to help them succeed under new models, including timely data and actionable feedback on their performance. Providers use DSTs and data at the point of care, extending their clinical workflow without hindering productivity and promoting delivery of quality care provided with efficiency for our members.

Because savings incentives are earned based upon achieving key metrics, transparency in sharing clinical data and track key metrics is critical. Value-based care requires a modern, connected infrastructure. As such, *Link* reduces manual processes and automates connections and data sharing among providers, our staff, government entities and other authorized users. ***Link*** offers providers convenient access to **CommunityCare** and its Population Registry, which can be used to share data with providers about their performance and achieving outcomes that can result in enhanced payment. These tools give providers the ability to track, trend and respond to practice performance. We conduct regular Joint Operating Committee meetings with providers to review their performance using these tools and claims analysis from our **SMART** data mart. These tools allow us to work with providers using a Plan-Do-Study-Act approach to develop ongoing clinical initiatives to improve performance and position providers to benefit from VBPs. Within our performance-based programs, we offer three value-based payment models described below.

"I love it! I work with a number of websites on a daily basis and this is by far my favorite. It's easy to use and now with chat, you can get the explanations you need at the click of a mouse."

–Link Dashboard user

Performance-Based Programs

We know not all providers are at the same level of integration or readiness, so our VBP models offer the flexibility to meet providers where they are and facilitate their movement up or down the VBP continuum based upon their readiness and performance. Our VBP models are collaborative partnerships with providers with whom we modify their reimbursement structure to support their achievement of improved quality outcomes and avoidable medical expense. Our models are nimble enough to adjust reimbursement structure, risk and metrics as necessary to align with MLTC's quality goals. We know it can be challenging to be successful if providers have misaligned incentives or complex and varied reporting methodologies. Therefore, we offer models that support payment reform and make those models adaptable so they can be refined to the specific models that MLTC encourages or selects for implementation.

Basic Quality Model (BQM). This model is designed to support practices with more than 150 UnitedHealthcare members to achieve improvement in patient health through closing gaps in care related to preventive screenings, tests, referrals, chronic disease monitoring and the opportunity to be rewarded for their performance. Through plans of care, the program encourages PCPs to conduct preventive health screenings, improve HEDIS scores and focus on state quality performance metrics. These metrics help inform members and their caregivers of potential gaps in care as motivation for them to complete these suggested interventions. Practices may earn bonus payouts in addition to their fee-for-service (FFS) reimbursement for meeting or exceeding quality measure local thresholds that are established at the practice level based upon historical performance. In Nebraska, we have executed five BQM contracts and, anticipate finalizing 10 more contracts by the end of 2016.

Episode-Based Shared Savings Model. For providers not yet ready for total population health arrangements, we work with state Medicaid agencies to advance an episode-based payment pilot. This approach gives the provider accountability for a given condition or procedure and the opportunity to be rewarded for quality and savings relative to an established benchmark cost per episode on a retrospective basis. This model is designed to reward coordinated, team-based, high-quality care for specific disabilities, conditions or procedures. For example, a pregnancy episode includes all care prenatal through delivery and the postpartum period. We look forward to working with MLTC on opportunities to develop this model in Nebraska in the future.

Accountable Care Shared Savings Model. At the most advanced end of the value-based spectrum are our programs focusing on population health, encompassing shared savings/shared risk models like ACCs and PCMHs, as well as capitation and capitation-plus-value-based contract. This model targets primarily larger care practices and FQHCs that are committed to collaborating toward the goal of clinical integration and comprehensive population management. Foundational to this model is advancing proactive care teams to support practice transformation by improving access, efficiency and quality of care for patients and give practices the opportunity to earn monthly PMPM reimbursement for clinical integration activities. The model includes both upside/downside shared savings and shared deficit provisions based upon performance against total cost of care or clinical efficiency metrics. As we grow our VBC efforts in Nebraska, we will identify practices that can move along the ACC model continuum.

Data and Evidence-Based Decision Support Tools Used in Care Delivery

Using technology at the point of care supports the delivery of care that is appropriate, timely and cost effective. Effective tools help providers and us to make sound decisions that reduce risk to the member and show continuous improvement in health outcomes and cost efficiency. Having the right information at the right time is essential to optimizing care delivery. Tools described in Table IV.L-7 make information available to our provider community, members and care management team.

Table IV.L-7: Decision Support Tools and Use in Care Delivery/Experience and Results
Reporting and Data Analysis Tool
Our SMART data warehouse collects, stores and reports quality measures, prior authorizations and claims data. We produce reports and conduct clinical, quality and UM/CM analyses used by our staff to drive our clinical initiatives. We develop and share scorecards externally with provider practices to identify opportunities for improvement in practice patterns and closing member gaps in care. ***Experience/results:*** Dr. Horn has met with and presented provider profiles to our key provider offices. The profiles have resulted in meaningful discussions and requests for additional data and CPC support to assist with closure of member gaps in care.
Risk Stratification and Predictive Modeling
Impact Pro population health risk ID/stratification tool (with evidence-based medicine care gaps) guides/drives the population and member-level clinical priorities of our model. The tool provides robust data that we will share externally with providers through CommunityCare. Impact Pro data is used with other tools to identify members at risk who are then assigned to our care management programs. We also use **SMART** and **Impact Pro** analyses to identify practices whose population health risk will benefit most from our ACC/PCMH model. We share data with PCMHs and identify our high-risk members. ***Experience/results:*** Based upon measures of predictive accuracy, Society of Actuaries risk-adjusters study showed Impact Pro to perform best in class. (Winkelman and Mehmud, 2007, Society of Actuaries)
Clinical Data Management
CommunityCare, our clinical management system, provides a holistic, centralized view of our members' CM information, including utilization of authorized services, pharmacy, health risk assessments, care plans, and CM and disease management programs. CommunityCare and its Population Registry give providers a comprehensive

Table IV.L-7: Decision Support Tools and Use in Care Delivery/Experience and Results
view of the services used by any given population, reports each member's risk level and identifies evidence-based medicine gaps in care. The Population Registry offers providers a comprehensive *member view* of the clinical history of the whole person, while the *population view* provides lists of members in the practice who need specific follow-up. ***Experience/results:*** We implemented CommunityCare in 24 states, including in Nebraska (March 2015).
Health Risk Screening
Care coordination begins when an MSA outreaches to welcome a member and conducts health risk screening. Results provide early identification and prioritization of member needs. Screening results may trigger the need for additional assessments and development of a plan of care for high-risk members. Initial health risk screening results are housed in a member's record in CommunityCare. ***Experience/results:*** In 2014, we completed health risk screening for 3,430 new Nebraska members.
Adverse Events Reporting Tool
Subsequent Events of Cluster Activity (SECA) report summarizes ER and inpatient adverse events via hospital ADT data files (if available) or claims activity and adds to the member Impact Pro risk score to identify members at highest risk who can benefit from our focused high-risk care management interventions. ***Experience/results:*** UnitedHealth Group has partnerships with state HIEs (four live, seven in progress) and individual high-priority facilities (more than 300) to acquire and integrate automated alerts into workflows. These alerts are fed directly to care managers who outreach to members and monitor 30-day readmission rates to assess outreach impact.
Clinical Care Guidelines
We provide clinical practice guidelines to our care managers and providers to support their efforts to render evidence-based clinical decisions that are aligned to a member's diagnosed conditions. Nationally recognized, best-practice level-of-care *MCG*, along with our clinical guidelines that complement *MCG*, offer clinical guidelines that promote a consistent, evidence-based approach to clinical reviews. The guidelines recommend support decisions about health interventions and are available to providers by accessing the Web-based provider portal. ***Experience/results:*** In 2014, our inpatient and surgical care national results showed 93 percent of our clinical staff (physicians/nurses) met or exceeded expectations in the consistent application of clinical care guidelines during authorization reviews.
Inpatient UM/CM Census
Blended Census Report Tool (BCRT) provides timely identification/tracking of members in facilities and allows our UM/CM team to conduct effective end-to-end UM/CM, discharge and care transitions. ***Experience/results:*** The inpatient CM team conducts daily reviews of the inpatient census using the BCRT tool to identify members who require observation status, those who will need post-discharge transition CM and those who may have barriers to safe, timely discharge.
Readmission Risk Assessment (RRA)
Care managers use this tool to assess the risk of readmission. The assessment dictates the level of discharge and transitional CM the member receives prior to discharge, allowing us to develop plans of care that reduce readmissions and to prioritize post-discharge follow-up care. ***Experience/results:*** Members identified via RRA and who engage in transitional CM are 27 percent less likely to have a 30-day readmission and 19 percent less likely to have a 60-day readmission compared to control group and are 21 percent more likely to complete follow-up visits.
Maternal Child Health Scorecard
This Web-based scorecard provides information, such as ante partum admissions, UM data, neonatal intensive care (NICU) data, average gestation, deliveries, rate of premature deliveries, C-section rate, admits/1,000, ER visits/1,000 and CM enrollment. This information informs clinical initiatives to improve prenatal/postpartum management and to reduce NICU admissions. In Nebraska since early 2014, the HFS Neonatal Resource Services (NRS) program has been providing inpatient UM for infants in NICU and post-discharge care coordination. NRS uses health risk screening and the HFS Initial Leveling Assessment to identify and risk-stratify program candidates

Table IV.L-7: Decision Support Tools and Use in Care Delivery/Experience and Results
and reviews the quarterly Maternal Child Health Scorecard to identify utilization trends and to guide initiatives. ***Experience/results:*** In 2015 YTD, our Nebraska NICU average length of stay decreased by 12 percent.
Hospital Benchmarking
Our clinical leaders review data with hospital leadership from the Hospital Inpatient Review (HIPR) tool, which provides detailed benchmark analysis of overutilization days by hospital by APR-DRG at the state or national level. We work with hospital partners to identify opportunities for improvement and develop annual and ongoing collaborative clinical initiatives to improve performance. ***Experience/results:*** Dr. Horn shares the HIPR report with key Nebraska provider practices/facilities.
ER Escalation Report
This report shows—by hospital and admitting physician—the propensity to admit to either observation or inpatient level of care, by diagnosis, compared to peer hospitals in Nebraska, regionally and nationally. Collaborative data sharing with hospitals/physicians drives dialogue about opportunities to reduce avoidable/costly care. ***Experience/results:*** Dr. Horn presented and discussed these reports with two large facilities this past year whose utilization patterns suggested opportunities for improvement.
***Link* Portal**
We are transitioning our traditional Web-based access, *unitedhealthcareonline.com*, to *Link*, which offers native applications and a simplified way of doing business with us. *Link* provides access to a variety of comprehensive plan and member-specific information, such as HEDIS. Providers can view a member's assessment results and plan of care and then add comments to the plan of care. ***Experience/results:*** Today, more than 600,000 providers nationwide and 3,500 Nebraska providers have access to *Link*.
MedMeasures/Universal Tracking Database (UTD)
MedMeasures is an NCQA-certified application that provides HEDIS quality reports and provider profiles containing preventive care, access to care and UM measures. UTD, a predictive NCQA HEDIS compliance/outreach tool, profiles individual providers and benchmarks them across all of our health plans, identifying providers falling outside the expected range for service delivery. Members view their gaps in care using CommunityCare, *myuhc.com*, *Health4Me*. Providers can view their gaps in care using *unitedhealthcareonline.com*, *Link*, *Health4Me*, CommunityCare and within the provider's practice management system with 270/271. ***Experience/results:*** In 2015, we implemented our new CPC program. Experienced CPCs share with our providers member-level detail reports that are pulled from MedMeasures. This allows providers to easily identify members with gaps in care for targeted outreach. The reports have been well received by providers who have subsequently initiated member outreach. In 2016, we will enhance our *Health4Me* app with a *Recommended Care* function that reminds members about care gaps and preventive services.
Provider Profiles – Achieving Clinical Excellence and ALERT® Programs
To improve quality of care among facility-based providers, we will launch Achieving Clinical Excellence **(ACE)**, our facility measurement program that gathers relevant data. ACE allows us to parse data into effectiveness and efficiency metrics to achieve improved clinical success. Network facilities in the ACE program receive risk-adjusted performance data based upon five effectiveness metrics and two efficiency metrics. Data is evaluated annually against regionally based benchmarks. Results are used to engage facilities by recognizing them for performance or helping them to mitigate variations in practice patterns—leading to improvements in outcomes and affordability. We will monitor outpatient care and measure outcomes through **ALERT** (Algorithms for Effective Reporting and Treatment), our outcomes-driven outpatient management program. ALERT is a key component of our BH program by emphasizing early identification and monitoring of high-risk cases among members in outpatient BH treatment, allowing us to focus our clinical resources where we can add the most value. ***Experience/results:*** ACE and ALERT have achieved multi-million-dollar cost savings in 2015 with 15 percent of ACE facilities reaching platinum status and no concurrent review requirements.

66. Provide a proposed plan for coordinating efforts for members who may be involved in multiple State programs, including those enrolled in HCBS waivers. Describe how the MCO will deploy care management activities under this RFP in a manner that will not duplicate the activities provided under HCBS waivers and will facilitate sharing of information across DHHS-administered programs. *3 pages*

With the inclusion of the ABD population who are dually eligible for Medicaid and Medicare, individuals who are part of an HCBS waiver program or those living in an institution, and continuing to serve our members in foster care, our care management activities will bridge across multiple systems (including providers, schools, facilities, state agencies and community-based organizations) that serve our Heritage Health members. Although managing services for members who are participating in multiple state programs can be challenging, our Nebraska team can leverage the experience in other markets where our health plans are responsible for comparable responsibilities. Similar to Nebraska, in Arizona, Hawaii, New Jersey and Texas, for example, we coordinate medical and BH care and services, while a state-designated agency retains responsibility for coordinating HCBS waiver services. Under these contracts, we provide coordinated services to address developmental disabilities and complex cognitive, physical, BH and chronic conditions. We monitor and evaluate the effectiveness of interventions and strengthen procedures and systems to provide a localized, hands-on approach that is responsive to members and their network of caregivers, representatives and advocates.

Our experience provides valuable insight into the expected utilization patterns for Heritage Health members participating in multiple programs. Nebraska's waiver populations include a wide range of individuals, such as those with mental and physical disabilities, dual diagnosis, adults, adolescents and children with complex or comorbid needs and individuals with substance use disorders. In anticipation of the addition of new populations to Heritage Health, we have outreached to community providers who serve these individuals. Providers serving the Nebraska I/DD population have confirmed to us high use of psychotropic meds by the I/DD population. Further, we know that children participating in Medicaid and foster care are four times more likely to be taking psychotropic medications than children who are in Medicaid and not in foster care. Our experience clearly demonstrates the importance of assigning a single point of navigation to members involved in multiple state programs. This knowledge coupled with our vast care management experience informs our approach to assure members receive the screening and assessments, medical and BH care (includes diagnosis, treatment and follow up) and social services and supports they need to meet member/family-defined goals and improve health outcomes. In addition, effective coordination improves communication flow and information sharing among providers, members/families/caregivers, systems and state agencies.

Plan to Coordinate Efforts for Members in Multiple State Programs

Navigating the health care system can be difficult for anyone, but is particularly difficult for someone, for example, like Fred who has multiple chronic conditions and is not receiving integrated care coordination. Fred is 65 years old and lives with his daughter and her three children. Fred suffers from chronic obstructive pulmonary disorder (COPD), hypothyroidism, diabetes and anxiety. Fred knows he has health coverage through multiple programs, but he finds it hard to navigate the health care system. When Fred has symptoms, like a low-grade fever or lightheadedness, he does not always know which doctor to call first. Sometimes it is just easier for Fred to go to the ER. In our model, Fred would not have to navigate the system by himself, rather he would be assigned to a care navigator (or care manager if he was assessed as high risk) who will answer his questions and help him navigate the system.

When providers and other members of the health care delivery system work together for the benefit of the individual and population served, coordinated care improves the individual's experience with the system and his/her health outcomes as well as reduces wasteful spending by avoiding duplication of care and

services. We look forward to bringing our best practices in coordinating care for Heritage Health members. We will use the following strategies to strengthen care coordination for those participating in multiple state programs:

- ***Building relationships and targeted staff training:*** Effective coordination begins with understanding the benefits other State programs provide. We are building relationships with these programs, including meeting with DHHS divisions and state agencies and the regions. We will cross-train our staff and state staff to understand the services provided by each entity. Targeted training promotes knowledge and understanding of how Medicaid and Nebraska's HCBS waiver programs work together and separately. Training promotes an understanding of health care and social service programs as well as initiatives offered by MLTC and other state agencies. With training, our staff will be fully competent to leverage state programs for members receiving medium and high-risk care management.
- ***Establish policies and procedures (P&Ps):*** A minimum of 60 calendar days in advance of implementation, we will submit to MLTC P&Ps for coordinating with HCBS case managers. The P&P will address our strategies to ensure care coordination services are not duplicated. We will designate points of contact (for example, care navigators, care managers and tribal liaison) to collaborate with other entities and programs serving our Heritage Health members. We will collaborate with other entities and programs involved with the member's care. We will work proactively to resolve any care coordination issues with other state agencies, tribes and other community providers.
- ***Proactive identification of members participating in multiple state programs:*** Using the enrollment file, we identify and document in the member's record any indication a member is participating in multiple state programs. In addition, we regularly perform retrospective review of secondary claims, as they are also indicators of additional coverage. Once identified, we use comprehensive health risk assessments to determine unique member needs, such as a BH diagnosis, substance abuse issues or social needs.
- ***Proactive identification of other case/care managers and caregivers and inclusion of them on the member's interdisciplinary care team:*** With a member's permission, we will request that other case/care managers (e.g., state-designated) and family/caregivers participate on an interdisciplinary care team, engaging them in care planning and coordinating care in a manner that complements, yet does not duplicate, the member's plan of care, services and supports.
- ***Strengthening care coordination efforts:*** Our care model assures assistance with navigating multiple programs, timely member assessment, development of a plan of care that promotes optimal independence and member self-responsibility, and completion of follow-up and monitoring activities. Our goal is to identify members who have special medical, behavioral or social needs and those who may be declining both medically and functionally. When these circumstances exist, we identify and coordinate options (including community resources) that can support an individual's ability to remain at home and avoid placement in a facility. *Advocate4Me* and care-management team members are our first-line resources used to address an individual's full range of health and functional needs. They identify the services and supports required to address member needs and goals, regardless of which program provides the benefit. A care navigator will be assigned to Heritage Health members participating in multiple programs, such as HCBS waiver programs. The care navigator provides ongoing support working with members/families/caregivers, MLTC and other state agencies, HCBS case managers and other stakeholders to help members navigate the overall health care system.

- ***Individualized benefit navigation assistance:*** Care coordination activities are driven by a member's risk level and complexity. In our model, members have access to MSAs, care navigators and care managers who have training and knowledge of HCBS waiver benefits. They can help members/families/caregivers navigate program benefits and assist members with questions. For example, if a member calls a care navigator but needs to speak with a state agency or enrollment broker, the care navigator will offer to dial and warm-transfer the call and then remain on the line, if requested. Care navigators explain processes and answer members' questions about covered benefits. Care navigators and MSAs, like care managers, adhere to established performance standards for calling back members and conducting screening or assessments on a timely basis. They can resolve a member's claim-related issues by working internally with our staff or by reaching out to a member's HCBS waiver case manager, if necessary. Members and their families or caregivers can call the 24 hours a day, seven days a week NurseLine and crisis line.
- ***Network services:*** Conflicting payment policies can result in a lack of coordination between providers of services covered only by the HCBS waiver program and those providing traditional state plan services. We will support member access to our robust provider network, which can meet all our members' complex care needs. Further, we will work with all providers to resolve any payment or service coordination issues.
- ***Recruiting and hiring:*** In addition to training all care navigators and care managers to meet our members' holistic needs and to work collaboratively with other care/case managers, we will recruit staff who has experience with members receiving HCBS waiver benefits and expertise with complex care needs. Care management staff assigned to the waiver population will attend DHHS meetings, as needed or requested.

Facilitating Information Sharing across DHHS-Administered Programs

Population health management requires leveraging data in near real time (e.g., clinical, claims, HEDIS) to quickly identify gaps in care, share data at the point of care and streamline the measurement process. For this reason, we implemented CommunityCare in Nebraska in March 2015. This HIPAA-compliant, cloud-based, population health and care management platform supports care team collaboration by sharing and tracking assessments, plans of care, evidence-based medicine gaps in care and interventions. CommunityCare improves coordination of capitated and non-capitated services and reduces duplication of effort by presenting authorized users with timely, relevant and actionable information, thereby improving health outcomes and reducing inappropriate use of health care resources. The system shares referrals, progress notes and registry data, such as pharmacy data, 24 hours a day, seven days a week. It can receive ADT data, providing real-time access to actionable information (e.g., electronic notifications of ER and hospital discharges). It supports MLTC's population health initiatives by enabling real-time data aggregation, year-round data collection and supporting technologies that integrate physical and BH data for providers and others serving our members. We will give MLTC and other DHHS agency staff, as part of the member's care team, access to CommunityCare to view and to contribute member-specific data (with member consent).

67. Describe the MCO's outreach program to encourage women to seek prenatal services during their first trimester of pregnancy and how the MCO will implement required health risk screening and follow up, when applicable, for pregnant members. *2 pages*

Our approach to pregnancy outreach integrates with our care management program and our focus on promoting prenatal services, wellness and assuring our youngest population has the best possible start to life by increasing compliance with evidence-based clinical care guidelines, best practices and quality metrics. The combination of analytics, outreach and innovative member engagement tools and subsequent positive health outcomes tells us that we can successfully influence member behavior and improve outcomes while reducing costs. We empower women to make their own health care decisions, including lifestyle changes that enhance their quality of life and help their babies thrive. **In 2014, our national pregnant population had a preterm birth rate of 11 percent compared to a U.S. national average of 12.3 percent. In Nebraska, our preterm birth rate is 10.9 percent (YTD 2015). In 2015, our national pregnant population had a C-section birth rate of 31.5 percent compared to a U.S. national average of 32.7 percent. In Nebraska, our C-section birth rate is 30.2 percent (YTD 2015).**

Identification, Health Risk Screening and Follow-Up Support

We will ensure our pregnant Heritage Health members begin receiving care within the first trimester or within seven days after enrolling with us or upon receiving notification of the member's pregnancy. Early identification of pregnant members is an essential element of achieving positive pregnancy and birth outcomes. Once we identify a pregnant member, we engage/make contact with the member, explain the Healthy First Steps (HFS) care management program, complete a leveling assessment to identify high-risk pregnancy risk factors and enroll the member in HFS and other pregnancy support programs, such as Baby Blocks and *Text4baby*. We assign a CHW to high-risk pregnant women to explain the benefits of HFS and encourage them to join the program. To help us identify pregnant members as soon as possible, we have established processes and systems that support early identification and risk screening:

- Frequent/ongoing **data analysis** of enrollment files, lab/physician/pharmacy claims data (e.g., prenatal vitamin prescription), lab and hospital census reports. We engage the majority of our current members identified as pregnant in the HFS program.
- **New member outreach**, including the *Member Handbook*, welcome calls and a **health risk assessment** (via telephone, IVR or online), which contains questions to identify pregnant women. Staff outreach and targeted materials educate members on the importance of notifying us as soon as possible so we can engage them in health care and social services that will support a pregnant mom's health and that of her baby. We have invested heavily in an outreach strategy, which includes targeted mailings, automated calls, direct telephone calls, health fairs/events and member newsletters (*HealthTalk*) with periodic articles promoting prenatal services, such as *Before Baby – Have a Healthy Baby* in our spring 2015 edition. Our *Member Handbook* reinforces the importance of prenatal care and reminds women to notify us when they become pregnant or give birth.
- **Referrals** received from members/family, PCPs/OBs/FQHCs, our CM staff, community or government-sponsored program staff (e.g., WIC program). Network providers have relationships with our members and are often the first to know when a woman becomes pregnant—we encourage providers to notify us after a member's first prenatal visit.
- Members can notify us if they suspect or have a confirmed pregnancy by calling our **Member Services** or **NurseLine**. Our staff helps women access the health care services/support and community-based social resources (e.g., WIC). Members can access online information about health/wellness topics, such as smoking cessation and postpartum depression, through

liveandworkwell.com (available through the *myuhc.com* member portal). This website provides confidential access to BH professional care, self-help programs, interactive tools and educational resources.

- All pregnant members are screened for possible referral into HFS case management by their OB/GYN or by an HFS nurse who conducts the **HFS Initial Leveling Assessment.** This assessment tool identifies pregnant members who are at high-risk; e.g., those with a previous preterm birth or other prior adverse pregnancy outcome.

Table IV.L-8 lists innovative pregnancy outreach strategies (embraces digital media like mobile apps and smartphone-based support) and engagement/follow-up support to encourage women to participate in prenatal services during the first trimester of pregnancy and beyond.

Table IV.L-8

Strategy	Overview of Engagement/Follow-Up Support
Healthy First Steps	Our staff of HFS nurses, social workers and health educators works with members and their doctors to assure healthier pregnancies and babies. HFS activities enhance the provider-patient relationship and our member's compliance with an individualized plan of care. HFS emphasizes activities and treatments that can help prevent pregnancy-related complications, such as hypertension or diabetes, using cost-effective and member-involvement strategies. HFS care managers conduct outreach calls to encourage women to complete prenatal care.
Collaboration with community and religious organizations	In Nebraska, we organize community baby showers (seven baby showers, reaching 141 members so far) for pregnant women/families to learn about the importance of prenatal/postpartum care. During baby showers, attendees ask questions about health care resources and receive pregnancy-related materials from our community partners (e.g., MOTAC tobacco prevention agency, Nebraska Breastfeeding Coalition, Family Housing Advisory Services and a DHHS community support specialist). A OneWorld Community Health Center educator reinforced the importance of prenatal, postpartum care and baby well-child checkups. We give attendees a gift bag and offer refreshments, drawings and prizes. When members mention they have barriers to accessing care (e.g., food, transportation challenges), our staff helps to resolve these barriers by referring members to community-based resources, using their knowledge of local resources and the *Healthify* tool, which contains Nebraska-specific resources. In addition, we have outreached to the Nebraska Association of School Nurses and a school-based clinic (high school) to collaborate on initiatives for pregnant teens to encourage screening and linkage to health care and social services. The OneWorld Teen and Young Adult Health Center, which open in mid-January, will be providing general medical visits, school physicals, sick visits as well as STI screening and pregnancy screening for teens and young adults ages 12-24. We will collaborate with the health center and key schools to participate in health events following the opening.
Baby Blocks pregnancy support	Our award-winning Baby Blocks program offers a unique approach to achieving improved health outcomes for pregnant and postpartum women and their babies. Through the dual appeal of an interactive game interface and attractive rewards, Baby Blocks reminds and rewards members for attending their appointments during their pregnancy and well-baby appointments into the first 15 months of their baby's life. The program uses mobile-optimized engagement tools, including an easy enrollment process, appointment reminders and brief, relevant health tips. The program delivers eight incentives to women who achieve health care goals during the 24-month program. Since the program's launch in Nebraska in October 2013, over 2,200 members have enrolled in Baby Blocks (48,000 members enrolled nationwide).
Text4baby	*Text4baby* is a free service for pregnant women and new parents. It delivers tips and support via text messages throughout pregnancy and the baby's first year. Topics include exercise, fitness and nutrition; labor and delivery; car seat safety; and breastfeeding. We deliver broadcast messages to members regarding access to local resources and access to additional resources, such as NurseLine.
Twitter	We outreach to members through social media. Expectant mothers can follow us on Twitter, @UHCPregnantCare (or @UHCEmbarazada) for messaging about health/wellness related to pregnancy, childbirth and general health information.

IV.M. Quality Management

68. Provide a description of the MCO's proposed QAPI program. Include the following in the description:

- The proposed structure, and policies and procedures that explain the accountability of each organizational unit.
- The program's infrastructure, including coordination with subcontractors and corporate entities, if applicable.
- Proposed QAPIC membership and committee responsibilities.
- How the MCO will comply with and support MLTC's quality strategy.
- How focus areas will be selected, including how data will be used in the selection process.
- The proposed QAPI work plan, including planned initiatives. *10 pages*

We have 33 years of national experience coordinating care for Medicaid and other publicly funded programs for more than 5.3 million members in 24 states plus the District of Columbia. We began serving Nebraska Medicaid members in three counties since 1996 and today, UnitedHealth Group serves more than 425,000 members in Nebraska, including nearly 60,000 Nebraska Medicaid members.

We bring a depth and breadth of expertise to the Nebraska Medicaid program because of our successful national Medicaid experience in quality management and supported by our "Commendable" NCQA accreditation status that achieved 100 percent compliance by receiving 50 out of the 50 available points. Leveraging the depths of this experience and our history serving MLTC, we are poised to offer innovative, high-quality integrated care programs and services that will maximize the long-term viability of Nebraska Medicaid success and value to the members and providers we are honored to serve.

We accomplish this with collaboration and valued input from MLTC, providers, behavioral health (BH) professionals, caregivers, members, associations and community organizations serving communities across the state supported by our integrated and cross-functional Nebraska Quality Assurance and Performance Improvement Committee (QAPIC). We are implementing the QAPIC as of Jan. 1, 2016, in advance of the new contract, so that we can immediately align with MLTC quality goals. Using the new Nebraska QAPIC infrastructure outlined in the Section M-4 as our foundation, Dr. Michael Horn medical director/chief medical officer, will chair and facilitate the creation of an integrated approach to quality, population health, patient-centered medical homes, drivers of clinical care, case management and UM.

Our population health-centric philosophy is a building block of our overarching QAPI program. Our approach seeks to build on our detailed understanding of the distribution of social, economic, familial, cultural and physical environment factors, which affect health outcomes among different geographic locations and groups in Nebraska. As we do today, we will continue to consider social determinants as we design and implement interventions essential to our efforts to achieve the *Triple Aim* of better health outcomes, improving the care experience and lower costs of care.

Quality Assurance and Performance Improvement

Quality Program Documents

Annually, we formally document our quality assurance and performance improvement (QAPI) through a trilogy of documents that help us drive continuous quality improvement (QI) throughout the Nebraska Medicaid program while monitoring its progress. These documents include the *Quality Assurance and Performance Improvement Program; the Quality Assurance and Performance Improvement Work Plan; and the Quality Assurance and Performance Improvement Program Evaluation from the prior year, which in turn informs the development of the Quality Assurance and Performance Improvement Program Description and Quality Assurance and Improvement Work Plan.* The Nebraska QAPIC and the board of

directors ultimately approve all three documents, and the documents are submitted to the applicable regulators as required.

- The ***QAPI Program Description*** provides detail regarding the goals, objectives, structure, oversight, leadership participation, resources, methodologies used (e.g., Plan-Do-Study-Act, Six Sigma, Rapid Cycle) and key components of the QAPI program. We set goals and objectives based upon the findings of the previous year's evaluation, and through direction from the Board and our executive team to ensure alignment with the UnitedHealthcare strategic plan. Both the board and the QAPIC approve the QAPI Program Description annually, and direct its revision as appropriate to the changing needs or strategy of UnitedHealthcare. The QAPI Program Description also describes the subcommittees of the QAPIC, including their scope, membership and frequency of meetings.
- The ***QAP) Work Plan*** is a living document, updated no less than quarterly. The QAPI Work Plan directs the routine activities under the QAPI Program and is the basis for our committee activities. Through quarterly updates and subsequent review and approval by the QAPIC, we verify that the QAPI Work Plan encompasses all aspects of clinical care, service and operations; designates responsible leaders and staff for each activity; and includes a time frame for completion and reporting of each activity to the appropriate committee. Each activity is also assigned measures, including process monitors, performance goals and benchmarks. Each item in the QAPI Work Plan aligns to a key component of the QAPI program as outlined in the QAPI Program Description.
- The ***QAPI Evaluation*** is the annual assessment of our effectiveness. The quality team reviews in detail the findings of each activity on the QAPI Work Plan for the prior year, as they align with the critical components in the QAPI Program Description, and evaluates our performance against the established, approved performance goals and benchmarks. Incorporating qualitative and quantitative data; clinical service and satisfaction data; and committee actions, the QAPI Evaluation assesses whether we have met our goals and objectives as set forth in the QAPI Program Description. Our QAPI is compliant with state-specific regulatory components and NCQA accreditation requirements. Barriers, opportunities and interventions identified in the QAPI Evaluation remain on the QAPI Work Plan for the next year, providing the mechanism by which the established, documented QAPI program drives ongoing quality improvement.

All clinical and non-clinical activities are detailed in the annual QAPI Work Plan, which we update for each clinical and service quality improvement area annually to reflect new priorities and needs. We focus on those measures identified by MLTC, our QAPI Work Plan and a broad range of program activities to include EPSDT services, preventive health and screening, chronic disease states, medication management, BH and member/provider satisfaction.

Proposed Structure, Policies and Procedures

We understand the importance of developing QM processes that assess, measure and improve the quality of care provided to members. We are modifying our quality committee structure as of Jan. 1, 2016, to align with the needs of MLTC and its members pursuant to the new QAPIC structure. *Our goal is to align the quality structure we have in place today with the one we are developing to meet the needs of MLTC tomorrow.* The new structure is based upon our current committee structure, working relationships and interdependencies that are successfully in force today. We leverage the considerable resources and expertise of our national organization, while deploying local resources through the quality management structure and oversight by Nebraska experts in population health and quality management. This blend of

local expertise and national experience is seen in the QAPI program structure and committee functions, always incorporating physical, behavioral, pharmacy and all functional areas. While the ultimate responsibility for the QAPI program lies with the board of directors, we delegate everyday management of our QAPI program to our QAPIC.

We have included a QAPIC organization chart illustrating the local quality committee structure supported by the national Quality Management Oversight Committee structure and the interdependent accountability and reporting structure of each committee.

Policies and Procedures

We have policies and procedures that include and integrate operational leaders from all functional areas who are empowered to make or change policies and processes in support of continuous improvement; functional areas include but are not limited to leaders from: quality management and performance, health services, network development, pharmacy, BH, vision, special populations, operations and customer service.

Quality Assurance and Performance Improvement Infrastructure

As seen in Figure IV.M-1, the QAPI Program infrastructure at UnitedHealthcare is a comprehensive program under the leadership of the medical director/chief medical officer Michael J. Horn, M.D. Dr. Horn will report to the board of directors, which includes UnitedHealthcare leadership and other designees as identified by the committee chair. Through the board's oversight, we demonstrate a senior-level commitment to quality and to our QI Program. Dr. Horn oversees a broad range of evidence-based QI program activities including QI measures and studies, clinical practice guidelines, health promotion activities including health equity, service measures and monitoring, ongoing monitoring of key indicators (e.g., overutilization and underutilization). He also has responsibility for QI issues related to continuity of care, health-plan performance analysis and auditing (e.g., HEDIS), care coordination, educating members and physicians, risk management and compliance with all external regulatory agencies.

Figure IV.M-1. Nebraska Medicaid QAPIC Structure

Driving Operational Performance Improvement

We use a comprehensive array of monitoring approaches and mechanisms as components of our QAPI program infrastructure to identify and prioritize areas for improvement, set quantifiable goals and metrics, and communicate clear expectations. This is accomplished through our integrated and cross-functional Nebraska QAPIC, under the direction Dr. Michael Horn, with support and expertise provided by our locally based QAPI team, led by quality management coordinator, Cyndi Margritz, RN, BSN.

To drive clinical and operational performance improvement, our QAPI team incorporates ongoing monitoring of critical quality indicators, formal performance improvement projects (PIPs), ongoing application of rapid cycle improvement and plan-do-study-act methodology, and compliance with federal and state regulations and NCQA health plan accreditation standards. Our Nebraska leaders set short- and long-term performance goals and our QAPI team assists them in benchmarking our performance against

Nebraska state and national rates. Our Nebraska QAPIC measures our successes through analysis of industry-standard measures of health plan quality, including but not limited to HEDIS measures, CAHPS surveys, CMS Adult and Child Core Measure Sets, EPSDT screening ratios, access and availability data, and through the feedback we receive as part of compliance audits and accreditation surveys.

Coordination with Subcontractors

Through our QAPI Program, we monitor and improve the quality of care and service delivered over a wide range of clinical and health service delivery areas, including subcontractors, health services, operations, network management, credentialing, compliance, member services, appeals and grievances, and claims. For our members, we place emphasis on the clinical areas related to management of chronic diseases, mental health and substance use disorder (MH/SUD) care, members with special needs and access to services for members.

Our material subcontractors for Nebraska include ***United Behavioral Health*** (Optum Behavioral Solutions), providing NCQA-accredited BH services; ***OptumInsight, Inc.,*** supplying data analytics, technology and operational services; ***OptumRx Inc.,*** providing a sophisticated array of high-quality integrated pharmacy benefit management services; and ***United HealthCare Services, Inc.,*** providing administrative management services. To the extent that these subcontractors prospectively or retrospectively evaluate the medical necessity of services, we will educate their leaders and staff on Nebraska Medicaid program requirements. This education will include the policy that, for Medicaid children under 21 years of age, we will provide medically necessary services to correct or ameliorate physical and BH disorders, a defect, or a condition identified during an EPSDT screening or preventive visit.

Proposed QAPIC Membership and Committee Responsibilities

The quality management program at UnitedHealthcare is a comprehensive program under the leadership of chief executive officer Kathleen Mallatt and medical director/chief medical officer, Michael Horn, M.D. We use an integrated approach to our QAPIC, shown in Table IV.M-1, including both local and national committees and resources, always incorporating physical, behavioral and pharmacy together into the quality systems. For example, while we will not provide dental care, our goal is to include a dental provider on our QAPIC to gain insight into the specific needs around this care for our quality program. This approach provides us with the ability to leverage the considerable resources and expertise of our national organization, while focusing those resources at the local level.

Table IV.M-1: Quality Assurance and Performance Improvement Committee (QAPIC)

Committee Name/Chairperson/Membership	Committee Responsibilities
Quality Assurance and Performance Improvement Committee (QAPIC) Chair: Michael J. Horn, M.D., medical director/chief medical officer ▪ Kathleen Mallatt, chief executive officer (ad hoc) ▪ Sean Jones, chief operating officer ▪ Cyndi Margritz, RN, BSN, quality management coordinator ▪ Alison Behrens, clinical quality specialist ▪ Jeremy Sand, provider services manager ▪ Tim Langdon, J.D., program integrity	Our QAPIC is the decision-making body with ultimate responsibility for the implementation, coordination and integration of all quality improvement activities including: ▪ Reviews and approves the QAPI program description and evaluation at least annually ▪ Reviews the QAPI work plan quarterly to assure continued progress to goals ▪ Oversees subcommittees' performance and effectiveness ▪ Assures integration and coordination of care and service between physical health, BH and Pharmacy functions ▪ Prioritizes and aligns the annual QAPI goals and objectives with the strategic objectives of MLTC, the Triple Aim and our Nebraska business plan

Table IV.M-1: Quality Assurance and Performance Improvement Committee (QAPIC)	
Committee Name/Chairperson/Membership	**Committee Responsibilities**
officer/contract compliance coordinator ▪ Kim Manning, marketing and community outreach director ▪ Barb Palmer, RN, MHA case management administrator ▪ Gary Rathbun, member services manager ▪ Network Providers ▪ Family members/guardians of children or youth who are Medicaid members ▪ Adult Medicaid members ▪ **Meeting Frequency:** The QAPIC meets no less than quarterly.	▪ Provides program direction and oversight of QI activities related to the unique needs of Nebraska Medicaid members and network providers in the areas of clinical care, service operations, satisfaction, patient safety, compliance and practitioner credentialing ▪ Evaluates on an ongoing basis, key quality indicators designed to provide a comprehensive view of our critical processes and outcomes to identify opportunities for improvement proactively ▪ Assures the allocation of needed resources to achieve the goals of the QAPI ▪ Monitors implementation of work plans and directs our policies as needed to embed improvements in our infrastructure in support of sustained improvement ▪ Responsible for the in-depth review and analysis of operations reports and metrics (e.g., claims lag, frequency of office visits, issue resolution time frames, delegation oversight reports) to monitor and improve performance ▪ Monitor access and availability, service quality, complaints, grievances and appeals, and other metrics and trends with recommended interventions ▪ Recommend interventions for performance goals based upon member and provider satisfaction survey results
Clinical and Provider Advisory Committee (CPAC) Chair: Michael J. Horn, M.D., medical director/chief medical officer ▪ Kathleen Mallatt, chief executive officer (ad hoc) ▪ Sean Jones, chief operating officer ▪ Cyndi Margritz, RN, BSN, quality management coordinator ▪ Alison Behrens, clinical quality specialist ▪ Jeremy Sand, provider services manager ▪ Barb Palmer, RN, MHA case management administrator ▪ Nick Steinauer, M.D., OB/GYN ▪ Sharon Stoolman, M.D., pediatrician/hospitalist ▪ Dwain Leonhardt, M.D., Internal Medicine ▪ Paul J. Nelson, M.D., Family Practice ▪ Hank Sakowski, M.D., Internal Medicine ▪ James Harper, M.D., pediatrician/Hematology/Oncology ▪ William Gossman, M.D., Emergency Medicine ▪ Donald Gibbens, M.D., OB/GYN ▪ Anthony Montegut, M.D., Family Practice ▪ Colleen Conoley, Ph.D.,	Critical to our QAPIC is the information we solicit from physicians through our CPAC. The CPAC serves as a forum for physician input on clinical improvement initiatives, clinical guidelines, data analysis, drivers of member and provider satisfaction, credentialing and quality of care and services monitoring including: ▪ Monitor performance on clinical indicators (e.g., HEDIS, state metrics, PIPs, and continuity and coordination of medical and BH care) conduct/review barrier analysis and recommend actions, as appropriate ▪ Review and accept nationally endorsed clinical practice guidelines, providing input, as appropriate ▪ Review and provide input into all policies, procedures and practices associated with CM and UM functions to include UM criteria ▪ Review and approve practice guidelines before implementation ▪ Review summary data regarding quality of care complaints, appeals and grievances; identify trends, conduct barrier analysis and recommend corrective actions as needed ▪ Review reports on mortality and inpatient quality issues, and recommend actions as indicated ▪ Perform peer review of care and service issues, including recommendations for improvement action plans ▪ Review and accept the National Credentialing Plan, with addendum for line of business regulatory requirements as applicable ▪ Perform peer review and provide oversight of final decisions by

Table IV.M-1: Quality Assurance and Performance Improvement Committee (QAPIC)	
Committee Name/Chairperson/Membership	**Committee Responsibilities**
psychology/neuropsychology (currently non-voting) ▪ Tony Sun, M.D., market medical director ▪ Key Providers: Dental, Pharmacy, Behavioral Health, Statewide Provider Organizations, ad hoc health plan staff as needed, ad hoc specialty physicians as needed ▪ **Meeting Frequency:** The CPAC meets a minimum of four times per year.	the Credentialing Committee for the credentialing and recredentialing process. Monitor process for compliance with regulatory and accreditation compliance ▪ Review, track, identify opportunities for improvement and make recommendations relating to medical record issues, and potential quality of care trends ▪ Review provider satisfaction survey results and make recommendations for improvement
Healthcare Quality and Utilization Management Committee (HQUM) Chair: Michael J. Horn, M.D., medical director/chief medical officer ▪ Sean Jones, chief operating officer ▪ Cyndi Margritz, RN, BSN, quality management coordinator ▪ Alison Behrens, clinical quality specialist ▪ Jeremy Sand, provider services manager ▪ Barb Palmer, RN, MHA case management administrator ▪ Sharon Whitman, clinical administrative nurse consultant ▪ Tim Langdon, J.D., program integrity officer/contract compliance coordinator ▪ UM staff as designated by the Chair ▪ Other staff members by invitation of Chair to lend subject matter expertise ▪ **Meeting Frequency:** The HQUM meets at least four times per year.	The HQUM monitors all clinical quality improvement and utilization management (UM) activities within the health plan, with responsibilities that include: ▪ Approval of any changes in UM policies, standards and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan ▪ Oversight of grievances and appeals (including expedited appeals and state fair hearings) related to UM activities to determine any needed policy changes ▪ Results review from internal audits of UM (e.g., live call monitoring and documentation reviews), to effect changes in policies and procedures and plan training activities ▪ Review and approval of DM and DM (Condition) programs including Healthy First Steps ▪ Oversight of implementation of the UM program ▪ Review and approval of UM performance metrics from all clinical areas, including BH services ▪ Monitor progress on clinical performance improvement programs ▪ Reports review of inpatient mortality and other clinical quality issues and advise improvement actions ▪ Evaluation of the consistency of the UM decision making process through inter-rater reliability reports ▪ Identify overutilization and underutilization issues and recommends corrective actions as indicated ▪ Monitor continuity and coordination of care. Recommend improvement actions as indicated ▪ Facilitate integrated collaboration across clinical functions, members include, but are not limited to, leaders from: QM and improvement, health services, pharmacy, BH, allied health, special populations and case management

Table IV.M-1: Quality Assurance and Performance Improvement Committee (QAPIC)	
Committee Name/Chairperson/Membership	**Committee Responsibilities**
Behavioral Health Advisory Committee (BHAC) Chair: The BH medical director ▪ Committee memberships include, in an advisory capacity, members, family members, certified peer specialists and provider representatives ▪ **Meeting Frequency:** The committee will meet at least quarterly.	The BHAC provides recommendations, input and prioritization of initiatives or issues that affect the BH provider community including: ▪ Provide input to the CPAC on network development and management strategies and policies for the provision of BH services ▪ Provide input and expertise relative to clinical issues, including policy development, service planning/evaluation, PIPs and training plans ▪ Gather valuable feedback, input and advice for enhancements to systems and changes to procedures in the provisioning of integrated BH services statewide
Member Advisory Committee (MAC) Chair: Kim Manning, marketing and community outreach director ▪ Alberto Cervantes, community outreach specialist ▪ Lilly Carbonell-Walker, community outreach specialist ▪ Other plan staff members by invitation to lend subject matter expertise ▪ Our expanded MAC participants will include family members, members and their caregivers (if desired or needed for member attendance), community groups and advocates, State agencies, homeless advocates, service providers and health plan representatives. The composition of the Member Advisory Committee will reflect the ethnic, gender identity, cultural, sexual orientation, age, religious and geographic diversity of Nebraska ▪ **Meeting Frequency:** The MAC meets no less than quarterly.	The MAC structure provides members and family representatives the opportunity to discuss and direct the Nebraska Medicaid program including: ▪ Allow member to provide input into the planning and delivery of services ▪ Provide input into quality improvement activities and program monitoring and evaluation ▪ Provide the plan with perspective on how to educate the community and members on Medicaid basic benefits and value-added benefits ▪ Gather recommendations on providing health and wellness education to the community and members ▪ Provide input into member, family and provider education ▪ Obtain feedback on how best to remind health plan members of their Member Rights and Responsibilities ▪ Empower agencies, community members and health plan members to feel engaged with their health care ▪ Allow us to be proactive toward learning about the health care challenges our agencies, community members and health plan members face with the delivery of health care ▪ Provide an environment for open and honest communications ▪ Provide a venue for presenters to speak to agencies, community members and health plan members on specific health care topics
Nebraska Health Equity Committee (NHEC) ▪ A joint community effort that will combine key stakeholders such as hospitals, colleges, FQHCs, Tribal interests, the school system, state medical society and patient advisory groups ▪ **Meeting Frequency:** The committee will begin with monthly meetings and then the group will determine meeting schedule.	We have maintained a strong presence in the state with members and their families. We welcome the opportunity to further our efforts to offer programs and services that reflect an understanding and appreciation for the cultural diversity of members, the community and diverse language needs. We will develop and establish the Nebraska Health Equity Committee. We will develop a joint effort between state and local agencies, community-based organizations, private and public human service organizations providers and other identified community members and stakeholders. The goal is to evaluate culturally appropriate programs, policies and services aimed at improving health equity and eliminating health disparities as part of our foundational strategy.

Compliance and Support of MLTC's Quality Strategy

In Nebraska, we leverage more than 33 years of national experience coordinating care for Medicaid and other publicly funded programs for nearly 5.3 million members in 24 states. We developed, and continue to refine the internal quality assurance systems on both the local and national level that we operate for MLTC and the members we serve.

We understand and respect the Nebraska Medicaid members comprise a unique population with complex health care needs, and we recognize the importance of having seasoned, experienced staff dedicated to ensuring quality for this population. To serve in this capacity, we have local, on-site employees dedicated to clinical quality in Nebraska and whom regional and national quality teams support. Our team members have extensive experience in their areas of expertise, and are dedicated to improving outcomes and the overall experience for our members.

We will fully support and comply with MLTC's quality strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. We have been successful to date in meeting the MLTC Quality Strategy. We understand that MLTC is in the process of revising its Quality Strategy to reflect changes in the managed care delivery system that will result in a robust care management strategy focused on the early identification of members who require active care management and the integration of social determinants of health in member health-risk assessments. We will comply and support MLTC's quality strategy in the following way:

- ***Compliance:*** Our functions will address all state and federal regulatory requirements, and those requirements identified in this RFP, any other applicable law and any resulting contract.
- ***Staffing:*** We will have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities. Our dedicated quality team includes RNs, certified care managers, Certified Professional in Healthcare Quality (CPHQ) and certified Six Sigma Black Belts.
- ***Proven Process and Methodology:*** Our QM program includes a QAPIC program; PIPs; quality performance measurement and evaluation; and member and provider surveys.
- ***NCQA and Credentialing Standards:*** We will maintain our NCQA accreditation and reaccreditation, including a comprehensive provider credentialing and recredentialing program. We are proud of our recent NCQA scoring where we **achieved 50 out of 50 points on accreditation standards.**
- ***Separation of UM, Care Management and Quality Management (QM) Activities:*** To validate the continued compliance integrity of our quality management activities, we maintain distinct separation of responsibilities, reporting, oversight and review processes for UM and care management from the quality assurance staff. We currently integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.

Selection of Focus Areas and Use of Data

We are planning to select focus areas based upon our knowledge of Nebraska Medicaid members and MLTC's priorities. This will be inclusive of the new enrollee groups now covered under the new integrated program such as individuals in home and community-based waiver programs and individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities for people with developmental disabilities (ICF-DDs). In addition, focus areas will broaden to meet the needs of the new service areas, BH initiatives and quality requirements related to pharmacy oversight such as benchmarking and medication adherence.

We understand the MLTC Quality Strategy, and we have consistently made and will continue to make proactive changes to our quality infrastructure to better support Nebraska Medicaid members, key stakeholders, providers, subcontractors, families and caregivers. We anticipate increased feedback and recommendations from Nebraska Medicaid stakeholders that will help to inform our choice of focus area in partnership with MLTC.

Using Data in the Selection Process

We will incorporate MLTC data in the selection process using quality indicators, clinical care data, supported by evidence-based quality improvement process and practices, described below.

Use of MLTC Quality Indicators

Our comprehensive quality scorecard includes key process and outcome indicators that allow us to identify systematically those opportunities for improvement on a continuous basis. For all quality initiatives, we objectively and systematically monitor and evaluate opportunities that may result in PIPs or other formal or informal quality improvement activities. These activities are aimed at improving the quality, timeliness and/or appropriateness of our care and service delivery.

Review of Clinical Care Data

When we start the PIP selection process, we perform a literature search and data review on all study topics to determine which are most problematic based upon the geographic area, the cost of treatment and the prevalence in the Nebraska population. As a result, the quality team may select obesity, asthma, follow-up after hospitalization for mental illness, or adolescent well-child exams as the areas for focused studies/PIPs. When selecting a study topic, our quality staff targets improvement in areas of clinical care that reflect the demographic characteristics, prevalence of disease and the potential consequences of the disease for Nebraska Medicaid members. Once we select the topics, the team researches information to develop a study question and study indicator for each disease process.

Evidence-Based Process for Trending and Evaluation of Data

Our QM and Performance Policy NQM-049 (Quality Improvement Projects) provides further guidance for selection, planning, implementation, evaluation and reporting of QM projects. The quality team reviews the data and trends monthly and meets quarterly to update these projects by monitoring improvements and revising interventions as needed due to barriers identified. In addition, the quality team collaborates with case management and other affiliate subcontractors such as pharmacy and BH to discuss project outcomes.

Planning and Initiation of Performance Improvement Project Activities

We have had significant success in selecting and completing PIPs to address specific concerns of Nebraska Medicaid members. For example, in Nebraska, the quality team completed a PIP to analyze the behaviors and barriers that lead to the inappropriate use of the ER and to develop effective interventions to reduce the number of non-emergent visits to the ER with a focus on Medicaid participants ages 1–17 who presented with upper respiratory symptoms or asthma. As a result of the interventions implemented in January 2014, we accomplished planning and initiation of PIP activities which included the **development of a database to obtain real-time, non-claims data regarding ER visits** and plan established interventions; and **1,244 telephone outreach (attempts) calls** to establish barriers to ER alternatives. We planned and initiated 10 interventions that ranged from developing a database for reporting of ER data; post ER visit contact by health coach, medical home RN or high-risk care manager; and established care management meetings with local ER case management staff to review members who are high users of the ER.

Proposed Quality Assurance and Performance Improvement Work Plan

We understand MLTC requirements under the new contract and are committed to helping MLTC attain their quality objectives. We are committing a robust quality infrastructure, innovative thought-leadership to improve member outcomes and providing experienced Nebraska staff that has collaborated with MLTC to achieve improved health care for members. Our QAPIC Work Plan initiatives include:

- ***Promoting and incorporating quality into the health plan's organizational structure and processes*** to facilitate partnerships and improving communication among key stakeholders through the new QAPIC structure
- ***Promoting effective monitoring and evaluation of patient care and services*** provided and align with the requirements of evidence-based medicine including provider performance monitoring and percentage improvements in HEDIS critical measures, CAHPS and provider satisfaction results
- ***Confirming prompt identification and analysis of opportunities for improvement*** with implementation of actions and follow-up, including ongoing feedback to both customers and provider related to QI activities
- ***Coordinating quality improvement, risk management, patient safety and operational activities*** to identify gaps, including quality of care issues and programs to promote patient safety
- ***Maintaining compliance with local, state and federal regulatory requirements and accreditation standards*** including completion of MLTC-required PIPs
- ***Reducing disparities in the delivery of services*** through analysis of member language, special needs and the associated barriers; continue to refine our patient-centered approach based upon our member populations
- ***Improving the health outcome of members with complex health needs*** including case management evaluation to appropriately identify, manage and serve these members

Performance Improvement Project Initiatives

In our collaboration with MLTC, we have developed PIPs to improve the health of Nebraska Medicaid members including members diagnosed with chronic conditions. To support them, and to support our commitment to monitoring and evaluating the quality of care members receive, PIP interventions are determined based upon the needs of the population in alignment with state and federal requirements. In 2014, because of our PIP interventions, we identified additional focus areas that are potential areas for 2017 implementation. They include ***Homelessness:*** We will look at focused meetings with this targeted population to address this issue; and, ***Behavioral Health Comorbidity:*** We will ensure that BH is addressed through an integrated model.

Using evidence-based practices, we will select a study topic for our QAPI consistent with 42 CFR 438.240. As mandated by MLTC, we will conduct a minimum of two clinical and one non-clinical PIP, in addition to one joint PIP in collaboration with other MCOs. The clinical PIP will address an issue of concern to our member population, to favorably effect health outcomes and enrollee satisfaction. The second clinical PIP will address a BH concern. Both PIPs will meet all relevant CMS requirements and approval by MLTC before implementation compliance with Section M-7.

69. Describe how the MCO will measure and track the outcome of individual quality improvement interventions over time. *3 pages*

As a health care organization committed to continuously improving the quality of care and service we provide to our members, our focus is one of ongoing improvement incorporated into every aspect of our health plan operations—from member services to provider credentialing to clinical services to overall operations.

We use multiple data sources and powerful analytic systems mechanisms to continuously measure, evaluate and improve the services provided to members over time. Each of these mechanisms are founded on continuous quality improvement (CQI) principles, which focus on the plan, do, study and act (PDSA) quality cycle as a means to meet or exceed the minimum performance standards. They include ongoing monitoring of critical quality indicators (e.g., Nebraska Scorecard), formal PIPs measurement and compliance with federal and state regulations and NCQA health-plan accreditation standards.

Measuring and Tracking Quality Improvement

Our quality program objectively and systematically monitors, tracks and evaluates the quality of care and services we provide to members through: 1) Our quality committee structure; and, 2) CommunityCare, our powerful analytic system that provides us with actionable clinical data for measuring and tracking outcomes in near-real-time. We use the ongoing data analysis to measure the current quality of member care and service and to prioritize opportunities for improvement.

Quality Committee Structure

Our comprehensive quality program and committee structure incorporates the concepts of both quality improvement and total quality management, leveraging a variety of tools to drive performance. *This is true of the quality structure we have in place today and the one we are developing to meet the needs of MLTC tomorrow.* Our commitment to these efforts is reflected in **our NCQA scoring of "Commendable," the highest rating received by any Medicaid plan in Nebraska for 2015–2016.**

Opportunities for Quality Improvement

To drive the clinical and operational performance that supports MLTC's Quality Strategy, we:

- Set short- and long-term performance goals
- Benchmark our performance against Nebraska state and national rates
- Measure our successes through analysis of industry-standard measures of health plan quality including: HEDIS measures, CAHPS surveys, CMS Adult and Child Core Measure Sets, EPSDT screening ratios, access and availability data and feedback we receive as part of compliance audits and accreditation surveys

Measures generated from these member data sources are maintained in our MLTC scorecard, which is reviewed by MLTC quality committees, and subsequently maintained as key records by the health plan. Our MAC and CPAC are active participants of the PDSA process to make sure their perspective is taken into account when planning and assessing quality interventions for our members.

Use of the Nebraska State Immunization Information System and Nebraska Health Information Initiative Data

We have successfully collaborated with DHHS to obtain immunization data. In the fall of 2013, we collaborated with the Nebraska State Immunization Information System (NESIIS) data exchange coordinator, Ernad Klipic, to obtain a NESIIS data extract from the immunization registry. Obtaining this registry data allowed us to capture full data and improve our documented HEDIS rates for all

immunization measures. Due in part to the use of the NESIIS data, we saw an **increase in the childhood immunization status of 5 percentage points and an increase in the screening for human papillomavirus (HPV) by 3 percentage points**. We shared the information in Table IV.M-2 with the DHHS Performance and Quality Analytics team.

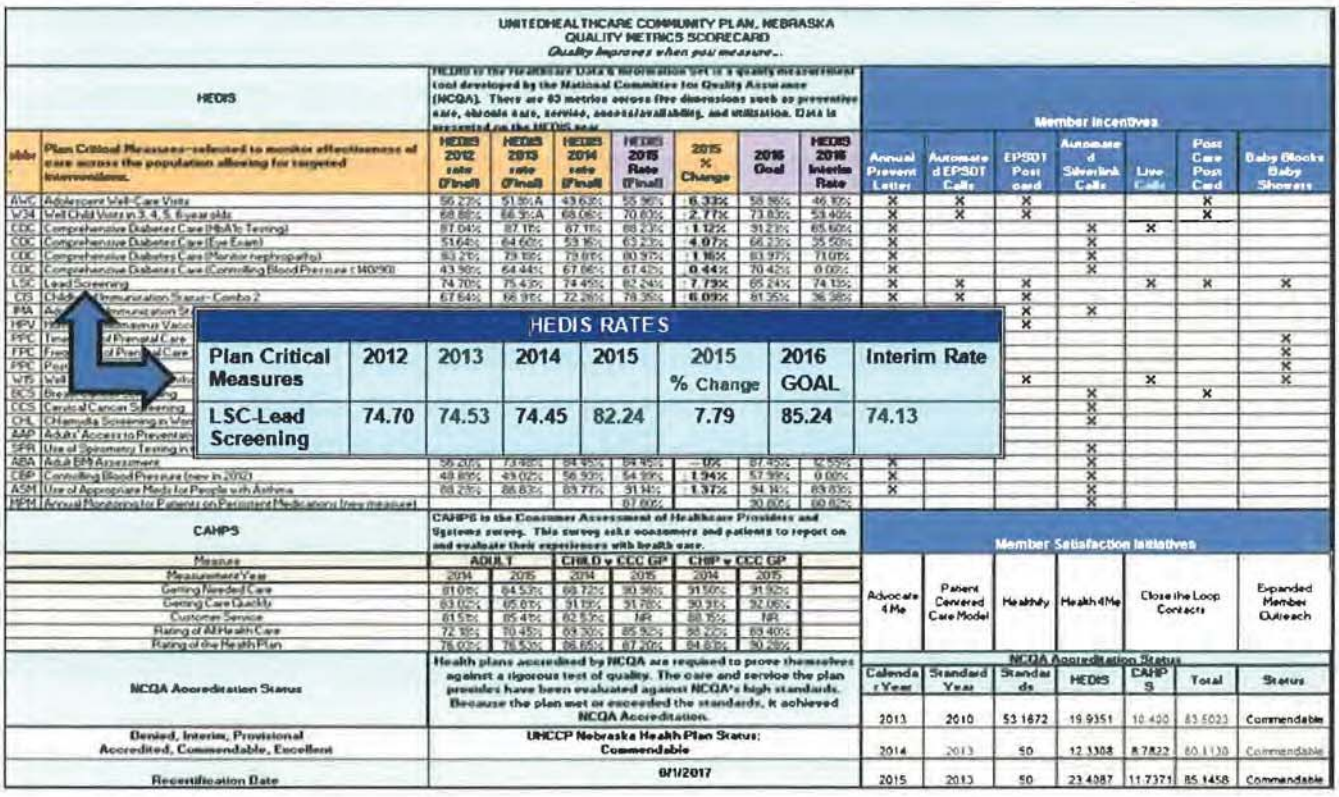
Table IV.M-2

Plan Critical Measure	HEDIS 2013	HEDIS 2014
Childhood Immunization Status - Combo 2	66.91%	72.26% ↑
Human Papillomavirus Vaccine for Female Adolescents (new in 2012)	23.11%	26.03% ↑

We are exploring additional ways to collaborate with the Nebraska Health Information Initiative (NeHII) and are working to establish an agreement for data sharing purposes. This will expand our capabilities in terms of both hospital and provider data use and analysis. Through this type of data sharing, we will increase our ability to analyze the care and services provided to our members and decrease the need for paper chart abstractions.

The Nebraska Quality Scorecard

In Nebraska, our comprehensive quality scorecard, shown in Figure IV.M-2, is one of many tools we use to identify systematically opportunities for improvement. We shared the Quality Scorecard at the request of Nebraska Medicaid director, Calder Lynch, who requested a quality dashboard. The scorecard was well received and Mr. Lynch provided positive feedback regarding its detail and content.



UNITEDHEALTHCARE COMMUNITY PLAN, NEBRASKA
QUALITY METRICS SCORECARD
Quality Improves when you measure...

HEDIS RATES

Plan Critical Measures	2012	2013	2014	2015	2015 % Change	2016 GOAL	Interim Rate
LSC-Lead Screening	74.70	74.53	74.45	82.24	7.79	85.24	74.13

Figure IV.M-2. Nebraska Quality Scorecard

For all quality initiatives, we monitor and evaluate opportunities that may result in PIPs or other formal or informal quality improvement activities. These activities are aimed at improving the quality, timeliness or

appropriateness of our care and service delivery and the quality scorecard provides a summary dashboard of key outcomes.

If we identify an opportunity for improvement, the appropriate methodology is identified, whether it is a formal PIP or an informal PDSA cycle, and the data are collected and analyzed based upon the topic. Rooted in both quantitative and qualitative analyses, our internal quality improvement activities and studies are designed to provide:

- Established baselines, measure interventions and timelines for follow-up re-evaluations
- Objective, clearly defined indicators based upon current clinical knowledge or health services research
- Intervention outcomes (e.g., changes in health status, functional status and member satisfaction) or valid proxies of those outcomes
- Identifiable clinical improvement opportunities based upon the needs of the population, collaborative opportunities with our state partners, or feedback from our participating physicians
- Feedback on the findings and initiatives and progress from the physicians on our CPAC and the members on our MAC
- Structured processes and scientific methodology set by the accrediting entity, regulatory agency or designated External Quality Review Organization (EQRO)

CommunityCare: Using Technology to Drive Clinical Initiatives

As we described previously, we use the most sophisticated data capture elements to engage providers and other key stakeholders to help us measure success or determine next steps. Using our proprietary technology, CommunityCare, we integrate a member's acute care, preventive care, chronic disease management, medical, behavioral and social needs into a comprehensive electronic record. The platform enables care collaboration by allowing providers, members and caregivers to share access to patients' gaps in care in near real time.

To date, UnitedHealthcare has implemented our technology, CommunityCare platform, in 17 state Medicaid programs including Nebraska. Leading quality indicators in our programs for our TANF members (pregnant women and families) suggest that our care model and case management technology are enabling us to monitor member care and ensure that each member is receiving an intensity of case management and timely interventions that are appropriate to their needs. Ultimately, this leads to members experiencing improved outcomes.

Nebraska Medicaid DataMart

As our health care services and quality functions are increasingly data driven, we are offering MLTC access to a customized clinical DataMart for Nebraska Medicaid members that will extract CDS providing access to our analytics. This will provide MLTC with the tools to access and track disease and health trends among specific communities. We will work with MLTC to train key stakeholders to access clinical analytics and to define CommunityCare access parameters in compliance with HIPAA privacy requirements. Our data security team uses data filters to assign parameter-driven privileges to ensure only select member populations are viewable by the user.

70. Describe experience in using results of performance measures, member satisfaction surveys, and other data to drive improvements and positive affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes. *5 pages*

Our integrated reporting and data analytics solution integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data, which we use to produce reports and analysis to meet MLTC requirements around predictive analytics; provider information support; fraud, waste and abuse; and UM and improved health outcomes.

We use data-driven, evidence-based care tools that identify members most likely to benefit from interventions and apply programs tailored to meet their needs, improving care delivery to the total population. After implementing interventions, continuous monitoring provides feedback on the impact of each intervention. Our efforts to use the results of performance measures, member satisfaction surveys and a broad range of clinical and non-clinical data are fundamental to our overall quality improvement goals and performance.

Monitoring Performance Data

We use the following tools and technology, shown below in Table IV.M-3, to assess performance to drive improvements and positively affect the health care status of our members.

Table IV.M-3

Performance Tools	Purpose
MedMeasures	We use MedMeasures (an NCQA-certified HEDIS software package) to monitor HEDIS compliance at the member and provider level. Using MedMeasures' enhanced measure analysis function, we identify incomplete, age-appropriate HEDIS services. Our quality team uses this member-specific information to identify the need for outreach activities to address gaps in care opportunities. When collaborating with providers, our CPCs use MedMeasures reports to identify members within a provider practice with gaps in care. CPCs collaborate with the practice to coordinate opportunities to close those gaps and verify members receive required services.
Universal Tracking Database (UTD)	We use UTD to monitor member compliance with well-child screenings and immunizations. UTD allows us to identify members who can benefit from outreach for gaps in care, educational mailings and member incentive programs. CPCs also use UTD to identify members who have fallen behind in making PCP appointments and to track provider performance with regard to preventive care and optimal treatment.
Strategic Management Analytic Reporting Tool (SMART)	The SMART data warehouse and analytics toolset contains claims information (e.g., inpatient, outpatient, physician and specialist, pharmacy, dental, vision and lab), member data, provider data, authorizations, external subcontractor data and predictive modeling information. SMART captures information, including geographic information, diagnosis and level of care, disease management categorizations, provider contracts, revenue capitation by rate cell, claims/encounters for each service category, service authorizations by day, actuarial reserving completion factors and risk stratification scores by member. We feed SMART data into HEDIS.
Health Effectiveness Data and Information Set (HEDIS)	We create every step in the design and build of the HEDIS rates report simultaneously with our certified HEDIS auditor. The result is NCQA-approved external data. HEDIS provides the quality team with monthly interim reports displaying the current HEDIS rate based upon administrative data. The annual report reflects the final audited HEDIS rates for administrative data and includes all rates resulting from data abstracted during the Hybrid season. The quality team reviews interim rates monthly and analyzes the data to assess performance improvement month-over-month. Based upon findings, the quality team identifies additional barriers and design interventions to overcome these barriers. We assess rates showing improvement and determine a correlation between

Table IV.M-3	
Performance Tools	**Purpose**
	the improvement and interventions. We provide a final audited report to NCQA and to MLTC in compliance with state regulations and NCQA accreditation.
Key Member Indicator Survey (KMI)	The Key Member Indicator member survey tool provides monthly CHIP member feedback on their experiences with UnitedHealthcare. It measures key "CAHPS-like" metrics to monitor impact, identify drivers of satisfaction, and inform decision-making and improvement planning. The KMI program is a tracking survey conducted among CHIP members/caregivers by a live telephone representative, and takes only seven minutes to complete. Close analysis of the data helps us determine the percentage of people who are highly likely to recommend us and the percentage of people unlikely to recommend us (e.g., Net Promoter Score). This is a new approach to assessing member satisfaction and is currently underway for members.
Comparative Market Analysis and Reporting Tool (CMART)	CMART confirms we can provide regulatory agencies, purchasers and members with information needed to reliably compare the performance of our health plans to drive value and quality-based decisions with accurate, timely information. CMART provides a centralized enterprise-reporting portal for HEDIS/CAHPS results annually with national benchmarking, trending and comparisons to competitor results to drive resource decisions and identify rate improvement activities.
Consumer Assessment of Health Plan Satisfaction (CAHPS)	We conduct the CAHPS member survey from February through June of each year by a certified vendor and measure the members' experiences with UnitedHealthcare during the prior six months. The CAHPS survey team analyzes and trends the results annually with review by the QAPIC to identify trends, opportunities for improvement and make recommendations to improve member experiences.
Member Grievances and Appeals Data	We review and analyze complaint, appeal and grievance data to monitor, evaluate and effectively resolve member concerns in a timely manner. We use this data to identify opportunities for improvement in the quality of care and service provided to Nebraska Medicaid members and to identify opportunities for improvement in our process. Data related to quality of care, quality of service, member experience and administrative issues are collected, reviewed and trended to identify opportunities for improvement. Quality of care issues receive further scrutiny and, depending upon their seriousness, may be taken to the CPAC for peer review and potential corrective action. We monitor member satisfaction with BH services in the same way—through BH surveys and the analysis of complaints and appeals.

Face-to-Face Member Feedback Opportunities

We collaborate with our members and through face-to-face opportunities in the community to gain insight on how our program is aligning with their needs. These include:

- ***Member Advisory Committee (MAC):*** We have had a MAC in place in Nebraska since 2012 and we have held multiple meetings throughout our service area in community-accessible settings. Our MAC, which meets a minimum of four times annually, is another important collaborative forum for our members to share successes, bring issues and ideas to the health plan and obtain feedback on new and future initiatives. The MAC provides an opportunity for input on BH services and services for members with special health care needs including individuals diagnosed with intellectual and/or developmental disability (I/DD). This may include policy development, planning of services, service evaluation, member/family/provider education and recommendations for innovative ways to improve and integrate service delivery. We document the discussion and feedback we receive in meeting minutes that are presented to the QAPIC and are used to facilitate improvements in our programs.

- ***Community Outreach:*** Building relationships and making community connections is a strong focus for our community outreach team. A key part of our efforts to generate feedback from our members, families, caregivers and key stakeholders is our community outreach team, led by marketing and community outreach director, Kim Manning. Outreach efforts in the community allow us to listen, observe and understand how community resources align with our mission of helping people live healthier lives and connect to MLTCs in supporting the Medicaid population. For example, in July 2015, we held a Lunch N Learn presented by the NE Urban Indian Health Coalition, Inc. & Indian Center, Inc., called "Soaring Over Meth and Suicide Prevention Program." In Nebraska and other states, youth suicide is at an epidemic level and we are developing a program whereby we sponsor tribes to expand and enhance their programming around suicide issues. One of our community outreach specialists is involved in a coalition whose mission is to develop youth suicide-prevention programs.

Experience Improving Outcomes in Nebraska

Example: HEDIS Performance Improves Preventive Member Care

We have been working with the MLTC since 1996 to improve the quality and appropriateness of care provided to Nebraska Medicaid members. Our quality team has regularly submitted combined Medicaid/CHIP HEDIS data to MLTC—beginning in 2000 and before our NCQA accreditation in 2005. We understand the importance of HEDIS ratings as a measure of plan performance, as evidenced by our position as the only Medicaid plan in Nebraska to reach a four-star performance level and the highest rated among all Medicaid plans in the state.

Results: Since 2013, our NCQA scored **HEDIS measures have improved by 3.5 points—from 19.9 to 23.4**—demonstrating our ability to improve overall clinical and preventive member care. For example, our interventions related to breast cancer screenings have improved significantly as described in Table IV.M-4.

Table IV.M-4: NCQA Accreditation Status

Calendar Year	Standard Year	Standards	HEDIS	CAHPS	Total	Status
2013	2010	53.1672	19.9351	10.400	83.5023	Commendable
2014	2013	50	12.3308	8.7822	80.1130	Commendable
2015	2013	50	**23.4087**	**11.7371**	**85.1458**	Commendable

Example: Breast Cancer Screenings Improve 11 points with Member/Provider Awareness

We measured the percentage of women 40–69 years who had a mammogram to screen for breast cancer during the measurement year and because of understanding the barriers to care, **improved our breast cancer screening measures by more than 11 percentage points since 2012** as shown in Table IV.M-5.

Table IV.M-5

Goal	2012 Rate	2013 Rate	2014 Rate
2014 Goal: 49.54%[1]	**42.53%**	**46.54%**	**53.86% ↑**
Analysis/Barriers	Actions and Interventions		

[1] Plan goal is 3 percent over the prior year final rate.

Table IV.M-5			
Goal	**2012 Rate**	**2013 Rate**	**2014 Rate**
Female members unaware of the importance of yearly mammograms	▪ Member newsletter article in the winter of 2014 titled "Crush Cancer: Are You Due for a Screening?" addressed educating and reminding women at the appropriate age on the importance of getting the testing done. ▪ In 2014, we continued the mailing of a post-care gift card incentive for noncompliant members obtaining a mammogram.		
Practitioners' lack of awareness of members who need the screening	▪ We distributed provider toolkits to providers in the second quarter, which included HEDIS Technical Specifications for breast cancer screening. ▪ Care managers queried the universal tracking database (UTD) and reminded members of any identified gaps in care. ▪ We collaborated with selected physician offices to send out cobranded letters to members notifying them of needed preventive care services. ▪ We mailed annual preventive letters that identified preventive service benefits available to members, which included breast cancer screening. ▪ Noncompliant members received a targeted IVR Silverlink call for women's health, which included breast cancer screening.		

Example: CAHPS Scores and Member Satisfaction Improve Overall

We complete three annual consumer surveys in Nebraska asking members to report on and evaluate their health care experiences. CAHPS is conducted by an independent, third-party company and measures a number of things related to our members' experience with their health care, such as their satisfaction with getting needed care, getting care quickly, customer service, ability to understand our materials, and overall rating of the health plan.

Annually, we conduct an NCQA-certified CAHPS survey to assess overall member satisfaction and to identify and prioritize opportunities for improvement. Our surveys are conducted by DSS Research, an independent vendor certified by NCQA to conduct the CAHPS 5.0H survey unless instructed otherwise by our state partners

We use CAHPS survey results to assess the quality and appropriateness of care provided to members and create action plans for improvement. We use the CAHPS member survey results to measure health plan and provider network performance in the following areas:

- Overall levels of satisfaction with UnitedHealthcare, which helps us assess broadly whether we meet our members' expectations
- Customer service, which allows us to implement ongoing improvements in the overall member experience
- Provider communication, which gives us data to help inform our education programs
- Member satisfaction with his/her PCP and the specialty care practitioners he/she visits most often, as a key driver of overall member satisfaction
- Monitoring of access to primary and specialty care, tests and treatment, which allows us to identify members' perceived barriers to access and availability

Results: In 2015, we conducted the three MLTC required surveys to include adult, child and CHIP CAHPS surveys and the surveys for children with chronic conditions. We are proud of our results. We made **improvements in all three surveys** as shown below in Table IV-M-6, an excerpt of the Nebraska Scorecard.

Table IV-M-6: CAHPS - The Consumer Assessment of Healthcare Providers and Systems Survey						
Measure	**Adult**		**Child + CCC GP**		**CHIP + CCC GP**	
Measurement Year	2014	2015	2014	2015	2014	2015
Getting Needed Care	81.01	**84.53 ↑**	88.72	**90.96 ↑**	91.50	**91.92 ↑**
Getting Care Quickly	83.02	85.81 ↑	91.19	91.78 ↑	90.91	92.06 ↑
Customer Service	81.51	85.41 ↑	82.53	NR	88.15	NR
Rating of All Health Care	72.18	70.45	89.30	85.92	88.22	89.40 ↑
Rating of the Health Plan	76.03	76.53 ↑	86.65	87.20 ↑	84.83	90.28 ↑

We have improved in a number of areas because of several initiatives undertaken in 2014 and 2015. These improvement initiatives included:

- Education on the use of the member website
- Promotion and education on NurseLine
- Provider advocate education for our providers on the prior authorization process
- Member materials translated and available in multiple languages
- Increased monitoring of member complaints and grievances
- The addition of *Advocate4Me*, our award-winning innovative solution to member engagement

71. Describe how the MCO will assess the quality and appropriateness of care furnished to members with special health care needs, members with co-occurring physical and behavioral health concerns, and dual-eligible members. *3 pages*

Our QM structure is designed to meet the integrated physical, behavioral and pharmacy needs of the Nebraska Medicaid population including members with special health care needs, co-occurring physical and behavioral health concerns and dual-eligible members. Chief executive officer Kathleen Mallatt and medical director/chief medical officer Michael Horn, M.D., direct activities to align our integrated delivery strategies, human resources, health information technology (HIT) and reimbursement policies to achieve MLTC's objectives of improved health outcomes, enhanced integration of services and quality of care with an emphasis on person-centered care.

As an organization, we understand the needs of these populations and why a unique quality framework is essential and will use our QM and UM infrastructure to provide timely access to appropriate, high-quality programs. We are committed to facilitating improvement in care and services to our members to help them improve their lives and well-being. One of the ways that we demonstrate this commitment is through specifically monitoring the quality and appropriateness of care furnished to members with special health care needs, members with co-occurring physical and behavioral health concerns and dual-eligible members.

As an example, individuals with I/DD have unique service utilization patterns that differ significantly from other Medicaid beneficiaries. *We know that among Medicaid-only beneficiaries qualifying based upon disability, there is a high prevalence of mental illness (47 percent), cardiovascular disease (38 percent) and central nervous system diseases (28 percent). Almost half of individuals diagnosed with I/DD have three or more chronic conditions.* These unique health-service utilization characteristics are important differentiators from other populations, and we consider them when developing effective and appropriate ways to monitor the quality of care these members received and its overall impact on their quality of life.

Measurement of Quality and Appropriateness of Care

As an organization, we engaged the expertise of a National Advisory Board to assist in the understanding of the special needs of these populations and to determine appropriate measures to assess the quality and effectiveness of care. The National Health Plan Advisory Board (NHAB) serves as an independent advisory council that provides input to UnitedHealthcare in actively engaging members, providers, advocacy groups and other key stakeholders in the design and delivery system supporting individuals with special health care needs. The NHAB makes recommendations, develops and champions innovations and advises on member engagement strategies that support clinical approaches.

The NHAB is vital to our ability to improve member satisfaction, member outcomes and seeks to inform programming enhancements that may better meet the needs of our members. A member, a direct care worker, and family member of a child with special health care needs (along with advocacy leaders in aging and disability) have served and do serve on this board. The board has directed and developed training programs for care coordinators in abuse, neglect and exploitation prevention, and on cultural and disabilities competencies. These trainings and learnings have provided insights into improvements in our clinical platforms. The board advised on the model development for intellectual and developmental disabilities, providing important insights into the priorities and needs for individuals served by these programs. Most recently, the board has worked with us on a refreshed approach to measure the quality for LTSS, I/DD and serious mental illness (SMI) populations, ensuring that health plans are focusing on the

most relevant and tangible program requirements to ensure an improved member experience through managed care programs.

Along with the board, we have completed extensive review of the literature and existing quality measures proposed by advocacy organizations, policymakers and states. As a result, we have identified metrics specific to these special needs populations (Table IV.L-7) to provide a focused review and analysis that will aid us in ensuring the quality and appropriateness of care provided to this specific population:

Table IV.L-7: Quality and Timeliness of Care

Area	Measurement	Benefit to Stakeholders
Members with Special Healthcare Needs	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CMS 416 *Screening Ratios* in compliance with the Nebraska Health Check Program	Unlike HEDIS rates that are reliant on a member's continuous enrollment, the CMS 416 EPSDT report includes all children and adolescents enrolled, adjusted by their length of enrollment with UnitedHealthcare. Subsequently, EPSDT measures of pediatric and adolescent preventive health will provide insight into utilization of this important service for this population, which helps members to establish a regular ongoing source of care and receive recommended examinations, medically necessary treatments and referrals from one provider to another.
Foster Care	Percentage of members receiving a health screening	Providing transparency into these critical measures will not only allow monitoring of program effectiveness, but also increase the awareness of stakeholders regarding the importance of these initial screenings, therefore enabling ongoing discussion regarding barriers and collaborative efforts to improve access to care.
Foster Care	Percentage of members under 4 years of age who receive a developmental assessment	These assessments are important as they allow the opportunity to develop treatment plans for foster- and justice-involved youth, who are more likely to experience mental and physical health problems that could benefit from specialist intervention.
Behavioral Health	HEDIS measures for *Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication* (ADD) and *Follow-Up After Hospitalization for Mental Illness* (FUH)	These measures will provide stakeholders insight regarding the continuity of BH care provided to these children, critical to each child's long-term health and well-being. Of particular interest to stakeholders may be the ADHD/ADD measures, as the prevalence of these conditions is higher than the national average.
Behavioral Health	*Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)*	A new measure for the CMS Child Core Measure Set, this quality indicator may be more important for the Heritage Health members than the general pediatric and adolescent population as a whole.
Behavioral Health	HEDIS measure for *Follow-Up Visit Within Seven Days of Discharge After Hospitalization for Mental Illness*	It is important to hold a follow-up with patients after they have been hospitalized for mental illness to ensure the individual's transition to the home or work environment is supported and that gains made during hospitalization are not lost.
I/DD	ER visits	Recommended by the Centers for Disease Control and Prevention (CDC), measuring ER visits is uniquely important for people with developmental disabilities as it provides insight to individuals' access to primary care and needed supports.

Table IV.L-7: Quality and Timeliness of Care		
Area	**Measurement**	**Benefit to Stakeholders**
I/DD	Hospitalizations	A measure recommended by the CDC, this could be of particular interest to stakeholders as rates of hospitalization among those with developmental disabilities are nearly twice the national average.
I/DD	Increased competitive employment	An increased number of people with developmental or physical disabilities or with significant mental health treatment needs will gain and maintain competitive and integrated employment.
I/DD	Percent of participants with POC	Percent of participants that have a plan of care (POC) that is adequate and appropriate to address needs (including health care needs) as indicated in assessment.
I/DD[2]	Choose where they live	There is a national care indicator.

Care Navigators

Nebraska members with special health care needs will be assigned to a care navigator. Care navigators are a part of our population-focused, person-centered care model. Living in communities across Nebraska, they will coordinate services for our specialized populations including members participating in an HCBS waiver program, members eligible to participate in Medicare and Medicaid, and special needs populations (such as ABD, I/DD, foster care children/youth and Katie Beckett) who need additional support. Support includes enhanced communication among all treating providers, identification and resolution of gaps in care or access to care issues, connections to culturally sensitive community-based services and supports that help prevent avoidable ER visits and hospitalizations for members with lower to medium risk.

Care navigators outreach to new members identified as having special needs through the enrollment file or through other information, such as the health risk screening or predictive profiling. They use best-practice techniques, such as motivational interviewing, to solicit member/family input, and identify and solve for any unmet physical and/or behavioral health care need. They refer members to the most appropriate provider(s) for their condition and coordinate care in a holistic manner. The care navigator program will assist in the ongoing monitoring of the care provided to this population.

Results

Currently, there is no consistent national approach for quality measurement for LTSS, I/DD or SMI. Because of this, states have begun to develop state-specific metrics, leveraging a mix of process and structure measures, lacking focus on outcomes and creating inconsistency in how quality is measured and tracked both across states and longitudinally.

In conjunction with our NHAB partners and national stakeholder organizations and local state partners, UnitedHealthcare is leading a national charge to create a roadmap for states to adopt our recommended measures.

Results of these important metrics will be reviewed by the HQUM and BHAC on a quarterly basis and annually as part of the UM Program effectiveness.

[2] NCQA measures are administered by the State and we would like to collaborate with the State to obtain and assess this indicator.

72. Describe the MCO's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the MCO's quality of care. 2 *pages*

We understand the importance of obtaining feedback from Nebraska Medicaid members, families, caregivers and key stakeholders regarding the care provided to them or their family members. We have a process in place to gather and implement key stakeholder feedback and recommendations at the member level and we provide a broad variety of opportunities to engage members. We support member engagement by providing transportation, childcare and stipends for meeting attendance, language interpretation (e.g., meetings, telephonic) and members can attend with their caregivers if preferred.

Soliciting Feedback from Families and Caregivers

We solicit member feedback using face-to-face, written and telephonic interaction with our members as shown in Tables IV.L-8 and IV.L-9 below:

Table IV.L-8: Face-to-Face Engagement with Members

Key Stakeholder Feedback Process	Feedback Related to Quality of Care
Care Management of Katie Beckett Waiver-Eligible Members	
To confirm that we are providing Katie Beckett waiver-eligible members with the depth of support they need to live healthy, meaningful lives, our care management staff meets with members and their families weekly or monthly, depending upon the member's need. We also conduct yearly, multidisciplinary care conferences for all Katie Beckett waiver-eligible members and invite PCPs, specialists, nursing agencies, school personnel, family members and DME vendors.	During one care conference, the mother of the member stated that she needed a new position chair and bed for her daughter. The DME company shared with the team how a member used a position chair; the school physical therapist shared the benefits of the chair. By working collaboratively within the team, the member was able to receive a new position chair within a few days of the care conference.
Member Advisory Committee	
We have had a Member Advisory Committee in place since 2012 and we have held multiple meetings throughout our service area in community-accessible settings. At a recent meeting, we had 13 participants and we conducted the entire meeting in Spanish to meet the needs of the members in attendance. The MAC provides an opportunity for input on BH services and services for members with special health care needs including individuals diagnosed with I/DD. This may include policy development, planning of services, service evaluation, member/family/provider education and recommendations for innovative ways to improve and integrate service delivery.	At a recent meeting, several members said they were not aware that they were entitled to a second medical opinion. They felt that if the doctor made a recommendation they did not agree with that they needed to follow through with that recommendation. We advised them that as long you use a network provider, you are entitled to a second opinion without a referral.
Nebraska Health Equity Committee (NEHC)	
The NEHC committee will begin with monthly meetings and then the group will determine the meeting schedule. We will develop a joint effort between state and local agencies, community-based organizations, private and public human service organizations providers and other identified community members and stakeholders.	The goal is to evaluate culturally appropriate programs, policies and services aimed at improving health equity and eliminating health disparities as part of our foundational strategy.

Table IV.L-8: Face-to-Face Engagement with Members	
Key Stakeholder Feedback Process	**Feedback Related to Quality of Care**
Community Outreach	
Building relationships and making community connections is a strong focus for our community outreach team led by marketing and community outreach director, Kim Manning. Outreach efforts in the community allow us to listen, observe and understand how community resources align with our mission of helping people live healthier lives and connect to MLTC to support the Medicaid population.	We are working on an initiative to collaborate with Food Bank for the Heartland to deliver daily meals in Cass County (Plattsmouth, Nebraska). Recognizing the great need our community outreach specialist recognized an opportunity in the community and arranged for the Food Bank to meet with One Life Church in Plattsmouth. The Plattsmouth School District is working to qualify them for "free or reduced" lunch for the students. The health plan continues to stay connected with the school district to assist with the completion of the necessary paperwork so Cass County students can benefit from hot meals afterschool for children. We know that access to a healthy meal can improve our members' health and for these children, performance in school.

Table IV.L-9: Member and Provider Feedback	
Feedback Process	**Feedback Results Related to Quality of Care**
Consumer Assessment of Health Plan Satisfaction (CAHPS)	
We conduct the CAHPS member survey from February through June of each year by a certified vendor and measure the members' experiences with UnitedHealthcare during the prior six months. The CAHPS survey team analyzes and trends the results annually. The QAPIC reviews them to identify trends, opportunities for improvement and make recommendations to improve member experiences. We established a CAHPS workgroup to review and analyze the results of the CAHPS survey for limitations and barriers.	One of the identified barriers was that some members were not aware of the website and the key functions it provides (e.g., provider look up, urgent care facilities, benefits information, health information, the *Member Handbook* and *myuhc.com*). As a result, we now include member website information on all materials; we created a member-website reference guide for member welcome kits and newsletters; and we request member feedback on website usability and improvements and share this with our digital team.
Physician and Practice Manager Satisfaction Surveys	
Our provider surveys are designed to assess which services are important to health plan providers, determine satisfaction with UM processes and assess satisfaction with continuity and coordination of care. We conduct provider satisfaction surveys annually.	We summarize provider survey results, which are reviewed by our national network team and the quality committees to identify areas for improvement and develop action plans for improving our provider relationships.
Member Grievances and Appeals (Telephonic and Written)	
We review and analyze complaint, appeal and grievance data to monitor, evaluate and effectively resolve member concerns in a timely manner and use this data to identify opportunities for improvement in the quality of care and service we provide. Data related to quality of care, quality of service, member experience and administrative issues are collected, reviewed and trended to identify opportunities for improvement. Quality of care issues (both medical and BH) receive further scrutiny and, depending upon their seriousness, may be taken to the CPAC for peer review and potential corrective action.	Because of reviewing member appeals in 2014, we identified that providers required additional education on our appeal process. As a result, we undertook several provider education initiatives to: 1) Educate providers on the appeal processes and initial documentation requirements during their regular meetings; 2) Outline the appeal process in the *Provider Administrative Guide*; and 3) Work with key provider groups on the submission of appropriate documentation for DME services.

73. Describe the MCO's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the MCO, and how operations improved because of their results. Discuss how the MCO will collaborate with MLTC and other MCOs to conduct statewide PIPs. *3 pages*

We design PIPs for the entire Nebraska population or a targeted population or subgroup. We design our PIP studies to include measurement of performance, interventions, improving performance and systematic and periodic follow up on the effect of the interventions. Performance improvement indicators are objective, clearly defined, based upon current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status and member satisfaction, or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement. We review the results of evaluations and recommendations at least annually by the appropriate QAPIC.

In addition, our comprehensive quality scorecard developed for Nebraska includes key process and outcome indicators for MLTC, and allows us to identify opportunities for improvement on a continuous basis. For all quality initiatives, we objectively and systematically monitor and evaluate opportunities that may result in PIPs or other formal or informal QI activities. We focus these activities at improving the quality, timeliness and/or appropriateness of our care and service delivery. Medical director/chief medical officer Michael J. Horn, M.D., and quality management coordinator Cyndi Margritz, RN, BSN will continue to lead the ongoing effort to achieve the quality benchmarks under the new Heritage Health contract.

We have in-depth experience operating various integrated and coordinated physical and behavioral state managed care programs with demonstrated outcomes and proven results. With national and local experience gained from operating these programs, we access best practices, national clinical experts and resources to successfully develop and implement innovative PIPs for Nebraska Medicaid members. **We agree to collaborate and support MLTC in conducting the required clinical (two) and non-clinical PIPs in compliance with the contract requirements.**

Identifying and Designing Performance Improvement Projects

We are committed to the objective and systematic monitoring and evaluation of the quality and appropriateness of care and service provided to members. To support this, PIP interventions are determined based upon the needs of the population and state or federal requirements. We identify PIPs to improve the health of members who have been diagnosed with multiple or severe chronic conditions or where service should be considered for improvement. The PIPs we design align with MLTC's Quality Strategy and specifically improve access to preventive services or health outcomes for vulnerable groups within the Medicaid population.

- ***Data Collection:*** Data are collected and analyzed that measure member health outcomes and satisfaction with health plan services. We review HEDIS data, utilization data, care management and disease management data, member satisfaction surveys, CAHPS data and member grievance data. We categorize member grievance data by quality of care issues, member access, attitude and service, billing and financial issues and quality of practitioner office sites. Topics are selected by MLTC or, based upon the prevalence of the issue within the membership, the importance/risk of the issue to the membership, and reported rates versus established benchmarks.
- ***Review and Approval:*** We present PIPs to the applicable quality committee and MLTC for input and approval.
- ***Setting Benchmarks:*** We establish quantifiable indicators, which clearly and accurately measure and evaluate the activity. Indicators measure changes in health or functional status or member

satisfaction. Baseline benchmarks and goals are set along with information on the derivation of the benchmarks and goals. In addition, process measures are established and evaluated as applicable to verify that interventions are being implemented and progressing as planned.

- ***Development:*** After conducting an initial analysis, the QAPIC develops and implements an intervention(s) that has a high chance of success. We select interventions that we know to be effective and suitable to the population selected. The timing and course of interventions must also be determined in addition to the date the intervention begins; the number and percent of the population who actually received the intervention; and whether the intervention was conducted as expected or if issues arose which interfered with the implementation.
- ***Analysis:*** We conduct a quantitative analysis to determine if there has been a rate change in the original measurement selected or if we have attained goals and benchmarks. We determine if changes are statistically significant or if they correlate to the timing of the intervention. Based upon the quantitative and qualitative analysis, we perform additional analysis to determine if interventions should continue or if we need to institute a change. If QI actions were successful, the new processes are standardized and monitored. The QAPIC will determine if actions are successful and implement required changes to the current interventions.
- ***Re-measurement:*** The QAPIC conducts re-measurement to determine if new interventions have resulted in improvement. We may discontinue projects when we have not demonstrated sustained improvement. A three-year cycle is common, but projects may extend longer depending upon the topic, design and results.
- ***Monitoring:*** Interventions that result in sustained improvement are standardized and monitored. We present final project reports and recommendations for termination, before the applicable health-plan quality committee for approval before project discontinuance.
- ***Reporting:*** We report PIPs on the performance-improvement project form. We update the PIP reports and present them to the quality committee and MLTC for review and comment annually.

We continually endeavor to improve the quality of services to find areas of our operations that we can modify so that we can support our commitment to continuous quality improvement. We identify and establish PIPs to improve our program performance. Our quality committee continuously evaluates, discusses and approves PIP-related progress reports.

Performance Improvement Project Improvements

We have significant experience and success in selecting and completing PIPs to address specific areas of opportunity identified to affect our members. The following is a description of how we improved operations with a PIP and continue to sustain improvements.

Breast Cancer Screening Performance Improvement Project

The plan completed a breast cancer screening PIP that included a targeted member incentive, member education and provider communication. **The results of this PIP showed an 11.33 percentage point increase in the number of members receiving their breast cancer screening** (Table IV.M-10)**.** The member outreach incentives were determined to be effective in lifting the overall screening rate and therefore improving the care of these members. This resulted in a process improvement that continues for these members.

Table IV.M-10

Care Measure	2013	2014	2015
Breast Cancer Screening	42.53%	46.54%	53.86%

Adolescent Depression Screening Performance Improvement Project

The goal of the Adolescent Depression Screening PIP is to measure and improve the screening rates for depression in adolescents' ages 12 to 18 years of age and to assess and improve follow-up care if indicated. Specifically, determining the percentage of depression screening completed during all visits. We implemented the interventions from The Adolescent Depression Screening PIP and interventions were initiated in January 2015.

We are working with our selected partner, OneWorld, to assess the screening and treatment documentation for UnitedHealthcare members. We also have quarterly meetings with Magellan to collaborate on analysis, barriers and interventions. This included facilitating response to a number of questions posed by Magellan to assess their tools and make recommendations for improvement.

Collaboration with MLTC

We are currently completing two MLTC required PIPs and participate in MLTC-led quality training annually. We have been collaborating since 2014 with Magellan to improve depression screening, documented follow up and appropriate referral to the higher level of care as needed. We are currently collaborating on a joint PIP with other managed care organizations and agree to take a leadership role in future PIPs for MLTC with the topic determined by MLTC.

74. Discuss the MCO's approaches to annual member satisfaction surveys. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes. *1 page*

Our approach to member satisfaction relies on the robust QAPI program that we have in place today to monitor, measure and implement program changes that improve the health outcomes of Nebraska Medicaid members and their families. Our fully integrated QAPI Program includes a systematic process for monitoring, evaluating and improving the quality and appropriateness of all services to members, including their program satisfaction.

Approach to Member Satisfaction Surveys

Annually, we conduct an NCQA-certified CAHPS survey to assess overall member satisfaction and to identify and prioritize opportunities for improvement. Unless instructed otherwise by our state partners, DSS Research, an independent vendor certified by NCQA conducts our CAHPS 5.0H surveys. In addition, we participate in clinical studies and use CAHPS survey results to assess the quality and appropriateness of care provided to members.

Implemented Quality improvements

Recent CAHPS results identified health promotion and education as an area for improvement, which led to the development and implementation of multiple member incentives focusing on education and health promotion. This included a focus on child, adolescent and adult members. Through these programs, we were able to **increase well-child visits by 3 percentage points, adolescent well visits by 6 percentage points, and diabetic eye exams by 4 percentage points**.

Nebraska Child Medicaid Survey Results – CAHPS Survey Results

In 2015, we conducted a CAHPS survey for our Nebraska membership as well as the survey for children with chronic conditions. The following measures are in the **90th percentile or higher nationally based upon NCQA accreditation benchmarks,** meaning we performed better than 90 percent of the plans that reported their data nationwide.

- Rating of Personal Doctor
- Health Promotion and Education
- Customer Service
- Getting Needed Care
- How Well Doctors Communicate

Behavioral Health

We will collect data about opportunities for collaboration between medical and BH care including use of psychotropic drugs/special needs of members with severe and persistent mental illness (e.g., HEDIS performance related to antidepressant medication management, ADHD follow-up). We also will monitor both the access and availability of practitioners providing BH care services. Through collaboration with our BH partners, we will collectively analyze the results, identify opportunities for improvement and take actions, as needed, to drive improvement.

In addition to the member satisfaction efforts in place today, we continue to monitor and request feedback from Nebraska Medicaid members through several other venues such as the Member Advisory Committee, review of member appeals and grievances, our key member indicator survey and through community events, such as the KidzExplore Family Festival (Omaha/Council Bluffs), the Cinco de Mayo health fair (south Omaha) or Community Asthma Education Initiative (Lincoln).

75. Discuss the MCO's experience with submitting HEDIS measures. Indicate whether the measures were reported for a State Medicaid, CHIP, or commercial product line. *1 page*

Our quality team has regularly submitted combined Medicaid/CHIP HEDIS data to MLTC—beginning in 2000 and before our NCQA accreditation in 2005. We understand the importance of HEDIS ratings as a measure of plan performance, as evidenced by our position as the only Medicaid plan in Nebraska to reach a four-star performance level and the highest rated among all Medicaid plans in the state. In addition, since 2013 our HEDIS measures overall have improved by 3.5 points—from 19.9 to 23.4—further establishing our "Commendable" NCQA status.

UnitedHealthcare has extensive national experience working with our state partners to monitor, track and submit HEDIS measures. In total, for 2014 (for care rendered in 2013), we completed **15 Medicaid health plan HEDIS submissions, 86 commercial submissions and 158 Medicare submissions.** Our external, NCQA-certified HEDIS auditor, validating our administrative and medical record data collection methods, deemed all submissions reportable. We participate in clinical studies and use HEDIS rate data to regularly assess the quality and appropriateness of care provided to members.

"We're honored to serve Medicaid members in the state of Nebraska and feel very privileged to play a role in helping Nebraskans get the right care at the right time, empowering them to protect and improve their long-term health and well-being."

–Kathleen Mallatt, UnitedHealthcare CEO. Medicaid Health Insurance Plan Ratings Press Release October 13, 2015

HEDIS serves as our standard set of indicators to continuously measure plan performance. Results are used to identify current gaps in care or service and are integrated into our QI projects and member incentives. Furthermore, we fully integrate quality measures (both HEDIS and non-HEDIS) related to medical health, BH services and other ancillary services as appropriate to provide a comprehensive Quality Program representative of the full continuum of care.

HEDIS measures allow us to track and benchmark performance across the following areas:

- Preventive (e.g., lead screening, immunizations, cervical cancer screening, breast cancer screening, chlamydia screening and well-child visits)
- Chronic care (e.g., diabetes, cholesterol management and treatment of asthma)
- Behavioral health (e.g., follow-up after hospitalization for mental illness, antidepressant medication management)
- Access to and availability of care

We generate HEDIS data using NCQA-certified HEDIS software, MedMeasures, which provides us with monthly reports and ad hoc reports to support continuous QI, and our annual, certified final HEDIS results. An NCQA-certified HEDIS compliance auditor audits our final HEDIS results. Monthly analysis of our HEDIS performance allows us to implement and participate in clinical studies and to target interventions. It also allows us to periodically and regularly assess the quality and appropriateness of care provided to our Nebraska members.

76. Provide the MCO's vision for the MCO's Clinical Advisory Committee. Discuss how the requirements of the RFP will be met. *2 pages*

To meet State requirements and address MLTC's vision for the Clinical Advisory Committee (CAC), the CAC will become part of the quality committee structure as the Clinical and Provider Advisory Committee (CPAC) in 2016, under the direction of the medical director/chief medical officer, Dr. Michael Horn. The vision for the CPAC, when implemented, is designed to:

- Enhance the integration of care through a patient-centered approach
- Reduce the need for costly care through preventive care services and care management support
- Ultimately, to produce improved health outcomes for members across Nebraska

We extended the membership and scope of the prior PAC to form the new CPAC and blended additional clinical performance responsibilities to include regular consultation with experts who are familiar with standards and practices of treatment. This includes diseases and chronic conditions common in the Medicaid population (e.g., asthma, diabetes), disabilities and mental health or substance use disorder treatment for adults, children and adolescents in Nebraska.

Clinical and Provider Advisory Committee

The CPAC, which meets a minimum of four times annually, provides input into all policies, procedures, and practices associated with care management and UM functions, including clinical and practice guidelines, and UM criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska. All practice guidelines will be reviewed and approved by the CPAC prior to initial use and whenever significant changes are made.

We expanded CPAC membership to include providers who care for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities and who have an awareness of differences between rural and urban populations. The CPAC now includes pharmacists, physical health providers and BH providers. CPAC members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. Non-credentialing peer review must include at least one member of the involved party's specialty and must meet state regulatory requirements.

Responsibilities of the Clinical and Provider Advisory Committee

The CPAC performs peer review activities, including review of credentialing and disposition of concerns about quality of clinical care provided to members as requested by Dr. Horn. In addition, the CPAC is responsible for the initial review and approval of all clinical and practice guidelines, UM criteria, and evaluating and monitoring the quality, continuity, accessibility, availability, utilization and cost of the medical care rendered within the network. The responsibilities of the CPAC are to:

- Monitor performance on clinical indicators (e.g., HEDIS, state metrics, PIPs, and continuity and coordination of medical and BH care) conduct/review barrier analysis and recommend actions, as appropriate
- Review and approve nationally endorsed clinical and practice guidelines, and UM criteria, providing input as appropriate
- Review summary data regarding quality of care complaints, appeals and grievances; identify trends, conduct barrier analysis and recommend corrective actions as needed
- Review reports on mortality and inpatient quality issues, and recommend actions as indicated

- Perform peer review of care and service issues, including recommendations for improvement action plans
- Review and accept the National Credentialing Plan, with addendum for line of business regulatory requirements as applicable
- Perform peer review and provide oversight of final decisions by the Credentialing Committee for the credentialing and recredentialing process
- Monitor process for compliance with regulatory and accreditation compliance
- Review, track, identify opportunities for improvement and make recommendations relating to medical record issues, and potential quality of care trends
- Review provider satisfaction survey results and make recommendations for improvement, including strategies to improve the administrative experience of network providers

The current CPAC membership includes:

- Michael Horn, M.D., medical director/chief medical officer (Chair)
- Kathleen Mallatt, chief executive officer
- Sean Jones, chief operating officer
- Nick Steinauer, M.D., OB/GYN
- Sharon Stoolman, M.D., pediatrician/hospitalist
- Dwain Leonhardt, M.D., Internal Medicine
- Paul J. Nelson, M.D., Family Practice
- Hank Sakowski, M.D., Internal Medicine
- James Harper, M.D., pediatrician/Hematology/Oncology
- William Gossman, M.D., Emergency Medicine
- Donald Gibbens, OB/GYN
- Anthony Montegut, M.D., Family Practice
- Colleen Conoley, Ph.D., Psychology/Neuropsychology (currently non-voting)
- Tony Sun, M.D., market medical director
- Cyndi Margritz, RN, BSN, quality management coordinator
- Alison Behrens, clinical quality specialist
- Jeremy Sand, provider services manager
- Barb Palmer, RN case management administrator

We will add additional providers as we expand the CPAC in 2016 to become the CPAC. This includes a dentist, pharmacist and additional BH providers.

77. Describe the MCO's practice of profiling the quality of care delivered by PCPs, specialists, and hospitals, including the methodology for determining which and how many providers will be profiled.

- Submit sample quality reports.
- Describe the rationale for selected the measures that are gathered/reported.
- Describe the proposed frequency of profiling activities. *3 pages, excluding sample quality reports*

We recognize the value of our profiling practice on the quality of care delivered by providers to our members. The value of our provider profiling is that when members make progress by taking healthy actions, providers receive rewards too. Our quality program includes mechanisms to detect and address both overutilization and underutilization of services to profile and assess the quality of care rendered, which ultimately supports both members and providers. To support providers in creating this critical link, we have in place a sophisticated array of reporting that connects them with critical feedback, education and support from our field-based clinical practice consultant team.

Case Study: Nebraska FQHC Provider Profiling

In November 2015, Dr. Michael Horn, medical director/chief medical officer, and Cindy Holloway, RN, clinical practice consultant (CPC), met with the chief medical officer of an FQHC provider partner. Dr. Horn presented provider profiles for the clinic as whole and for individual providers. These reports included both utilization data with comparative graphing and HEDIS quality metrics benchmarked against all providers in the health plan by specialty.

The quality metrics were of special interest because this provider partner recently signed a value-based contract (VBC) that included incentives for achieving agreed-upon quality improvement targets. Dr. Horn reviewed several key areas with opportunities for improvement such as Adolescent Well Care Visits, Childhood Immunizations and the use of the Baby Blocks incentive for the women's clinic.

The meeting outcome was for Ms. Holloway to review "*Members in Need of Services*" reporting with her counterpart for all members by the end of the year, to produce and mail out our cobranded letters to members in need of services and supply Baby Blocks brochures for the clinic. Dr. Horn also will look to drill down on data regarding pharmacy costs for any additional insights.

Sample Quality Reports

We have provided the following quality report samples in **Attachment 19 Q77** and described their rationale and methodology in the table below:

- PCP Provider Profiling Sample (**Attachment 19 Q77-1**)
- HIPR Utilization Summary Report Template (**Attachment 19 Q77-2**)

We accomplish this through different profiling mechanisms for PCPs, specialists, hospitals and related to evidence-based pharmacy utilization and prescribing patterns as described in Table IV.M-11 below.

Table IV.M-11	
Profiling Rationale	**Methodology**
Provider Profiling Rationale: Our rationale for profiling providers is to monitor and identify variation in practice patterns and identify outliers compared to established clinical practice guidelines (CPGs) for acute, chronic and preventive care. The rationale behind the use of CPGs is that they are evidence-based using extensive and unbiased research; they are replicable, adaptable to individualized care and provide an accepted standard of care. With the oversight of our QAPIC, our quality team reviews overutilization and underutilization monitoring, quality of care monitoring, identifying when a provider is not practicing in accordance with established evidence-based clinical guidelines. ***Frequency:*** Annual	We profile high-volume providers, at a minimum annually, by examining utilization patterns, such as ER visits, hospital readmissions, lab and pharmacy encounters, member visits to providers other than their assigned provider, in and out-of-network specialty referrals, and utilization by high-risk members. The clinical and quality teams partner to review reports on metrics and determine if there is evidence of inappropriate underutilization and overutilization. We also use this data to inform providers on their patterns of care. We have policies and procedures in place to monitor variation in practice patterns and identify outliers. With the oversight of our QAPIC, our quality team monitors participating providers against established clinical practice guidelines for acute, chronic and preventive care. We have provided a sample provider profile and provider-group profile report as Attachment 19 Q77-1 and 2.
BH and Specialist Profiling Rationale: As described above, we use best practices from across our organization to develop BH and Specialist profiling. We are developing prototypes to support expansion of our provider-profiling program to focus on specialists (e.g., obstetricians/gynecologists). Additionally, we are updating our nationwide patient safety work plan to refine several elements to reflect the needs of our Medicaid beneficiaries and state partners. **Frequency:** Annual	For practitioners focused on women's health, while not assigned members like a PCP, our methodology includes evaluating the inclusion of episodes of care particularly around prenatal/postpartum care with the goal of continuing to improve our maternity outcomes. As part of our specialist profiling initiatives we are anticipating hospital profiles, aligned with national patient safety objectives and our own hospital pay for performance methodologies. Such profiles may include: ▪ Mortality rate for three conditions based upon epidemiological assessment and collaborative discussion with hospital patient safety staff ▪ National Patient Safety and National Quality Forum ▪ Hospital CAHPS (HCAHPS) ▪ Early elective delivery
Facility Profiling	
Hospital Profiling Rationale: Assessing the impact of quality reporting on hospital operations can inform decisions about whether and how programs should be modified to best drive the quality of care delivered. ***Frequency:*** Quarterly	We generate the Hospital Inpatient Performance Report (HIPR) Utilization Summary Template on a quarterly basis, with rolling four quarters of data for the largest hospitals. The data source is the Variant Days Analysis (VDA) report. We share HIPR reporting during Joint Operating Committee meetings with hospital administration and their clinical leadership, focusing on areas of opportunities and reduction of readmissions. We have provided a sample HIPR Utilization Summary Template as Attachment 19 Q77-3.

Table IV.M-11	
Profiling Rationale	**Methodology**
BH Outpatient Profiling Rationale: We monitor outpatient care and measure outcomes through our proprietary model, ALERT (Algorithms for Effective Reporting and Treatment), our outcomes-driven outpatient management program. ALERT is a key component of our behavioral health program. The model emphasizes early identification and monitoring of high-risk cases among those members in outpatient behavioral health treatment, allowing us to focus our clinical resources where we can add the most value. ALERT is configured to address the needs of children and adolescents through a pediatric wellness assessment. ***Frequency:*** Annual	ALERT algorithms are developed from evidence-based medicine. As care is delivered, ALERT identifies and stratifies risk resulting in more refined targeting of intervention, which leads to greater improvement. Rather than relying solely on claims data, ALERT is activated at the first outpatient BH visit and again at set points in treatment to identify triggers that may indicate lack of progress in treatment, when treatment is delivered outside of evidence-based practices and high-risk situations that may require more intensive treatment, including comorbidities, and completion of treatment goals. ALERT supports population-based analyses of clinical outcomes, outpatient service patterns, psychotropic medication adherence and prescriber patterns.
BH Facility Profiling: To improve the quality of care among our facility-based providers, we recently launched Achieving Clinical Excellence (ACE), our facility measurement program. ACE evaluation data allows us to stratify BH facilities on an annual basis and help identify and promote those facilities delivering more effective and efficient health care. Every April, ACE will tier facilities according to evaluation results and assign facilities a tier designation of platinum, gold, silver, bronze or criteria not met. Facilities achieving platinum status receive two stars on the *Live and Work Well* member website (*myuhc.com*) and recognition on the provider portal. ***Frequency:*** Annual	We evaluate BH facility data annually against regionally based benchmarks. We use the results to engage facilities by recognizing them for outstanding performance or by helping them to mitigate variations in practice patterns—resulting in improvements in outcomes and affordability. ACE methodology adds the dimension of allowing us to parse this data into effectiveness and efficiency metrics to achieve improved clinical success.
Pharmacy Profiling: The program encompasses retrospective and prospective DUR (Drug Utilization Review). Clinical pharmacists conduct reviews of complex cases in conjunction with the medical staff as an integral part of the clinical team. We also manage appropriate utilization via the Prior Notification System (PAS). Our dedicated internal staff of clinical pharmacists drives appropriate utilization by administering guidelines developed by our clinical staff following accepted medical practice. Our internal Pharmacy & Therapeutics (P&T) Committee reviews and approves these guidelines. **Frequency:** Ongoing audits for review of claims and outliers; Audits (Desktop Audit) and On-site Audits (Annual)	Methodology for criteria development is based upon expert opinions and published literature. We analyze the member health records for those members meeting the criteria and, as appropriate, contact members and caregivers. From the set of all identified members, we further identify the subset of prescribers whose prescribing patterns exceed acceptable parameters. We use narrower criteria that focus our efforts on the most critical issues to target prescribers for peer-to-peer intervention. For example, we initiate peer-to-peer discussions with the treating practitioner to determine the rationale and appropriateness of the therapy; educate the prescriber; and, if appropriate, recommend alternative practices. We have provided a pharmacy profile report as **Attachment 19 Q77.**

78. How will the MCO use the Member Advisory Committee to improve quality of care and direct quality and operational changes? What representation does the MCO plan to have on each committee (e.g., stakeholder types, from what geographic areas)? How will the MCO identify participants of the Member Advisory Committees?

Provide examples from other states where the MCO has collaborated with members for program improvement. *5 pages*

The Member Advisory Committee (MAC) provides a collaborative forum for our members to share successes, bring issues and ideas to the health plan, work together on opportunities for community outreach, identify common ground around legislative issues, obtain feedback on new and future initiatives and review how these programs fulfill our mission. (Figure IV.M-3) We have had a MAC in place in Nebraska since 2012 and we continue to reach out to our members to obtain their feedback, suggestions and insight on how we can better serve them and their families. The MAC also provides an opportunity for input on BH services and services for members with special health care needs including I/DD populations.

The Member Advisory Committee: Improving Quality of Care

The MAC meeting is an important piece of the quality structure, providing valuable information from members, families, caregivers and key stakeholders. Within the quality infrastructure, the MAC reports to the QAPIC allowing for the action planning and development for areas identified for improvement. We are committed to the work we do with members and their families to improve the quality of care. To support this commitment, we:

- ***Create a welcoming, inclusive environment*** and hold MAC meetings in locations that are accessible to all and conveniently located. We change locations to accommodate members in different locations throughout the state.
- ***Listen to our members and gain experience*** from their diverse perspectives. Our meetings support open and honest communication. This provides us with a wealth of understanding about the health care challenges our agencies, community members and health plan members face with the delivery of health care and provides members with the opportunity to provide input into quality improvement activities, monitoring and evaluation of those activities.

Figure IV.M-3. Photo of the Member Advisory Committee in Nebraska. Members and their families are welcome.

- ***Empower members to feel engaged with their health care,*** to ask questions about the scope of their benefits and to understand their *Member Rights and Responsibilities.* Gather recommendations and obtain feedback on providing health and wellness education to the community and members.
- ***Remove barriers to participation*** by providing childcare, arranging transportation or reimbursing representative mileage to support participation and alleviate barriers to attendance. As shown in the photo, family members are always welcome to attend.
- ***Provide a member participation stipend.*** Since participants attending in a professional capacity, we can compensate members and member representatives through a $50 stipend.
- ***Build community.*** In addition to members and consumers, our MAC meetings are an opportunity for key stakeholders such as agencies, community members, tribal members and advocacy

organizations from a variety of community and program entities to meet face-to-face to forge and develop community connections that would not otherwise have the opportunity to flourish.

- ***Provide an educational dialogue*** for presenters to speak to agencies, community members and health plan members on specific health care topics that can enrich the lives of members.
- ***Design MAC meetings to respect diverse cultural needs.*** At a recent meeting, we had 13 participants and we conducted the entire meeting in Spanish to meet the needs of the members in attendance.

Examples of Members Driving Program Change in Nebraska

On June 26, 2014, we held a MAC meeting in Lincoln, Nebraska, at the Educare Center and provided childcare for members in attendance. We chose specific topics to discuss from the *Member Handbook* and received feedback on the layout of the *Member Handbook*. We provided guidance on when to use the ER versus urgent care; when and how to change a PCP; the importance of using your ID card; and member rights and responsibilities.

Key topics identified during our MAC meetings have resulted in targeted articles in our member newsletters and actionable member education and innovation as described in Table IV.M-12.

Table IV.M-12

Feedback from MAC Members	Action Taken Based Upon Feedback
ID Cards and Benefits: One family member shared that she used the ER after having a car accident while pregnant. Another family member shared using urgent care, but receiving bills for services due to not using her ID card and benefits.	We provided education during the meeting on when to use each facility as well on the importance of using the ID card and understanding benefits. Information was added to the member newsletter.
Member Handbook: Feedback on the handbook was that it was too large. A smaller size handbook would be easier to manage. The families felt that an electronic version would be best. Busy schedules and home life left little time to read the handbook.	Based upon this feedback, the plan launched *Health4Me* in July 2015, which provides access to an electronic version of the *Member Handbook* online.
Changing PCPs: We advised families on process and frequency for changing PCPs. One family member disclosed her older child's PCP was no longer in network (due to termination of LMEP) and she chose to switch plans for that child.	We provided education at the meeting and *Member Handbook* information was presented. We discussed the appropriate steps for PCP changes.
ID Card Information: The families felt the information listed on the ID cards was sufficient and appropriate; however, both had times when more than one ID card was sent for each member or ID with wrong PCP or wrong PCP phone number.	This information was discussed at the quality committee and the information was shared with the operations team as an opportunity for improvement.
Baby Blocks: One family member with a newborn used the Baby Blocks incentive and felt the program was easy to use. However, she expressed that Old Navy was not at a convenient location to shop and would have preferred a Wal-Mart or Target gift card.	We provided this information to our Baby Blocks team for consideration during program updates. We now provide members with a choice for the reward: a gift card or a diaper bag.
Preventive Care Communication: The group reviewed a preventive care letter provided by the quality team for feedback. Neither of the families had seen the letter in the past, but felt there was good information.	Participants discuss these issues during the meeting and a suggestion was made to provide the information via phone or text. This information has been provided to the quality team for consideration.

The Member Advisory Committee: Member Representation

In 2015, we expanded the MAC to include members who reflect our diverse community agencies and membership. These members represent various community resource agencies, cultures, family dynamics, urban and rural settings and build a foundation for broad community connectedness to improve coordinated care for members.

Participation is encouraged by engaging members, member representatives and their families at community outreach events and through referrals from partner organizations, MAC members, statewide advocacy organizations and from those who express interest via our member services center.

We also obtain input from advocacy groups such as the Arc of Nebraska. This may include policy development, planning of services, service evaluation, member/family/provider education and recommendations for innovative ways to improve and integrate service delivery. We hold meetings in multiple community locations within our service area, meeting members in the community where they live. The MAC has provided input that was used to enhance member materials, communication, plan processes and service gaps.

The Member Advisory Committee: Identifying Member Participants

Our expanded MAC participants will include family members, members and their caregivers if desired or needed for attendance, community groups and advocates, State agencies, homeless advocate and service providers and health plan representatives. The composition of the MAC will reflect 51 percent members or member representatives, and the ethnic, gender identity, cultural, sexual orientation, age, religious and geographic diversity of Nebraska.

Member participation is encouraged by engaging members and their families at community outreach events and through referrals from partner organizations throughout member-accessible locations statewide. Currently, we have a rotating member and representative membership driven by community needs and participation. Going forward, we will set a goal to select participants that will commit to a full year of participation. We are dedicated to gaining participation from members, members' representatives, provider and advocates that reflect our population and the communities we service. We accomplish this with a focus to ensure that the committee represents the cultural and racial diversity throughout the state.

Member Advisory Committee Examples from Other States

We have extensive experience forming, collaborating and soliciting guidance from MACs in other states where we have served similar populations. The following examples illustrate the flexibility and function of the MAC (or MAC equivalent based upon State requirements), in very different environments, as we work together to improve the health outcomes of our members.

Mississippi Member Advisory Committee Experience

In Mississippi, we have a Community Partner Advisory Committee that provides a forum for Mississippi members, the community and nonprofit organizations to discuss health education, disease management and outreach programs.

We also address how these programs fulfill the UnitedHealthcare mission, support health education, information and program needs of our Community Partner Advisory Committee members, and the community. Our MississippiCAN member services and community outreach director leads this committee and reviews its recommendations for proposed implementation enhancements.

Tennessee CHOICES Advisory Group

A Thank You from a Tennessee Member

"It's been a little more than three years since I joined the TN CHOICES program administered by your firm. The purpose of this letter is to let you know that from my perspective as a member... you got it right! And, to thank you and the countless members of your firm for their exceptional efforts.

As you know, I have been very outspoken, often very critical and no doubt have proven to be a real nuisance on too many occasions. Even so, you, your office, and every single other person at UnitedHealthcare with whom I have spoken have always listened attentively and have graciously received whatever it was that I made the 'extremely important topic' of the day. Not only did you listen, but you responded.

I can only hope that you folks will continue to administer this program. This is one of the few really great governmental programs. It is a win/win for everyone."–Gary Sullivan, *Member TN Choices*

In Tennessee, we use direct member feedback and information gathered at our five quarterly regional member advisory committee meetings consisting of members, providers and other community supports individuals, to provide community education, be champions of the LTSS community and receive feedback so we can make changes to the program. The CHOICES Advisory Group (CAG) participants include family members or caregivers, State oversight representatives, members, providers, community groups and advocates, State agencies, APS homeless advocate and service providers, and health plan representatives.

The CAG promotes a collaborative effort between members, providers and UnitedHealthcare to understand what is working well in the program and what needs adjustment. We share information from the CAG at our internal LTSS leadership meetings and quality management meetings to make leadership and staff members aware of CHOICES operational member issues. We also share with the State through the semiannual reports to provide TennCare with an understanding of the operational obstacles members experience.

UnitedHealthcare National Advisory Board

To demonstrate our commitment to a member-centric culture, UnitedHealthcare's National Advisory Board (NAB) improves the way we deliver services to dual-eligible individuals, including seniors and persons with disabilities. The NAB serves as an independent advisory council that provides input to UnitedHealthcare in actively engaging members, providers, advocacy groups, and other key stakeholders in the design and delivery system supporting individuals with special health care needs. To improve the way we deliver Medicaid services, the NAB has initiated innovative training strategies that have been incorporated organization wide to include:

- ***Diverse population and disability training initiatives***, based upon the NAB's focus on cultural competency
- ***Americans with Disabilities Act (ADA) training***, based upon the NAB's focus on individuals with disabilities
- ***Clinical training on elder abuse***, based upon the NAB's focus on elderly care, abuse and neglect

Our NAB consists of distinguished and highly respected health care thought leaders, consumers, providers and community advocates. Membership includes at least 10 external board members who are external advocacy leaders and consumers representing various audiences and perspectives, and members of our local UnitedHealthcare leadership.

79. Describe the information the MCO will provide to members and providers about the QAPI program. *2 pages*

We are committed to simplifying the member experience. We leverage our advanced technology-based capabilities along with our health care resources as an organization to improve access to health and well-being services, simplify the health care experience for our members, promote quality and make health care more affordable. We provide customized tools and expertise that assist members in making informed health care decisions.

Quality Assurance and Performance Improvement Program Information to Members

We share information on the QAPI program and progress toward its goals with members:

- ***Member Handbook:*** All members will receive the Heritage Health *Member Handbook*, which contains information on our QAPI Program. The graphic provides an excerpt of the information we provide to Nebraska members.
- ***Periodic Mailings:*** Members receive periodic mailings updating them on quality and performance initiatives as well as results of completed or in-progress initiatives.
- ***Member Newsletter:*** The member newsletter in, shown in Figure IV.M-4, contains topics that reflect QAPI priorities for promoting members' health.
- ***Quality Information Request:*** A member may request information about the QAPI at any time, and is reminded at least annually in the member newsletter of this right and the process to follow.
- ***Member Advisory Committee:*** Under the leadership of Kim Manning, marketing and community outreach director, the committee will meet at least quarterly. A specific activity of the MAC includes a direct avenue for review and recommendations on the QAPI Program, as well as review of progress toward goals.
- ***Health4Me:*** *Myuhc.com* is also available on our *Health4Me* mobile application, supplying members and their families with instant access to critical health information. Users can simply download the application to their smartphone and log on, using their *myuhc.com* login credentials to sign into their account for convenient access.

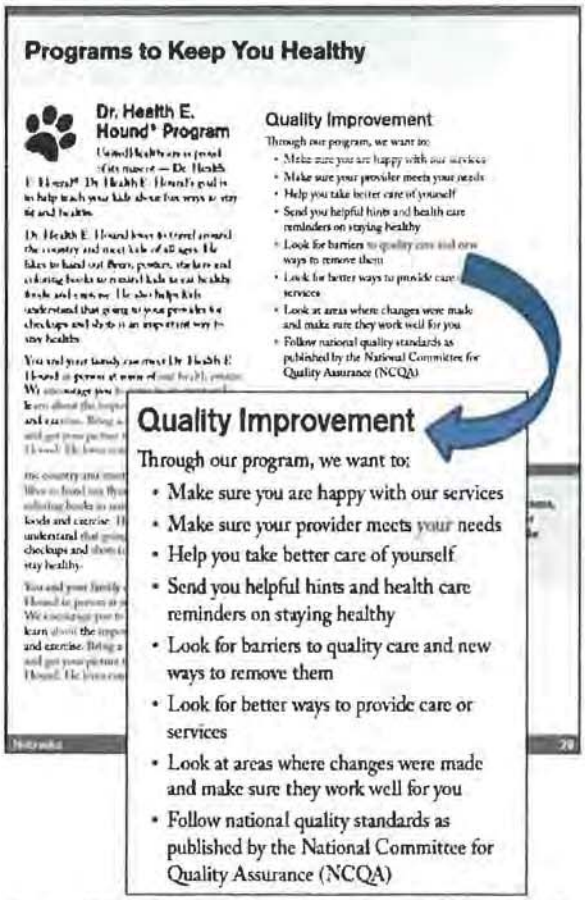


Figure IV.M-4. QAPI Priorities for Promoting Members' Health.

Quality Assurance and Performance Improvement Program Information to Providers

As part of our overall strategy to encourage providers to participate in our QAPI Program, we have in place the following initiatives to engage them:

- ***Provider Outreach:*** Visit participating providers at least annually to distribute and solicit feedback on quality indicators through provider profiles. Our provider services staff or Dr. Horn conducts these visits.

- ***Implementation of Clinical Tools:*** Contractually require network providers to participate in QAPI Program activities. Examples include clinical practice guidelines implementation, medical record standards compliance or review of their quality indicator reports. We will share tools and be available to train and assist providers as they implement the quality requirements into their own practice site and focus on mutual goals of safe, efficient and quality patient care.
- ***Clinical Provider Consultants (CPCs):*** Our CPCs work directly with providers to close preventive, chronic, and BH gaps in care. When collaborating with providers, CPCs use MedMeasures reporting to identify members within a provider practice as part of our overall QAPI strategy.
- ***Clinical and Provider Advisory Committee (CPAC) Participation:*** We invite qualified providers to join our CPAC. The medical director or director of quality solicits provider membership on committees. Qualified providers possess an interest or passion for quality work, leadership ability or influence in a market or provider group. Providers who are interested in our QAPIC are referred to the medical director or director of quality, who will outreach to discuss and potentially recruit the provider.

Through the CPAC, providers provide meaningful input, guidance and improvements to our QAPI Program, as well as oversee the credentialing process. Ways in which providers participate include but are not limited to:

- ***Plan:*** Approve provider communications, plan interventions for PIPs, recommend HEDIS interventions, recommend changes to QI program and work plan.
- ***Design:*** Recommend interventions if access metric not met by a provider, design PIP studies, formulate CAPs for peer review cases.
- ***Implement:*** Conduct peer review and oversight of credentialing activity.
- ***Review:*** Evaluate QI program and effectiveness, review reports on access, availability, medical record reviews, practice guidelines adherence and HEDIS results. The current PAC membership includes several providers who have more than three years of participation in our QAPI program.
- ***Peer Credentialing:*** We encourage provider participation in our credentialing process as an active member of the Credentialing Committee. A provider's involvement enables him/her to review our Credentialing Plan and make recommendations for improvement.

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IV.N. Utilization Management

80. Describe the MCO's approach to utilization management, including:

- Innovations and automation the MCO will use for its UM program.
- Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers.
- Mechanisms to detect and document over- and under-utilization of medical services.
- Processes and resources used to develop and regularly review utilization review criteria.
- How the MCO will use its UM Committee to support UM activities. *5 pages*

Our Approach to Utilization Management

We have successfully managed utilization for our Medicaid members for nearly 20 years through robust processes, policies, procedures and systems that are used by our knowledgeable and experienced clinical team to make the most appropriate decisions for each member's individualized needs and conditions. Led by our medical director/chief medical officer (CMO) Michael Horn, M.D., and behavioral health (BH) clinical director, Charles Freed, M.D., with a specialty in Child & Adolescent Psychiatry, our utilization management (UM) program is multi-faceted; part of an integrated continuum of care including physical health, BH, pharmaceutical and dental services and supports; linked to our clinical care management system; and continually monitored for improvements.

Our approach is built upon our medical necessity definition, best practice and nationally recognized clinical criteria, established clinical practice guidelines (CPGs), interdisciplinary and integrated care management practices and an innovative claims platform. Our UM program meets the requirements in RFP Section IV.N. Utilization Management and applicable state and federal and requirements and assures the delivery of the most appropriate services and supports in the amount, duration, scope and environment for the member's condition.

Innovations and Automations

Our UM approach is flexible, scalable and innovative and will assure our ongoing ability to meet the integrated needs of our Heritage Health members including those with diverse and unique conditions such as members with BH conditions, intellectual and/or developmental disabilities (I/DD), and in the foster care system. We will accomplish this through a comprehensive clinical view across disciplines and defined accountabilities for monitoring and evaluating accessibility and availability, continuity of care, timeliness and outcomes. Table IV.N-1 describes resources and programs, including innovations and automations that link our UM processes to our person-centered care management processes to improve our ability to bridge gaps in care, access care for members with special health care needs and share information while reducing duplication of services and administrative burden for our providers.

Table IV.N-1: Utilization Management Innovations and Automations

CommunityCare	Our secure, Web-based clinical case management platform, CommunityCare, links our UM functions to our care management functions by providing a comprehensive view of our members' health record so that our clinical reviewers can make the most appropriate decisions for our members. CommunityCare includes the following types of member information: ▪ Diagnoses including physical, BH and co-occurring conditions ▪ Screening and assessment results ▪ Integrated care plan including identified member needs, strengths, goals, objectives and preferences

Table IV.N-1: Utilization Management Innovations and Automations	
	▪ Current and historical service provision such as physical, BH, pharmacy and dental services ▪ ER use, hospitalizations, hospital readmissions ▪ Care management, disease management and medication therapy management services ▪ Support system and social determinants Our UM clinicians use this information as well as information from the provider's prior authorization request to approve services, identify gaps in care, conduct concurrent and retrospective review and work with the member's care manager to assure our members access needed services for their conditions. For example, CommunityCare sends our care managers and UM clinicians alerts for members with asthma who have not filled a prescription for a rescue inhaler so that we can conduct outreach to the member and assist with any barriers to obtaining the medication.
Provider Portal	Our provider portal, *Link*, streamlines and simplifies the administrative experience of our providers, by providing a single platform to request services that require prior authorization (PA) for their members. *Link* supports access to our medical necessity definition, clinical criteria, CPGs, list of services requiring PA, user-friendly automated PA processes and information on available peer-to-peer consultation as needed. Providers can also attach member records for our consideration and communicate in real-time to exchange information and documents with UM staff directly. For example, our Algorithms for Effective Reporting and Treatment (ALERT) system is a key component of our BH program by early identification and monitoring of members with high-risk BH conditions and treatment, allowing us to focus clinical resources where they are most needed. In addition, we will deploy our Achieving Clinical Excellence (ACE) program that rewards facility-based providers based upon achieving five effectiveness and two efficiency metrics.
Dedicated Durable Medical Equipment (DME) Authorization Team	Dedicated to managing PA requests for complex specialized devices (e.g., training prosthetics, power wheelchairs) for members in an expeditious manner, our DME department has dedicated clinical administrative coordinators (CACs) and RNs who provide a standardized and efficient approach to reviewing and authorizing DME requests upon receipt. Our providers can submit DME requests via phone, fax or online 24 hours a day, seven days a week. DME requests are referred directly to the DME authorization team where the CAC reviews member information, verifies that a letter of medical necessity and/or a physician order is present and requests additional documentation if needed. Our RNs then use our care management system to review the member's health record to make a determination. If needed, the RN will request consultation with our medical director to assure the most appropriate decision for our members. Our DME authorization team also makes sure the most appropriate DME is provided based upon condition, need, age, living environment and social determinants.
Provider Profiling	We profile providers, at a minimum annually, by examining utilization patterns, such as ER visits, hospital readmissions, lab and pharmacy encounters, member visits to providers other than their assigned provider, in and out-of-network specialty referrals, and utilization by high-risk members. Our clinical and quality teams partner to review reports on metrics and determine if there is evidence of inappropriate underutilization and overutilization. We use this data to identify and monitor variation in practice patterns among our providers, identify outliers and inform providers on their patterns of care. With the oversight of our Quality Assurance and Performance Improvement and Healthcare Quality and Utilization Management committees, our quality team monitors providers against our CPGs for acute, chronic and preventive care.

Table IV.N-1: Utilization Management Innovations and Automations	
Remote Patient Telemonitoring (RPM) Pilot	This pilot is integral to our strategy to improve quality of care and member outcomes and reduce unnecessary or inappropriate use of health care services, such as unnecessary inpatient readmissions. Through this pilot, we will implement high-touch telemonitoring solutions to help manage the care of members who have been hospitalized two or more times for the same condition within the last 12 months and with chronic disease, such as congestive heart failure or other related comorbid conditions and who are capable of or have someone who is able to use the equipment. RPM helps us achieve our improvement objectives by providing medication management, promoting adherence with seven-day and 30-day post-discharge visits and providing virtual clinic visit services to members in areas where the delivery of telehealth services from the member's residence is allowed.
Home Visits for Members in the Katie Beckett Waiver Program	We provide in-home visits and services to our young members who would otherwise be hospitalized due to their high level of health care needs through intensive monitoring and care coordination activities. Our services are tailored to the member's needs and may include in-home nursing care, immediate discharge planning upon hospitalization and supplies and DME based upon the member's needs.
Multidisciplinary Training	Our clinical staff participate in ongoing cross-training activities to assure understanding of current challenges in the system of care such as the recent Nebraska conference on individuals diagnosed with fragile and specialized health care needs that included members, families, State case workers, school personnel, PCPs, specialists and nursing agencies.

Accountability for Developing, Implementing and Monitoring Compliance

Under the direction of Dr. Horn and Dr. Freed, we will continuously monitor our Heritage Health UM program for ongoing effectiveness of UM interventions, verify year-over-year improvement and develop strategic initiatives to assure we adhere to medical necessity and CPGs; provide integrated care that is individualized to the member's condition and needs; engage members in supports and interventions including care coordination and clinical specialty programs; address overutilization and underutilization trends; and identify potential or actual fraud, waste and abuse. In collaboration with our national organization, our Quality Assurance and Performance Improvement Committee, Healthcare Quality and Utilization Management Committee, Clinical and Provider Advisory Committee and Behavioral Health Advisory Committee, we will assure accountability for state, federal and contractual compliance while meeting the holistic services of our members.

Assuring Consistent Application of Criteria. To assure our utilization review standards are maintained by each individual reviewer and promote consistency surrounding the decision-making processes, it is our policy that our clinical reviewers make decisions in adherence with our 1) medical necessity definition, 2) physical health CPGs based upon *MCG*s (formerly Milliman Care Guidelines), 3) substance use disorders CPGs based upon American Society of Addition Medicine (ASAM) criteria and 4) internally developed MH level of care guidelines (LOCGs) that are aligned with best practice, evidence-based and nationally recognized criteria. Our guidelines are used in combination with sound clinical judgment from licensed health care professionals with the expertise that is most closely aligned with the member's condition. As described in Table IV.N-2 below, we assure our providers adhere to medical necessity guidelines when requesting services for their members as well as assuring our UM clinicians consistently apply medical necessity guidelines and do not arbitrarily deny or reduce services by:

Table IV.N-2	
Utilization Management Clinicians	**Providers**
▪ Requiring training on our medical necessity definition and CPGs during orientation, ongoing, annual and ad hoc training	▪ Training on medical necessity, services requiring PA, how to request those services and peer-to-peer consultation opportunities

Table IV.N-2	
Utilization Management Clinicians	**Providers**
▪ Reviewing PA approvals to determine decision-maker adherence to medical necessity criteria and CPGs to assure appropriateness of care ▪ Assuring medical directors and UM staff have the requisite expertise and licensure for determining medical necessity ▪ Conducting inter-rater reliability (IRR) testing to determine the consistency of criteria application during decision-making processes ▪ Reviewing grievances, appeals and fair hearing requests for practice improvement opportunities	▪ Providing medical necessity and PA information in our *Provider Administrative Guide* on our secure provider website at *uhconline.com* to support real-time PA information ▪ Reviewing PA requests on a routine basis to assure providers understand requirements for both physical and BH service requests ▪ Conducting one-on-one training upon identification of adherence challenges and implementing corrective action as needed for continued inappropriate practices

Detecting and Documenting Overutilization and Underutilization

We take the health, care and safety of our members very seriously and use a variety of means to detect potential or actual overutilization and underutilization including reviewing and analyzing claims data and reports from our clinical staff such as our care managers (RNs and BH clinicians), CHWs, disease educators and pharmacy staff; ER utilization, hospitalizations and hospital readmissions; seven-day and 30-day follow up; provider profiling; provider requests for PA; member grievances and appeals; diagnosis to service utilization comparisons; satisfaction surveys; and service verification reports. We use performance indicators and metrics for outcome measures, stratification and other criteria through our state-of-the-art technology shown in Table IV.N-3 below.

Table IV.N-3	
Tools	**Description**
Impact Pro	Our multidimensional, episode-based predictive modeling tool uses automated algorithms to identify members who have a history of ER use, repeat hospital admissions, high utilization of outpatient services and medications, potential quality of care issues or an indication of duplicative services from multiple providers. Impact Pro's risk scoring and stratification components allow us to identify members with complex physical or BH conditions to support proactive outreach and care management. This powerful tool assigns an overall future risk score to each member, which represents the degree to which our care management program can impact the members' health status, utilization and clinical outcomes and assists our care managers in identifying members who are most likely to benefit from interventions.
Strategic Management Analytics Reporting Tool (SMART)	Our SMART data warehouse collects, stores and reports quality measures, PAs and claims data. It links with and receives data from our clinical management system to allow reporting on our clinical performance. SMART provides comparative cost data, cost trends, utilization data, profiling and predictive modeling capabilities. Using SMART's reporting/data analytics capabilities, we produce reports and conduct clinical, quality and UM/CM analyses that allow us to monitor and evaluate utilization management related to medical and BH management and care management.
Universal Tracking Database (UTD)	Our UTD facilitates compliance with EPSDT and other standardized benchmarks related to preventive care. The UTD accepts information from all claims sources, medical record reviews and outreach calls and provides EPSDT functions and related reporting. We monitor, analyze and evaluate statistics on EPSDT screening rates to identify PCPs and individual members with greatest gaps in compliance against NCQA measures and allowing us to conduct outreach to members who are due for screenings.

Upon identification of overutilization and underutilization, we conduct interventions for both members and providers. For members, we conduct outreach to identify any unmet, new or undiagnosed conditions; offer care management services; or assign the member to our pharmacy restriction program to prevent overutilization of medications or drug-seeking behaviors. For providers, we conduct additional provider education, peer-to-peer consultations, and site or treatment record audits as needed which may result in ongoing monitoring, development of corrective action plans, adverse benefit determinations and referrals to peer review, the Credentialing Committee or our compliance department for further investigation and reporting to MLTC as applicable. If our analysis identifies a systemic problem, we adjust our processes such as education for care managers and community health workers (CHWs) to use during member interactions. If the issue is broad enough, we incorporate the change in our member and provider manuals and secure websites.

Processes for Developing and Reviewing Utilization Review Criteria

We develop, adopt and review our utilization review criteria in accordance with the requirements described in RFP Section IV.N Utilization Management through our local and national committee structure. While our UM program is based upon our national UM program consisting of several national committees that oversee our national UM program, we adapt our clinical criteria and CPGs to address MLTC program goals, local nuances and social determinants that impact our members' health and quality of life. Our committees described above collaborate to analyze our review criteria and CPGs annually to:

- Determine whether a guideline has been updated based upon new scientific evidence
- Monitor whether new guidelines relevant to our membership have been issued
- Develop, review, evaluate and approve clinical protocols, policies and procedures
- Review inter-rater reliability (IRR) results, PA requests, and grievances and appeals outcomes
- Evaluate new treatments/technologies and new indications for treatments/technologies

We communicate and review the results of our UM program evaluation with MLTC to assure our criteria and CPGs are appropriately tailored to Nebraska-specific objectives, goals and mandated guidelines; policies or regulatory requirements; and the requirements of the Heritage Health program. We make our medical necessity definition and clinical criteria readily available to our members in the *Member Handbook* and at *myuhc.com* and our providers in our *Provider Administrative Guide* located on our provider panel.

Using our Utilization Management Committee to Support Utilization Management Activities

Our Healthcare Quality Utilization Management (HQUM) Committee reports directly to our Quality Assurance and Performance Improvement Committee (QAPIC) and oversees the development, implementation, and monitoring of the UM program and work plan. This committee supports UM activities by identifying and implementing approved changes to our medical necessity definition, clinical criteria, CPGs and UM processes including PA. This committee monitors our grievances and appeals process as well as state fair hearings for quality of care and UM decision-related issues. Our HQUM reviews utilization data to identify and address gaps in care; overutilization and underutilization; and fraud, waste and abuse as well as addresses results from internal audits including documentation reviews of PA determinations and IRR tests to identify opportunities for improvement. Our HQUM also monitors progress on clinical initiative and continuity and coordination across clinical and UM functions.

81. Describe the process the MCO will have in place to determine appropriate practice guidelines (including for behavioral health), notify providers of new practice guidelines, and monitor implementation of those guidelines. *2 pages*

Process for Determining Appropriate Practice Guidelines

We have nearly 20 years of experience determining the most appropriate practice guidelines for our members in our Nebraska Medicaid program. In addition, our 20 affiliate health plans across the nation possess more than 30 years of combined experience in determining the most appropriate guidelines for mental health and substance use disorders (MH/SUD). Under the direction of Dr. Horn, we will continue to align our guidelines with MLTC's medical necessity definition defined in Question 22 of this RFP as well as RFP Section IV.N Utilization Management and will work with other selected managed care organizations (MCOs) to assure alignment of our CPGs to prevent our providers from having to use conflicting guidelines.

We use evidence-based, nationally recognized *MCGs* for physical health care services, internally developed mental health (MH) guidelines for MH services, the ASAM criteria for substance use disorder (SUD) services, and levels of care based upon published references and research from nationally recognized organizations. This includes the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, ASAM, the Substance Abuse and Mental Health Services Administration and the current Diagnostic and Statistical Manual of Mental Disorders.

Recently, MLTC requested that Dr. Horn provide his opinion on the OncotypeDX Breast Cancer assay. Dr. Horn consulted with a Nebraska-based oncologist with expertise in this area to discuss the benefits and limitations of the test. This physician not only recommended this test as standard care for node negative, estrogen receptor positive tumors less than 2cm in size, but was a contributor to a recent *New England Journal of Medicine* article on the utility of this assay. Dr. Horn recommended that MLTC provide coverage for this test. We believe it is our privilege and responsibility to provide input when requested by our customer, MLTC, in a timely and relevant leadership manner.

Our national UM committee oversees UM programs for our 20 affiliate health plans across the nation and reviews and analyzes our guidelines at least annually to:

- Determine whether a guideline has been updated based upon new scientific evidence
- Monitor whether new guidelines relevant to our membership have been issued
- Develop, review, evaluate and approve clinical protocols, policies and procedures
- Evaluate, revise and approve commercially developed/externally licensed guidelines
- Review guidelines developed by and for the use of UnitedHealth Group
- Develop and adopt medical policy (e.g., adoption of Utilization Review Guidelines)
- Evaluate new treatments/technologies and new indications for treatments/technologies

All Nebraska-specific guidelines are reviewed and approved by MLTC and our Clinical and Provider Advisory Committee and Quality Assurance and Performance Improvement Committee. Dr. Horn leads and coordinates the review to assure our guidelines are appropriately tailored to MLTC's requirements, mandated guidelines, policies or regulatory requirements and the Contract. We also collaborate with MLTC and consider the opinions of local experts and thought leaders to consistently improve our clinical practices in response to advances in health care. We review our medical necessity definition, clinical criteria and CPGs at least annually and on an as-needed basis to respond to federal and state changes; nationally recognized clinical research; and identified trends, issues or patterns in utilization. On an

annual basis, we will make recommendations to MLTC for updates to our CPGs based upon our care management, quality management and UM activities including compliance and outcome measures.

Notifying Providers of New Practice Guidelines

Should we make changes to our medical necessity definition, clinical criteria or CPGs, we notify our providers through modification alerts via a posting on our secure provider website or email. Our online provider portal, *Link*, provides real-time updates to our medical necessity definition, clinical criteria, CPGs and quality and utilization requirements in our *Provider Administrative Guide* that is available 24 hours a day, seven days a week. We also provide written notification of changes through our provider newsletter, *Practice Matters*, and targeted mailings as needed. Our provider advocates are community-based and support our providers through telephonic and in-person contact to provide information and technical support for providers who need additional assistance such as submitting a prior authorization (PA) request that adheres with our guidelines. We distribute updates to participating providers within required time frames at least annually and following any changes and to non-participating providers upon request.

Monitoring Implementation of New Practice Guidelines

Because we take the health, care and safety of our members very seriously, we continually monitor our providers and clinical review staff to ensure updated CPGs are implemented through the activities shown in Table IV.N-4:

Table IV.N-4

Resource	Description
Prior Authorization	We educate and train providers on our new practice guidelines including how to apply the new criteria when submitting PA requests. We also review PA requests on a routine basis to assure providers understand the new requirement and upon identification of non-adherence, we conduct outreach to our providers for one-on-one training including technical assistance for submitting a request. We also monitor utilization for unnecessary ER visits, hospitalizations and readmissions to identify providers who may not be adhering to CPGs such as for seven-day and 30-day appointments following discharge.
Integrated Clinical User Experience (ICUE)	Our UM system, ICUE, includes an automated tasking and reminder system that supports our UM clinicians through the authorization process. For example, our clinicians are required to open tasks that follow our CPGs during the review and if those tasks are not closed during the process, an alert is sent to the clinician's supervisor for assistance in completing the authorization and additional intervention such as coaching, additional training and load balancing.
Inter-Rater Reliability (IRR) Reviews	Our IRR reviews compare decisions among our UM clinicians for similar cases and then uses statistical measures to assess consistency and identify potential sources of inconsistency. Upon completion of the assessment, the results are reviewed by management and are reported to our HQUM for process revision consideration and/or corrective action, as indicated. We conduct IRR reviews annually on all UM staff and on an ad hoc basis as concerns, trends or inconsistencies are identified.
Retrospective Review	Clinical auditors review records from clinician and physician reviewer caseloads annually or more often as needed using a standardized tool that evaluates appropriate documentation of the review and demonstration of adherence to medical necessity, CPGs and required time frames. Audit thresholds are 95 percent and individual audit results are provided to each clinician reviewer and his/her supervisor. For those clinicians falling below our established threshold, a remediation plan is put in place including additional training on clinical guidelines and application of criteria. We also use these results to outreach to our providers for learning opportunities related to inappropriate PA requests.

82. As one of the largest payers in Nebraska, MLTC has an important role to play to move the health care system to a more cost-effective model that improves outcomes. Provide specific initiatives the MCO will pursue to deal with "waste" in the existing system and improve outcomes. Provide specific information regarding the initiatives that will be pursued to improve quality and enhance cost containment (including the stakeholders involved, the timelines, and the desired outcomes). *4 pages*

Initiatives for Dealing with Waste and Improving Outcomes

We have successfully and mindfully addressed waste, improved quality and enhanced cost containment for our Medicaid members for nearly 20 years. We define waste as overutilization, underutilization or misuse of services, supports and resources that, directly or indirectly, result in unnecessary costs to our program. We adhere to established policies, procedures and processes for identifying and addressing potential and existing waste. We also prevent future waste by proactively developing and implementing innovative programs that address inappropriate practice patterns and utilization trends. Because our organizational culture is based upon thoughtful challenge of the status quo, our existing and future clinical and operational initiatives described below have been developed with the goal of achieving simpler, sustainable and cost-effective approaches that improve outcomes for our members.

Current and Ongoing Initiatives for Dealing with Waste and Improving Outcomes

The initiatives shown in Table IV.N-5 for dealing with waste and improving outcomes in our Heritage Health program exist today in Nebraska. They are continually reviewed for ongoing meaningfulness and improvements and will be readily scaled to include the new services in our members' benefits package such as BH and pharmacy services. Our initiatives not only identify and address challenges in the current system of care in Nebraska but **will expand to include new populations, services and supports to promote system transformation to full-integration.**

Table IV.N-5
Value-Based Contracting
Our value-based contracting program offers our providers a comprehensive portfolio of payment innovation models that focus on achieving better health outcomes, increasing member satisfaction, improving transitions across care settings and reducing health care costs by improving access to care, reducing inappropriate ER use, reducing avoidable hospitalizations and improving care for members with high-risk conditions. Conflicting payment policies can result in a lack of coordination between providers that are being reimbursed primarily by Medicare versus those paid by Medicaid. We support our robust provider network with training as well as financial incentives/value-based contracting to achieve better health outcomes and lower costs. In Nebraska, patient centered medical homes (PCMHs) and integrated providers such as UniNet already employ case managers. We will continue to support the growth of these provider models to assure provider involvement in care coordination for members with complex needs resulting in a more integrated system of care.
Emergency Room Performance Improvement Project (ER PIP)
The goal of this performance improvement project (PIP) is to analyze the behaviors and barriers that lead to the inappropriate use of the ER and to develop effective interventions to reduce the number of non-emergent visits to the ER with a focus on Medicaid participants ages 1–17 who presented with upper respiratory symptoms. Our current ER PIP focuses on addressing access to care challenges that may result in a member's inappropriate use of the ER in our current 10 geographic services areas in Nebraska. We identify members through our risk stratification and predictive modeling processes as well as ongoing claims monitoring. Our health coaches outreach to members to discuss potential or actual changes in the member's condition, address any new or unmet needs and discuss alternatives to the ER such as primary or urgent care. We identify and address any access barriers such as setting up transportation or assuring our providers comply with same-day and after-hours appointment requirements. Through ongoing collaboration with our providers to improve access and educate our members, we will continue to empower member self-management and improve the quality and affordability of ER care by reducing unnecessary utilization through an expansion of this initiative in key service areas. We share updates on the ER PIP with MLTC on a quarterly basis.

Table IV.N-5

Managing to the Appropriate Level of Care

We focus on eliminating 30-day readmissions, reducing avoidable one-day admissions and promoting self-management/medication adherence through our care management and UM processes including risk stratification, predictive modeling and concurrent and retrospective review. Our successes are demonstrated by our reduction in our year-over-year comparisons:

Year	30-Day Readmissions	1-Day Admissions
2012	9.84 percent	4.44 percent
2013	8.85 percent	3.06 percent
2014	6.82 percent	1.79 percent
2015 (year to date)	5.48 percent	1.03 percent
Overall Improvement	55.7 percent	23.3 percent

Our care managers view inpatient census daily to identify member hospitalizations; initiate outreach to the member and discharge planning; work closely with the member's PCP to assure follow-up appointments are scheduled within seven days of discharge; identify and engage needed services that support the member's transition and works with the provider on engaging the member in post-discharge care. Led by our medical and BH directors, we conduct daily interdisciplinary rounds for members who are hospitalized to assure the member's needs are addressed to support discharge and to minimize readmission. Members with lengths of stay that exceed expected length are reviewed on a weekly basis.

Discharge Planning

Our discharge planning process, a core clinical competency, provides a proactive and well-coordinated plan for transitioning members from acute inpatient facilities or state psychiatric hospitals to the most appropriate level of care—whether we manage the process or one of our PCMH partners does. Our processes focus on quality, safety and member satisfaction and assure collaboration and communication with other providers involved in a member's transition to another level of care to optimize outcomes and resources while eliminating care fragmentation. In Nebraska, we monitor care management, quality and utilization metrics by region or county and targeted populations. *For example, in 2015 year-to-date results, our Nebraska discharge planning processes have* **improved follow-up physician appointments within seven days post discharge by more than 55 percent.**

Pharmacy Fraud, Waste and Abuse Monitoring

We use state-of-the-art data analytic tools to detect fraud, waste and abuse. Data analysis is particularly effective in identifying member card-sharing (as a means of illegally obtaining services for multiple individuals or as an indicator of identity theft) and suspected member overutilization. For example, data analytics can identify members who, during a six-month period:

- Filled prescriptions at more than three pharmacies or saw three physicians in the same specialty
- Obtained prescriptions from several different doctors or have early prescription fills and refills
- Persistently refused to follow prescribed treatments or comply with our requirements
- Excessively used physician, hospital, ER or prescriptions not medically indicated
- Engaged in drug-seeking behaviors including doctor- and pharmacy-"shopping"

We will work with MLTC to develop other agreed-upon criteria in addition to the foregoing for the identification of potential lock-in candidates. In addition, we will implement our pharmacy restriction program, retrospective drug utilization review, real-time desktop audits and on-site audits to assure we identify and address potential or actual fraud, waste and abuse.

Cost-Avoidance Analytic Tools

The focal point of our FWA Program is our three cost-avoidance analytical tools used to identify FWA by providers and members, and determine if a provider should be put on prepayment review status to investigate potentially improper activities in more detail including:

- ***Prospective Provider Flagging (P1):*** Identifies groups of claims from specific providers that have filed a large number of inappropriate claims but not enough to have been removed from the network
- ***Comprehensive Prospective Review (P2):*** Identifies claims that are suspect because of one or a combination of factors such as unlikely diagnosis and procedure code combinations
- ***Retrospective Fraud and Abuse:*** Suspected fraud, waste and abuse claims not detected prior to payment are

Table IV.N-5
identified through referrals, investigation and other analytics ▪ ***MedReview:*** Reviews facilities for inappropriate DRG use, cost outliers and readmission
eviCore (CareCore)
eviCore is the preferred third-party vendor delegated by UnitedHealthcare to manage pre-certification determinations for advanced imaging outpatient services for our members. Our approach to managing these benefits focuses on streamlining member care, improving quality and reducing cost. This program supports providers in decision-making processes, addresses appropriateness of imaging prior to being rendered, enhances consistency between the use of studies and current scientific clinical evidence and professional society guidance and reduces unnecessary radiation exposure, testing and medical spend.
Sharing of Information
We believe that collaborative partnerships and coordination between the member, provider and support systems are necessary to develop the targeted interventions and goals that lead to improved health care outcomes and decreased waste of resources. Reducing duplication, handoffs and improving processes are and will become increasingly important as we integrate BH and pharmacy services to assure quality care; reduce unnecessary ER use, avoidable hospitalizations and hospital readmissions; and address administrative burden on our members and providers. We promote information sharing through: ▪ ***CommunityCare*** is our care management system designed to share member-specific information electronically with the member and multidisciplinary care team. We provide near-real-time information and a comprehensive view of the services and supports used by our members promoting the delivery of appropriate care for the member's condition and reducing duplication and variation in care. ▪ ***Online prior authorization portal*** provides a streamlined method for providers to submit requests for authorization. This method is much less burdensome and significantly reduces the wait time for PA decisions and unnecessary paperwork. ▪ ***Waiving copays*** on covered physical, BH and pharmacy services will encourage members to adhere to well visits, BH appointments and medication schedules. ▪ ***Community health workers/BH specialists*** are non-clinical staff who collaborate with care managers and care navigators to locate/engage members who are difficult-to-find members and conduct an Access to Care screening. Through personal and face-to-face engagement with our members, CHWs leverage their local knowledge of the community and follow up with community organizations, providers and community groups to get updated contact information for our members. ▪ ***Working with MLTC case managers*** to assure the needs of our more vulnerable populations are met and not duplicated such as our members in foster care or those with intellectual and developmental disabilities. We will give MLTC and other DHHS agency staff, as part of the member's care team, access to CommunityCare to view member-specific data (with member consent).
Service Verification
We reimburse our providers only for services delivered at the level of care provided. We mail service verification notices to a random, sample group of our members on a monthly basis to verify our member received services indicated. Our role in safeguarding the Medicaid program includes verifying we pay providers only for delivered services and at the level of care performed. We currently mail 2,850 service verification letters quarterly to a random sample of members to confirm each member received the services indicated. In compliance with new requirements, we will select a minimum 2 percent sampling of claims per month. The statistically valid random sample of paid claims will include all provider specialties and claim types proportionally represented in the sample pool.

Future Initiatives

Table IV.N-6 reflects a few examples of future initiatives we have proactively identified to impact waste and improve outcomes, quality and cost-effectiveness in our existing program. As our footprint grows in enrollment, types of services and supports offered and stakeholder collaboration, UnitedHealthcare will work closely with MLTC to identify additional initiatives to assure our members receive high-quality, integrated and cost-effective services and supports for their conditions in a timely, safe and respectful manner in the environment of their choice.

Table IV.N-6	
Waste Initiative – Physician Performance Reports	
Description	Identify and remediate inappropriate Evaluation and Management (E&M) coding by office-based physicians (e.g., primary care, cardiology, internal medicine) and hospital physicians through retrospective review, provider education and pre-payment audit.
Stakeholders	Large provider offices identified as having billing issues.
Timelines	Identification of provider practices: 2016 Provider training and technical assistance: 2016 Ongoing review of practice improvement: 2016
Desired Outcomes	▪ Improve network clinical performance—best quality cost-effective care ▪ Reduce practice pattern variations ▪ Utilization consistent with medical necessity and clinical criteria ▪ Pay for performance and value-based contracting
Quality and Improving Outcomes Initiative – Value-Based Incentives	
Description	We have developed a modular suite of value-based incentive programs that can be leveraged to meet providers where they are relative to their level of clinical and financial integration, and risk readiness. Our framework consists of: ▪ Performance-Based Programs ▪ Bundled Payment Programs/Centers of Excellence ▪ Accountable Care Programs Together, these comprise our Accountable Care Platform. Our goal is to work in collaboration with our providers to introduce the concept of *Pay for Value* as an innovative strategy to ensure we maximize member access to comprehensive high-quality health care services.
Stakeholders	Large primary care practices located in urban and rural areas of Nebraska.
Timelines	Identification of provider practices: 2016 Implementation: 2016–2017 Ongoing review of provider practices: 2016–2019 Expansion of program based upon review results: 2019
Desired Outcomes	We believe that all care providers should be even more accountable for the level of integrated care they deliver, with some evolving to a shared risk or capitation plus performance-based contracting model. We have deployed these programs with physicians, hospitals, ancillary and BH providers.
Cost Containment Initiative – Program Integrity	
Description	Our innovative Payment Integrity Intel Center (PIIC) will provide intelligence support to the payment integrity department. Our PIIC proprietary technology creates a series of dashboards to establish a detection and evaluation mechanism for all value streams within our payment integrity process (e.g., fraud, waste and abuse; coordination of benefits, subrogation), as well as facilitate collaboration with payment integrity operations and analytics teams. For example, we will implement successful best practices from other states in Nebraska such as the Holy Trinity Drug Identification Program and the Anti-Retro Viral (ARV) Drug Diversion Program, both of which focus on members and providers who engage in drug seeking and diversion activities.
Stakeholders	Statewide Provider Network
Timelines	Implementation: 2016 Ongoing review of results and process improvement: 2016 through Contract Term
Desired Outcomes	Increased safeguards for the Heritage Health program and members and a reduction in fraud, waste and abuse, and erroneous payments.

83. Describe the MCO's proposed approach to prior authorization, including:

- The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated. Describe what will be considered in the reevaluation of need for current prior authorization requirements.
- The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization.
- The role of the Clinical Advisory Committee in developing service authorization procedures.
- The MCO's process for notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.

4 pages

Our Approach to Prior Authorization

Our UM program comprises integrated, interdisciplinary policies and procedures that assure the appropriate use of health care resources in the amount, duration and scope necessary to achieve desired health outcomes. Our program includes processes and workflows for processing requests for initial and continuing authorizations for services, including determining medical necessity. The PA process begins at intake, which is the point at which we receive PA requests from providers or become aware of inpatient, skilled nursing or residential treatment admissions. The intake process supports varied administrative processes within UnitedHealthcare, including referral into disease management and care management programs, advanced notification and admission notification and PA.

Medical directors, nursing staff and other professional support teams work closely with health care practitioners and providers to determine the medical necessity and appropriateness of care, avoid inappropriate use or duplication of services and to identify members who may need case management or need to be engaged with their provider upon discharge. We understand that PA staff must include a State-licensed registered nurse or physician's assistants. Staff must work under the direction of the medical director or the medical management coordinator and that the PA function must be located in the State. Once we receive a PA request from providers (or request for an inpatient or residential treatment admission), UM clinicians begin the process to determine medical necessity, which includes the following steps:

- Determine if the service request requires clinical review. If it does not require clinical review and it meets the requirements for administrative approval, approve the service request. Otherwise, refer the service request for clinical review.
- If the service request requires clinical review, review the service request to determine medical necessity and verify the service request complies with level of care criteria and promotes alignment with clinical practice guidelines.
- Request further information, as necessary, from the provider to make a determination. Cases requiring further review for determination are sent to a medical director with appropriate expertise treating the member's condition.
- If approved, notify the provider of the approval of the service request.
- If not approved, refer the service request to the appropriate medical director for review of any adverse benefit determinations. The medical director reviews service requests, may perform peer-to-peer consultation to make a determination and consults with the requesting provider, as appropriate.
- Notify the provider of the service denial if we deny the request for services following peer review.

We use evidence-based, nationally recognized *MCG* criteria for physical health care services and internally developed mental health guidelines based upon published references from the American Psychiatric Association (APA), the American Academy of Child and Adolescent Psychiatry (AACAP) and the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). We use ASAM criteria for SUD.

We make clinical coverage decisions that are consistent with the State's definition of medically necessary services and comply with all the contractually covered services, including the prevention, diagnosis and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain or regain functional capacity. Clinical coverage decisions are based upon the eligibility of the member; State and federal mandates; the member's certificate of coverage, evidence of coverage or summary plan description; UnitedHealth Group medical policy; medical technology assessment information; and CMS National Coverage Decisions (NCDs) and Local Coverage Decisions (LCDs).

Data Sources and Processes that Determine Which Services Require Prior Authorization

Data analysis drives our UM program by providing analysis and reporting on our operational performance. Our Strategic Management Analytic Reporting Tool (SMART) data warehouse is a comprehensive, integrated analytical environment that holds all Medicaid relevant information including claims data (e.g., medical, pharmacy, vision and lab), member data, provider data, authorizations, external subcontractor data and predictive modeling information. Using SMART's data analytics capability, we continuously monitor key metrics and trends across various dimensions through monthly performance reviews to determine which services should require PA.

If a trend seems to be varying from the norm or expectation, we use standard reports, as well as root cause analysis processes, to identify the cause of such variations. For instance, the root cause analysis of variations could lead to an increase in utilization for a specific diagnosis code, procedure code or provider. Some of these variations could be explained by uncontrollable factors like a flu epidemic whereas others could lead to actionable items like provider and member outreach/coaching about use of the ER versus a doctor's office. We review facilities, physicians (PCPs versus specialists), ancillaries (e.g., durable medical equipment, lab and surgical), and pharmacies; drill into key types of services as appropriate (e.g., inpatient—medical/surgical, outpatient—ER, radiology and therapies); analyze key trends by provider within these categories and identify outliers for potential opportunities to include or remove a service from our PA list.

Using these analyses, our clinical leadership team and Clinical and Provider Advisory Committee (CPAC) and Healthcare Quality and Utilization Management (HQUM) Committee review and approve all services that require PA at least annually to reduce the administrative burden associated with PA. We do this through continued review of services that require PA to determine if there are services that are generally managed in alignment with evidence-based guidelines and, therefore, have high approval rates across all providers. We remove services that require PA that are generally managed in alignment with evidence-based guidelines and have high approval rates. Once changes to the list of services that require PA have been approved, our CPAC and HQUM review, accept and adopt changes that will guide service delivery for our Heritage Health members..

Prior Authorization for Services from Non-Participating Providers

Our network development efforts assure the availability and accessibility of primary and specialty providers to meet the many diverse needs of our members including emergent, non-emergent, non-avoidable, specialized health care, telehealth and family planning needs. We do however, have times that

our members access their care from providers who do not participate in our network. If the current provider does not currently contract with UnitedHealthcare, we will work with the provider to join our network or assist the member in choosing a comparable in-network provider and transition the member when clinically appropriate.

During the member's transition, we will work with the provider to establish a single case agreement to provide services to make certain the member's condition remains stable, and services are consistent to meet the member's needs. The out-of-network authorization will continue until the authorized treatment plan is completed or until such time that we can provide comparable services to transition the member to a provider who will be able to meet the member's needs. For example, we allow pregnant members in their second or third trimester to remain under the care of the current OB through the postpartum checkup. We may continue existing relationships with out-of-network providers when necessary for continuity of care.

Expedited Prior Authorization

For urgent/expedited authorization requests (e.g., when a provider indicates or UnitedHealthcare determines that following the standard 14-day time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function), we make an expedited authorization decision and notify the provider as expeditiously as the member's health condition requires, and no later than 72 hours from the date of receipt of clinical information. We may provide an extension of up to 14 calendar days if the member or provider requests it, or we justify to the MLTC the need for additional information, and the delay is in the member's best interest. If additional information is needed to make a determination, we notify the provider and issue a Notice of Extension letter to the member before the third working day. Expedited requests are completed, and a notice issued as expeditiously as the member's health condition requires, with a possible extension of up to 14 days when it is in the member's best interest and additional information is needed to make a determination.

Role of the Clinical Provider Advisory Committee

Our CPAC is aligned with our HQUM and reports directly to our QAPIC. The primary role of this committee is to provide input and make recommendations to our parent organization and MLTC on all policies, procedures and practices associated with care management and UM functions, including clinical and practice guidelines and UM criteria to assure they reflect up-to-date standards consistent with research, requirements for evidence-based practices and community practice standards in the state. To accomplish this, our CPAC conducts activities such as regular consultation with experts who are familiar with standards and practices of treatment, including diseases/chronic conditions common in the Medicaid population, disabilities, and MH/SUD treatment for adults, children and adolescents in the state. Our CPAC also:

- Monitors provider performance and adherence to our guidelines through clinical indicators such as HEDIS and other state metrics
- Reviews data and reports on quality of care complaints and appeals and grievances to identify trends and barriers to care
- Recommends corrective actions and suggests opportunities for improvement related to quality of care trends and medical record issues
- Reviews and approves all practice guidelines prior to initial use and whenever significant changes are made
- Performs peer review activities, including review of credentialing and review and disposition of concerns about quality of clinical care provided to members

We will expand our Heritage Health CPAC membership to include providers who care for children, adolescents and adults in the state across a variety of ages and races/ethnicities and who have an awareness of differences between rural and urban populations including pharmacists, physical health providers and BH providers. Our CPAC will review our UM policies and procedures including PA and the list of services requiring prior authorization annually or more often as needed based upon state and federal changes as well as identified trends, issues or problems.

Provider Notification of Denials or Reduced Authorizations

Our policies and procedures for denying a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested service authorization request are compliant with RFP Section IV.N. Utilization Management and the requirements of 42 CFR 438.404. All UM decisions are based upon medical necessity, appropriateness of care and service and the existence of coverage. Our UM decision-makers are not rewarded for issuing denials of coverage or care nor do they receive financial incentives that encourage decisions that result in underutilization. We use the following process when denying a service authorization:

- The UM clinician sends cases requiring further review for determination to the appropriate medical director.
- Medical directors perform peer-to-peer consultation to make a determination and review requests that do not meet our coverage criteria, including medical necessity. The medical director consults with the requesting provider or practice.
- Should an adverse determination be made, the UM clinician communicates the service denial to the provider.
- We send a Notice of Action letter to the member and the requesting provider within the required timelines and format and with a clear explanation and basis for the adverse determination.

Each Notice of Action includes at a minimum the following: the action taken or intended to be taken; the reason for the action; the member's right to file an appeal with UnitedHealthcare; the procedures for exercising appeal rights including the right to request a State Fair Hearing; circumstances when expedited resolution is available and who to request it; and procedures for continued benefits and the member's potential financial obligation for them. We also include all appropriate parties to the appeal, including the member, legal representative, or legal representative of a deceased member's estate.

84. Provide a listing of services for which the MCO will require prior authorization and describe how the MCO will communicate this information, as well as the results of authorization decisions, to providers and members. *2 pages excluding the listing of services*

Services Requiring Prior Authorization

Along with our 20 affiliate health plans nationwide, we possess more than 30 years of combined experience overseeing the delivery of integrated services to individuals who receive their health care through Medicaid and Medicare programs through close collaboration with state partners, physical and BH providers and facilities, pharmacies and our pharmacy benefits manager (PBM).

We use our established PA and UM processes to make sure our members in Nebraska receive the most medically appropriate care at the right time and in the right amount and environment. Our medical necessity definition, clinical criteria, clinical practice guidelines (CPGs) and PA requirements provide guidance to our providers and clinical reviewers in making informed and meaningful decisions that are in the best interest of our members. A key component of this includes the development, implementation, communication and ongoing management of our list of physical health, BH and pharmacy services that require PA.

Our PA list for our Nebraska Medicaid program has been expanded to include new services in the Heritage Health benefits package and MLTC's list of pharmaceuticals requiring PA. We look forward to ongoing collaboration with MLTC to improve upon our PA list based upon our local and national expertise; accepted guidelines, research and literature from nationally recognized authorities; and local best practices and trends. See Attachment 19 Q84 Services Requiring Prior Authorization for a listing of our physical health, BH and pharmacy services requiring prior authorization.

Provider Communication of Services Requiring Prior Authorization

Our list of services requiring PA is in our *Provider Administrative Guide* that is located on our secure provider website available 24 hours a day, seven days a week. We educate our providers on these services during initial, ongoing, annual and ad hoc trainings provided in-person and through Web-based applications. We also provide instructions for submitting appropriate PA requests that adhere to our medical necessity definition, clinical criteria and CPGs as well as information and documentation needed for successful determination on the first submission during training as well as on our website.

In addition, we know that administrative activities can prevent our providers from having more time with our members, so we offer innovative ways for reducing that burden such as user-friendly automated decision-making capabilities through our provider portal, *Link*. *Link* supports immediate access to our medical necessity definition, clinical criteria, CPGs, list of services requiring PA, user-friendly automated PA processes and information on available peer-to-peer consultation as needed. Providers can also attach member records for our consideration, communicate in real-time to exchange information and documents with UM staff directly and track the status of the request as it goes through the various steps of medical necessity review.

We review and update the PA list at least annually and review PA process data to determine the continued need for or modification to PA. We distribute updated PA requirements to participating providers at least annually and to non-participating providers upon request.

Member Communication of Services Requiring Prior Authorization

We recognize the importance of our members understanding how to access the services and supports they need for their conditions. As a result, we provide initial and ongoing education and resources throughout our member's enrollment with us on the services that require PA, our medical necessity definition and

clinical criteria and provider processes and time frames for submitting a PA request. We accomplish this through the following sources:

- Network providers
- *Member Handbook*
- Secure member website, *myuhc.com*
- Member services advocates (MSAs) through our call center, *Advocate4Me*
- NurseLine clinicians available 24 hours a day, seven days a week
- Community health workers, care managers, care navigators and disease educators

We encourage members who have an inquiry about PA services and processes to call member services and speak to an MSA. Members who call our toll-free member services number are supported by a single point of contact for the duration of an issue—an MSA who answers questions about services requiring PA, benefits, available services and supports close to home, and how to file a grievance or appeal or request a state fair hearing. MSAs address our members' individual needs through timely, resolution-oriented activities. We serve members in their choice of primary language. Many of our MSAs are bilingual in English and Spanish, and all MSAs have access to Language Line interpretive services, which provide translators for more than 200 languages.

Communication of Results of Authorization Decisions

In accordance with RFP Section IV.N. Utilization Management and described more fully in Q85 Notice of Action in this response, we inform our members and providers of our authorization decisions within required time frames. This includes the following types of services:

- ***Physical and Behavioral Health Services:*** We provide verbal notification of approvals and adverse actions to our members and providers through telephonic outreach upon decision by our clinical reviewer. For denials, we send a written notice of action (NOA) letter to the member and requesting provider within 10 days of a standard request, five days if probable member fraud is verified and 72 hours for an expedited request—standard and expedited requests may be extended by 14 days at the request of the member or if the health plan determines more information is needed.
- ***Pharmacy Services:*** Our members receive notification of approval or denial at the pharmacy point-of-sale. Our automated system alerts us of a denial and allows us to communicate directly with the pharmacist to identify and resolve the reason for the denial including outreach the provider for needed information.
- ***Advanced Radiology:*** eviCore is our third-party vendor delegated to manage pre-certification determinations for advanced imaging outpatient services for our members and reviews the appropriateness of imaging prior to being rendered based upon current scientific clinical evidence and professional society guidance and reduces unnecessary radiation exposure, testing and medical spend. eviCore provides notification of urgent approvals and denials through telephonic outreach and written notification. For standard determinations, written notifications are sent within the required time frames described above.

We will continue to assure our PA list and processes are aligned with MLTC's goal of providing members with evidence-based care options that emphasize early intervention and community-based treatment.

85. Describe how the MCO will ensure members receive written and timely notice of action relating to adverse actions taken by the MCO. *1 page*

Assuring Timely Notice of Action

The timing and content of our Notice of Action for denied or reduced services complies with and meets the language and format requirements of RFP Section IV.N Utilization Management and applicable part of 42 CFR 438.404. We provide Notice of Action (NOA) in English, with footnotes in Spanish, Vietnamese and Nuer that directs our members or representatives to member services, *Advocate4Me*, for any assistance they need. We provide members and providers timely verbal and written NOA when an adverse determination has been made.

We provide verbal notification of adverse actions to our members and providers through telephonic outreach upon service denial by our clinical reviewer. We send a written NOA letter to the member and requesting provider within 10 days of a standard request, five days if probable member fraud is verified and 72 hours for an expedited request—standard and expedited requests may be extended by 14 days at the request of the member or if the health plan determines more information is needed.

Our NOA letters provide clear, understandable information at a reading level no higher than 6.9 and in the member's preferred language. We provide information on decision results; reasons for and date of the decision; legal citations or authorities supporting the decision; the appeal process, related time frames and the member's right to:

- Representation, submit relevant information and review all documentation
- Request a state fair hearing, procedures for doing so, time frames and how to ask for assistance
- Continuation of benefits including how to request this and the possibility of the member being held liable for provided services if the denial is upheld
- Expedited appeals process with notices that expedited external review can occur concurrently with internal expedited appeals

Over the years, we have welcomed feedback from NCQA and EQRO that resulted in improving our grievance and appeals process. For example, based on feedback from the EQRO, we made revisions to our member notification letters to assure the provision of clear, understandable language regarding the grievances and appeals process including applicable time frames. Since our updates, we have received favorable feedback from both EQRO and NCQA.

We provide information about the grievances, appeals and state fair hearing processes including NOA to our members in our *Member Handbook* provided in our welcome packet and located on our secure member website at *myuhc.com*. Our member identification cards also provide a toll-free number for our member services center, *Advocate4Me*, where our members can get information on how to file a grievance or appeal or request a state fair hearing. Members who do not speak English have access to bilingual MSAs and our Language Line interpretive services, which are available free of charge. A member who is deaf or hard of hearing can use our toll-free telecommunications relay service, and members with impaired vision can request that an MSA read the materials aloud. MSAs work with the member to answer any questions the member may have about the process including the NOA and assist the member in preparing and submitting a grievance or appeal. Additionally, care managers, care navigators, CHWs and our quality team help members write and file grievances and appeals and continue monitoring the member's issue through to resolution. We send our members an annual reminder about grievance and appeals system processes, their right to use these processes and how to ask for assistance.

86. Describe the MCO's process for conducting concurrent reviews for inpatient services. *2 pages*

Concurrent Reviews for Inpatient Services

While our robust provider network and established processes and programs for members with high-risk physical and behavioral health conditions support them in the community, our concurrent review and discharge planning processes assure the needs of our members who are admitted to a higher level of care such as the hospital, a residential facility or nursing facility are met prior to, during and following a member's transition back to the most appropriate environment for his/her condition. Our concurrent review processes, policies and procedures comply with the requirements in RFP Section IV.N Utilization Management and are updated a minimum of annually or more often as needed based upon updates to state and federal requirements and nationally recognized and local practices.

Inpatient Admissions

Concurrent review of and discharge planning from a higher level of care is completed by licensed clinicians including RNs and licensed BH clinicians with the expertise that is most closely aligned with the member's conditions. Our concurrent review clinicians use evidence-based, nationally recognized *MCGs* for physical health care services, internally developed mental health (MH) guidelines for MH services, ASAM criteria for substance use disorder services, and levels of care based upon published references and research from nationally recognized organizations. This includes the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, ASAM, the Substance Abuse and Mental Health Services Administration and the current *Diagnostic and Statistical Manual of Mental Disorders*.

Our UM clinicians conduct concurrent review and discharge planning on all admissions to:

- Promote continuity of care through the development of an integrated plan of care that meets the member's holistic needs
- Assure appropriate utilization of medical and BH resources
- Manage length of stay
- Facilitate collaboration among provider, care manager, UM clinician, and interdisciplinary team and inpatient facility staff
- Ensure the most appropriate services and supports are in place to promote a successful transition and prevent hospital readmission

Our concurrent review and discharge processes, policies and procedures address the following:

- ***Emergency Admissions.*** Upon notification that our members have been admitted to a higher level of care by our members and/or their families, providers, assigned care managers and care navigators and daily census for admissions, we immediately conduct outreach to facility staff to establish our member's well-being and initiate the concurrent review and discharge planning process.
- ***Non-Emergent Admissions.*** For non-emergent admissions, we contractually require our network providers to submit a request for services so that we can monitor the quality of care and service utilization. Provider requests for inpatient services are reviewed by our UM clinicians for medical necessity and in adherence with MHPAEA, our clinical criteria and clinical practice guidelines with notification of the decision within required time frames.

Admissions for all physical and BH conditions are routed to the most appropriate concurrent review clinician based upon our priority review list which currently includes the following:

- Unplanned admissions
- Readmissions within 30 days
- Non-priority cases that have reached the length-of-stay (LOS) threshold
- Sub-set of planned surgeries with known complex discharge planning needs or historic practice variation such as:

- Total hip replacement
- Open reduction, internal fixation (ORIF) for hip or femur
- Total knee replacement
- Large and small bowel procedures

Inpatient management is not limited to members undergoing these surgical procedures and our priority review list changes as needed depending on trends and other factors.

Using our Blended Census Report Tool (BCRT), and ICUE tool and direct interactions with inpatient facility staff, we hold daily care management calls. Our concurrent review system also includes provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based upon the medical necessity determination.

Discharge Planning

We focus on removing any barriers to aftercare and assure our members are connected to appropriate outpatient and community-based services following their discharge from the hospital. We also engage additional services to support the member in his/her community environment such as care management, durable medical equipment and peer support services prior to discharge for at-risk members. For example, for our members with BH conditions, our care managers focus on engaging members in their own recovery and assist them with the creation of wellness recovery action plans designed to tap into natural supports to manage crisis and to maintain community tenure. We also risk stratify our members to focus our UM efforts on members who have a more complicated psychiatric condition or who have a history of overusing the ER and other acute, high-cost services.

Special Programs to Reduce Unnecessary Hospitalizations and Readmissions

Realizing the frequency with which members with BH conditions seek BH care through the ER, we have developed several programs to assist our members in engaging in available services in the community including the following Table IV.N-7:

Table IV.N-7

Achieving Clinical Excellence (ACE)
To improve the quality of care among our facility-based providers, we recently launched ACE, our facility measurement program, which is the next transition from Facility Quality Measure (FQM). Our 11 years of experience with FQM laid the foundation to gather relevant data and ACE now adds the dimension of allowing us to parse this data into effectiveness and efficiency metrics to achieve improved clinical success. Network facilities in the ACE program receive risk-adjusted performance data based upon five effectiveness metrics and two efficiency metrics. Data is evaluated annually against regionally based benchmarks. Results are then used to engage facilities by recognizing them for their outstanding performance or helping them to mitigate variations in practice patterns—all leading to improvements in outcomes and affordability.
Algorithms for Effective Reporting and Treatment (ALERT)
Routine BH outpatient visits do not require a referral or PA. This removes potential barriers to accessing routine services, and aligns our model of care with the requirements of the MHPAEA. Members and families may call us 24 hours a day, seven days a week for a referral, select a BH clinician via the "Find a Mental Health Clinician" tool on our member portal or simply visit a network outpatient clinician directly. We monitor care and measure outcomes through our proprietary model, ALERT, our outcomes-driven outpatient management program. ALERT is a key component of our BH program. The model emphasizes early identification and monitoring of high-risk cases among those members in outpatient BH treatment, allowing us to focus our clinical resources where we can add the most value. ALERT is specifically configured to address the needs of children and adolescents through a pediatric Wellness Assessment.

87. Describe the MCO's process for conducting retrospective reviews to examine trends, issues, and problems in utilization. *2 pages*

Process for Conducting Retrospective Reviews

Since 1996, we have conducted retrospective reviews on services delivered to our Medicaid members to validate medical necessity, appropriateness, quality of care, timeliness and accuracy of billing. Our retrospective review processes allow us to assess the abilities of our providers including hospitals and facilities to deliver the most appropriate services for our members and our clinical reviewers to consistently use sound clinical judgment and apply medical necessity, clinical criteria and CPGs when making care decisions for our members.

Under the direction of Dr. Horn and Dr. Freed, we will expand our retrospective review processes to include BH, pharmacy and the care for priority populations such as members with special health care needs. We will conduct retrospective review on higher levels of care including inpatient, residential, rehabilitation and skilled nursing facilities as well as primary care, preventive, BH and pharmacy services such as off-label drug use to identify potential or actual overutilization and underutilization; inappropriate utilization; and fraud, waste and abuse. Our retrospective review process, policies and procedures will adhere to the requirements in RFP Section IV.N Utilization Management and will be submitted to MLTC for review and approval a minimum of 60 days prior to the Heritage Health Contract start date.

Examining Trends, Issues and Problems in Utilization

Our retrospective review processes for identifying and examining trends, issues and problems is multi-faceted and based upon the following review processes:

- ***Clinical Audits.*** We review records from clinician and physician reviewer caseloads annually or more often as needed using a standardized tool that evaluates appropriate documentation of the review and demonstration of adherence to medical necessity, CPGs and required time frames. Audit thresholds are 95 percent and individual audit results are provided to each clinician reviewer and his/her supervisor. For those clinicians falling below our established threshold, a remediation plan is put in place including additional training on clinical guidelines and application of criteria. We also use these results to outreach to our providers for learning opportunities related to inappropriate PA requests.
- ***Data Review.*** Our SMART data warehouse collects, stores and reports quality measures, PAs and claims data. It links with and receives data from our clinical management system to allow reporting on our clinical performance. SMART provides comparative cost data, cost trends, utilization data, profiling and predictive modeling capabilities. Using SMART's reporting/data analytics capabilities, we produce the following types of reports and dashboards, shown in Table IV.N-8, as well as conduct clinical, quality and UM/CM analyses that allow us to monitor and evaluate utilization management related to medical and BH management and care management (CM).

Table IV.N-8
Inpatient Utilization Reports
We review information on inpatient admissions and authorizations from a variety of views to establish a comprehensive understanding of the factors that impact member hospitalizations. This includes, but is not limited to, an overall summary report of monthly inpatient admissions as well as categorized by member age, diagnoses, length of stay, gaps in care and other criteria. We also categorize inpatient days by our top 20 diagnosis codes, facilities and month in a descending order based upon admits for the time period selected. We integrate SMART membership data with inpatient authorization data from our care management platform, CommunityCare, allowing us to identify members who are enrolled in our clinical programs such as care management, disease education and pharmacy restriction programs.

Table IV.N-8
Variant Day Analysis (VDA)
Our VDA tool analyzes more than three years of claims data integrated from all of our national affiliate health plans to support comparisons and identification of outliers. The VDA also provides hospital and diagnosis-related groups (DRG) length of stay and readmission opportunity information at various levels of aggregation. Our VDA allows analysis of length of stay, adjusted readmission rate within 30 days, one-day stay and short stay percentage, top variant APR-DRGs for opportunity days, top variant APR-DRGs for readmissions, top APR-DRGs for observation conversions and readmission metrics.
Data Variance Analysis
We systematically review weekly, monthly and quarterly reports that compare inpatient admissions, length of stay, admission and readmission diagnoses, and ER utilization to professionally recognized standards of care and performance metrics (AP-DRGs). We monitor utilization patterns for members with greater than 12 outpatient visits, repetitive inpatient stay and excessive ER visits such as members with special health care needs based upon total costs and utilization of services. We monitor for underutilization of preventive services and overutilization of specialty care particularly if combined with underutilization of primary care.
Inpatient Utilization Dashboard
This dashboard presents days per 1,000, admits per 1,000 and average length of stay through an interface that provides multiple views of the data from our CM platform. We refresh the data weekly and include views by case types, length-of-stay groups, age bands, facility and top 20 diagnoses. We group authorizations into reporting months based upon the effective start date. For authorizations with stays longer than one month, the total length-of-stay is accounted for in the month in which the stay began.
Utilization Management Scorecard
Our UM scorecard compares prior year data against current year goals for UM metrics, admits, days and average length of stay. This dashboard has an easy to use interface that provides multiple views of the data from our CM platform and is refreshed monthly. The reports provide additional detail on inpatient utilization metrics by various case categories and trend information on readmissions. We group authorizations into reporting months based upon the occurred bed day and for stays longer than one month, the length of stay is counted in multiple months.
Preventive Services Monitoring
We monitor underutilization of primary care and preventive services through our Universal Tracking Database (UTD). This database includes information on member compliance with recommended preventive health services. The UTD generates letters to remind members and their providers of the members' need for the identified services. We also conduct telephonic and clinic outreach.
Predictive Modeling Reports
Our predictive modeling reports identify care opportunities, such as potential medication interactions, compliance with CPGs and recommended health screenings and assessments that are tailored to our members' needs. We work with members and providers to close gaps in care and encourage the member to engage in services. We do this at every member touch point through our community-based staff who work directly with our members to support them in the community such as our CHWs, care managers and care navigators who also work closely with our UM staff. In addition, our nurses and medical directors work directly with providers to close preventive, chronic and BH gaps in care.
Provider Profiling
We profile providers, at a minimum annually, by examining utilization patterns, such as ER visits, hospital readmissions, lab and pharmacy encounters, member visits to providers other than assigned providers, in and out-of-network specialty referrals, and utilization by members who are high-risk. Our clinical and quality teams review reports on metrics and determine if there is evidence of inappropriate underutilization and overutilization. We use this data to identify and monitor variation in practice patterns among our providers, identify outliers and inform providers on their patterns of care. With the oversight of our QAPIC and HQUM, our quality team monitors providers against medical necessity, clinical criteria and CPGs.

88. Describe the initiatives the MCO will implement to control unnecessary ED utilization, avoidable hospitalizations, and hospital readmissions. Discuss how the MCO will ensure that care is provided in the most appropriate and cost effective setting. Include strategies that address access to primary care services through patient centeredness principles; the use of urgent care centers and retail clinics; and, interventions targeted to super-utilizers, such as patients with asthma, diabetes, chronic pain, and/or behavioral health conditions. *6 pages*

Initiatives to Control Unnecessary ER Utilization, Avoidable Hospitalizations and Hospital Readmissions

We understand that individuals who do not have the services and supports they need when they need them may have avoidable ER visits and even potentially avoidable hospitalization or hospital readmission. Paramount to reducing avoidable utilization is ensuring our members have access to the most appropriate, effective, high-quality medical and BH services, supports, medications and supplies for their condition at the right time and in the right amount and most appropriate cost-effective setting. Under the direction of Dr. Horn, UnitedHealthcare will continue to collaborate with our members, providers, community-based organization and MLTC to identify, develop and implement the following types of strategies, programs and special initiatives to maximize member access to the care they need and deserve.

Managing Unnecessary ER Utilization, Hospitalizations and Readmissions

Table IV.N-9 describes our programs that directly address members who have inappropriately used the ER and/or are admitted to the hospital. These programs focus on addressing barriers to access, gaps in care and the process of supporting our members prior to, during and following discharge from an inpatient facility.

Table IV.N-9
Emergency Room Diversion PIP
The goal of this PIP is to analyze the behaviors and barriers that lead to the inappropriate use of the ER and to develop effective interventions to reduce the number of non-emergent visits to the ER with a focus on members aged 1–17 who presented with upper respiratory symptoms. Our current ER PIP focuses on addressing access to care challenges that may result in a member's inappropriate use of the ER in our current 10-county geographic service area in Nebraska. We identify members aged 1–17 through our risk stratification and predictive modeling processes as well as ongoing claims monitoring. Care coordinators outreach to members to discuss potential or actual changes in the member's condition, address any new or unmet needs and discuss alternatives to the ER such as primary or urgent care. We also identify and address any access barriers such as setting up transportation or ensuring our providers comply with same-day and after-hours appointment requirements. Through ongoing collaboration with our providers to improve access and educate our members, we will continue to empower member self-management and improve the quality and affordability of ER care by reducing unnecessary utilization through an expansion of this initiative in key areas across Nebraska.
Discharge Planning – Inpatient Care Management (ICM)
Our ICM program is focused on reducing lengths of stay and successful transition of our members to the community without readmission. When a member is admitted to a medical or BH inpatient facility, CommunityCare, our collaborative, comprehensive and innovative clinical case management platform, alerts our inpatient case manager (ICM) and case management team about the admission using utilization information received through admit, discharge and transfer (ADT) data such as our Blended Census Report Tool (BCRT) that identifies and tracks members in facilities (e.g., hospital daily census); and through direct hospital data feeds where available. Our ICMs, as part of our UM team, immediately monitor the member's care during the stay and initiate planning for the member's discharge from the hospital. ICMs collaborate with the member, caregiver, inpatient UM staff, the attending physician and hospital case manager, our transitional case manager (TCM) and the member's PCP and other providers. We conduct interdisciplinary team rounds that include the ICM, TCM and Dr. Horn to discuss the member's needs, such as the need for ongoing case management or identify additional services, such as home health, BH services or community-based services. In addition, the ICM strongly emphasizes the involvement and support of family members, relevant providers, community-based organization resources and various government social service programs in planning for the member's discharge.

Table IV.N-9
Transitional Care Management (TCM)
To better support our members as they transition from a higher level of care, we have adopted the Coleman Care Transition Model that includes discharge planning, outreach, education, member monitoring, care coordination, service planning and delivery, and information sharing and, as appropriate, collaboration with State-assigned case managers (for example, the foster care and waiver populations). In addition, we have implemented our CommunityCare platform, described more fully below, enhances member-specific information sharing; created our innovative automated care transition software; and established P&Ps (already built into our Nebraska transition of care process) for following up with discharging members with high risk for readmission to enhance the care transition process in a meaningful way and to coordinate service planning and delivery among hospital discharge planner(s), care managers and interdisciplinary care team members. Our protocols ensure high-risk members are effectively transitioned after an acute hospital stay or discharge from a residential facility.

Improving Access to Non-Emergent Services

Table IV.N-10 describes our person-centered approach to our members accessing the most appropriate care for their conditions at the right time and in the right place to improve their health and quality of life as well as prevent inappropriate use of the ER and avoidable hospitalizations and readmissions.

Table IV.N-10
Person-Centered Approach to Care Delivery
Our approach to the delivery of integrated care is person-centered, comprehensive, coordinated, accessible and focused on integration of care management, UM and quality improvement. We require our network providers and our own staff to adopt and implement those philosophies and strategies. Our framework, which includes locally based CHWs, supports each of the following person-centered principles: ▪ Understanding the member/family's preferred lifestyle ▪ Motivational interviewing to develop member goals based upon the aspirations, preferences and cultural background of a member/family ▪ A commitment to meaningful outcomes for the member/family ▪ Health risk assessment strategies that produce a significant understanding of an individual's strengths, preferences and communication capabilities ▪ Interventions that improve access to preferred settings, activities and community ▪ The right of all members to be treated with respect and dignity ▪ Respect for the right of all members to participate in their own health care decisions and engage and partner with their own integrated treatment community and support systems Our technology facilitates communication, information and shared decision-making. With member consent, all care team members have access to the member's centralized record.
Improving Access to After-Hours Care Primary Care
We work closely with our providers to support after-hours and weekend appointment availability and monitor compliance through random telephonic sampling of PCPs and specialty types such as BH, cardiology, physical medicine, rehabilitation specialists, pulmonary practitioners, allergy specialists and OB/GYN providers. We also educate our members on the availability of and how to locate Minute Clinics, urgent care facilities and retail clinics and when to use these versus the ER when they have non-emergent needs including pharmacies where members can access preventive information and care such as flu-shots and include urgent care facilities in our network development and contracting processes. With 49 of 54 identified Minute Clinics, urgent care facilities and retail clinics contracted statewide, we already have a robust network of providers with extended hours. We will continue to identify and contract with any of these types of facilities in the statewide expansion areas that provide care to Heritage Health members to expand access to extended physician offices hours and walk-in clinics.
Community-Based Staff
Our care managers, care navigators and CHWs work directly with our members to support them in the community and are an integral part of our care team and knowledgeable about the communities they serve. As BH benefits are included in this contract, we also will use BH specialists who are CHWs with BH experience to work with members having serious mental illness/severe emotional disturbance (SMI/SED). CHWs engage members in their homes

Table IV.N-10
and communities to establish and promote sustained, continuous relationships between members and their PCPs, BH providers, specialists and community resources cultivated through regular face-to-face meetings. Our CHWs help members understand their benefits package, rights and responsibilities and how to have voice and choice in their health care decisions. CHWs can assist our members in choosing a PCP, making appointments and accessing shelter, food, electricity, transportation and clothing. Our CHWs are trained to conduct questionnaires that identify potential risk for our members and how to escalate concerns to an RN or BH clinician as needed.
Disease Education and Management Program
We take a proactive approach to managing specific conditions and disease states. The core program targets diabetes, asthma, congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD) and attention deficit/hyperactivity disorder (ADHD) prevalent in our Nebraska population. Key components of our Nebraska-tailored program include educational support, self-management techniques, caregiver support, support of the physician's plan of care and informed decision-making. Our approach involves engaging individuals to set health improvement goals, working with them to develop realistic care plans, using a series of direct and indirect contacts and information systems to monitor symptoms, then following clear protocols for when and how to make timely changes to care plans, as necessary. Program educational materials and newsletters offer condition-specific information, including recommended routine appointment frequency, necessary testing, monitoring and self-care. Materials (culturally and linguistically competent) are designed to empower members to take responsibility for their own health and to equip themselves with the information necessary to manage their condition as successfully as possible and live a healthy lifestyle. All recommendations in the educational material are based upon evidence-based medical guidelines. Staffing for DM programs includes teams with experience and expertise related to chronic conditions, and programs are structured to support a partnership between the PCP, community-based case manager (LTSS), care manager, CHW and the member/family.
Medication Therapy Management (MTM) Program
We believe that person-centered MTM helps our members adhere to their medication regimen and promotes Preferred Drug List (PDL) and therapy management adherence. Our MTM program is designed, not as a hand-off to a vendor, but a collaboration between local experts to meet the unique and diverse needs and conditions of our members in the Heritage Health program through the most appropriate, safe and cost-effective prescribing and medication monitoring practices. Because we believe that member education improves health and quality of life by supporting medication adherence resulting in reductions in ER visits, hospitalizations and readmissions, we will partner with our MTM subcontractor, Mirixa, and MLTC to deliver a more person-centered experience that is tailored to the individual needs of each member in the MTM program by: ▪ Reviewing all current medications including over-the-counter medications and herbal agents ▪ Assessing for all potential or actual medication-related issues ▪ Documenting medication reconciliation in our care management system that will provide near-real-time access to the member, PCP, specialty provider, care manager and UM staff to support self-management and care coordination and continuity ▪ Integrating medication-related services into the member's holistic care plan to track progress toward goals and objectives ▪ Identifying situations needing intervention including collaborating with other clinicians such as the member's PCP or BH provider Mirixa also offers call center solutions to serve members when their regular retail pharmacist is not available thereby improving access to the care they need when they need it.

Support Behavioral Health Conditions

We understand that our members with complex or co-occurring BH including SUD conditions may frequently use the ER to have their needs met often resulting in an unnecessary hospitalization. Because of this, we will implement the types of programs and initiatives in Table IV.N-11 to further support these members in the community.

Table IV.N-11
Peer Supports for Members with Behavioral Health Conditions
We recognize MLTC has invested in the training and certification of peers and the development of peer support

Table IV.N-11
programs, which are Medicaid-covered services. We will leverage that expertise to support expansion of member and family peer services and resources across Nebraska through the following types of peer programs. ▪ ***Peer Support Specialists*** work with members to develop individualized Wellness Recovery Action Plans (WRAPs) that identify specific goals and actions the member and support system should take to engage the member in needed services and supports, ways for the member to ask for help such as our member services call center, *Advocate4Me*, NurseLine, *Health4Me* and *liveandworkwell.com*. ▪ ***Peer Warm Line*** will be a future initiative for collaborating with other MCOs through joint funding to support a peer-run warm line staffed by people who have experience living with mental health issues. ▪ ***Liveandworkwell.com*** is an award-winning online BH resource and information website for members, families and caregivers that addresses recovery topics and makes it simple for members to find information on wellness, take self-assessments, locate community resources, identify clinicians and facilities and download apps. Topics address healthy living, healthy aging, recovery and resiliency, addictions, mental health and chronic medical conditions, improving coping capabilities and helping members and families make the most of their lives. ▪ ***My Way to Health*** emphasizes healthy eating and physical activity behaviors at home, work and the community through weekly discussion with a peer support partner. ▪ ***Question, Persuade and Refer (QPR)*** is an evidence-based practice recognized by SAMHSA as an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. ▪ ***Seeking Safety*** for adolescents is an evidence-based, present-focused, coping-skills therapy to help children, youth and young adults attain safety from trauma or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines, but may also be conducted in-group or individual format for adolescents in various settings (e.g., outpatient, inpatient).
Omaha Psychiatric Emergency Room
In Omaha, where a committee has been convened by Region 6 to explore a new psychiatric ER to relieve the strain on other ERs in the city, we have met with Community Alliance and the Region 6 Administrator to engage in, assess and support implementing this community-based solution to avoid unnecessary ER utilization and hospitalizations for our members with BH conditions. To further ensure a streamlined and coordinated approach to crisis response, crisis stabilization and follow-up care, we will contract with the same providers that comprise local crisis response systems in each of the regions.

Using Technology-Based Resources

We believe that broadening our outreach and educational opportunities through the innovations and automations listed in Table IV.N-12 will further support our members in accessing the care they need when they need it including provider training and sharing of information resources.

Table IV.N-12
CommunityCare
Our secure, Web-based clinical care management system, CommunityCare, facilitates the coordination of services across the continuum by sharing vital member clinical information with the member and member's care team to help us deliver the right care, at the right time and in the right place. CommunityCare allows the member to provide access to the member's care plan and other information to participants of his/her choice such as the assigned care manager; supports access to near-real-time information and tools needed to monitor progress toward achieving goals and improved health outcomes; and offers a suite of tools that support clinical care management activities such as developing and monitoring the individualized care plan; integrating updated claims, labs results and gaps in care data into the member's health record; and alerting the care coordinator when a member may not be adhering to the care plan, such as a member with asthma not filling a prescription for a rescue inhaler.
Member Tools and Applications
We have and will continue to improve access to information that is critical to supporting our members and helping them find community-based resources that promote their self-management and engagement in their health care such as locating an urgent care in their area, understand their health care benefits and identifying local organizations that assist with social needs. We have implemented innovative resources and tools to provide support to members and help them find alternatives to using the ER (e.g., by locating an urgent care center)

Table IV.N-12

including the following:

- ***myuhc.com*** is our secure member portal that allows members to search for covered benefits, update contact information including email addresses for facilitating contacts and information exchange, request an ID card and "Find-a-Doc" through a searchable Provider Directory.
- ***KidsHealth Online Support Center***, part of the Nemours Foundation Center for Children's Health Media, is an online resource offering more than 200 videos and 10,000 articles that provide support on a range of physical, emotional and behavioral issues that affect children and teens.
- ***Health4Me*** is a free mobile application designed to help members manage their health care easier and faster with access to secure health and wellness information 24 hours a day, seven days a week. *Health4Me* provides members, their families and guardians with a convenient way to review their health benefits and coverage and claims and locate in-network providers and an urgent care center, including an electronic ID card.
- ***Healthify*** is a Web-based tool that helps the clinical ER case manager and CHW connect members to relevant and available community resources that deliver services, such as food, housing, employment assistance, energy, support groups, child care and clothing. *Healthify* improves our ability to help members with unmet social needs, and improve quality of life.
- ***liveandworkwell.com*** provides information on a variety of topics including recovery, well-being support and health management. The online health and wellness library features more than 12,500 articles, 60 videos and texting programs relating to BH, lifestyle and well-being issues from reliable resources (e.g., Johns Hopkins University).

Telehealth – Remote Patient Monitoring (RPM)

Our RPM pilot includes UM telemonitoring objectives for managing the care for members that have been hospitalized two or more times for the same condition within the last 12 months as part of their person-centered care plan. RPM will be used with members diagnosed with CHF and other related comorbid conditions. Introducing and expanding this high-tech, high-touch model of care has been proven to reduce post 30-day same diagnosis readmissions. RPM success metrics also complement our quality of care and cost reduction objectives by providing medication management and coordination of care efforts to support seven-day follow-up visits with PCPs and 30-day post-discharge visits and the potential to provide virtual clinic visit services to members in areas where telehealth services are allowed from the member's residence.

Targeting High Service Utilization

Understanding the unique care needs and requirements of members with complex medical, behavioral or social needs that often result in high utilization of medical and BH resources is the first step toward developing appropriate interventions and initiatives. These members often have multiple chronic physical health problems and can face a variety of socioeconomic barriers (e.g., unstable housing, lack of transportation) that impede access to care. Our person-centered approach to integrated care management begins with collecting person-specific information about members and using advanced data analytics and assessment results to proactively identify and stratify members who have high utilization and may benefit from additional support including care management services.

We also review our ***Top Utilizers Report*** to determine how we can help the member access his/her PCP, engage a specialist if needed, schedule appointments and resolve medication or other issues. In addition to many of the initiatives identified above that address inappropriate utilization, Table IV.N-13 contains just a few examples of our targeted interventions for members with chronic conditions often associated with high-utilization.

Table IV.N-13

Asthma

In 2016, we will pilot an intervention to improve asthma care in Omaha where well-identified asthma disparities exist, particularly in the eastern portion of Douglas County. While death rates due to asthma have been decreasing these past 20 years, there continues to be a greater impact in Douglas County and, African Americans have an average annual death rate twice as high as Caucasians. Due to these recognized asthma disparities in Omaha, we

Table IV.N-13

aim to empower those in most need of assistance. The goals of the pilot are to improve self-management skills and medication adherence by providing inhaler attachments capable of automatically tracking usage. These sensors can connect to mobile applications, providing asthma education, medication reminders and other self-management tools. Primary benefit of the program will be improved asthma control level as measured by increased control medication adherence, reduced rescue inhaler use, and reduced hospitalizations and ER visits. Through direct mailing, telephonic or face-to-face outreach, we will offer enrollment in this asthma care program initially to 100 members who have had an asthma-related hospitalization or ER visit within the past 12 months and an asthma medication ratio below 50 percent.

In addition, we review and analyze drug utilization patterns on a regular basis, with special focus on identifying patterns of inappropriate or underutilization. Claims data is categorized according to frequency of prescription, cost, side effects, physician education opportunities, member risk for hospitalization, controlled substance use and inappropriate utilization. When potentially adverse patterns are identified, we implement interventions such as member or provider outreach and education. Reporting is provided on a pre- and post-intervention basis to demonstrate program effectiveness and identify opportunities for repeat interventions as warranted. Mailings are sent to newly identified members each month that include tips on working with the PCP, medicines for treating asthma and lifestyle changes.

Behavioral Health Conditions

We will work closely with our retail pharmacists/pharmacies to address members who are assigned to a restricted status due to potential drug-seeking behaviors and overutilization. Our medical director will conduct outreach to the prescribing physician or psychiatrist for peer-to-peer consultation including medication reconciliation, medication adherence and potential unmet needs of the member. The member will be assigned to a care manager with expertise that is closely aligned with the member's condition who outreaches to the member to discuss his/her needs and the pharmacy restriction. ***An example*** of this activity includes, during a monthly review of pharmacy restrictions, one of our affiliate health plans identified a member who was prescribed a large dose of Adderall. The medical director contacted the prescriber to review the case and identified that the member was also seeing a psychiatrist. A care conference was scheduled to discuss the awareness between the treating providers of the member's needs and potential health risks associated with the combined prescribing. An action plan was developed that focused on the member's needs, services and supports.

Diabetes

We work with the Children's Hospital and Medical Center in Omaha for our young members diagnosed with juvenile diabetes. Our high-risk case managers collaborate with hospital staff to arrange for insulin pumps as needed for our members who are at high-risk for diabetes-related ER utilization or hospitalization. We have worked with eight children thus far who need the specialized equipment. We collaborate with the hospital staff to ensure the members and their families receive comprehensive education on how the pump works; how, when and who to call for help as needed; and the importance of attending follow-up care with the member's PCP and/or specialist. Our high-risk care manager continues to provide support to the member and member's family to support attendance at appointments, monitor the impact of the pump on the member's symptoms and identify any unmet needs on an ongoing basis.

Chronic Pain

We believe identifying members with chronic pain and assuring they have access to the most appropriate specialist and appropriate supports (e.g., pain management) will improve health and quality of life and reduce inappropriate ER utilization. We will assist members who are identified as high utilizers in being "self-advocates" by coaching them to have the confidence to get what they need from their provider to manage their pain as well as educate them on the option of pain management injections as appropriate (e.g., members with degenerative disk disease). We are knowledgeable about and sensitive to issues our members can experience with chronic pain and associated medications (e.g., opiates) and will monitor these members for potential or actual overutilization of medications. We will accomplish this through our pharmacy drug utilization review (DUR), close coordination with the member's pain specialist and utilization of our pharmacy restriction program, if necessary.

89. Describe the MCO's proposed MTM program, including a description of the inclusion criteria that the MCO proposes to use. Also, include any vendor(s) that will be subcontracted by the MCO to perform or support MTM services. Provide a detailed description of tools the MCO will use to ensure the active engagement of the retail pharmacies in the MTM program. *4 pages*

Proposed Medication Therapy Management Program

We believe that person-centered MTM helps our members adhere to their medication regimen and promotes PDL and therapy management adherence. Our MTM program is designed, not as a hand-off to a vendor, but collaboration between local experts to meet the unique and diverse needs and conditions of our Heritage Health members through the most appropriate, safe and cost-effective prescribing and medication monitoring practices.

Under the direction of Dr. Horn and our pharmacy director, Jeanne Cavanaugh, and in collaboration with MLTC and our MTM vendor, Mirixa (described more fully below), we will support improved health outcomes by identifying and monitoring prescribing patterns, member care plans and pharmacy utilization data for the use of psychotropic medications, medications at risk for abuse and other medications to ensure the following:

- Evaluation of the safety, appropriateness and efficacy of medication treatment plans
- Identification of potential or actual care gaps
- Benchmarking against quality standards
- Elimination of costly inefficiencies

We will submit an annual description of our MTM program to MLTC that includes the activities we have performed, the effectiveness of our efforts over the previous year and proposed activities for the following year.

Medication Therapy Management Inclusion Criteria

We will work closely with Mirixa and to identify and approve inclusion criteria that are aligned with the prevalent conditions in Nebraska taking into consideration barriers to access including social determinants. We will use retrospective pharmacy claims data from MLTC and other available data to identify trends, issues and problems associated with utilization, predict health risks for our members and prospectively identify members who may benefit from and/or qualify for MTM services. Our inclusion criteria may include, but not be limited to, the following:

- Complex, chronic and/or co-occurring conditions or disease states such as asthma, diabetes and substance use disorder (SUD)
- Complexity of the member's therapeutic regimen such as multiple medications or combinations of medications that may be contra-indicated
- Elderly members with a higher prevalence of multiple, chronic disease states who must be managed concurrently
- Unnecessary ER use and avoidable hospitalizations and hospital readmissions
- Members who see multiple providers
- History of adherence to therapy

Through our participation on MLTC's P&T Committee and in collaboration with Mirixa, we will assure the continued evaluation of our inclusion criteria to adjust to identified trends or utilization patterns or

changes in best practices for MTM. We will review and approve changes to our inclusion criteria through our QAPIC, CPAC and Behavioral Health Advisory Committee.

Member Education on Our Medication Therapy Management Program

Because we believe that member education improves health and quality of life by supporting medication adherence resulting in reductions in ER visits, hospitalizations and readmissions, we will partner with Mirixa and MLTC to deliver a more person-centered experience that is tailored to the individual needs of each member in the MTM program by:

- Educating the members about how to effectively communicate their preferences and needs with their prescribers
- Reviewing all current medications including over-the-counter medications and herbal agents
- Assessing for all potential or actual medication-related issues
- Documenting medication reconciliation in our care management system that will provide near-real-time access to the member, PCP, specialty provider, care manager and UM staff to support self-management and care coordination and continuity
- Integrating medication-related services into the member's holistic care plan to track progress toward goals and objectives
- Identifying situations needing intervention including collaborating with other clinicians such as the member's PCP or BH provider

Our MTM program also offers call center solutions to serve members when their regular retail pharmacist is not available thereby improving access to the care they need when they need it.

Outreach to Members Identified for Medication Therapy Management

Local pharmacists who are extensively trained to receive member records and perform services for members identified for MTM perform outreach to schedule face-to-face or telephonic appointments with members. At these meetings, the pharmacist delivers and documents service using a structured interview process consisting of one of the following types of reviews, as clinically appropriate:

- ***Comprehensive Medication Review:*** A comprehensive review includes a review of all medications that a member is taking assessing for drug interactions and side effects the member may be experiencing. The pharmacist also reviews for therapeutic duplication or overutilization or under-utilization of prescribed medication verifying that the member is getting the correct medications for his/her diagnosed conditions at a dosage that provides therapeutic effectiveness while minimizing the potential for adverse side effects.
- ***Targeted Medication Review:*** A targeted review is concentrated on one or more prescribed medications for a single diagnosed condition. This review focuses on the member's ability to adhere to and tolerate the therapy. If the member appears to have adherence challenges, the pharmacist offers applicable recommendations, either to the member to make therapy easier to manage or to the PCP to discuss medication alternatives, as clinically appropriate.

Whether the review is comprehensive or targeted, the member's medications are evaluated in a holistic manner, with consideration of all of the member's conditions and medications. For both types of review, the pharmacist works with the member to develop a manageable medication action plan and personal medication list. The medication action plan includes instructions for the member's medication, who to contact should the member continue to have difficulties and a follow-up schedule for the pharmacist.

Our Medication Therapy Management Vendor

Our MTM vendor, Mirixa, is the leading provider of MTM and targeted, pharmacist-delivered services to health plans across the county with the largest and most comprehensive pharmacy services network in North America. Mirixa's nationally contracted retail network comprises more than 54,000 pharmacies in the United States. Mirixa's network represents all major Pharmacy Service Administration Organizations (PSAOs) which are group-contracting entities for independent pharmacies, many regional chains and most national chains. The following are just a few examples of successes our affiliate health plans who subcontract with Mirixa have experienced through their MTM program:

- ***Kansas:*** Our health plan affiliate in Kansas has been partnering with Mirixa since 2013. In 2015, the health plan partnered with Mirixa to perform a complete review of membership and claims data to ensure the program design was optimal for meeting the unique and diverse needs of the Kansas membership. As a result, the health plan made several changes to the program such as customizing the inclusion criteria to prevalent disease conditions in Kansas to better identify and outreach to members with high-risk conditions who may not have qualified for MTM under the previous design.
- ***Louisiana:*** Through the current MTM program, more than 67 percent of members in the MTM program participate in a comprehensive medication review (CMR) by a local, licensed pharmacist. Of those members identified with one or more safety risk(s), more than 33 percent experience discontinuation of at least one medication to promote the member's safety and health.
- ***Washington:*** Mirixa partnered with the health plan and state partners to customize the MTM program to meet the local nuances and social determinants of the geographic service area including plans for engaging pharmacies and pharmacists in rural and hard-to-reach areas of the state.
- ***Delaware:*** Our Delaware affiliate experienced reduction in medication duplication by 20 percent through Mirixa's duplicative therapy alerts that provided electronic notification to the health plan and supported provider outreach and education including online trainings and peer-to-peer consultations as needed.

As an MTM pioneer since 2006, Mirixa has focused on harnessing the knowledge and skills of pharmacists to engage individuals and deliver measurable results.

Ensuring Retail Pharmacies are Engaged in Our Medication Therapy Management Program

We will work with Mirixa during the implementation process to identify eligible pharmacies for outreach and education activities. We will assure our network pharmacies, including small, independent pharmacies and pharmacy groups are educated on our MTM program and the associated pharmacist-delivered care and the requirements for participating in the program.

- ***Pharmacist Training:*** As part of our MTM program, health plan-approved training materials will provide health plan-approved training materials including processes and procedures for delivering MTM services at the POS and in the community including how to interact with their members in the MTM program. MTM training will be available prior to implementation and throughout the life of the program through the training opportunities such as weekly online, live training that covers key components of the MTM program service description manual provided by Mirixa and required prior to inclusion in the program; required documentation of member interactions to include motivational interviewing and medication adherence strategies, medication-related issues and provider interactions on the member's action plan; and the core elements of the MTM service model.

- ***Record Reviews:*** We will assure the review of select and random records, analyze various reports and documentation of program elements to assess pharmacy participation and performance and identify trends, thus enabling Mirixa to offer feedback to pharmacies, in the form of network communications and training materials, and to consider program improvements and platform enhancements designed to alleviate potential areas of weakness. If we become aware of significant documentation deficiencies or quality issues, whether through its periodic analysis or other means, we will oversee the investigation of those situations and take corrective action as appropriate.
- ***Performance Improvement Activities:*** By tracking, reporting and sharing rates of engagement including served members, declined members and face-to-face rates with our pharmacies, we can identify and support practice improvement opportunities as well as adjust pharmacy training programs and materials to reflect the priorities of the program. Pharmacy training materials are updated for various reasons on a regular and "as needed" basis, which include but are not limited to:
  - Enhancing our technology platform enhancements
  - Improving our program design such as updating our inclusion criteria
  - Updating our quality measures or standards such as Star Ratings
  - Responding to changes in CMS requirements
  - Identifying the need for improved or targeted trainings such as overutilization or underutilization patterns

As part of the MTM program, we offer suggestions and highlight best practices for service delivery in addition to information on industry trends in an online newsletter distributed to all participating pharmacies.

90. Describe the MCO's DUR program including prospective and retrospective DUR activities. Include a description of:

- Prescriber and pharmacy education programs.
- Collaboration with MLTC's DUR.
- How DUR results will be used to inform MTM education and outreach. *3 pages*

Drug Utilization Review Program

Our approach to pharmacy benefit management is embodied by the principle that pharmacy benefits comprise one component of our members' overall health care and all components are interrelated. That key principle guides our development of an integrated drug utilization review (DUR) program that improves the health and quality of life of our members. Dr. Horn, Dr. Freed and Ms. Cavanaugh, will work closely with MLTC to implement a program that increases medication adherence, reduces unnecessary utilization of health care resources and controls pharmacy spending without increasing costs in other health care categories. Our restricted services program is compliant with 471 NAC Chapter 2 and we will submit written policy and procedures to be approved by MLTC.

Together, we will accomplish this through member and prescriber education, partnerships with local and national pharmacy experts and integrated technology that provides access to real-time data for our members, providers, prescribers and health plan staff. The following DUR activities and systems will comply with the requirements in Section IV.N Utilization Management of this RFP and applicable federal and state requirements.

- ***Prospective Activities:*** Our prospective activities rely on our comprehensive library of criteria from evidence-based guidelines (EBGs) and literature for evaluating claims at the point-of-sale before a prescription is even dispensed. When a prescription triggers an edit, it is flagged and the pharmacist receives a message in real-time that indicates either a hard reject of the prescription or a "soft" warning that prompts interaction and discussion with the member to determine the appropriateness of the prescribed medication.

  We use multiple algorithms for comparing submitted prescription data with pre-determined EBGs to identify potential issues such as medication interactions. Our system screens member profiles for drug allergies, potential cross-sensitivities and age-based drug therapy contraindications as well as scans member claims history for duplicate therapy and overutilization or underutilization. The system also adheres to dosage parameters and profiles specific drugs to determine if a dosing change is indicated after a specified period of time. Our database supports this process by storing all filed claims for a minimum of one year.
- ***Retrospective Activities:*** We review and analyze drug utilization patterns on a daily basis, with special focus on identifying patterns of fraud, waste, abuse and inappropriate or unnecessary prescribing practices. We categorize claims data according to frequency of prescription, cost, side effects, prescribing practices, member risk for hospitalization, controlled substances and inappropriate utilization. We implement existing or new interventions as potentially adverse patterns are identified, and we provide reporting on a pre- and post-intervention basis to demonstrate program effectiveness and identify opportunities for repeat interventions as warranted. We review all prescription drug claims quarterly to establish utilization profiles for members, pharmacies and physicians. Retrospective DUR program components may include targeted letters, reports, educational pieces and other communications. In a continuous improvement loop, issues identified through retrospective DUR also feed the prospective review processes described above.

- ***Targeted Retrospective Activities.*** Based upon identified local utilization patterns, we also review pharmacy claims data for focused drug classification interventions or targeted DURs including, but not limited to, the ones in Table IV.N-14:

Table IV.N-14	
Program	**Description**
Polypharmacy	Addresses multiple medication use that together can result in adverse effects, drug and disease interactions, and inappropriate dosing.
Potential Medication Misuse/Abuse	Designed to minimize the occurrence of drug abuse, diversion and inappropriate use in members who have been prescribed high-risk medications while promoting optimal pharmacologic therapy for the management of members who struggle with pain.
Asthma Therapy Optimization	Promotes the appropriate use of long-term control medications and quick-relief asthma medications through outreach to providers treating members with demonstrated inappropriate use these therapies.
Inappropriate Age for Medication	Addresses the incidence of potentially inappropriate medication prescribing and promotes safe and appropriate medication use in children under 18 years of age and members over the age of 65.
Drug Interaction Alerts	Targets providers who have submitted pharmacy claims for drugs that, based upon well-established clinical references, have demonstrated potential for adverse interactions.

Prescriber Communications

Because our prescribers are on the front line for ensuring our members receive the most appropriate medications for their conditions, we support easy access to real-time, complete and accurate information about the pharmacy benefit including the PDL, services requiring PA, PA processes, grievances and appeals information, and how to access for help when needed. We accomplish this through the following:

- ***Provider Administrative Guide:*** All providers receive a hard copy and an up-to-date version is available on our secure provider website at *uhconline.com* and includes a complete description of the pharmacy benefit including information on the PDL, our look-up tool, *Quick Reference Guide*, medical necessity, prior authorization processes, DUR processes, and who and how to ask for assistance or peer-to-peer consultation.
- ***Provider Newsletters and Targeted Mailings:*** These written materials provide medical necessity and PDL updates as well as reminders to visit our website for complete and up-to-date PDL information and P&T Committee decisions on a quarterly or as-needed basis.
- ***Provider Advocates:*** Our provider advocates receive PDL and PA instructions directly from our pharmacy team enabling them to assist our providers through telephonic outreach and face-to-face for education on medical necessity, clinical criteria, services requiring PA and how to complete PA requests.
- ***PDL Database:*** Our Web-based application can be downloaded onto a handheld device and provides messaging on quantity limits, PA requirements and step therapy.
- ***Peer-to-Peer Consultation:*** Our medical and BH directors are available to discuss member-specific medication plans including medical necessity and best practices.

Pharmacy Communications

Our pharmacy claims system is the primary means of communication with pharmacists. In addition to the variety of plan-specific edits that trigger real-time messages, pharmacies have immediate access to current PDL information including recent changes and live consultation with one of our medical or BH directors. For example, if a pharmacist submits a claim for a medication that is no longer on the PDL, our claims

processing system will return a message in real-time that indicates the change in PDL status and suggests alternative medications. Pharmacy providers are also notified by fax when major changes are made to the PDL or to the pharmacy process. We will provide comprehensive education to our contracted pharmacies on the pharmacy benefit initially and on an ongoing basis through a variety of opportunities such as our Web-based resources including, but not limited to, our *Provider Administrative Guide*, *BH Toolkit* and *I/DD Toolkit*, community-based forums such as town halls, one-on-one interactions through our provider advocates and peer-to-peer consultations, and our MTM vendor, Mirixa.

Collaboration with MLTC's Drug Utilization Review

Our medical director/chief medical officer, Dr. Michael Horn, will have oversight responsibility and accountability for our pharmacy management team and the integration of pharmacy services into our care delivery processes, policies and procedures. We will work closely with MLTC to provide a seamless transition from the existing fee-for-service pharmacy benefit to the carved-in benefit including care coordination and continuity during implementation and the ongoing delivery of the most appropriate pharmacy services for our members' conditions. We will accomplish this by:

- Using MLTC's historical data to identify over-, under- and mis-utilization; provider prescribing practices; unnecessary ER utilization, hospitalizations and hospital readmissions; risk stratification; predictive modeling; and fraud, waste and abuse
- Participating on MLTC's Pharmacy and Therapeutics (P&T) Committee to collaborate on ways in which to implement and improve our delivery of pharmacy services such as ongoing review of the PDL in accordance with nationally recognized best practices and improving our policies and procedures to improve timely access to needed medications
- Developing and implementing service delivery programs for meeting the pharmaceutical needs of members residing in rural and frontier areas in the state such as MTM and telepsychiatry services
- Monitoring psychotropic medication prescribing to ensure the safety and well-being of our members diagnosed with BH conditions

Using Drug Utilization Review Results for Medication Therapy Management Education and Outreach

We will use DUR results to identify opportunities to enhance our MTM education and outreach program for members, prescribers and pharmacists alike. Our organizational structure will include a number of multidisciplinary committees that will include key health plan staff and external resources such as MLTC and local pharmacists as appropriate to support the definition, development and ongoing review of our pharmaceutical management procedures.

Our oversight committees will include our MTM Oversight Committee, DUR Board, Clinical Advisory Committee and the QAPIC. In addition to participating on MLTC's P&T Committee and working with Nebraska's Pharmacy Association, our committee structure will assure our clinical pharmacy programs improve or maintain the health and quality of life for our members by maximizing safety and minimizing the frequency of under- or over-utilization, inappropriate or medically unnecessary care and potential and actual fraud and abuse.

91. Describe the MCO's proposed psychotropic drug oversight program to ensure appropriate utilization, including a description of the inclusion criteria that the MCO proposes to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of:

- Tools to monitor and measure psychotropic prescribing patterns and usage.
- Processes to actively engage retail pharmacies and pharmacists in the oversight program.
- Plans for prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member.
- Processes to ensure that psychotropic medications prescribed to children are being used appropriately and for the indicated diagnosis.

4 pages

Psychotropic Drug Oversight Program

With extensive experience managing 20 affiliate health plans across the nation, we manage and oversee the use of psychotropic drugs for members who receive their health care through Medicaid and Medicare. We recognize monitoring psychotropic drug utilization is a vital component of an integrated system of care and will use existing best practices in Nebraska and other states to develop and implement a robust, effective psychotropic drug oversight program for our members in the Heritage Health program. We also recognize the use of psychotropic medications is an integral part of health care for our members diagnosed with BH conditions and SUDs as well as those with complex and chronic physical conditions that can often be exasperated by BH issues including depression and/or anxiety.

We will monitor our members' use of psychotropic medications to ensure our members receive the most appropriate and safe medications for their conditions with the least amount of adverse side effects possible. We will work proactively and collaboratively with prescribers to improve the quality and efficiency of psychotropic drug prescribing patterns and to improve the health outcomes of our members. Our program will ensure the safety of members who are prescribed psychotropic medications, reduce or prevent the adverse side effects and help those who are taking psychotropic medications receive optimal functioning and positive clinical outcomes through the following:

- ***Prescriber Training and Education:*** Our comprehensive prescriber training and educational program support evidence-based, best practice prescribing while encouraging self-regulation amongst our prescribers thereby avoiding the need for excessive controls such as prior authorizations or limited access to psychotropic medications. Prescribers who deviate from best clinical practices are identified through our provider profiling processes and contacted through routine care alerts, letters, educational materials and peer-to-peer consultation. Corrective action occurs for continued deviation not excluding termination from our provider network.
- ***Psychotropic Inclusion Criteria:*** Our psychotropic inclusion criteria are developed based upon nationally recognized best practices and will include edits.
- ***Clinical Programs:*** Our clinical programs allow us to reach members, providers and pharmacists with educational materials and specialized tools to improve our members' health and deliver positive outcomes and cost management. We will develop proactive strategies to address several key trends, including double-digit inflation and increased consumer demand for heavily marketed products.
- ***Claims Monitoring and Utilization:*** We review, monitor and stratify claims data to identify and respond to inappropriate or unsafe prescribing patterns, medication prescribing such as psychotropic use with children younger than 5 years of age or prescribing outside of our quantity limits and whether prescribers make changes following intervention including our peer-to-peer

consultation. We analyze utilization data and present system solutions to build a plan for managing costs and outcomes in support of the total plan goals. We provide detailed trend reports tracking drug trends monthly, quarterly and annually.

Inclusion Criteria for Monitoring Psychotropic Medications

We will work closely with MLTC to identify and approve inclusion criteria that are aligned with the prevalent conditions in Nebraska taking into consideration the safety of our members and barriers to access including social determinants. We will use retrospective pharmacy claims data from MLTC and other available data to identify trends, issues and problems associated with utilization; predict health risks for our members; and prospectively identify members who may be inappropriately using psychotropic medications and providers who may be inappropriately prescribing medications. Our inclusion criteria include the following types of edits:

- Psychotropic medications without therapeutic interventions
- Multiple medications in the same therapeutic class
- Three or more drugs of same class—more than 60 days
- Medications prescribed without clinical indicators
- Excessive or inadequate dosing
- Discontinuation due to no timely refill
- Rapid switching of medications
- Two or more physicians prescribing the same medication
- Two or more concurrent antipsychotics
- Three or more concurrent atypicals
- Anxiolytics and sedative hypnotics—more than 60 days
- Multiple anxiolytics or sedative hypnotics to same member concurrently
- Atypical antipsychotics above or below FDA recommended levels
- Switching of atypical antipsychotics too quickly for drug to take effect

Tools to Monitor and Measure Psychotropic Prescribing Patterns and Use

We review and analyze drug utilization patterns on a daily basis, with special focus on identifying patterns of fraud, misuse, abuse, and inappropriate or unnecessary care. Drug claims data are categorized according to cost, side effects, physician education opportunities, member risk for hospitalization, frequency of prescription, controlled substance and inappropriate utilization. Potential fraud and abuse are identified through edits for controlled substance abuse, excessive utilization and excessive drug dosing. We review all prescription drug claims quarterly to establish utilization profiles for members, pharmacies and physicians. Interventions, which may take place by mail, telephone or in a face-to-face encounter, occur only after a clinical pharmacist has reviewed the prescribing information and we have approved the intervention plan.

We also review pharmacy claims data for our focused drug classification interventions or targeted DURs. We implement existing or new interventions as potentially adverse patterns are identified and provide reporting on a pre- and post-intervention basis to demonstrate program effectiveness and identify opportunities for repeat interventions as warranted. The pharmacy claim system includes a robust reporting tool that allows for scheduled or ad hoc reporting. Our standard reporting package includes

numerous reports that monitor individual physician prescribing patterns, such as the sample prescriber detail report and sample top prescriber report.

We employ various strategies to reduce inappropriate prescribing patterns with physicians identified by these physician profiles. One strategy involves physician-specific mailings with member-specific reports and educational materials. The pharmacy team uses that data to identify providers who are prescribing controlled substances outside of the norm. System reporting of adjudicated claims allows capture of rejected claims and paid claims. This gives a fuller picture of prescriptions brought to the pharmacy and the prescribers who write them. Our pharmacy team concentrates their efforts on pharmacy provider review, both through real-time, desk audits and on-site reviews. While focusing on the pharmacy provider community, these tools often flag prescriber patterns that require investigation, since members often prefer to go to pharmacies located near their physicians.

Through its support of the development, maintenance and clinical oversight of our psychotropic DUR programs, the DUR Oversight Committee assures real and significant improvements in the quality of care provided to our members. The primary improvement levers include promotion of patient safety and reductions in the frequency of patterns of fraud, abuse, gross overuse and inappropriate or medically unnecessary care among physicians, pharmacists and our members. Our DUR Oversight Committee also spurs innovation through development of pharmacy initiatives to support and enhance the overarching medical management strategies for our members.

Engaging Retail Pharmacies and Pharmacists in Oversight Programs

Our approach will promote the engagement of retail pharmacies and pharmacists in our psychotropic drug oversight program. Prior to and following implementation, we will perform a gap analysis using pharmacy claims data to identify non-contracted pharmacy providers including independent pharmacies that are crucial to serving our members in rural and frontier areas and solicit participation from these identified providers in our pharmacy network.

Through pharmacy data analysis, we identified that members across our markets were using medications without a documented diagnosis supported in the medical claims file. As a result, we added diagnosis data to our pharmacy claims system allowing our pharmacists to enter the diagnosis in the clinical segment of the claim and if the diagnosis is a match, the claim is processed. If not, pharmacists can use traditional PA processes for medical necessity review.

Prescriber and Pharmacy Interventions for Inappropriate Prescribing

Our monitoring policies and procedures to ensure prescriptions for psychotropic medications remain within established parameters include a quarterly review of the pharmacy data, revolving algorithms, and peer-to-peer outreach to 10 prescribers a quarter. The data analysis looks at changes in identified outlier prescriber profiles and specific member profiles pre- and post-peer-to-peer consultation and overall analysis on drug costs pre- and post-peer-to-peer consultation. We believe this monitoring mitigates the trend in atypical antipsychotic, substance abuse and ADHD medication utilization, modifies outlier prescriber behavior and improves the quality of care for members through appropriate prescribing of psychotropic medications.

Assuring Appropriate Prescribing to Children

To monitor the prescribing of psychotropic medications for children and youth, including those in foster care, we translate our pharmacy guidelines into prospective DUR edits, PA algorithms and retrospective DUR analysis. As an example, we can establish a PA requirement that directs the pharmacist to contact the prescriber to initiate a PA request the first time a psychotropic drug is prescribed for a member under

the age of 5 years. The prescriber will have to document the need for that drug including rationale such as non-responsiveness to cognitive-based therapy, justification for duplicate antipsychotics or antidepressants in a member under the age of 18 years. Prior authorizations for youth will be reviewed by a Nebraska-licensed child and adolescent psychiatrist.

We routinely conduct retrospective drug utilization review analyses to identify appropriate drug use by age. We use algorithms specifically targeted at psychotropic use by children and adolescents that also incorporate any state-preferred and HEDIS guidelines. We retrospectively look at utilization to detect medication adherence, such as gaps in use of psychotropic medications or overutilization of psychotropic medications. We identify prescribers whose prescribing patterns exceed acceptable parameters. We provide education to the identified prescribers through our care managers, peer-to-peer contacts and written materials. *For example, if a child meets one of the following criteria, we initiate peer-to-peer discussions with the treating practitioner to determine the rationale and appropriateness of the therapy and, if appropriate, recommend alternative practices.*

To assure safe and effective use of psychotropic medications for our young members, we analyze claims data and review the member's clinical status for the following types of prescriptions:

- Absence of a thorough and documented DSM diagnosis
- Two or more concomitant stimulants, alpha agonists, antidepressants and antipsychotics
- Three or more concomitant mood stabilizers
- Prescribed medication not consistent with appropriate care for the diagnosis or with documented target symptoms usually associated with a therapeutic response to the medication prescribed
- Polypharmacology (two or more medications) prior to using psychotropic monotherapy
- Dose exceeds usual recommended doses by the FDA or literature-based dosages
- Psychotropic medications prescribed for children of very young age, including children less than 5 years of age
- Stimulants in children less than 4 years of age including alpha agonists, antidepressants, antipsychotics and mood stabilizers
- Absence of timely follow-up visits for children ages 6 to 12 years of age prescribed ADHD medication
- Antipsychotic medication prescribed continuously without appropriate monitoring of glucose and lipids at least every six months

We developed these criteria based upon expert opinions and published literature. We analyze the member health records for those members meeting the criteria and, as appropriate, contact members and caregivers. From the set of all identified members, we further identify the subset of prescribers whose prescribing patterns exceed acceptable parameters. We use narrower criteria that focus our efforts on the most critical issues to target prescribers for peer-to-peer intervention. *For example, we initiate peer-to-peer discussions with the treating practitioner to determine the rationale and appropriateness of the therapy; educate the prescriber; and, if appropriate, recommend alternative practices.*

92. Describe the MCO's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities. *2 pages*

The methodology we use to assess and correct health disparities in treatment across races and ethnic groups supports our belief that cultural competency is at the heart of serving our members, meeting their special health needs and honoring their unique circumstances. Our proposed methodology to assess and correct disparities in treatment across races and ethnic groups is in compliance with MLTC's goals for incorporating cultural awareness into the delivery of care. It provides support for an organizational framework that values and advances diversity within our organization. Cultural sensitivity is also a vital part of realizing our goal of supporting member recovery and resiliency in meaningful ways and supporting individuals relevant to their unique cultural experiences and values.

We use a broad spectrum of reporting on a monthly, quarterly, semiannual and annual basis to understand membership demographics, assess membership utilization and health outcome results, and identify disparities in care associated with member age, gender, race/ethnicity and/or geographic location. These reports include the 834-enrollment file report, HEDIS measure noncompliance and the Health Plan Manager (HPM) report, which can assist with intervention needs based upon race and geographic location.

Health Disparities in Nebraska's Minority Populations

When we identify disparities, we use current programs and services to address identified disparities, as well as develop population-specific programs and culturally tailored services to the specific individual. We develop and continually improve culturally relevant and linguistically appropriate services as part of our integrated service delivery model. This requires foresight and a willingness to tackle complex service delivery problems, while respecting the integrity of the cultures and populations with whom we work. It also requires a clear sense of the operational resources needed to manage a health care program that serves unique populations. For example, Table IV.N-15 below shows some of the emerging opportunities for eliminating health disparities in Nebraska.

Table IV.N-15

Nebraska Disparity[3]	Populations Affected By:	% Population Receiving "F" Score[4]
Socioeconomic/ Population Health	Families Living Below the Federal Poverty Level	Native American (38%), African-American (32%), Hispanic (25%)
Maternal and Child Health	Teen Births (Per 1,000 Females 15-19)	Hispanic (100%), American Indian (100%), African-American (84%)
Mortality Disparities	Diabetes HIV/AIDS	Native American (93%), African-American (62%), African-American (7%), Native American (6%)
Access to Care	No Personal Physician	Hispanic (35%)

Reducing Barriers to Care

To assess disparities in treatment among members, address issues of population health and correct those disparities, we will use advanced technology to ensure that high-quality, timely and appropriate health care is available to all members and our sophisticated clinical risk stratification tool confirms that our members are receiving optimal care. In addition, our cultural competency strategy will include the following Heritage Health initiatives:

[3] Nebraska DHHS Office of Health Disparities and Health Equity Health Disparities in the Heartland Report, July 2015
[4] F=Unacceptable disparity immediate intervention needed

Initiative 1: Prepare and provide provider cultural competency training

We are providing links to providers for abstracts of peer-reviewed journal articles relevant to patient health literacy and the promotion of a health-literate society. Additional cultural sensitivity and health literacy materials are available to physicians at *unitedhealthcareonline.com.* This training provides easy, accessible, user-friendly tools that can improve the cultural competency of physicians and other health care professionals.

Initiative 2: Create a training/claims lab for Indian Health Services (IHS) billing and claims

Nebraska is home to four Native American tribes with most of this population residing in three counties: Thurston, Douglas and Lancaster. To monitor integration and build our relationship and understanding with tribal liaisons, we will provide training for their staff related to billing, coding, claims and other operational issues. Kim Manning, tribal network liaison, and Alberto Cervantes, community outreach specialist, will lead this effort.

Initiative 3: Develop and establish the Nebraska Health Equity Committee

We will develop and establish the Nebraska Health Equity Committee (NHEC), a joint effort between state and local agencies, community-based organizations, private and public human service organizations providers and other identified community members and stakeholders. The goal is to develop and evaluate culturally appropriate programs, policies and services aimed at improving health equity and eliminating health disparities as part of our foundational strategy.

Initiative 4: Prepare and provide cultural competency training for staff

UnitedHealthcare has collaborated with the U.S. Department of Health and Human Services Office of Minority Health, to disseminate cultural competency education modules (up to nine hours) which are located on *unitedhealthcareonline.com* (*Tools and Resources> Training and Education> thinkculturalhealth.com*). This also supports care coordination staff to ensure the delivery and coordination of culturally competent care.

Initiative 5: Continue to foster trust and relationships with key vulnerable populations, and Initiative 6: Develop a BH model framework for addressing health disparities related to suicide

We will continue to foster trust and relationships by hosting *Lunch N Learns* with key tribal community clinicians and community events such as *Hoops for Life* and *The Good Life in My Moccasins,* an outdoor family fair with a goal of connecting Native American families and low-income communities to health care services including specialty and supportive services. This includes promoting opportunities to break down the barriers to mental health care related to the associated stigma. We have also built relationships with refugee coalition organizations and the Mexican Consulate to better support member populations.

Initiative 7: Develop model and approach for community-based services plan

Community-based services continue to stress importance and ties to local organizations and members of the community. Within the community-based services plan, we will include the addition of a tribal liaison FTE. This role will focus on:

- ***Member education*** on benefit services, gaining access to care, acting as advocate for internal claims processing, and coordinating community events
- Continuing to leverage the ***Nebraska Health Equity Committee*** and identify barriers facing the tribal community
- ***IHS-specific materials*** for tribal members (e.g., claims handbook)

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IV.O. Program Integrity

93. Describe the MCO's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the MCO has utilized in other states. *4 pages*

With nearly 20 years of experience serving Nebraska Medicaid members, we are well positioned to continue enhancing our Fraud and Abuse Detection and Prevention program as we expand into all 93 counties and sharpen our focus to include behavioral health (BH) and pharmacy services.

We know that with the national shift toward managed care service delivery systems of integrated care, health plans are on the front line of the fight against Medicaid fraud, waste and abuse. We also recognize this shift has led to an increased level of oversight and scrutiny by federal officials of state and managed care organization (MCO) efforts in fraud, waste, abuse and erroneous payments (FWAE) prevention. Together, with our partners at the Nebraska Medicaid Program Integrity Unit (NMPIU) and the Medicaid Fraud and Patient Abuse Unit (MFPAU), of the Nebraska Attorney General's office, we currently meet and always strive to exceed all contract requirements. Our FWAE compliance plan successfully safeguards the program and is continually refined as we implement best practices realized in Nebraska and our other states.

Building upon our existing prospective detection; tips; data analysis and review; retrospective investigations and provider and member education, we will add dedicated BH and pharmacy program integrity teams responsible for anti-FWAE services.

Our comprehensive Nebraska FWAE compliance plan serves as a roadmap for the prevention, detection, reporting and corrective action of suspected cases of fraud and abuse in the administration and delivery of services. Our plan ensures that at a minimum we will meet the requirements in Section O.8 of Part IV. Project Description and Scope of Work and is based upon the seven elements of an effective Compliance and Ethics Program as specified by 42 CFR 438.608.

Prevention

We are a leader in FWAE prevention and we continually focus on how to save the Medicaid program the cost of recovering inappropriate payments due to FWAE. We recognize the best time to address FWAE is before a claim is paid, which requires post-pay identification, investigation and recovery. Therefore, we use aggressive prevention techniques and are continuously evaluating opportunities to expand and improve our program. The main components of our FWAE prevention approach are:

Safeguards to Prevent Improper Payments

There is power in data when it comes to preventing improper payments. We have, and continue to, make use of the significant amount of claims data received daily to create algorithms and front-end system edits to stop potentially improper claims. For example, one claims analytics tool we use saved the State more than $490,000 in state fiscal year 2015.

Provider Education, Awareness and Outreach

Provider education has been a significant part of our FWAE plan. Coding and billing updates, the transition to ICD-10, and information on how to report fraud and overpayments received are examples of recent provider education letters and communication. These efforts have been fruitful. Analysis of national billing and coding data indicate that **each provider education letter generates $900 in annual savings and a 30 percent reduction in incorrect claims submissions.**

Employee Education and Training

Training is required of all our employees and subcontractors upon hire and annually thereafter, and is a condition of employment. Required training content includes general Compliance and Ethics Program, FWAE expectations, a review of pertinent laws and regulations, including the False Claims Act, privacy and security, examples of potential FWAE and schemes, and a review of the resources available for reporting suspected instances of potential FWAE. All employees must understand, follow and acknowledge receipt of our Code of Conduct, and are required to review and attest to it at least annually during employment.

Additional training also takes place on the procedures for the timely, consistent exchange of information and collaboration with MLTC. We manage mandatory training and annual re-training through our Web-based LearnSource system, which automatically tracks required training for all employees.

Safeguards to Prevent Prohibited Affiliations

In accordance with 42 CFR 438.610, we do not knowingly have a relationship with individuals or entities that have been excluded, debarred, or suspended from participation or procurement with federal or state health care programs.

We proactively conduct monthly searches of the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the System of Award Management (SAM) and the Nebraska Medicaid Excluded Providers list. We report all exclusion information discovered to NMPIU as identified and immediately begin efforts to sever the relationship with a debarred or excluded individual. We understand if we are not compliant with these requirements, NMPIU will notify the U.S. Department of Health and Human Services (DHHS) Secretary of noncompliance and may not renew or extend our contract.

Detection

We employ multiple detection methodologies to identify FWAE, including a special investigations unit (SIU), hospital bills audit, analytical tools, service verifications and provider audits. The intent of these methodologies is to identify aberrant and excessive billing practices and trends, inappropriate treatment, fictitious and unqualified providers, and fictitious and ineligible members.

Special Investigations Unit

The SIU comprises highly qualified investigators with significant experience in health care and prescription drug fraud and abuse, industry business practices and systems infrastructure, plus knowledge of federal and state law enforcement and litigation practices. Their analytical functions include a full range of investigative activities as well as presenting evidence in litigation to support civil and criminal prosecutions. SIU staff will be located in Nebraska, and staffing will be at a minimum of one investigator per 50,000 or less members.

Hospital Bill Audits

Our Nebraska Hospital Bill Audit program reviews DRG assignments and data surrounding cost outliers and readmissions. These areas can generate some of the highest cost improper payments and detecting them has been a valuable innovation, leading to **a seven-figure savings during state fiscal year 2015**.

Analytical Tools

Three analytical tools aimed at cost avoidance form the foundation of our FWAE program. These tools, shown in Table IV.O-1, identify FWAE by members and opportunities to flag providers for prepayment review.

Table IV.O-1: Fraud, Waste and Abuse Analytical Tools				
Tool	**Timing**	**Focus**	**Actions**	**Claims Reviewed**
Prospective Provider Flagging (P1.0)	Pre-payment generally after front-end edits	All or, if supported by the claims platform, groups of claims from specific providers that have filed a large number of inappropriate claims but not enough to have been removed from the network	Identify claims to pend (hold) to request medical records to review and determine whether to deny or approve payment of a lesser amount, if claims were inappropriate	Professional and Institutional
Comprehensive Prospective Review (P2)	Pre-payment generally after front-end edits	Claims that are suspect because of one or a combination of factors such as unlikely diagnosis and procedure code combinations	Identify claims to pend to request and review medical records for eventual denial or payment	Professional and Institutional
Retrospective Fraud and Abuse	Post-payment	Suspected FWAE claims not detected prior to payment are identified through referrals, investigation and other analytics	Depending on situation, can start with an on-site audit, a request for medical records or a demand for re-payment. Leads to re-payment request/offset if claims were inappropriate	Professional, Institutional, Pharmacy and Dental

Additionally, our systems support Health Care Reform mandates, including National Correct Coding Initiative (NCCI) bundling, medically unlikely event (MUE) and health care acquired conditions.

Service Verification

Our role in safeguarding the Medicaid program includes verifying we pay providers only for delivered services and at the level of care performed. We currently mail 2,850 service verification letters quarterly to a random sample of members to confirm each member received the services indicated. In compliance with new requirements, we will select a minimum 2 percent sampling of claims per month. The statistically valid random sample of paid claims will include all provider specialties and claim types proportionally represented in the sample pool.

Audits

Detailed audits are an effective method to detect FWAE. Twice yearly, we will complete an audit of a statistically valid random sample to monitor error rate measurements, medical necessity and provider documentation. Additionally, we will complete quarterly audits to identify services paid after the recipient's death or incarceration and home-based services. This audit will include prescription drugs, therapies or medical supplies, received by the patient while that patient was hospitalized, or living in or treated in a setting reimbursed at an all-inclusive rate. The quarterly audit will supplement a current retrospective algorithm run on a monthly basis to identify claims paid to providers for members who later were disenrolled for either terminating from the plan or death.

Reporting

We currently notify NMPIU when we identify data mining outliers, audit concerns, critical incidences, hotline calls, or other internal and external tips with potential implications about significant provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15). We make this notification via current quarterly reports and on an immediate basis as needed to NMPIU staff, only after

a thorough investigation. In compliance with the monthly reporting requirements, we will expand on the information currently reported each quarter to NMPIU as detailed in the RFP.

Implementation of Corrective Actions

In addition to our detection, investigation, payment prevention and recovery efforts, we take corrective action when we discover FWAE. Corrective action may include, but is not limited to:

- Notifying and educating the provider and/or member involved
- Issuing a corrective action plan to the provider
- Referring a matter to law enforcement officials or prosecutors for criminal prosecution
- Reporting providers to state professional licensing authorities and medical boards
- Creating and implementing new data mining queries/rules to identify the scheme at issue

Tim Langdon, program integrity officer, along with business leaders of the impacted functional area(s), will monitor and evaluate the implementation of a corrective action plan and monitor progress made. This team is responsible for documenting that remediation activities are effective and addressing concerns detailed in the corrective action plan.

Best Practices

We will expand our current FWAE program in Nebraska with the addition of dedicated BH and pharmacy program integrity teams. In addition to proven techniques such as real-time, on-site and desktop audits, these groups will deploy best practices proven in other states.

One example is a new drug diversion program. In 2014, the pharmacy team piloted the "Controlled Substance Drug Diversion Program" (Program) in collaboration with TennCare Payment Integrity. The Program's goal is to identify, validate and refer (for clinical review or to law enforcement) those members and providers (prescribers and pharmacies) allegedly involved in the diversion of the "holy trinity" drug combination ("holy trinity" being the drug combination's street name and consists of an opioid, anti-anxiety medication and a muscle relaxant). As a result of our program integrity fraud's collaboration with TennCare, 10 leads involving 124 targets were produced for criminal prosecution of 66 members, 15 medical professionals and 43 pharmacies.

Another best practice implemented in other states and new to Nebraska is the Payment Integrity Intel Center (PIIC). It uses proprietary technology to create a series of dashboards to establish a detection and evaluation mechanism for all value streams within our payment integrity process (e.g., FWAE, coordination of benefits [COB], subrogation), as well as facilitate collaboration among all of our payment integrity operations and analytics teams.

94. Describe how the MCO currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the MCO apply methods in Nebraska? *2 pages*

Having served Nebraska Medicaid members for nearly 20 years, we have longstanding relationships and knowledge of processes in Nebraska. We will build upon and strengthen these relationships and processes in expanding from our current 10-county service area to all 93 counties in the state.

All entities involved in investigating and prosecuting FWAE are working to meet heightened expectations and increasingly stringent requirements as the trend toward managed care service delivery and integration continues. For example, the 2015 OIG Audit Plan includes increasing oversight of managed care entities as a focal point and federal Center for Program Integrity reviews of states will have a heavy emphasis on how well states are performing managed care oversight. The strength of our program and level of collaboration with investigative and prosecutorial bodies can help MLTC to meet any new requirements.

Our SIU leadership and staff are members of and attend various trainings and conferences sponsored by a number of entities responsible for investigating and prosecuting FWAE. These agencies include, but are not limited to, the National Association of Medicaid Fraud Control Units (NAMFCU), National Health Care Anti-Fraud Association (NHCAA), HHS-OIG, American Health Lawyers Association, National Association for Medicaid Program Integrity (NAMPI) and CMS Healthcare Fraud Prevention Partnership (HFPP).

Mr. Langdon understands the nuances of the current Nebraska Medical Assistance Program landscape, as well as the new Heritage Health program and MLTC's expectations on combating FWAE. He and chief executive officer Kathleen Mallatt are fully committed to building upon the partnerships already established in Nebraska with NMPIU, MFPAU and other MCOs in Nebraska to prevent FWAE and protect our members and the Heritage Health program.

Mr. Langdon and local leadership are actively involved in efforts with other entities that investigate and prosecute provider and member fraud, waste and abuse as highlighted below:

- Actively participate in quarterly meetings with MLTC Medicaid Program Integrity Unit
- Actively participate in biannual program integrity collaboration meetings with all MCOs and Nebraska Medicaid Program Integrity
- Participate on MLTC's Healthcare Fraud Task Force chaired by the Nebraska United States (U.S.) Attorney's Office
- Make referrals to the Nebraska Medicaid Program Integrity Unit who evaluate and pass on cases to the MFPAU
- Interact directly with the MFPAU by providing notice when we have identified overpayments to confirm our actions do not impact current investigations by the Attorney General's office

Through our experience, we understand that FWAE is not isolated to payers. If we detect FWAE, chances are other MCOs serving Heritage Health members are experiencing similar patterns with the same providers. We will continue to work collaboratively with other Nebraska investigators to identify potential offenders and aggressively impose appropriate corrective and disciplinary actions to promptly reduce the potential for recurrence and support ongoing compliance with applicable regulatory requirements.

Regulatory and Law Enforcement Collaboration

We recognize success in program integrity requires collaboration with NMPIU, the MFPAU, and all MCOs in the state. Mr. Langdon serves as the primary point of contact for issues related to FWAE collaboration. Recent collaborative efforts include sharing high potential FWAE cases with other MCOs, receiving a complete list of NMPIU open cases to cross-reference against our open case list, responding to multiple requests for information, and participating in joint meetings with NMPIU, other MCOs and the MFPAU. For example, we presented information to NMPIU, the Nebraska MFPAU, and other MCOs in the state during meetings held on April 2, 2015, and Sept. 30, 2015, on topics such as national fraud trends, the "Holy Trinity" and local issues identified by NMPIU.

When we identify recoupment opportunities, we will continue to collaborate with and promptly notify NMPIU and the MFPAU to confirm our actions do not disrupt a current or potential investigation or case. When notified of credible allegations of fraud by NMPIU, we have and will continue to comply with 42 CFR 455.23 by suspending payments to a provider.

Healthcare Fraud Prevention Partnership

The UnitedHealthcare program integrity (PI) advanced analytics and fraud teams work closely with various industry and private anti-fraud associations, and attend conferences sponsored by these organizations, to keep abreast of new FWAE schemes and methods to identify and combat them. Working with key relationships developed across the industry, the fraud team supports anti-fraud and criminal prosecution efforts. Additionally, we share information regarding the termination of providers and pharmacies from UnitedHealth Group (e.g., UnitedHealthcare and OptumRx) networks with other MCOs through participation in anti-fraud activities such as the Healthcare Fraud Prevention Partnership (HFPP) studies and alerts, health care fraud task forces/working groups and industry presentations.

- The HFPP is a public-private partnership between the federal government, State officials, law enforcement, Medicaid programs, private health care plans, and health care anti-fraud associations to proactively detect and prevent health care fraud by identifying fraud schemes and widely sharing information.
- The UnitedHealthcare PI advanced analytics team supports the company's submission of de-identified data to the HFPP, and the fraud team receives, analyzes and validates HFPP study output. Validated leads are then referred to internal/external partners. Additionally, the HFPP maintains a fraud "alert" system whereby information relating to fraud scheme identified by an HFPP partner is shared. The fraud team analyzes (and contributes) information received through the Partner-to-Partner "alert" system.
- The data sets submitted to support HFPP-sponsored studies include data from all three lines of business: Medicaid, Medicare and commercial. Similarly, the fraud schemes identified through the "alert" system are applied to all three lines of business.

With a line of sight to both local and national efforts and activities, Mr. Langdon is able to communicate lessons learned to local staff and incorporate changes to policies and procedures, processes and training.

95. Currently, how does the MCO educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the MCO apply methods in Nebraska? *3 pages*

We understand members and providers are the on the front line in the fight against Medicaid fraud and abuse and it is critical they understand what to look for and how to report suspicious behavior. In Nebraska, we take member and provider education seriously and have implemented multiple strategies to support engagement in the prevention and detection of Medicaid fraud and abuse. In the paragraphs that follow, we discuss our current and proposed strategies and highlight the information we also will bring to Nebraska from our other states.

In Nebraska, we train and educate internal and external individuals and entities, including members and providers, about our Compliance and Ethics Program and obligations to report suspicion of unethical or illegal behavior. Information provided includes general Medicaid FWAE definitions and issues, how to identify FWAE, and privacy and security requirements. We also share information on how and where to report suspected FWAE.

Educating Members

Our FWAE program focuses on proactive prevention, detection and investigation of potentially fraudulent and abusive acts committed by providers and plan members. Members receive printed materials at the time of enrollment, and ongoing, that describes FWAE policies and procedures. We also currently conduct quarterly service verification with a random sample of our members by mailing 2,850 letters quarterly to verify receipt of services as indicated.

Our *Member Handbook* and member website, *myuhc.com*, provide information about fraud, waste and abuse prevention, detection and reporting; and encourage reporting suspicions of noncompliance, unethical behavior and/or fraud, waste and abuse. The *Member Handbook* also provides common examples of fraud and abuse and reminds members to never give their member ID card to anyone else to use.

Our toll-free member services number is printed on the back of the member ID card. Additionally, our member services number and MLTC's toll-free Fraud Control number are posted on *myuhc.com* and are listed in the *Member Handbook*. We provide training to members on where to find these numbers and how to facilitate the reporting process. Educational resources for members pertaining to FWAE include:

- New Member Welcome Packet
- *Member Handbook*
- Newsletters and mailings
- *Myuhc.com* (our online member services portal)
- Directly through a toll-free number that connects them to the Heritage Health member services center
- Member events that provide education and raise awareness of the Heritage Health Program

Educating Providers

Proactive provider outreach during orientation and ongoing is essential to the successful implementation of any FWAE program. Without appropriate outreach and education, provider pushback and appeals can occur. Modes of communication to educate providers on FWAE include:

- ***Provider Administrative Guide:*** All network providers receive a printed copy of this guide upon request, with an electronic version posted on the online provider portal.

- ***Provider Newsletter (Practice Matters) and Service Bulletins:*** Our quarterly provider newsletter contains information on program updates, claims guidelines, and information regarding policies and procedures.
- ***Provider Portal:*** Our Web-based provider portal (*uhccommunityplan.com*) supports Nebraska Medicaid providers through many innovative features and tools.
- ***Provider Relations Team:*** Our experienced, local provider relations team is led by our provider services manager and includes full-time provider advocates, all of whom live in Nebraska. Provider advocates meet with key providers to build relationships, answer questions, provide education and address compliance issues.
- ***Provider Services Call Center:*** Our toll-free provider services call center responds quickly to provider inquiries. Provider phone representatives specifically trained on the Nebraska programs (Heritage Health and FFS) will staff the Nebraska-based call center.
- ***Written Materials:*** Written materials are our primary educational resource and include email and fax blasts, and individual letters conveying provider-specific information.
- ***Webinars:*** We offer a full slate of monthly interactive webinars, all conducted in real-time by a live facilitator. Webinar training encompasses many topics including contract requirements; UM; FWAE; PA; and cultural competency.
- ***Town Halls:*** Town halls provide information in the most effective and convenient way possible for providers, with a variety of topics, and may include discussion of FWAE.

UnitedHealthcare Fraud, Waste and Abuse Education Prevention Program

Our FWAE Education Prevention Program aims to influence provider behavior to reverse aberrant billing habits. This program includes:

- ***Provider Awareness:*** Provider engagement method deployed as a way to interact with a high volume of providers who demonstrate aberrant billing patterns in a collaborative, less-abrasive manner than medical record reviews. This allows for influence of billing practices through tailored provider engagement strategies, including letters, telephonic outreach and in-person meetings.
- ***Provider Education:*** Provider engagement method that allows for influence of billing practices through sharing of comprehensive reports based upon aggregation of prepay findings from a clinical review of a provider's medical records.
- ***Coding Reviews:*** Provider engagement method aimed at addressing coding issues through the issuance of a Provider Education report.
- ***Provider Behavior Management:*** Provider monitoring program to examine claim submission trends by analyzing case management databases and findings from post pay and prepay audits to verify providers are being characterized appropriately as waste/error, abuse or fraud.
- ***Provider Behavior Monitoring:*** Reporting program to show the extent to which our actions influenced a provider's go-forward billing practices.

Intensive Coding Reviews

We also conduct intensive coding review for providers, which is the most in-depth form of provider engagement in the FWAE program. This solution was conceptualized for providers with a wide range of coding issues and who require more than a Provider Education report to remedy the issues. The goal of this activity is to build relationships with facilities and large physician groups and to engage in ongoing dialogue related to coding issues we observe through our clinical review findings.

Assisting Providers in Understanding Enhanced Federal Regulations

Regulation shapes all aspects of America's health care industry, from the flow of dollars to the communication between physicians and patients. It is the engine that translates public policy into action. We recognize our role in helping providers adapt to the ever-changing regulatory environment, including the forthcoming managed care regulations, the Accountable Care Act and the Deficit Reduction Act. To help providers understand and comply with enhanced federal regulations, Mr. Langdon and other local and national employees provide education, training and timely communication of information essential to helping providers understand new requirements. Mr. Langdon and other staff are personally available to answer provider questions. Additionally, providers receive information through a variety of communication methods such as periodic mailings, articles in our quarterly newsletter *Practice Matters*, secure emails, blast faxes, and updates to the *Provider Administrative Guide* and provider portal *uhccommunityplan.com*.

- ***Forthcoming Managed Care Regulations:*** The proposed rule updating the Medicaid Managed Care regulations represents a potential major change to program integrity requirements for providers, state agencies, members and MCOs. We continue to monitor and plan for these changes and will communicate with stakeholders as needed on issues including subcontract relationships and delegation, provider screening and enrollment, program integrity, compliance program content and procedures, overpayments and payment suspension.
- ***The Accountable Care Act (ACA):*** The ACA added significant program integrity requirements in a number of areas including provider enrollment, ownership disclosure, implementation of Recovery Audit Contractors, and the requirement to report and return overpayments within specified time frames. Since the implementation of the ACA, we have worked across the scope of our businesses in all states to provide needed information to our partners, including providers and state agencies, on these issues and any changes that affected our mutual operations.
- ***The Deficit Reduction Act of 2005 (DRA):*** Our contracted providers and their staff are subject to the DRA, which contains many provisions reforming Medicare and Medicaid. We communicate this requirement to providers through the *Provider Administrative Guide* and through our online provider portal *uhccommunityplan.com*. The UnitedHealth Group policy titled "Integrity of Claims, Reports and Representations to Government Entities" is posted on *uhccommunityplan.com*. Special attention is given to DRA Section 6032, which is aimed at providers who receive at least $5 million in Medicaid payments and outlines additional specific requirements.

96. Describe the MCO's method and process for capturing TPL and payment information from its claims system. Explain how the MCO will use this information. *3 pages*

The escalating cost of health care programs and federal regulations dictate the need for flexible methods to verify MLTC is the payer of last resort. We are committed and understand we are responsible for making every reasonable effort to identify and validate when a third party should be responsible for claim payment. We have proven processes and procedures to effectively carry out third party liability (TPL) discovery, cost avoidance and recovery activities in Nebraska and across the United States. In fact, last year alone our efforts saved Nebraska Medicaid more than $7 million. Our experienced TPL staff provides careful oversight and thoroughly researches and tracks indication of other third-party coverage.

Our experienced and knowledgeable COB operations staff manages all COB/TPL activity. A dedicated associate director of COB, COB project leads and COB subject matter experts in Nebraska coordinate COB activities with our COB operations staff, COB vendors and internal departments, such as claims operations and health plan operations. They will cooperate with MLTC in any manner required on COB and third party collection efforts.

Proven Methods and Processes for TPL Identification and Recovery

Our team of dedicated experts identifies members who have overlapping coverage spans with different carriers through a variety of information sources, including:

- ***TPL Identified and Communicated to us by MLTC:*** We load TPL information into Community Strategic Platform (CSP), according to MLTC's schedule.
- ***Nebraska's TPL Vendor/File:*** We receive and manage monthly feeds from MLTC's TPL vendor/file.
- ***Commercial Carriers:*** We use sophisticated algorithms to identify members with overlapping coverage from monthly and weekly feeds received from multiple companies that capture data from other insurance carriers. We participate in the COB SMART utility sponsored by the Council for Affordable Quality Healthcare, a consortium of payers.
- ***Internal Units (e.g., prior authorization, claims and member services):*** All TPL information collected by our claims management, prior authorization, or member and provider services teams is forwarded to the COB team for validation and loading to CSP.
- ***Data Analysis:*** Using our claims data, we identify members who potentially have other coverage; e.g., a member who turns 65 and becomes eligible for Medicare. Upon identifying the member's other coverage, we validate and verify the primary carrier to coordinate claims payment, cost avoid in the future, or recover overpayments.
- ***Direct Eligibility-File Connections with CMS:*** We match our membership with Medicare membership at CMS to identify members with Medicare primary coverage.
- ***Member Communications:***
  - *New Member Welcome Call* – Member services advocates (MSAs) make welcome calls to our members and ask COB questions during the member's welcome call. The information obtained is forwarded to the COB team for validation and loading into CSP.
  - *Member Services Center* – When an inbound call is received, the MSAs will ask if the member has other insurance. When there is a possibility of other coverage, the information is gathered and forwarded to the COB team for validation and loading into CSP.

- *Explanation of Benefits (EOB) and Explanation of Medicare Benefits (EOMB) Submitted with Claims* – We review all EOBs and EOMBs submitted with claims for evidence of overlapping coverage.

Functioning of the Third Party Liability Process

Our method and process for capturing TPL and payment information from CSP includes built-in logic that links a member's COB information to the processed claim, as shown in Figure IV.O-1. It looks for COB eligibility dates, the type of insurance coverage, whether an EOB is attached, primacy COB, whether it is a pay and pursue code, a non-covered Medicare code, etc., and will process the claim accordingly.

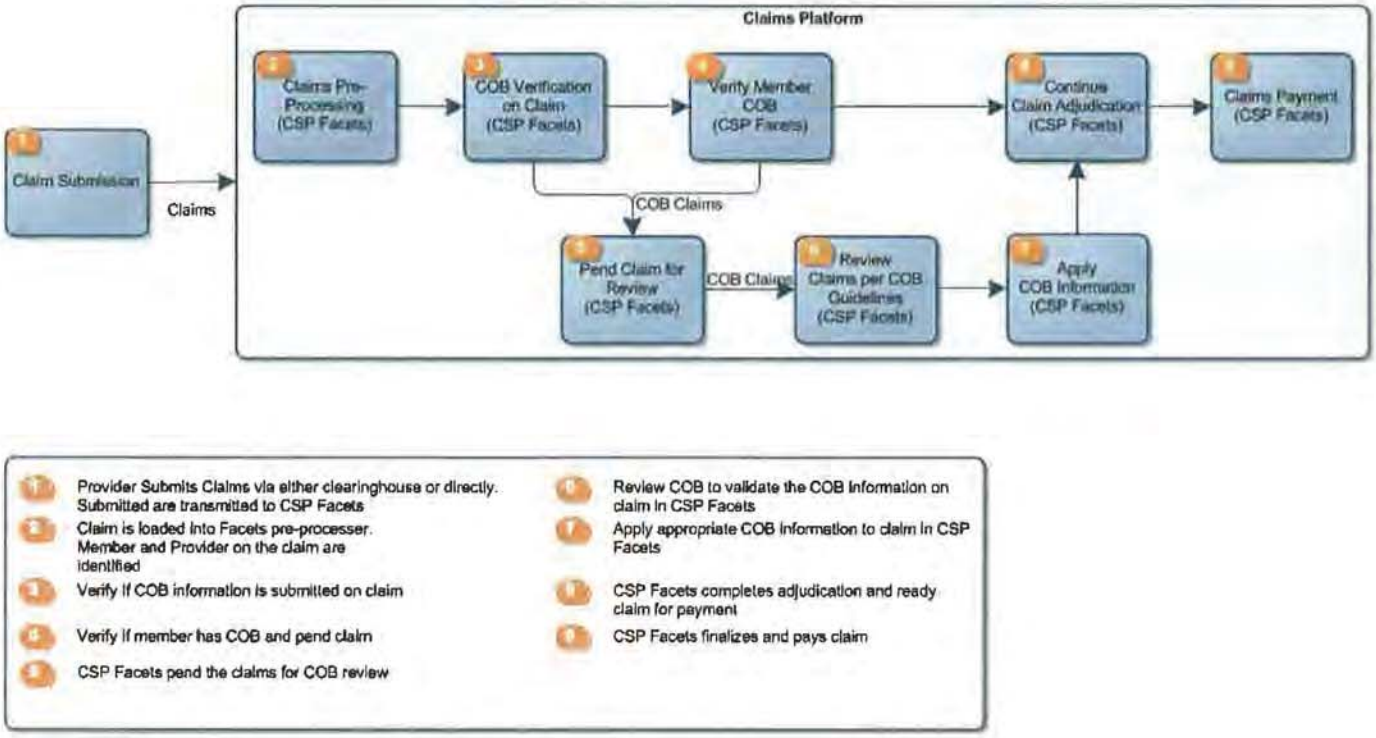


Figure IV.O-1. Systems Diagram - Coordination of Benefits. CSP, our claims system, includes built-in logic that links a member's COB information to the claim being processed.

Our aggressive identification and validation of subrogation and TPL are critical to our cost-avoidance strategy of immediately rejecting claims covered by other resources. We have robust edits in place to coordinate with a variety of payers, such as auto insurance and commercial health insurance carriers. When CSP encounters a claim that is flagged for possible subrogation and TPL, the claim is pended for manual adjudication. In the manual adjudication process, our claims examiners coordinate benefits with the primary payer's EOB. Regardless of whether the claim is from an in-network or out-of-network provider, we pay in full any copayment, coinsurance or deductible required by the primary payer, up to MLTC's allowed amount.

We reject claims received without the primary payer's EOB and instruct the provider to pursue payment from the primary payer. An exception to this, however, is claims for dual-eligible LTSS members for services not normally covered by Medicare (e.g., custodial nursing home care or personal care in the community), which are manually adjudicated. If the subrogation and TPL information cannot be validated through online resources or a phone call to the alternative carrier, the claims are paid as primary by us. If

we discover a member has a primary payer after claims have been paid, we use CSP to adjust the claim and recover primary payments from the COB effective date forward.

Validation of Third Party Liability Data

Each unverified TPL lead we receive from providers, members or MLTC is validated by a team of dedicated and skilled COB operations staff. Once a vendor TPL file is received, validation methods include:

- EOB received with claims
- Outbound calls to referenced carriers
- Council for Accountable Quality Healthcare (CAQH)
- Web-based eligibility tools
- Online verification systems

Council for Affordable Quality Healthcare

To further reduce costs, we participate in the CAQH COB Smart Utility. This utility matches eligibility information from participating payers across the nation, and supplies the results back to the payers on a weekly basis. We use this information to set COB flags in CSP. Since Jan. 1, 2015, in Nebraska, we have set more than 1,000 COB flags through our partnership with CAQH.

Updates to CSP occur weekly with validated information, whether it is new information or an update to an existing COB record. We report new TPL coverage to MLTC and include all TPL data specified in Section S, 15.

How UnitedHealthcare Uses Third Party Liability Information

Last year our subrogation services team from cost avoidance and cash recoveries saved the State $315,303. The team conducts data-mining activities on a regularly defined schedule to identify members who have accident-related diagnosis codes in their medical claims data files. Once identified, we reach out to those members for more information about their cases. If we are unable to reach a member, we continue to follow up every 45 days, making up to three separate attempts.

Diagnosis and trauma edit processes as well as post-payment recovery activities serve as the foundation for our subrogation services, which include:

- Identification of accident claims
- Thorough investigation to determine facts surrounding a case
- Identification of all potential sources of recovery
- Assertion of our client's legal rights of subrogation or reimbursement
- Assigning the payment liability to the responsible third party
- Recovering paid claims resulting from motor vehicle accidents, occupational injuries, property liability, product liability and malpractice
- Consulting on subrogation program performance
- Legal subrogation support and litigation

When an injury-related third party is involved in a claim payment, such as automobile insurance, worker's compensation or property insurance, we coordinate the claim payment upon receiving an EOB from that injury-related payer. If a claim is submitted without an EOB and is potentially related to an accident or injury for which another party may be responsible, we first pay the claim as primary and then pursue any other responsible party for reimbursement. We accomplish this by using claim diagnoses and algorithms—along with member questionnaires—to identify third parties responsible for our members' injuries and collect reimbursements, as appropriate.

IV.Q. Provider Reimbursement

97. Provide a detailed description of the MCO's approach to implementing a value-based purchasing model with providers. Include at a minimum the MCO's:

- Philosophy regarding value-based purchasing and risk-sharing agreements and evidence of effective use in Nebraska or other markets
- Approach to identifying initiatives and performance measures on which to focus, proposed engagement strategies to encourage provider participation, incentives the MCO will use, and methodology and timing for determining if providers have met requirements
- Plan for entering into value-based purchasing agreements with 30% of its provider network by Dec. 31, 2019.
- Discussion of best practices and lessons learned. *6 pages*

We recognize today's health care environment affords us an opportunity to take a more holistic approach to provider partnerships by developing physical and behavioral health models of care appropriate for specific populations and shifting from fee-for-service to a pay-for-value approach. To advance this commitment, we have developed programs across all lines of UnitedHealthcare business, with the goal of advancing and integrating evidence-based models of care and value-based purchasing (VBP) provider contracts with market level customization. Our suite of VBP models spans the clinical integration and reimbursement continuum allowing us to link reimbursement to provider performance and quality. Each model in our VBP portfolio includes quality measures and performance metrics that reward providers for proactively conducting preventive health screenings and improving patient health by closing gaps in care. We have a comprehensive suite of HEDIS screening, management and control measures, and are committed to making any changes in our VBP approaches necessary to collaborate and remain compliant with MLTC's priorities throughout the term of the contract.

Philosophy Regarding Value-Based Purchasing and Risk-Sharing Agreements

Overall, an estimated 38 percent, or $43.1 billion of our national network health care spend is currently tied to value-based contracts across our commercial, Medicare and Medicaid lines of business. Nationally, and in Nebraska, by the end of 2019, we are committed to increasing the value of contracts we have with doctors and hospitals based upon quality and cost-efficiency measures. As illustrated in Figure IV.Q-1, we segment our value-based models into the three primary categories. We describe below each category, including evidence of our use of the programs and a description of the operation of common models within each category:

Figure IV.Q-1. Our Value-Based Purchasing Continuum

Performance-Based Programs

Encompassing primary care incentives and performance-based programs for physicians, facilities and other service providers (e.g., laboratory and dialysis services), our performance-based programs reward

providers for achieving specific metrics, such as readmissions, hospital-acquired conditions and some HEDIS measures. These programs span more than 55,000 physicians and 1,000 hospitals across all UnitedHealthcare lines of business.

Episode-Based Shared Savings Model:

For those providers not yet ready for total population health arrangements, we work with state Medicaid agencies to advance episode-based payment pilots. These pilots are built upon the FFS reimbursement foundation with retrospective shared savings opportunities based upon the cost of care of all services related to conditions or procedures that are critical to our state partners. This approach gives the primary accountable provider for a given condition or procedure the opportunity to be rewarded for quality and savings relative to market average benchmarks for the cost per episode on a retrospective basis. Nationally, we are currently piloting this model in partnership with state Medicaid programs on a limited scale, focusing on a list that is aligned with each state's primary cost-reduction goals. Programs typically focus on critical, high-cost conditions and procedures such as perinatal care, asthma, chronic obstructive pulmonary disease (COPD), joint replacement and cardiac procedures. Our approach is to assess the efficacy of these programs before we make strategic decisions regarding expanding them more broadly.

Accountable Care Programs

At the most advanced end of the value-based spectrum are our programs focusing on population health, encompassing shared savings/shared risk models like accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), as well as capitation and capitation-plus-performance based contracts. We are currently involved in 750 accountable care arrangements, including 50 commercial ACOs, across the country. These organizations are focused on driving innovation in payment and delivery system reform with the Triple Aim of improving population health and patient experience, delivering the best possible quality outcomes, and reducing medical cost and medical trend.

Accountable Care Shared Savings Model: This model targets mainly larger primary care practices and FQHCs that are committed to collaborating toward the goal of clinical integration and comprehensive population management. Foundational to this model is advancing proactive care teams to support practice transformation by improving access, efficiency and quality of care for patients and give practices the opportunity to earn monthly PMPM reimbursement for clinical integration activities. The model includes both upside/downside shared savings and shared deficit provisions based upon performance against total cost of care metrics.

Innovative Behavioral Health Facility Reimbursement: The shift toward increased collaboration, outcome-based payment and new benefit design is transforming how we pay for and deliver health care. We are an industry leader in the use of performance-based contracting with behavioral health (BH) providers and have been recognized for managing the largest tiered network in the country and for rewarding care providers for delivering improvements in quality and cost-efficiency. We have 21 markets with performance-based BH facility contracts in place, and another five markets in process, with 2,377 group providers and 18,771 individual providers participating in our outpatient performance-based contracting initiative. We anticipate continued growth through 2015 to represent nearly 20 percent of the BH inpatient expenditure.

Optum Behavioral Health Solutions Performance Recognized by *Open Minds*
Monica Oss, CEO of *Open Minds*, a leading BH consulting organization, recognized Optum Behavioral Health as the organization that has "made the most progress" in moving from pay for volume to pay for value.

Evidence of Effective Use in Nebraska

We have had a value-based arrangement in place with UniNet Healthcare Network for 16 years. This agreement is one where the providers are aligned and working with us in a shared risk structure. UniNet is a physician-led, clinically integrated network (CIN) of medical providers across Nebraska and western Iowa that work together to promote a high standard of care quality and efficiency for our communities. UniNet's CIN is a selective partnership of independent and employed health care providers, collaborating with hospitals and ancillary facilities to improve patient outcomes while lowering medical costs. Our finance and care management staff meets with their administration, medical director and care manager on a monthly basis to assess their enrollee population and collaborate on the management of enrollees with complex medical needs. For those cases that need PCP involvement, UniNet's care manager helps gain PCP input. For the five-year period of 2010–2014, the shared savings arrangement with UniNet has outperformed with an MLR that has been, on average, 150 basis points lower than the Health Plan average for the same period. In addition UniNet has outperformed the Health Plan in a number of HEDIS measures including, but not limited to, childhood and adolescent immunizations and cervical cancer screening. These results reflect the collaborative efforts with UniNet.

A Letter of Recommendation from UniNet

"We have had a relationship with UHC Community Plan through a risk contract for the last 16 years. You have a dynamite team to focus on quality and cost. Through these collaborative efforts, we have developed a strong partnership with UHC Community Plan that we are confident will continue to result in positive results and benefits for Medicaid enrollees. This focus between the two entities is making a difference in the quality of care of the Medicaid population in the Omaha area."

- Ann E. Oasan, President

We also currently have five basic quality model agreements with clinics in the existing service area. These agreements were implemented this year and we have community practice consultants working with these offices.

We have also demonstrated our ability to collaborate with providers on quality models currently in place with other product lines that have achieved lowered costs and improved outcomes. For example 79 percent of the clinics on a quality model for Medicare Advantage Product in Nebraska received incentive payments in 2015. Additionally, for our Medicare Advantage Product, we were awarded a 4.5 star rating for 2016.

Our Value-Based Purchasing Process

We have begun an aggressive transformation of our provider network and have plans for a significant ramp-up of alternative payment models by 2018. We continue to explore and implement multiple innovative payment and delivery system configuration models based upon varying degrees of provider accountability and ability to assume clinical risk. Our focus is on the Triple Aim of 1) improving population health and patient experience, 2) delivering the best possible quality outcomes and 3) reducing medical cost and medical trend.

Identifying Measures, Proposed Engagement Strategies and Incentives Used

We know that there is no single payment model that works for every provider. Each provider has a different appetite for financial risk, and providers are more or less integrated in their care delivery (ranging from solo practitioners to large integrated delivery systems). We recognize the need for a modular set of value-based payment models that align with a provider's risk readiness and capabilities. In our most progressive value-based contract models where providers share in financial risk, it is imperative that we manage and monitor both provider risk readiness as well as ongoing performance. Before engaging in any shared risk program with a provider, we conduct an extensive review of their risk readiness, which includes assessment of the provider's financial, structural and cultural capabilities

necessary to succeed in a risk-sharing contract. We use a comprehensive quantitative and qualitative approach to engaging provider participation in the most appropriate of our VBP programs. One of the tools used in this evaluation is our VBP Readiness Assessment. This survey gives us insight into providers' organizational structure, Health Information Technology infrastructure, level of patient engagement, care coordination capabilities, high-risk patient management, VBP experience with other payers and willingness/readiness to accept risk. Used in concert with a review of providers' historical quality performance and management of avoidable medical expense, we are able to collaborate with them to determine which VBP program they are best suited for. Next, we require the appropriate safeguards are in place to verify success of the contract. This includes establishing requirements for provider stop loss and reinsurance, as well as establishing financial reserve requirements based upon the level of financial risk and the volume of services where risk is involved. Finally, once provider risk contracts are in place, we actively work with the providers to make certain they succeed under the contract. For our various value-based payment models, we support providers with appropriate benchmark and ongoing performance reports. For ACOs and PCMH programs, we support providers with clinical consulting. In addition, our strong analytical capabilities, data and reporting tools help our partner ACOs identify areas of improvement. We also can provide clinical support to assist ACOs in developing and/or augmenting clinical programs.

Methodology and Timing for Goal Determination

We offer an array of industry-leading tools and capabilities for our ACO partners. We modify our process regularly if interventions are not successful in helping to attain targets by implementing a solution to address the problem a provider is facing: supporting practice with additional outreach resources, such as Clinic Days and health fairs, and additional provider and member education. We also provide service interventions for those providers who are working to meet their VBP targets, but are facing staffing or communication barriers. Finally, as the leading national carrier to offer Medicare, Medicaid and Commercial plans, the size and variation in the population we represent allows us to test our ACO strategy across a more varied population. We produce and share an Interim Scorecard with results from the first six months of the measurement period. A final scorecard is then produced and shared with providers showing results during the full 12 months.

Future Approach to Value-Based Purchasing

We share MLTC's goal to advance value-based arrangement and recognize that we must enter into value-based purchasing agreements with 30 percent of our provider network by the third year of the contract, and 50 percent of our provider network by the fifth year of the contract. During the first year of the contract, we will submit to MLTC for its review and approval our plan for further advancing and implementing our value-based purchasing agreements. We currently have 16 percent of our 10-county provider network contracted in value-based purchasing agreements. We have a three-pronged approach to expand our value-based purchasing agreements in Nebraska.

First, we plan to continue to advance our current models with new and existing providers in our current geographic footprint, advancing providers to more sophisticated models as our membership grows. We have a special focus on FQHCs, who were among the earliest adopters of VBP initiatives. We believe it is incumbent upon us to maximize and support the expertise of safety net providers. We have recently executed five Basic Quality Model contracts and have 11 more targeted for 2016. If a provider in the statewide expansion is ready to immediately start a VBP contract with us, we will start them on our BQM model. We designed this model to support PCP practices with more than 150 UnitedHealthcare members to achieve improvement in patient health through closing gaps in care related to preventive screenings and chronic disease monitoring, with an opportunity to be rewarded for their performance. The program

encourages PCPs to proactively conduct preventive health screenings, improve HEDIS scores, focus on state quality performance metrics and help members become more informed, engaged patients. Practices may earn incentive payouts in addition to their FFS reimbursement for meeting or exceeding quality measure thresholds established at the practice level based upon performance targets and goals.

Second, we are exploring options such as a Pediatric ACO, described below. As we expand to include more provider types, we are exploring a Pediatric Balanced Incentive Model, wherein to further the advancement of our quality and cost goals, we have created a program to reward pediatric providers for their performance against quality and affordability goals for our members. Eligible providers will have at least one PCP open to new members, and for the duration of each Program Year, the provider's weekly hours of operation, including availability of PCPs, must be a minimum of 44 hours and include evening hours (after 6 p.m. local time) at least one day per week or weekend hours. Performance bonuses can be based upon quality performance, affordability performance and/or clinical engagement.

Finally, we will expand into new geography with new providers where we can develop value-based purchasing agreements. Flexible VBP models for new expansion areas of service allow us to accelerate engagement with providers in new geographies. In new geographies, as we recruit providers for network participation, we will identify viable practices for VBP contracting. From the outset, we will develop clinical action plans and begin collaborating with these providers to improve quality outcomes, close gaps in care and reduce avoidable medical expense. Through our **Clinical Integration Plan (CIP)-Glide Path Model**, we are exploring ways to accelerate engagement with new providers. Selected providers participate for one year as an initial benchmarking period. During this time, we establish a clinical action plan, provide data and collaborate with them to improve performance. In the second year, we review their performance, validate membership eligibility and evaluate what VBP model would be a best fit—advancing the provider up our VBP continuum.

Behavioral Health

We offer the industry's largest tiered network, identifying the best-performing providers through both quality and cost metrics that offer transparent ratings to our members. Metrics that guide our pay for performance reimbursement strategies are derived from our Achievements in Clinical Excellence (ACE) program shown in Table IV.Q-1:

Table IV.Q-1

Inpatient Metrics	Outpatient Metrics
▪ Seven- and 30-day risk adjusted readmission rate ▪ Seven-day follow-up after mental health hospitalization (HEDIS) ▪ Spending per beneficiary ▪ Peer review rate (a measure of clinical concordance) ▪ Case-mix adjusted average length of stay	▪ Severity adjusted effect size from a member-reported wellness assessment tool—a peer reviewed tool that meets key reliability and validity constructs ▪ Case-mix adjusted average number of visits ▪ Average cost per episode

For the inpatient program, participating providers with a minimum of at least 50 admissions annually are eligible for additional benefits and incentives and receive regular scorecards and consultation monthly in ways to enhance performance. Outpatient providers must have a minimum of 10 patients annually to have a meaningful data set to review results. Providers achieving thresholds for these performance metrics earn an enhanced rate, and are noted in the directory of this achievement through star ratings (1 star for quality and 1 star for efficiency).

Best Practices and Lessons Learned

Our VBP programs are true partnerships with our network providers; we have learned that working together to establish joint goals and objectives along with providing and sharing data is effective in driving transformation. We have learned that we need to be flexible and are willing to modify providers' reimbursable risk and contract terms off-cycle to make certain they are successful in achieving their quality and affordability goals. A good example where we have years of this type of collaborative model is our partnership with El Rio FQHC in Arizona. Through the sharing of data, including providing daily reports showing which of their patients were in the hospital, we have seen significant reductions in admissions and ER use. We have learned from the high volume of expansions that we have done across the country the necessity of designing a Glide Path Model to help engage providers early and bridge the gap of a lack of historical baseline data with which to establish performance metrics. We solved for this by creating our Clinical Integration Glide Path approach described earlier in this section.

Experience in an El Rio FQHC

We have seen through our experience in VBP, that engaging with providers in a risk sharing agreement and data sharing leads to positive results. In a recent analysis of a longstanding FQHC partner in Arizona, we found a 21 percent reduction in patient admissions. Reducing these unnecessary hospital services correlates directly with improved health and quality outcomes for our members.

Our strategy and approach to developing VBP solutions is not stagnant and builds on our continuous efforts, leveraging feedback from our provider partners and emerging industry best practices. We have learned that a relative incentive structure can promote a "race to the top," creating perverse incentives for providers to allocate resources to improvement on a measure that may not yield the greatest clinical benefit and which may lead to overtreatment of patients. Achieving 100 percent performance on a measure also may not be appropriate and may lead to overtreatment. No matter how well the performance measure is constructed, and despite attempts to exclude from the denominator patients who should be excluded, it is unlikely that any process measure will be applicable to 100 percent of the population.

In practice, there are often sound reasons why some small percentage of patients does not receive recommended processes of care. These reasons include patient preferences regarding treatment, contraindications to recommended therapy (e.g., allergies or intolerance of medications), prior rare side effects, and the clinical challenges of balancing treatment of multiple clinical conditions and interactions between medications. We have learned that some providers prefer establishing absolute attainment thresholds, but there is concern that this approach removes the motivation for providers to continue to improve once the threshold has been attained. Therefore, we adjust our goals with providers each year so that continuous improvements upon quality outcomes and cost are required. We look forward to continuing to collaborate with providers throughout the state to improve access, quality and total health care costs for members enrolled in Heritage Health.

98. Provide a description of the MCO's proposed MAC program, including methods for setting MAC prices, criteria used to select covered MAC drugs, process for resolving disputes regarding the MAC value, how the MCO will evaluate its MAC program, and any other program components the MCO considers important for achieving the State's NMMCP goals. Describe the MCO's experience with establishing MAC programs in other states, and highlight strengths and challenges. *6 pages*

Maximum Allowable Cost Program Description

Under the direction of our medical director/chief medical officer, Dr. Michael Horn, and our pharmacy director, Jeanne Cavanaugh, we will collaborate with our pharmacy benefits manager (PBM), OptumRx, to set and maintain our Maximum Allowable Cost (MAC) pricing for our Heritage Health program. **Our MAC strategy is simple: provide market-based pricing and reduce client generic drug costs.** We will support cost savings for MLTC by establishing a comprehensive MAC program that promotes cost containment through the utilization of generic medications and reducing reimbursement to pharmacies for multiple source drugs based upon market prices for each drug in accordance with our established criteria.

To better support our pharmacy network and achieve cost-savings for MLTC, we also will work closely with the Pharmacy Association in Nebraska. In accordance with RFP Section IV.Q Provider Reimbursement, we will provide a description of our MAC program to MLTC for review and written approval within 90 calendar days prior to our Contract start date and a MAC file to MLTC's Preferred Drug List (PDL) on a quarterly basis in MLTC's desired format.

Methods for Setting MAC Prices

Our MAC list is determined by actual acquisition costs of the available generics that are on the MAC lists. Factors affecting how we determine MAC prices include, but are not limited to, actual acquisition costs (AAC), average wholesale prices (AWP), CMS Federal Upper Limit (FUL), drug availability, number of manufacturers and 180-day exclusivity. To keep up with the dynamic nature of the generic drug market and assure our pharmacies are sufficiently reimbursed for drugs, we will update and re-calculate MAC price for both price increases and decreases on a weekly basis. On an ongoing basis, we will work directly with OptumRx's pharmacy team to identify and respond to opportunities for additional MAC savings on existing MAC agents, adding new agents to the list and providing an overall evaluation to assist in achieving Nebraska's Medicaid Managed Care Program goals.

We regularly meet with OptumRx's network pricing department to review marketplace issues and pricing adjustments and review upcoming generic launches. We also will provide timely notification of MAC pricing updates to our network pharmacies through electronic notifications and on our secure provider website—this information will be reviewed and updated weekly by our PBM and pharmacy department.

Criteria Used to Select Covered MAC Drugs

We analyze drugs for inclusion on our MAC list by examining AACs, AWPs, competitive market data, availability, drug exclusivity and other factors. Multisource products are subject to MAC pricing, based upon the availability of cost-competitive products. Examples of our criteria include the requirement that pharmacies are able to purchase sufficient quantities of the drug.

We may remove a drug from our MAC list or modify MAC rates in a timely manner if the following conditions exist:

- The drug is no longer available.
- The number of generic product manufacturers is reduced, leaving one manufacturer.
- Product costs can no longer sustain MAC reimbursement.
- Product quality/safety issues, such as a recall or FDA warning, exist.

We will override the MAC on drugs from the PDL when the name-brand drug is preferred over the generic drug and our policies and procedures for providing brand-name drugs when the prescriber appropriately determines that the brand-name drug is medically necessary for the member's conditions will meet federal and state requirements.

We recognize that close oversight of changes is vital to achieving incremental cost savings, as delays in response to market dynamics can have an impact of thousands of dollars per day.

Process for Resolving Disputes Regarding the MAC Value

Our retail network providers may contact our network department or pharmacy department to ask questions and share concerns regarding our MAC pricing. These complaints will be forwarded to our MAC analyst for consideration during our update process. However, on many occasions, we provide recommendations to the pharmacies and pharmacy chains on how to lower acquisition costs for specific drugs by using more effective acquisition strategies.

Our MAC processes, policies and procedures will assure our pricing is appropriate and not routinely below the wholesale price available to our Nebraska pharmacists. Should our network pharmacies/pharmacists have concerns about our MAC pricing, we have established grievances and appeals processes they may use to contest our pricing. We will adhere to federal, state and MLTC requirements for MAC grievances and appeals including the following:

- We will respond to a provider who has contested a MAC rate through this procedure within seven calendar days of the complaint.
- We will take steps to determine if the MAC price is appropriate given current Nebraska market conditions.
- If an update is warranted, we will make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network.

Experience Establishing MAC Programs in Other States

We actively administer MAC programs for 16 other states and across all lines of business. We have a detailed knowledge of the generic market as both a payer and a purchaser of generic products. Third party reviews of our MAC program suggest that **our management has historically been a market leader in managing costs**. This comes from a process that balances strong client pricing stewardship with market appropriateness in price for pharmacies. Our strengths include market experience of a MAC program in 16 markets. Challenges can include State legislation related to pharmacy network reimbursement that may limit an MCO's ability to manage network pricing and bring value to our state partner.

99. Describe the MCO's approach to ensuring that out of network prior authorization and payment issues are resolved expeditiously in instances when the MCO is unable to provide necessary services to a member within its network. *2 pages*

Out-of-Network Authorization and Payment

Network access to a broad range of service providers is critical to member care and satisfaction. Relying upon our decades of experience in Nebraska, we have established a current comprehensive statewide network to provide members with access. Our approach is to deliver a comprehensive network of providers including cross-border providers to keep out-of-network use to a minimum and to provide access to medically necessary services.

If a contracted provider is not available to meet member access and availability needs, we will expeditiously arrange for the services to be provided through an out-of-network provider. Out-of-network providers' licensure and Medicaid statuses are validated as they are reimbursed at the State Medicaid reimbursement rate. We also work with the member to arrange transportation and lodging for the appointment, especially when the approval is for a service outside of our service area. Once an authorization is made for out-of-network care, the member is eligible to receive services immediately. The care managers enter an authorization into the care management system approving the service. This authorization feeds to our claims processing system, Community Strategic Platform (CSP), which allows for the claim to process and pay timely in accordance with state requirements. The out-of-network authorization also flags the claim to be reviewed by our claims processing team to ensure correct payment.

Expedited Service Authorization
When a young member was identified as having a life-threatening form of immunodeficiency, we quickly worked to obtain a single case agreement from the only tertiary care facility in the nation capable of treating his/her disorder. We collaborated with the State's transportation vendor to arrange transportation. Upon securing the availability of services and transportation, we coordinated lodging and food for the member's mother. As a result of our coordination, the member received the needed care and returned home to Nebraska when medically appropriate and the provider received accurate and timely payment for authorized services.

We provide for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. For example, if a new member previously received services from an out-of-network provider, we continue to authorize services for that provider for continuity of care purposes if our medical director deems it in the member's best medical interest. We work with the provider to extend a contract to participate in our network and providers who meet credentialing requirements can become a participating network provider, thereby expanding member convenience and network options for services.

In the event that an out-of-network provider sees our members through a single case agreement, we will coordinate the billing process with the provider so that the member is not billed for the services. We make all claim filing procedures and reimbursement policies readily available to all participating and non-participating providers through our provider website and *Provider Administrative Guide*. This information includes the type of claim form, required documentation (if applicable), required fields to be completed and instructions for submitting claims via paper and electronic mechanisms. We work with the provider to accept Medicaid fee-for-service rates. We will make three attempts to contract with the provider and will pay no more than 90 percent of the Medicaid fee schedule to providers that do not participate.

Single Case Agreements

For those cases where we need to use providers that are out-of-network or out-of-state and not already in our network, we use a single case agreement process. Members or providers contact one of our care managers to request authorization for out-of-network services. Nurse reviewers authorize referrals for out-of-network and out-of-state services based upon approval guidelines that consider local availability of specialty care. When review staff cannot approve the authorization, they forward it to the medical director or a designated physician reviewer for a decision. The medical director review considers the member's unique health needs when making a determination on whether to cover out-of-network or out-of-state care. With our experience in BH, we understand we must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) to provide the same process for out-of-network coverage for mental health or substance use disorder benefits that we make available for medical and surgical benefits.

Emergency Services

We understand that members who have emergencies must go to the nearest ER or urgent care facility. Through the *Provider Administrative Guide*, our website, member services advocates and periodically through enrollee newsletters, we instruct members to use the nearest ER if an emergency arises. Our network is very comprehensive, which means that there should be a relatively low incidence of enrollees using non-network providers in emergencies. UnitedHealthcare covers emergency services for members. In accordance with 42 CFR 438.114, we will cover emergency services 24 hours a day, seven days a week without the need for ER providers to seek prior authorization or approval for payment. CSP is set up to pay ER claims timely and within requirements. We will not deny payment for emergency services and have demonstrated our claims accuracy in payment of claims in our existing service area.

Family Planning

We acknowledge that family planning services are a covered benefit for members. Our members can access family planning services directly, without prior authorization and with the provider of their choice, both in-network and out-of-network providers, without a referral. We have arranged for family planning services to be provided by either the member's PCP, an in-network OB/GYN or from a variety of family planning clinics. We provide family planning services through our comprehensive network of providers and engage our PCPs to support a coordinated educational effort for our enrollees. CSP is set up to pay these family planning claims without prior authorization or approval for timely payment and within requirements. We will not deny payment for Family Planning services for providers enrolled with MLTC as we have demonstrated accuracy with providers in our existing service area.

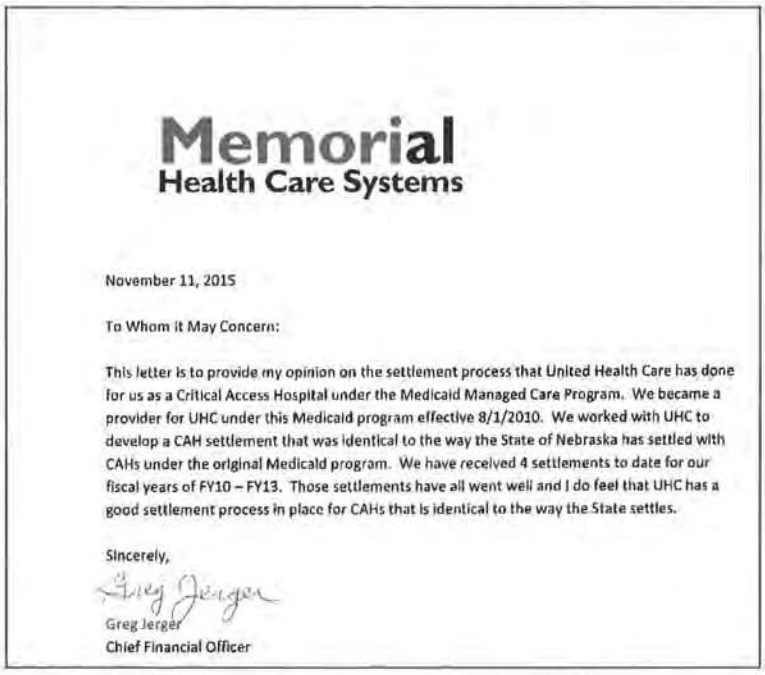
Native Americans

We will meet the requirements of Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5 by allowing any Native American to receive services from a participating or non-participating Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) provider and will reimburse the provider at a rate not less than the level and amount of payment that would be made if the provider were in-network. Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization or provision by an out-of-network Tribal provider. CSP is set up to pay Native American provider claims without prior authorization or approval for timely payment and within requirements. We will not deny payment for Native American providers, as we have demonstrated accuracy with providers in our current service area.

100. Describe the MCO's proposed process for the annual year-end cost settlement process with critical access hospitals. *1 page*

In compliance with Section 10 Critical Access Hospital Contracting and Reimbursement of the IV. Project Description and Scope of Work, and per 471 NAC 10-010.03F and 10-10.06A, we will make all critical access hospital (CAH) inpatient payments using interim per-diem rates calculated by MLTC with an annual year-end cost settlement. Outpatient rates are calculated by MLTC on a cost-to-charge basis with an annual year-end settlement. The annual year-end cost settlement occurs at the end of each CAH's fiscal year.

Designed to meet state requirements, our year-end cost settlement process with critical access hospitals was established in collaboration with the chief financial officer from Memorial Health Care System in Seward. This process has been successfully rolled out to the other critical access hospitals and has been in place since 2013. Under the direction of network management leadership, our network team maintains a critical access database, which contains all critical hospital information, which we then use to track the settlement process through completion. Within 30 days of CAH Fiscal Year End, a request is sent to the facility to obtain the prior year's final cost report. A complete listing of CAH facility names and tax ID numbers (TINs) and the settlement completion status updates is kept in the critical access database.



Memorial
Health Care Systems

November 11, 2015

To Whom it May Concern:

This letter is to provide my opinion on the settlement process that United Health Care has done for us as a Critical Access Hospital under the Medicaid Managed Care Program. We became a provider for UHC under this Medicaid program effective 8/1/2010. We worked with UHC to develop a CAH settlement that was identical to the way the State of Nebraska has settled with CAHs under the original Medicaid program. We have received 4 settlements to date for our fiscal years of FY10 – FY13. Those settlements have all went well and I do feel that UHC has a good settlement process in place for CAHs that is identical to the way the State settles.

Sincerely,

Greg Jerger

Greg Jerger
Chief Financial Officer

Once the final cost report is received, our network team works with an internal team member in health care economics to analyze applicable period claim data and assigns information into corresponding cost centers. Overall cost is calculated using the CCR or per diem according to cost center categories assigned. Overall cost is then compared to actual claim payments expended. The compiled analysis is reviewed for accuracy by our network team. Once approved, calculation documents are uploaded to the database for settlement team approval. After settlement team approval is received, settlement agreement and supporting calculation files are sent to the critical access facility for their review and acceptance. Once the facility accepts the calculation file and executes a settlement agreement, if balance is due to us, a check should be returned within the time frame stipulated in the settlement agreement. If balance is due to the facility, a check is issued by us within the time frame stipulated in the settlement agreement.

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IV.R. Systems and Technical Requirements

101. Provide a general system description that details how each component of the MCO's health information system will support the major functional areas of NMMCP. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements.

Describe how the MCO's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the MCO's systems. If modifications or updates or updates are required, describe them and the MCO's plan for completion prior to program operations. *12 pages, not including the systems diagram*

General Systems Description

For nearly 20 years, UnitedHealthcare has maintained an integrated management information system (MIS) supporting the Nebraska Medicaid program. Today our state-of-the art, scalable platform integrates physical and behavioral health, pharmacy, and social service support in compliance with all Heritage Health Program requirements, including Section R, Systems and Technical Requirements of Part IV Project Description and Scope of Work. Our MIS enables the day-to-day management of key operations including, but not limited to:

- Eligibility, enrollment and disenrollment management and data exchange
- Provider network management, credentialing, enrollment and confirmation file exchange
- Member and provider information access through secure online portals
- Report generation and transmission to facilitate standard and ad hoc reporting
- Care coordination and case management for physical health and behavioral health, including integration of pharmacy data
- Claims processing, edits and adjustments
- Claims adjudication, payment and coordination of benefits (COB) for claims with third party liability (TPL)
- Financial management and accounting

At the center of our MIS architecture is Community Strategic Platform (CSP), our TriZetto Facets claims platform with interfaces that optimize the exchange of information to other key systems. Using CSP, our IT team configures business rules such as claims payment of specific program services, authorization requirements, benefit limits and reporting requirements. Our system captures and reports multiple data elements critical to an effective enrollment process. It accommodates fee schedules, procedure and types of service coding. CSP validates data fields such as edits to confirm all monetary field values are digits and line items of a claim sum to the total charge.

To support medical necessity review and prior authorizations, we are upgrading our clinical platform to the Integrated Clinical User Experience (ICUE) application starting July 1, 2016. This application offers integrated medical and behavioral health capabilities on a single member record and provides auditable, measurable, high-quality results related to utilization management; high-risk/high-cost events (e.g., ER overuse, readmission management); metrics and reporting; and total population engagement (e.g., facilitates identification of future at-risk members to prevent escalation to acute episodes).

Our Heritage Health Program Systems Diagram, Figure IV.R-1, presents the components of our MIS and the expected interconnectivity and data transport with Nebraska Health Information Initiative (NeHII) and MLTC under the new contract.

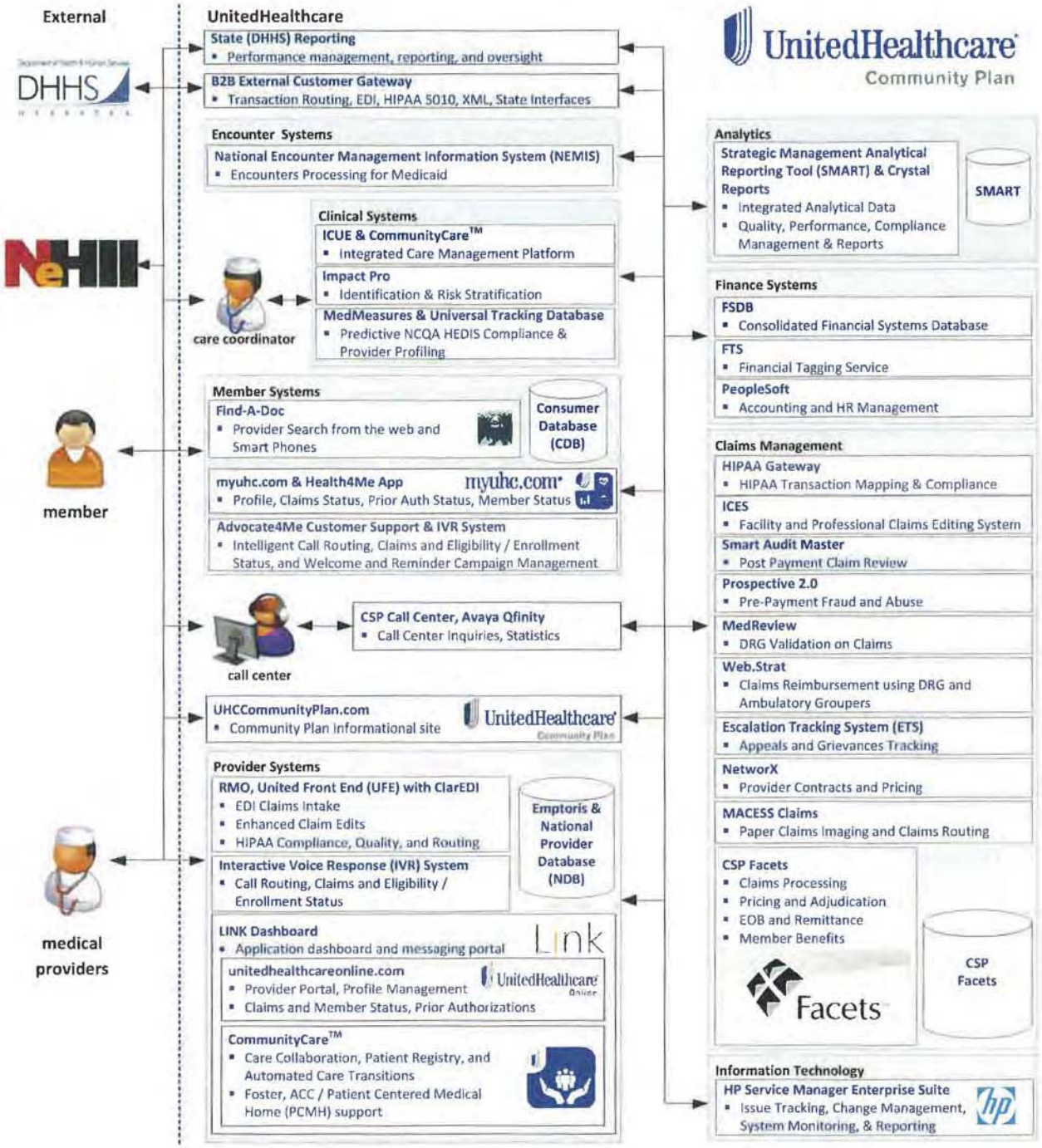

Figure IV. R-1. Systems Diagram. Our systems are fully interoperable and fluidly exchange information, allowing us to adapt to support current and future requirements.

Our systems architecture accommodates scalable expansion, allowing us to quickly introduce routine upgrades, while giving us the latitude to plan for significant increases in computing needs without risk or material operational impact. Our platforms actively store files for at least six years in our live systems and 10 years in archival systems. We run incremental backups daily and full backups weekly. We comply with off-site storage and remote back-up requirements, including operating instructions, procedures, reference files, system documentation and operational files, as described in Section R.12.

Our information management and systems director, Cybele Kanin, is responsible for the management and oversight of all information systems functions including establishing and maintaining connectivity with MLTC information systems and providing necessary and timely data and reports to MLTC. Ms. Kanin has been with UnitedHealthcare since 2007 and has more than 18 years of experience in information systems, data processing and data reporting.

Systems Supporting Functional Areas

Our MIS is composed of multiple systems properly interfaced to support the delivery and management of integrated health care services. As explained below, our MIS collects, analyzes, integrates and reports data for core functional areas such as member management including enrollment and disenrollment, care management, utilization management, claims adjudication and payment, grievances and appeals, and provider and network management.

Member Management (Enrollment and Disenrollment)

As a current Nebraska Medicaid contractor, we accept and process daily enrollment files and monthly enrollment and disenrollment reconciliation files via HIPAA-compliant ASC X12N 834 transactions in the 5010 format. We process MLTC-initiated disenrollments in the same manner as any other termination. Within 24 hours of receipt of the 834 file, we update CSP, our eligibility and enrollment database. Upon completion of data validation and load to CSP, enrollment data are available to our downstream systems including *Link* (explained under the Provider Services heading below) for online eligibility verification support, as well as to our IVR system for automated telephonic support of eligibility inquiries. See Figure IV. R-2:

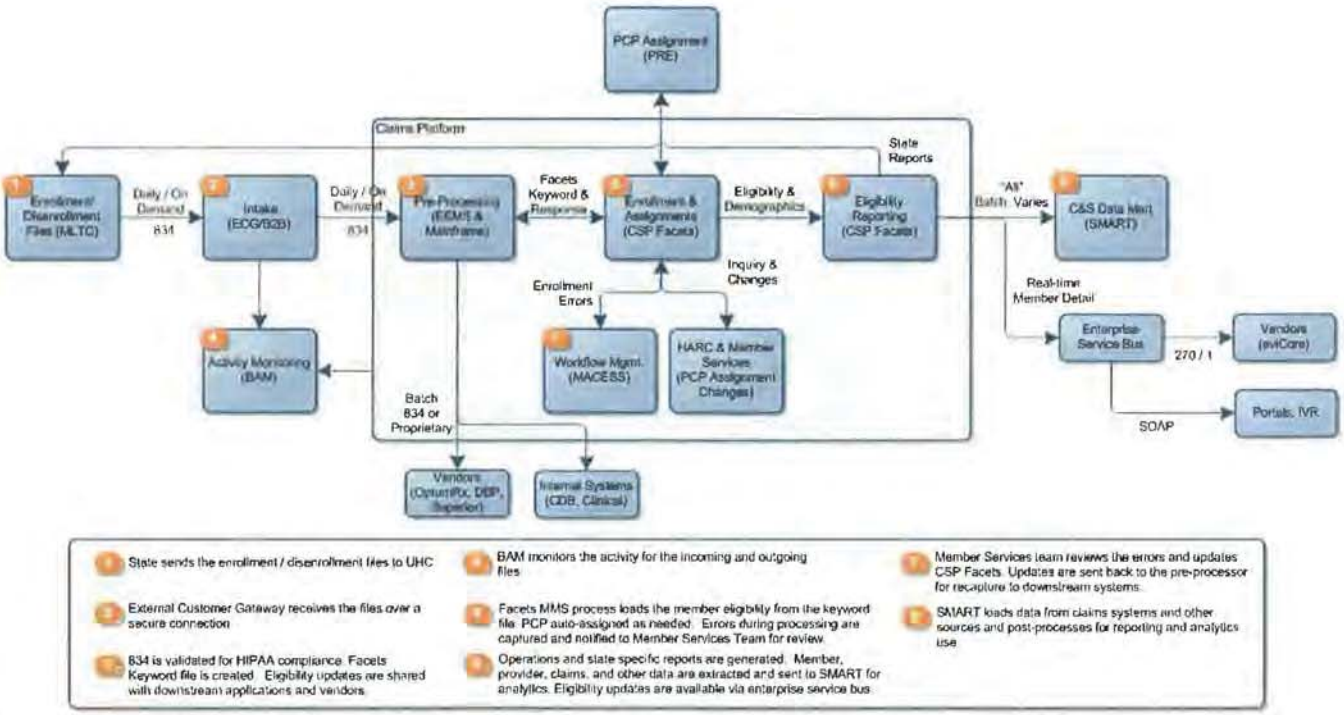

Figure IV. R-2. Systems Diagram - Enrollment Flow. We currently process daily and monthly enrollment and disenrollment files for Heritage Health program members. Our enhanced enrollment module will improve end-to-end eligibility load cycle time.

Members are assigned unique member numbers that we use on all member-specific materials and for all member-related processing. The system cross-references these numbers to other member-unique numbers such as Social Security number and MLTC assigned ID.

Table IV.R-1 is a summary of system components and tools we use for member management.

Table IV.R-1: Area: Member Management	
Information System	**General Description/Functions Supported by System**
Electronic Enrollment Management System (EEMS)	EEMS loads 834 files and allows our enrollment team to manage eligibility information electronically within 24 hours of receipt, providing more timely and accurate results. Incoming customer eligibility files are processed and results are displayed online and passed downstream to CSP and other applications.
Community Strategic Platform (CSP)	CSP processes enrollment automatically and enables manual entry for off-cycle enrollment and error correction. It also stores eligibility information including state program code, region and the members' health care benefit package.
Public Member Portal (*uhccommunityplan.com*; Find-a-Doc)	UnitedHealthcare public Web presence used for posting general information, handbooks and bulletins—common entry point for members. Find-a-Doc provides flexible provider search capability by type of provider, specialty and location for Web and mobile users.
Secure Member Portal (*myuhc.com* and secure member mobile app, *Health4Me*)	Secure portal (*myuhc.com*) where members may search for covered benefits, update contact information including email addresses for facilitating contacts and information exchange, request an ID card and "Find-a-Doc" through a searchable Provider Directory. *Health4Me* is a free mobile application designed to help members manage their health care easier and faster with access 24 hours a day, seven days a week to secure health and wellness information including an electronic ID card.
Facets Customer Service Module	The module supports member services center operations in assisting members with common inquiries (e.g., obtaining ID cards and searches for providers) and grievances. Allows the member services advocates (MSAs) to log information about the call and the outcome.
Advocate4Me with Interactive Voice Response (IVR) System	The IVR handles basic member inquiries and directs incoming calls to the most appropriate member services center professional. This provides the MSA with a pop-up window with additional information or answers the member may need while on the phone. Hewlett-Packard (HP) Qfiniti supports call center operations, call monitoring and quality reporting.
Escalation Tracking System (ETS)	The ETS serves as a centralized database to facilitate escalation management of grievances and appeals.
Consumer Database (CDB)	CDB is a single database of all UnitedHealthcare members that serves as a "master index" of members across all UnitedHealthcare systems. This provides UnitedHealthcare with a single source of truth for all systems related to enrollment information, thereby minimizing the replication of errors.

Care Management

An interdisciplinary care management approach is central to our clinical model. We provide the tools to support the member, PCP, care managers and the care coordination team. CommunityCare, a care management collaboration platform, provides PCP information, member Medicaid ID, a record of each service event, appointments, a record of all immunizations, a listing of the member's durable medical equipment (DME) along with the ability to capture notes and store attachments. CommunityCare integrates evidence-based medicine gaps in care and hospital admission, discharge and transfer (ADT) messaging and allows providers to input information about interactions with members such as post-ER discharge follow-up and care opportunity outreach. Our utilization management (UM) system, the ICUE platform, will be the system of record for medical service authorization data and coordination of BH

CommunityCare
Nationwide, we implemented CommunityCare in 24 states, including in Nebraska in March 2015.

services. We use member and authorization data based upon authorization transactions processed in ICUE and passed back to CSP for claims management and CommunityCare for care management activities.

Our care team uses our Universal Tracking Database (UTD) to identify gaps in care based upon EPSDT or HEDIS criteria for age, sex and frequency of services. In addition to population-wide queries based upon specific measures, the tool enables viewing of individual member's gaps in care. For example, a care manager can view a member's record in UTD to provide up-to-date, accurate reminders during member interactions.

Our ***CommunityCare platform***, which includes our **Accountable Care *Population Registry,*** gives providers and care communities a comprehensive view of the services used by any given care population. Using the *member view* within the Population Registry, providers have the clinical history of the whole person, while the *population view* provides lists of members in the practice who need specific follow-up and integrates processes and scripts for specific steps.

For children in foster care, CommunityCare supports person-centered, integrated care by allowing access to any member of a child's care community, including clinicians, guardians and social workers, and presenting the care team with timely, relevant and actionable information about each child. For instance, information captured includes, but is not limited to the following:

- Member-specific information such as name, address of record, date of birth, race and gender
- Advocate information such as the name and address of the member's PCP, caregiver, authorized medical concenter, children and family services specialist and other advocates
- Behavioral and medical health information, along with prescription history

Designated stakeholders can access the system 24 hours a day, seven days a week—except for scheduled downtime.

Table IV.R-2 shows the system components and tools we use for care management.

Table IV.R-2: Area: Care Management/Clinical Systems

Information System	General Description/Functions Supported by System
CommunityCare	Centralized and comprehensive cloud-based tool containing claims information from CSP and authorization data from ICUE. Promotes integration of medical, behavioral, social and long-term support services by enabling enhanced care collaboration by giving PCPs, case managers and care team members, including foster care social workers and legal guardians, updated and shared access to members' plan of care and supports alignment of clinical problems, goals and interventions. CommunityCare can also provide automated notifications of care transitions.
ICUE	Beginning mid-2016, our UM team will use ICUE for prior authorization and UM Data from this system will be populated in CommunityCare.
Impact Pro	Multidimensional, episode-based predictive modeling and care management analytics solution that allows our care managers to use clinical, risk and administrative profile information to provide targeted health care services to members.
MedMeasures and Universal Tracking Database (UTD)	MedMeasures is an NCQA-certified application that creates and provides HEDIS quality reports and provider profiles and UTD is a predictive NCQA HEDIS compliance and outreach tool.

Utilization Management

Through our UM program, we gather quality measures, prior authorizations, clinical and claims data, and data from providers or subcontractors. We continuously monitor and manage overutilization and underutilization of services across our health plan using reporting, dashboards and scorecards developed from data gathered and analyzed by our Strategic Management Analytic Reporting Tool (SMART) data warehouse. SMART links with and receives data from our clinical management system, ICUE, which provides an integrated, single solution for managing service authorizations for physical and BH services.

Providers can submit prior authorization requests for new or continuing medical or BH services 24 hours a day, seven days a week via several methods, including telephone, fax or through our secure provider portal. Through the provider portal, providers can submit authorization requests, verify approvals, submit electronic referrals and obtain real-time online verification of membership. Providers can also view gaps in care using CommunityCare and within the provider's practice management system with 270/271 EDI integration. Members can view their gaps in care using *myuhc.com*, *Health4Me* or CommunityCare.

Table IV.R-3 shows the system components and tools for UM.

Table IV.R-3 Information System	General Description/Functions Supported by System
Area: Utilization Management	
Strategic Management Analytic Reporting Tool (SMART)	Comprehensive, integrated analytical environment that holds Medicaid and Medicare relevant information, including claims data (e.g., medical, pharmacy, dental, vision and lab) and prior authorizations from ICUE. This tool also: Supports quality management, performance management and compliance reporting Provides consolidated patient census (common store of all patients currently receiving care)
ICUE	Beginning mid-2016, our utilization management team will use ICUE for prior authorization and utilization management. Data from this system will be populated in CommunityCare.

Claims Adjudication and Payment

The CSP captures the claim-received date and assigns a unique claim number for all incoming claims. Incoming claims undergo many data edits to confirm the data are compliant, complete, accurate and appropriate under the terms of the contract. Our NetworX tool supports provider contract configuration and claim pricing. Claims with invalid data points are rejected or denied as appropriate, and those with valid data are adjudicated (even denied claims). See Figure IV.R-3:

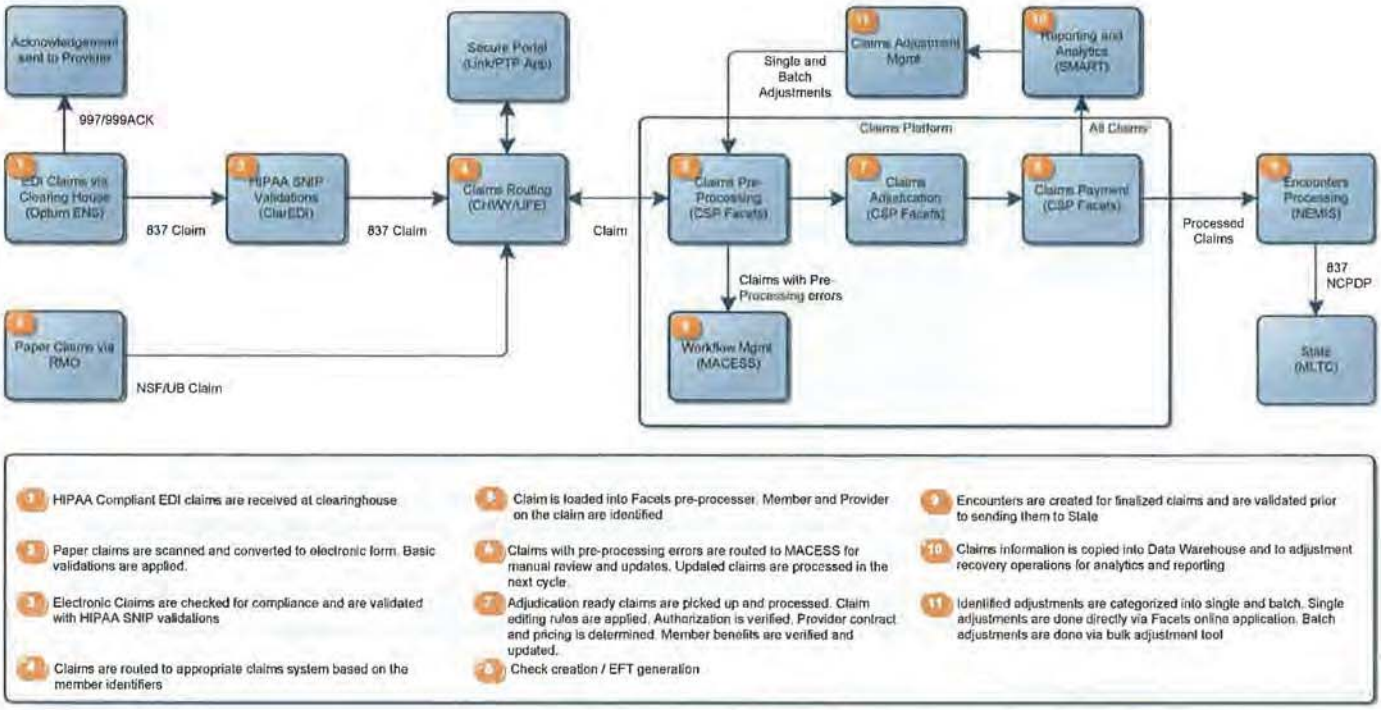

Figure IV.R-3. Systems Diagram - Claims Flow. We apply many data edits to incoming paper and electronic claims to confirm the data are compliant, complete, accurate and appropriate under the terms of the contract for eligible members and providers.

Table IV.R-4 shows the system components and tools we use for claims management.

Table IV.R-4: Area: Claims Adjudication and Payment Systems

Information System	General Description/Functions Supported by System
ClarEDI	Comprehensive HIPAA testing solution for pre-production transaction testing and certification that enables us to test and certify our HIPAA transaction sets and validate our electronic data interchange (EDI) transactions are compliant with standards, regulations and payer requirements.
HIPAA Gateway	Comprehensive EDI validation solution that enables us to test and certify HIPAA transaction sets and validate compliance with standards and regulations.
Intranet Document Retrieval System (iDRS)	Web-based application that provides access to view paper documents mailed to us and uses optical character recognition (OCR) to electronically load claims. It also stores scanned paper documents (e.g., enrollment forms and letters), and enables electronic viewing of documents via the intranet.
United Front End (UFE)	Application that enables universal claim intake and routing into CSP and our current-day claims platforms.
Community Strategic Platform (CSP)	Our managed care information system that is built on the Facets core transaction processing system: ▪ Claim pricing and adjudication ▪ Claim data including processing status ▪ Explanation of benefits and remittance advices ▪ Data for provider payment issuance purposes
OptumInsight Claim Edit System (iCES)	Claim edit system that analyzes health care claims based upon business rules that automate reimbursement policy and industry standard coding practices.
Prospective 2.0	Tool with proprietary algorithms that identifies fraud and abuse prior to claims payment, enabling a greater recovery than post payment.

Table IV.R-4: Area: Claims Adjudication and Payment Systems	
Information System	**General Description/Functions Supported by System**
MedReview	Reviews the validity and appropriateness of diagnosis-related groups (DRGs) submitted on a claim.
WebStrat	Calculates reimbursement for claims using DRGs and ambulatory procedural classifications (APC).
Smart Audit Master (SAM)	Claims payment validation tool that screens for common errors.
MACESS	Facilitates claim processing, including imaging of paper claims and supporting documentation, and routing of claims to claim processors.
OptumRx RxClaim®	Flexible, easy-to-use system that manages all aspects of pharmacy benefits. Provides point-of-sale processing and real-time decisions of pharmacy claims.
NetworX	Supports provider contract configuration and claim pricing.
Electronic Payments & Statements (EPS)	EPS manages electronic payment/electronic funds transfers and electronic delivery of payment reports (835 transactions, Provider Remittance Advices [PRAs] and EOBs) to providers.
Payment Engine (PE)	Payment Engine processes provider claim payments and provides consolidated provider 835s and PRAs across UnitedHealthcare business segments.

Grievances and Appeals

Our Escalation Tracking System (ETS) maintains records and stores all grievance and appeals activity, which allows us to perform tracking and trending activities. Our system comprises an appeal process, a grievance process and access to the external State Administrative Law Hearing system. We track and report data related to grievances and appeals in compliance with NCQA, reporting for accreditation purposes in quality of care; access; attitude and service; billing and financial issues; and quality of practitioner office site. This allows us to identify opportunities for improvement and to implement appropriate interventions.

The ETS provides standard management reports to track our resolution time frames and ad hoc query functionality. ETS affords us significant flexibility to add or remove data fields, as specified by MLTC, and to provide reporting capabilities based upon multiple data elements, filters or sorting options.

While ETS maintains the master record of grievance and appeals activity, often resolution of reported items results in review and task creation within CSP, or in our ICUE clinical platform, to make adjustments when necessary to authorizations, claims, providers' records, and so forth. When activity in those applications is complete, the grievance and appeals team updates ETS with the final resolution status, updates notes and closes out the task.

Table IV.R-5 shows the system components and tools for grievance and appeals:

Table IV.R-5: Area: Appeals and Grievances Systems	
Information System	**General Description/Functions Supported by System**
Escalation Tracking System (ETS)	ETS is a centralized database that facilitates the administration and escalation management of grievances and appeals.
ICUE	Beginning mid-2016, our UM team will use ICUE for prior authorization and UM Data from this system will be populated in CommunityCare.
Community Strategic Platform (CSP)	Our managed care information system that is built on the Facets core transaction processing system: ▪ Claim pricing and adjudication

Table IV.R-5: Area: Appeals and Grievances Systems	
Information System	**General Description/Functions Supported by System**
	▪ Claim data including processing status ▪ Explanation of benefits and remittance advices ▪ Data for provider payment issuance purposes

Provider Enrollment and Network Management

We use a multistep process to efficiently load and verify provider contract data according to MLTC business rules. This process starts with the receipt of an executed contract, and includes verification of demographic information such as the NPI and the Medicaid identification number. Additionally, the verification process confirms the provider application and credentialing documentation is complete, including site survey results when applicable. Provider information is loaded into our Network Database (NDB), which feeds into CSP enabling provider selection and claims payment.

The NDB, currently in use in Nebraska, is our single repository of provider information, including provider fee schedules and contracts. NDB houses information on all providers having contractual relationships with us and other UnitedHealth Group affiliates. NDB data are the source of truth for populating our *Provider Directory* and automatically updates daily into CSP. See Figure IV.R-4.

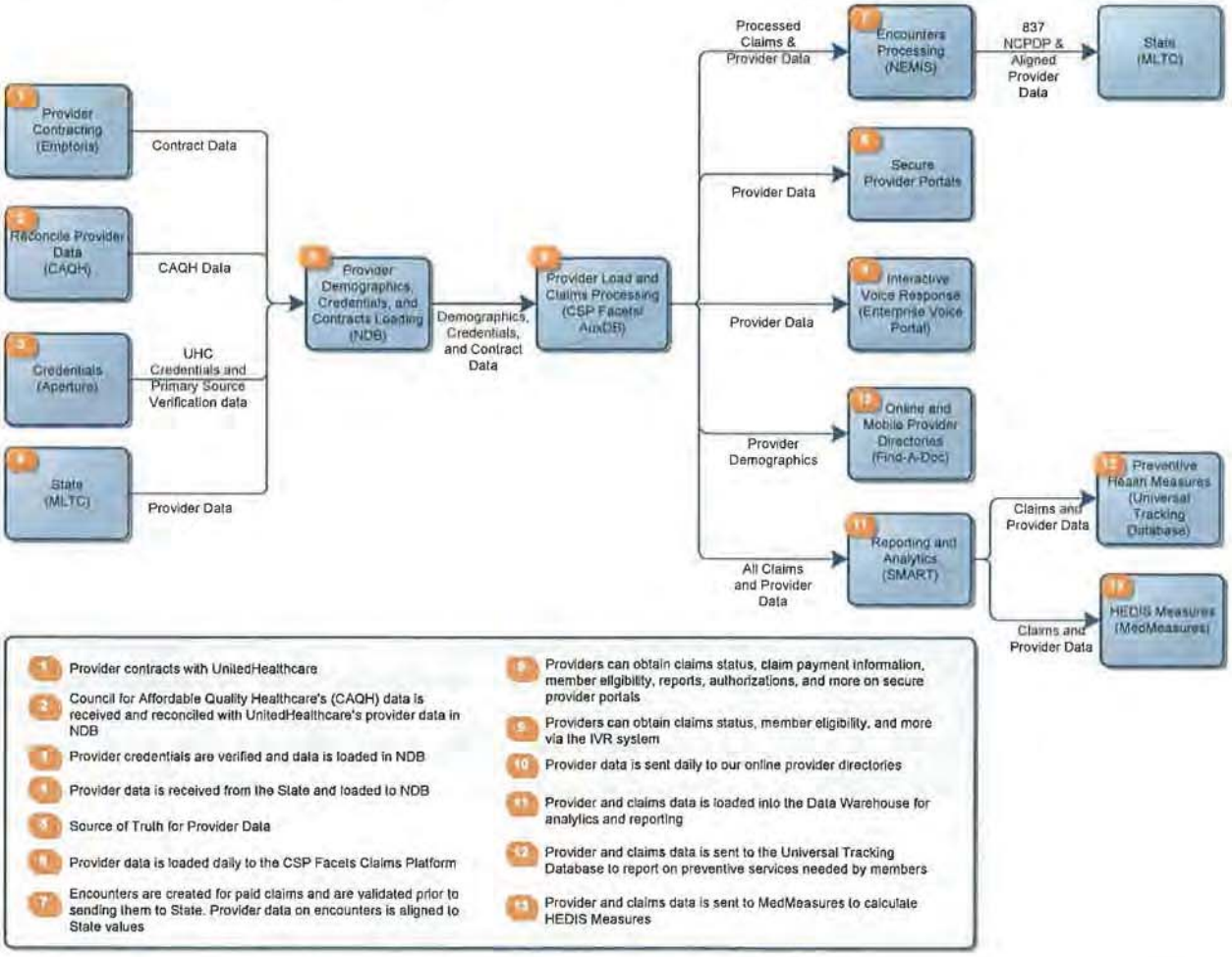

Figure IV.R-4. Systems Diagram - Provider Flow. Our Network Database and CSP maintain provider data, including demographics, contracting/credentialing status, affiliations, specialties and types.

To coordinate provider enrollment records, we use the published list of Nebraska Medicaid provider types and specialty codes in all provider data communications with MLTC and the enrollment broker.

Further, we have linked NDB with the Council for Affordable Quality Healthcare's (CAQH) Universal Provider Datasource (UPD) to reconcile key data elements. The UPD is a part of CAQH's credentialing application database project that seeks to make the provider credentialing process more efficient for providers and managed care organizations. We are enhancing our linkage between NDB and CAQH and extending our use of UPD as the industry source of truth, streamlining the provider's experience in working with multiple payers.

Table IV.R-6 is a summary of system components and tools we use for provider network management.

Table IV.R-6: Area: Provider Enrollment and Network Management

Information System	General Description/Functions Supported by System
Network Database (NDB)	Single enterprise repository of all UnitedHealthcare provider information. Includes: ▪ Audit trail and history of changes made to the provider file ▪ Automated interfaces with major licensing and medical boards ▪ Automated alerts when provider licenses are nearing expiration ▪ Retention of NPI requirements ▪ System-generated letters to providers when their licenses are nearing expiration ▪ Linkages of individual providers to groups ▪ Provider office hours ▪ Provider languages spoken ▪ Provider disability accommodations
Emptoris	Manages workflow and stores provider contract information for all UnitedHealthcare participating providers.
Aperture	Manages workflow and stores provider credentialing information for all UnitedHealthcare participating providers.
CSP/AuxDB	Provider data necessary for claims adjudication is loaded to CSP. Data necessary for directories and for reconciliation with State systems is loaded to the auxiliary provider data database.
National Encounter Management Information System (NEMIS)	Manages submission of encounters to MLTC and is aligned to State provider data value sets.

Provider Services

We continue to pursue innovative solutions to streamline and simplify our providers' administrative experiences. Our most recent evolution of online tools is a cloud-based website, *Link*. At the foundation is a goal to create a single provider platform. *Link* brings together multiple websites on the dashboard, shown in Figure IV. R-5, incorporating new applications to improve efficiencies for our providers. Heritage Health Program providers will have a tab on *Link*, with icons for the following capabilities for ease of use:

- Eligibility & Benefits Center
- Prior Authorizations
- *Unitedhealthcareonline.com*
- Optum Provisioning
- Claims Management
- CommunityCare
- *Uhccommunityplan.com*

With accessibility 24 hours a day, seven days a week, *Link* gives providers the flexibility to access our secure portal with a single sign-on when it is convenient for them.

Figure IV. R-5. *Link* Dashboard. Preview of the cloud-based *Link* Dashboard with a sampling of some of the applications that will be available.

Table IV.R-7 is a summary of system components and tools we use for provider services.

Table IV.R-7: Area: Provider Services	
Information System	**General Description/Functions Supported by System**
Secure Provider Portal (*unitedhealthcareonline.com*)	Secure provider portal where enrolled providers can, among other functions, update their profile, verify member enrollment status and covered benefits, submit prior authorization requests where appropriate, and look up the status of claims.
Link	Our most recent evolution of online tools is a cloud-based website that is the foundation of our goal to provide a single provider platform, bringing together clinical and administrative functions. It supports administrative functions (e.g., prior authorizations, claims submission, remittance reviews and claims adjustment requests).
Uhccommunityplan.com	Our public Web presence for general information, handbooks, bulletins and serves as a common entry point for providers.
Facets Customer Service Module	This module supports provider services center operations by assisting providers with common inquiries (e.g., verifying member eligibility and verifying claims status).
Interactive Voice Response (IVR) System	Our enterprise voice portal handles basic provider inquiries (e.g., member eligibility/enrollment status and claims status) and directs incoming calls to the most appropriate service center professional.
Escalation Tracking System (ETS)	The ETS serves as a centralized database to facilitate administration and escalation management of grievances and appeals.
CommunityCare	Centralized and comprehensive cloud-based tool containing claims information from CSP and authorization data from ICUE. Promotes integration of medical, behavioral, social and long-term support services by enabling enhanced care collaboration by giving PCPs, case managers and care team members updated and shared access to members' plan of care and supports alignment of clinical problems, goals and interventions. Can provide automated notifications of care transitions.

Information Reporting Systems

SMART, our robust, integrated reporting and data analytics solution enables us to achieve maximum plan effectiveness and meet MLTC and DHHS's reporting requirements. We integrate data into our data repositories from sources external to our core operations systems, including provider and claim data from our vision vendors and pharmacy claim data. Developing these composite data sets enables quality analysis such as HEDIS and others and supplements the medical management of the members.

Table IV.R-8 is a summary of system components and tools we use for information reporting.

Table IV.R-8: Area: Information Reporting Systems	
Information System	**General Description/Functions Supported by System**
Strategic Management Analytic Reporting Tool (SMART)	Comprehensive, integrated analytical environment that holds Medicaid and Medicare relevant information, including claims data (e.g., medical, pharmacy, dental, vision and lab) and prior authorizations from ICUE. This tool also: ▪ Supports quality management, performance management and compliance reporting ▪ Provides consolidated patient census (common store of all patients currently receiving care)
Healthplan Manager Application (HMA)	HMA allows us to manage the Heritage Health membership by segmenting member data using dozens of attributes and benchmarking the data to understand our member population to make better health care decisions.
ICUE	Beginning mid-2016, our UM team will use ICUE for prior authorization and UM Data from this system will be populated in CommunityCare.
(NEMIS	Strategic, internally developed encounter data submission and reporting system that initiates submission of encounters, tracks responses, provides error correction and resubmission of Medicaid encounters.
Escalation Tracking System (ETS)	ETS is a centralized database that facilitates administration and escalation management of grievances and appeals.
Impact Pro	Multidimensional, episode-based predictive modeling and care management analytics solution that allows our nurse care managers to use clinical, risk and administrative profile information to provide targeted health care service to members: ▪ Identifies individuals who have not obtained appropriate preventive care and screening and who are at risk for developing costly and debilitating health conditions ▪ Provides member risk stratification and scoring to target specific populations/individuals for different levels of care management intensity managed through ICUE

Encounter Data Reporting System

We extract encounter data from CSP and load the data into NEMIS. We require claims files from all of our external vendors to submit encounter data to MLTC for all covered services. These claim files are loaded into NEMIS with our medical claims. All claim types are submitted in the same proprietary encounter submission layout as required by MLTC. We submit encounters to MLTC on a daily basis.

We maintain and review reports to reconcile financial fields of a claim (e.g., health plan paid, billed amount, health plan allowed, etc.) with the financial fields of adjudicated encounters. The encounter team is responsible for running reports to confirm sent data, validating the claims system reconciles to the

encounter submission reports and verifying the financial fields of a claim match the financial fields of adjudicated encounters. See Figure IV.R-6.

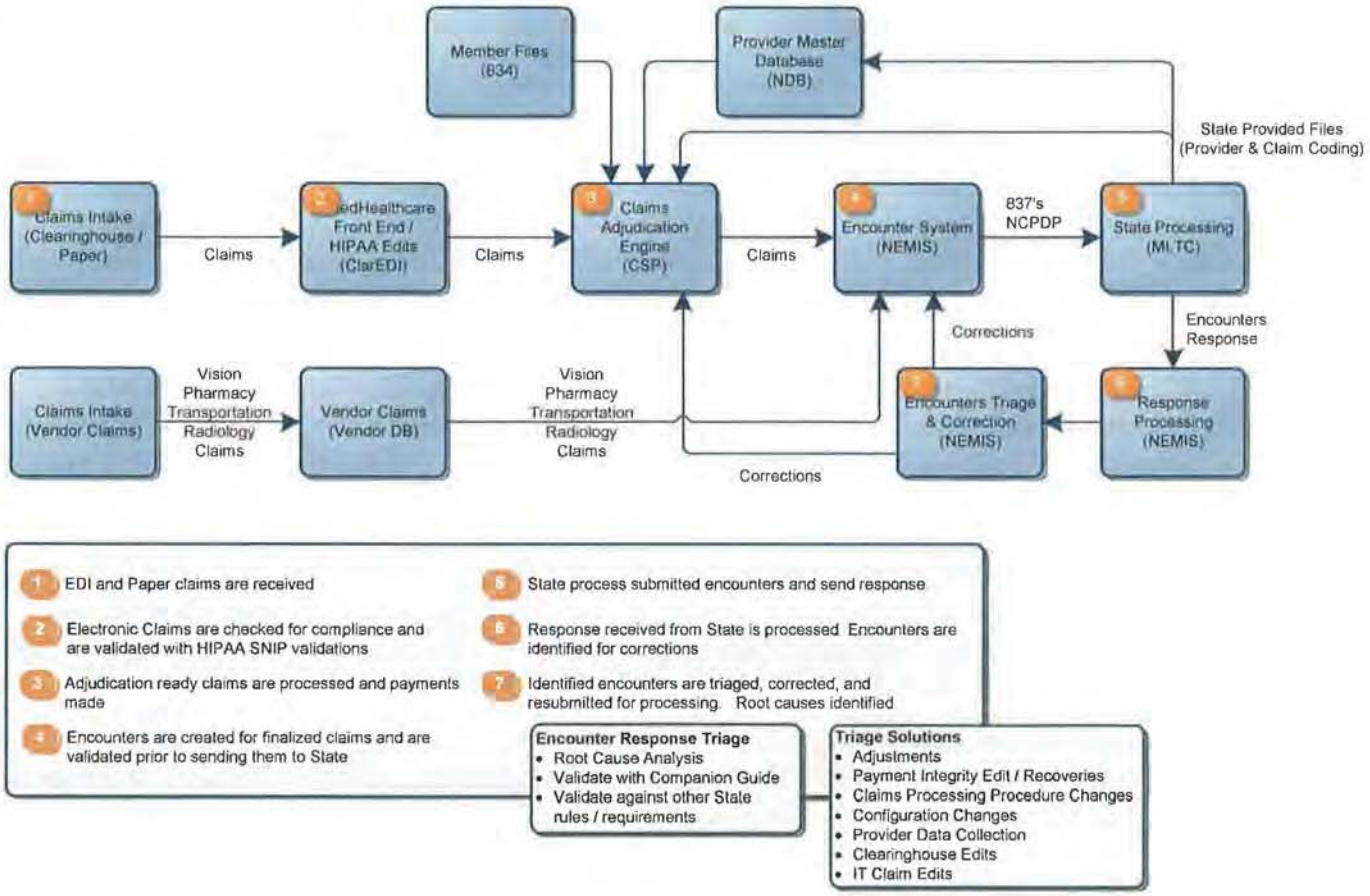

Figure IV.R-6. Systems Diagram - Encounters Flow. NEMIS performs automated edits and validations to confirm the accuracy and completeness of encounter data using processed claims data from CSP.

General ledger transactions are created in CSP and integrated into our resource management application, PeopleSoft. All financial transactions are auditable according to generally accepted accounting principles (GAAP) and supported by Sarbanes-Oxley (SOX) controls.

Table IV.R-9 includes system components and tools for financial and encounter management.

Table IV.R-9: Area: Financial and Encounter Management Systems	
Information System	**General Description/Functions Supported by System**
NEMIS	Strategic, internally developed encounter data submission and reporting system that initiates submission of encounters, tracks responses, provides error correction and resubmission of Medicaid encounters.
Financial Summary Database (FSDB)	Manages financial transactions to our general ledger and reserving process.
Financial Tagging Service (FTS)	The FTS increases the consistency and quality of financial tags in analytic data warehouses and financial tools: ▪ Establishes a single, repeatable approach to future integrations ▪ Verifies current integrations are aligned with an overall long-term solution; mitigates the risk of a point-in-time conversion

Table IV.R-9: Area: Financial and Encounter Management Systems	
Information System	**General Description/Functions Supported by System**
PeopleSoft	Enterprise financial management solution containing several modules, such as general ledger, asset management, purchasing, accounts payable and accounts receivables, to provide a consolidated view of financial data.

Sharing Information to Avoid Duplication of Effort

As a matter of best practice, we automate all key interfaces with MLTC and between our systems to reduce cycle times, minimize manual work, reduce error rates and minimize any duplication of effort. These interfaces include enrollment, eligibility, provider demographics, encounters, payment information and rate files.

CommunityCare improves continuity and coordination of capitated and non-capitated services by presenting authorized system users (e.g., PCPs, case managers, care team members, foster care social workers and legal guardians), with timely, relevant and actionable information and care plans for each child, thereby improving health outcomes and reducing inappropriate use of health care resources. For instance, children in foster care often encounter health care barriers due to frequent changes in their environment and associated barriers to information exchange due to changes in placement. Their challenges are exacerbated by disparate technologies and data sources used by the numerous public and private agencies and care providers trying to help them. It is clear a comprehensive, integrated managed care information system, such as CommunityCare, plays a key role in facilitating service management and continuity of care for these children and helps avoid a duplication of effort.

Additionally, we have considerable experience in the adoption of electronic health records (EHR) and ties to health information exchanges (HIEs). We find reductions in duplication of effort (and services) because these systems enable case managers and member services advocates to access a single repository for member contact information, condition list, medications, service dates and outcomes, history, provider visits, diagnoses, issues, progress notes and case conference notes, lab results, gaps in care and medication adherence.

Required Modifications or Updates

Our best-in-class enrollment and claims platform, CSP, is currently operational in Nebraska and supports Nebraska Medicaid members in Douglas, Sarpy, Lancaster, Cass, Dodge, Gage, Otoe, Saunders, Seward and Washington counties. Our IT team stands ready to expand our CSP configuration to include all 93 counties in the state under the new Heritage Health contract.

For the expansion, our implementation effort consists of a configuration and direct integration effort with MLTC, including development of any new MLTC-specific integration points and requirements. The overall effort includes:

- Update our product structure and benefits configuration to account for state product changes, to include BH, and expanded service areas for all of our interfacing systems including clinical, financial, encounter, IVR, portals, etc.
- Configure and retest our existing interfaces with OptumRx and other third parties
- Configure new state-specific interfaces including with NeHII

Plan for Completing Modifications or Updates

Our extensive implementation experience provides the infrastructure to seamlessly transition new members into our care management programs upon a solid foundation of technical capabilities. As we

configure and test CSP and surrounding applications to expand throughout all 93 counties, our approach will focus on six key program management elements during the implementation prior to program operations:

- ***Critical Path and Timelines:*** Document early our critical path milestones and the timeline required for defining, developing and testing the technology prior to go-live.
- ***File Formats and Companion Guides:*** Work together to develop agreed-upon file formats and companion guides that clearly define the integration requirements.
- ***Detail Design and Development:*** Develop detailed design documents with input from all key stakeholders to confirm the development outcome meets the integration needs.
- ***Test Files and Testing:*** Develop test files and test scenarios, considering all possible inputs and outcomes. Conduct full end-to-end testing.
- ***Participate in State Readiness Review:*** We will work with MLTC and its contractor(s) to prepare for and participate in readiness review assessment. Our team will work with MLTC to gather the requisite areas of interest for readiness review and will demonstrate that our Nebraska system and operations to verify for MLTC are ready for implementation.
- ***Go-Live Coordination:*** Team dedicated to coordinating the successful launch of the integration with key stakeholders on call for critical issue resolution.

We plan to execute these major program elements on a timeline as illustrated below.

Implementation Work Plan

We maintain our overall implementation work plan in Microsoft (MS) Project. Organized into functional segments (e.g., member services, provider services, clinical, technology, operations), each work plan represents a dedicated implementation team that focuses on their specific component of the implementation. This comprehensive project management approach provides the foundation for each functional team to simultaneously achieve the milestones within their units yet stay connected on active interdependencies across multiple functions. See Figure IV.R-7.

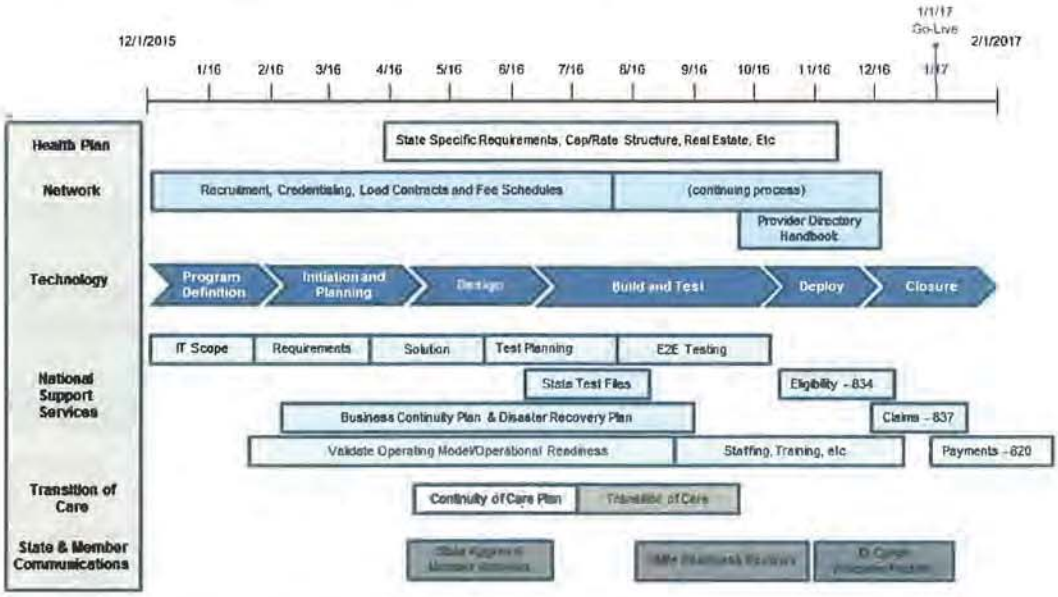

Figure IV.R-7. Timeline for Completing Modifications/Updates. With our extensive implementation experience, we are acutely aware of all the tasks, tests, action steps and deliverables involved in a timely implementation.

System Refresh and Upcoming Platform Enhancements

We will provide MLTC with an annual Systems Refresh Plan. UnitedHealth Group IT management continuously reviews and assesses opportunities to modify, upgrade or replace application software, system operating hardware and software, telecommunications infrastructure, or related policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, or any other relevant issues.

The plan also will indicate how we confirm the version or release level of all of our system components (application software, operating hardware, operating software) are formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF for support.

We are dedicated to continuous improvement by investing in information systems—people, process and technology. Between now and the Jan. 1, 2017, go-live, we are making significant investments in our underlining platform to keep us on the leading edge of technology and capabilities. Here is a summary of the infrastructure upgrades:

- ***Upgrade to Facets 5.2:*** To maintain support and compliance, we are upgrading CSP to the most recent, leading-edge version of Facets. This update is scheduled for completion in March 2016.
- ***Upgrade to Oracle Exadata X5 Database:*** In conjunction with upgrading CSP Facets to version 5.2, we are upgrading our Medicaid data warehouse, SMART and encounter management system, NEMIS, to a common Oracle Exadata X5 Database platform. This is the latest, most advanced hardware for managing database loads, providing for the fastest in-memory databases with redundant hardware and fastest failure recovery times possible. This will improve data freshness for SMART, NEMIS and Facets reporting from a day or weeks to as little as real-time. With this hardware, we go from measuring time for recovery for system outages to measuring mean time between failures. The X5 platform provides capability for zero planned downtime for hardware maintenance.
- ***Eligibility Enrollment Management System (EEMS):*** Over the course of the next year, we are rebuilding our enrollment module for CSP to provide greater flexibility for eligibility sources, improved speed to market for format changes, reduced maintenance costs and improved end-to-end cycle time for loading eligibility.
- ***Clinical Platform:*** We continue to evolve our clinical management platforms. Before Q4 2016, we expect to upgrade CareOne to our next generation technology, ICUE.
- ***Myuhc.com:*** Over the course of 2016 into 2017, we will upgrade the user experience for our member portal, *myuhc.com*, to offer a more robust member experience.
- ***Link Portal:*** We continue to improve the provider experience by transitioning our traditional Web-based access, *unitedhealthcareonline.com*, to a cloud-based platform called *Link*, which offers native applications and a simplified way of doing business with us.

Health Information Exchange: We stand ready to support MLTC in its efforts to further MCO participation in the use of health information exchanges in Nebraska including ADT, immunizations and quality data exchanges. We are working with NeHII to develop a pilot proposal that we can jointly present to MLTC. This will incorporate a value-based contract with a significant provider organization/partner, which will support health care transformation through the creation of a secure, Web-based health information exchange to serve Heritage Health members.

102. Provide a description of how the MCO will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the MCO's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the MCO's internal membership records, including differences in members' addresses. *3 pages*

We maintain systems that receive, transmit process and store data in a manner compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), as well as Nebraska state laws. We have implemented a robust regulatory monitoring process to maintain compliance with state and federal laws. Our system fully complies with the HIPAA-compliant standards for information exchange, including the 5010 version. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 820 Payroll Deducted/Other Group Premium Payment for Insurance Products
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response (including unsolicited)
- ASC X12N 278 Utilization Review Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- NCPDP Pharmacy Claims
- Proprietary flat-file and XML-based formats, where required

Access Management and Information Accessibility

To manage access restrictions and comply with HIPAA privacy requirements, all applications use role-based protocols to limit access to screens, functions, data and actions by group and users assigned to the group. The IT team uses data filters to assign parameter-driven privileges to confirm that only select member populations are viewable by the user. In accordance with SOX requirements, our Information Risk Management (IRM) team audits role-based security on an annual basis to certify that users have only the access required for their jobs.

Our security services and access control team uses the "Secure" provisioning tool to manage appropriate access to our systems and platforms and conducts an annual entitlement review. Secure requires three levels of approval, thereby gating and recording appropriate system access and enabling efficient auditing and entitlement reviews.

Data Release Governance

Our Data Release Governance program makes certain that personally identifiable information (PII) and protected health information (PHI) exchanged outside of UnitedHealthcare follows HIPAA policies and industry-standard security procedures. The Data Release Governance includes a process, presented in Figure IV.R-8, to register and approve the release of protected information (e.g., individual member data such as explanation of benefits or credit card statements) sent to an external entity (e.g., customer, member, provider or vendor).

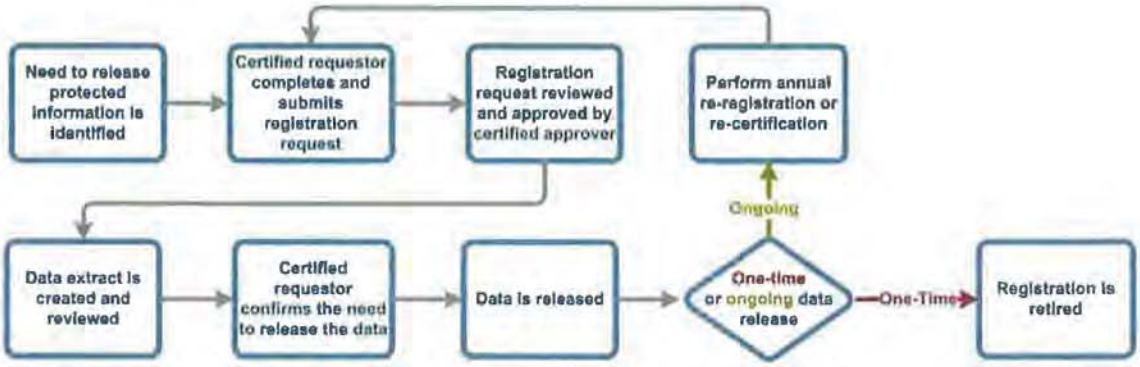

Figure IV.R-8. Data Release Request/Approval Process. We have a comprehensive process in place to protect PII and PHI exchanged outside UnitedHealthcare.

Today, we are working successfully with MLTC to transmit data. All eligibility, enrollment, disenrollment and other data are exchanged using the External Customer Gateway (ECG). ECG provides a secure electronic transport mechanism for internal entities and external business customers to exchange on-demand or scheduled data files using job automation and control services, including transmission validation. Among other formats, ECG uses Secure File Transfer Protocol (SFTP), Hypertext Transfer Protocol Secure (HTTPS) and, for encrypted files, simple File Transfer Protocol (FTP) transport methods. Access is further limited with firewalls and physical separation of processing systems to prevent unauthorized access.

General Activities to Safeguard Confidentiality and Compliance with HIPAA

The UnitedHealthcare Government Programs Privacy Office provides overall direction and compliance activities for the privacy compliance for all health plans supporting government programs. The responsibilities of the Privacy Office include the development, implementation and administration of a privacy compliance program. Local program integrity officer Tim Langdon works with our national HIPAA privacy/security officer to oversee compliance.

A key component of our HIPAA-compliance effort is our employee-training program. When our employees access, transmit (via Secure Delivery) and store data files containing PHI or PII, it is always protected. We train our staff to recognize and adhere to HIPAA security, confidentiality and privacy requirements. Our staff undergoes mandatory HIPAA training during our New Employee Orientation program, along with annual refresher training. Completion of these courses is required for ongoing employment.

Additionally, we publish company HIPAA policies and procedures on our intranet site that are always available for employees to reference. We provide ongoing HIPAA awareness training and issue monthly email security reminders to the entire organization, many from our segment information security officer. Topics include strong password selection, HIPAA requirements and PHI safeguards, workstation security, incident reporting, viruses and malicious software.

As detailed in our response to Q.105, we have a number of network, security monitoring and encryption technologies to protect our environment.

Process for Identifying and Resolving Member Eligibility Discrepancies

We process millions of member transactions per month, including demographic changes to keep accurate addresses on file, rate cell changes and eligibility changes (e.g., modification to begin and end dates). Our claims management system, CSP, integrates member demographic data with provider information, service

provision data, claims submission and reimbursement data to perform multiple functions, including claims processing and service authorizations.

The CSP programmatically reconciles member enrollment file discrepancies, including differences in members' addresses. In addition, CSP provides automatic error alerting that triggers error correction processes and procedures for manual correction by our eligibility team. Upon receipt of the daily and monthly enrollment files, our eligibility team compares and reconciles the roster of members to verify that there are no discrepancies. To confirm data integrity, we:

- Compare the membership files received against our CSP membership records monthly and look for changes in name, gender, group number, phone number, address, birth date, effective date and Social Security number (SSN). We also look for discrepancies in MLTC's membership file and our CSP membership records.
- Generate a batch input file for electronic update into CSP.
- Produce an exception report identifying member information not meeting electronic update criteria.
- Review exception reports daily and make corrections, as needed.

Additionally, the eligibility team produces a daily error report of discrepancies identified when processing the daily eligibility file. The report details the nature of the discrepancy, what was done to resolve it, and the before-and-after data element in question. For example, this process identifies duplicate or potential duplicate member records that exist in CSP. The system looks at critical data elements, such as name, date of birth and SSN to identify potential duplicates, which are added to a work queue, investigated and resolved (after confirmation from MLTC).

Upon completion of the automated data validation and load to CSP, enrollment data are available via interfaces to our downstream systems including *Link* for online eligibility verification, as well as to our IVR system for automated telephonic support of eligibility inquiries.

Members are assigned unique member numbers, which are used on all member-specific materials and for all member-related processing. These numbers are cross-referenced to other member-unique numbers such as SSN and MLTC-assigned numbers.

Downstream of the claims systems, we use our Revenue Accuracy Manager (RAM) application to perform a final reconciliation between the enrollment and payment files to verify completeness and accuracy. When errors are identified, we take corrective action and, where necessary, report corrections back to MLTC.

In compliance with MLTC requirements regarding a change in member status, we will notify MLTC via ACCESSNebraska of any changes in contact information or living arrangements for families or individual members within five business days of identification, including changes in mailing address, residential address, email address and telephone number, in a manner and format required by MLTC.

Furthermore, we will initiate a request for disenrollment through the enrollment broker for other known changes in status, including but not limited to, death, or entry into involuntary custody or incarceration.

103. Describe the MCO's approach to monitoring system availability issues and the resolution process. Provide a description of the MCO's system help desk. Include the MCO's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to MCO management within one business day of recognition and are promptly corrected. *2 pages*

Monitoring System Availability

Our approach to monitoring system availability issues includes using sophisticated monitoring tools and performing system tests. This approach provides proactive insight into unfavorable service conditions, helps reduce service restoration time and enables us to identify trends indicating we need to add additional systems capacity to continue to meet contract requirements.

We use tools, such as AlarmPoint and Hewlett Packard (HP) OpenView, to monitor our systems. AlarmPoint monitors data and automatically generates service manager incidents and automated notification of support staff. HP OpenView monitors systems and networks 24 hours a day, seven days a week by polling key operating system performance and utilization metrics every five minutes and stores the data in log files for analysis. We have defined thresholds for each metric and the system alerts us if the threshold for that metric is violated.

Integrated with HP OpenView, HP Service Manager is the primary logging and alerting tool that takes alerts/logs and creates service tickets and alerts. All systems alerts and user-reported issues are assigned a priority based upon pre-existing criteria by application, number of users, business capability impacted, and the service organization responds based upon priority of the issue. Priority 1 and 2 issues generally result from systems outages or major incidents and result in a war-room response with immediate pager notification to needed resources to resolve the issue at hand. Priority 3 to 5 issues have a longer open service level objective for response time. As new information develops, the help desk escalates incidents accordingly.

Help Desk Services

UnitedHealth Group maintains an enterprise systems help desk called the United Support Center (USC) that provides a single point of contact for all technical, telecommuter and voice support for more than 135,000 end users, using more than 4,000 applications. A specialized team within the USC will serve as the Nebraska Systems Help Desk (SHD) and provide help desk services to MLTC staff that may have direct access to our systems. This help desk is available 24 hours a day, seven days a week, exceeding MLTC's requirement of 7 a.m. to 7 p.m. Central time, Monday through Friday. Our USC is scalable to meet MLTC's requirements.

The SHD representatives can assist with a wide variety of computer and telephone related problems, remote connection and security-related issues. As part of our information gathering protocol, callers are asked to provide a callback number in the event an issue cannot be immediately resolved. Currently our support center representatives:

- Answer questions regarding UnitedHealth Group's system functions and capabilities
- Report recurring programmatic and operation problems to appropriate staff for follow-up
- Redirect problems or queries that are not supported by USC, as appropriate, via a telephone transfer or other agreed-upon methodology
- Redirect problems or queries specific to data access authorization to the appropriate health plan staff for review with MLTC, if needed
- Use our help desk service management systems to record, track and report all questions or problems reported

Recurring Problems Resolved Promptly

Recurring problems not specific to systems unavailability can be identified by the USC staff or by the application support teams. These are documented under a problem ticket within HP Service Manager and reported to UnitedHealthcare management within one business day of recognition and are resolved promptly.

Our help desk service management system enables our information management and systems director, Cybele Kanin, to generate reports that identify categories of problems encountered, length of time for resolution, and any other MLTC-defined criteria.

Ms. Kanin assists in triage of Nebraska-specific issues along with the systems owners, and assists in dispositioning the issues according to severity, range of impact, and level of effort required to remediate. Simple break-fix issues are assigned through HP Service Manager directly to the application support teams. Larger issues follow a work order process and are executed by the applications maintenance development team. When needed, larger issues are handled as a formal project supported by and scheduled with the broader applications development teams. Larger issues requiring more rapid resolution follow a Fast Track process from inception through delivery to enable prioritization throughout the capital allocation, scheduling and software development lifecycle development processes.

System Changes

We will respond to system problems, not resulting in system unavailability, in writing within five calendar days and make corrections or submit a requirements analysis and specifications document within 15 calendar days. In the case of a requirements document, we will correct the deficiency by the effective date determined by MLTC.

Core systems and online portals adhere to preplanned maintenance windows. Any non-routine scheduled downtime will be coordinated with MLTC and our help desk before scheduled downtime occurs. We will work with MLTC pertaining to any testing initiative as required by MLTC and will provide sufficient system access to allow testing by MLTC.

Systems Policies and Procedures

In compliance with RFP Section R.3.b, we have written systems policies and procedures in place that document all processes, including the safeguarding of all our information. Additionally we:

- Maintain and distribute to all users (including MLTC) distinct systems design and management manuals, user manuals and quick reference guides.
- Confirm systems user manuals contain information about, and instructions for, using applicable systems functions and accessing applicable system data.
- Make manuals and reference guides available in printed form and on our website.
- Update the electronic version of these manuals immediately, and update printed versions within 10 business days of the update taking effect.

104. Provide a description of the MCO's eligibility and enrollment database. Include a description of how the MCO will:

- Complete updates within the timeframes specified in the contract.
- Identify members across multiple populations and systems.
- Monitor, track, and resolve any discrepancies between the enrollment files and the MCO's system (e.g., duplication of records and information mismatches). *2 pages*

Enrollment/Eligibility System Description

Our enrollment/eligibility system is built on our CSP core transaction processing system. The enrollment processing function within CSP establishes begin and end dates for members under their current program eligibility category and plan enrollment, thereby maintaining the integrity of information feeding clinical, finance and other subsystems. For example, the foster care membership is uniquely identified as a cohort by configuring subgroup values in our system and supplying that data to downstream systems, such as the ICUE clinical platform and all vendors, including Superior Vision.

Members are assigned unique member numbers within CSP that we pass downstream to all systems and use on all member-specific materials and for all member-related processing. The system cross-references these numbers to other member-unique numbers such as SSN and MLTC-assigned Medicaid ID. This allows us to uniquely identify members in all our systems across multiple benefits programs, waiver populations and across our entire 5.3 million member population.

Within CSP, the Subscriber/Family module collects and stores member demographics, ethnicity, language preference, disability and special circumstances (such as pregnancy), eligibility and PCP assignment. CSP can track eligibility and segment the information by program, providing member-tailored benefits administration, reporting and customer service and claims payment across multiple populations. CSP Subscriber/Family module functions that support enrollment and eligibility are included in Table IV.R-10 below:

Table IV.R-10: CSP Subscriber/Family Module Features

Function	How it Supports Enrollment and Eligibility
Demographic Information	CSP stores basic demographic information allowing us to update and refine program materials, provider networks and community resources.
Eligibility	CSP stores eligibility information allowing us to determine benefits eligibility and opportunities for COB.
Data Exchange	CSP accepts enrollment files in various transactions/formats, including 834 file transactions/formats and ASC X12 formats.
File Processing	CSP processes millions of member transactions per month, processes enrollment automatically and enables manual entry for off-cycle enrollment and error correction. CSP also maintains a history of changes and adjustments and audit trails for current and retroactive data.
PCP Assignment	CSP assigns members to the appropriate PCP. Once actively enrolled, the member is added to the appropriate PCP roster using our rules-based Provider Recommendation Engine. If a member changes his/her PCP, the change is made in CSP.
Discrepancy Reconciliation	CSP provides automatic error alerting that triggers error correction processes and procedures.

Completing Updates within Specified Time Frames

Our dedicated enrollment team oversees eligibility file processing and reconciliation. This team will continue to work closely with MLTC to ***maintain accurate and timely eligibility files***. Daily and monthly enrollment files are accepted and processed via secure FTP as HIPAA-compliant 834 transactions in the 5010 format. We identify new members or changes to existing members (e.g., name, date of birth, PCP changes or Medicaid benefit) using data from the daily and monthly 834 files.

Eligibility Enrollment Management System (EEMS)
Over the course of the next year, we are rebuilding our enrollment module for CSP to provide greater flexibility for eligibility sources, improved speed to market for format changes, reduced maintenance costs, and improved end-to-end cycle time for loading and distributing eligibility data.

Within 24 hours of receipt, we automatically update CSP, our eligibility and enrollment database. By automatically loading the enrollment files in our systems, we eliminate duplicate manual data entry and avoid opportunities for keying errors. The system looks at critical data elements, such as name, date of birth and SSN to identify potential duplicates, which are resolved (after consulting MLTC).

Monitoring, Tracking and Resolving Discrepancies

CSP programmatically loads and reconciles member enrollment files; the system validates file format and content, updates our systems for new members and for existing members where data elements do not match, and reports on discrepancies and records that do not load. In addition, CSP provides automatic error alerting that triggers error correction processes and procedures for manual correction by our eligibility team. Upon load of the daily and monthly enrollment file, our eligibility team examines the load reports and addresses issues from the member roster load to verify that there are no remaining discrepancies or errors. To guarantee data integrity, we:

- Compare the membership files received against our CSP membership records monthly and look for changes in name, gender, group number, phone number, address, birth date, effective date and SSN. We also look for discrepancies in MLTC's membership file and our CSP membership records.
- Generate a batch input file for electronic update into CSP.
- Produce an exception report identifying member information not meeting electronic update criteria.
- Review exception reports daily and make corrections, as needed.

Additionally, the eligibility team produces a daily error report of discrepancies identified when processing the daily eligibility file. The report details the nature of the discrepancy, what was done to resolve it, and the before-and-after data element in question.

In compliance with MLTC requirements regarding a change in member status, we will notify MLTC via ACCESSNebraska of any changes in contact information or living arrangements for families or individual members within five business days of identification, including changes in mailing address, residential address, email address and telephone number, in a manner and format required by MLTC.

105. Provide a description of the MCO's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities. *3 pages*

Protecting our members' information is a top priority for us. We invest significant resources in our information security program, which includes a robust cyber defense program. We use a number of network, security monitoring and encryption technologies to protect our environment and maintain the confidentiality and integrity of our data, and routinely test and validate our systems' security. Across UnitedHealth Group, our security team consists of more than 400 security professionals dedicated to protecting and securing data entrusted to us. To further fortify our technology environment, UnitedHealth Group recently deployed the following:

- ***Smart Cards for Computer Access:*** Improves security through a multi-factor authentication process, which requires employees to use the card along with a PIN when accessing their computer. Employees are required to remove the card from their workstation when they step away from their computer, thereby providing an additional level of security.
- ***Invincea FreeSpace for Web Browsing:*** Blocks malware from company workstations. When browsing on the Internet, untrusted websites and documents open in a parallel, protected browser to isolate computers from Internet-based attacks. Pop-up messaging provides needed instructions to protect workstations.
- ***Phishing Awareness Programs:*** Builds employee awareness of phishing schemes by sending mock suspicious emails to employees randomly and providing feedback on appropriate responses if they open or respond to them.

In compliance with RFP Section III, F: Insurance Requirements, we will obtain Cyber Liability Insurance with the specified coverage.

Role-Based Security

To manage access restrictions and comply with HIPAA privacy requirements, all applications use role-based protocols to limit access to screens, functions, data and actions by group and users assigned to the group. The IT team uses data filters to assign parameter-driven privileges to confirm that only select member populations are viewable by the user. In accordance with SOX requirements, our information risk management (IRM) team audits role-based security on an annual basis to certify that users have only the access required to complete their jobs.

Our security services and access control team uses the "Secure" provisioning tool to manage appropriate access to our systems and platforms and conducts an annual entitlement review. Secure requires three levels of approval, thereby gating and recording appropriate system access and enabling efficient auditing and entitlement reviews.

Unique User ID

Each user is assigned a unique user ID, and their role determines their access. No global (super user) capability currently exists; nor do we plan on this capability in the future, per policy.

Automated Lockouts

After three failed credentialing attempts, systems automatically engage lockouts. The IRM team tracks login attempts and lockouts. Users must provide two or more identifiers to unlock failed passwords.

Timestamps

The systems apply timestamps to online inquiries, transaction logs and report generation. For all records in CSP, the system documents the date and timestamp along with the system user ID or system job that last modified the record.

Preventing the Alteration of Finalized Records

Our systems prevent the alteration of finalized records. For example, CSP contains finalized records such as claims and enrollment data. Through various programs run within CSP, claims complete a finalized cycle that prevents any further changes to data elements in the records. We control access to finalize these claims using the role-based security system.

Controls for Managing Information Integrity

Access to UnitedHealth Group network and systems is limited through use of firewalls, VPN and physical separation of processing systems. Our customer service applications are protected by these firewalls. Our Remote Access Security Standard defines appropriate usage, configuration, care and security for all individuals who remotely access the UnitedHealth Group internal network. Our remote access solutions for desktop use include the Cisco VPN software client and RSA Secure ID strong two-factor authentication. These solutions provide secure remote access, stable connectivity and quick reconnects and failover. Users with a documented business reason and management approval, again through our Secure system, may access confidential information remotely.

The IRM infrastructure services security team uses two network-based intrusion detection technologies to identify the potential risk of security breaches:

- ***Intrusion Prevention System (IPS):*** Allows for "detect" and "deny" action
- ***Intrusion Detection System (IDS):*** Allows for a "detection" action

The IPS/IDS systems detect or protect against malicious traffic. They include real-time alerts and provide detection and prevention of known attack characteristics (e.g., denial of service attacks, worms, viruses, etc.) within the scope of all network-based protocols.

Our IRM team works in unison with our Enterprise Resiliency & Response (ER&R) and our information management and systems director, Ms. Kanin, to deploy response mechanisms as soon as they become aware of an event that may disrupt our systems.

Audit Trails

Our systems maintain a history of changes and adjustment and audit trails for current and retroactive data using logging, journaling and audit tables to maintain a record of all changes to transactions and data within each application. Audit trail logs are protected from unauthorized access, modification or destruction and are retained according to UnitedHealth Group's Record Management Policy and Records Retention Schedule.

Physical Safeguards of Data Processing Facilities

Our technology resources are compliant with industry standard physical and procedural safeguards. To store, restore and recover data and the base platform, we have a data archive and retrieval system, and we adhere to our information system contingency and disaster recovery plan. Our plan is based upon National Institute of Standards and Technology (NIST) encryption standards, National Fire Protection Association (NFPA), and International Standards Organization (ISO) guidelines for disaster preparedness and recovery. We handle confidential information in compliance with HITECH, HIPAA and state privacy requirements.

We maintain several large-scale data centers in geographically dispersed locations, as seen in Figure IV.R-9. Redundantly interconnected, these data centers support both circuit load balancing and backup interconnection for failover scenarios. We provision all applications with geographically dispersed production and backup infrastructure, allowing full application support in the event an application's primary data center becomes disabled. Our highly secure network of data centers significantly mitigates risks from data center disabling events and provides 24 hours a day, seven days a week availability of key production systems and data.

- ***Controlled access:*** Critical data center areas (e.g., server and mechanical and electrical rooms) are secured with proximity sensor card readers and monitored with cameras. Visitors are required to present and leave photo identification with the security guard and must wear visitor identification.
- ***Cameras:*** Pan, tilt and zoom cameras are provided in internal and external locations. The surveillance images they capture are displayed at the security desk on multiple monitors. Cameras, card readers and intercoms are located at site entrance gates and lobby doors.
- ***Additional physical security:*** Our name does not appear anywhere on the exterior of the building. A landscaped earthen berm provides protective separation of the facility from the street. There are no external windows to the server, mechanical or electrical rooms.
- ***Fire retardant capabilities:*** Smoke and heat detection systems are located throughout the building. A multi-zone pre-action sprinkler system provides fire control. Fire alarm monitoring stations are located throughout the building.

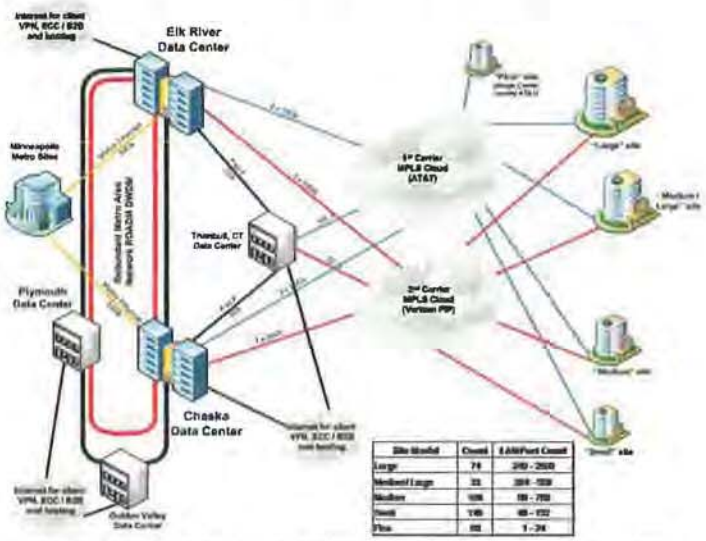

Figure IV.R-9. Network Diagram. UnitedHealthcare has a geographically distributed network of data centers that exceed ANSI/TIA 942-Data Center Tier 1-3 standards.

We undergo an annual SOX audit to verify that data integrity controls are in place for all our systems. Program integrity controls range from referential integrity in our relational databases, automated job monitoring and record balancing of data exchanges, Public Key Infrastructure (PKI) authentication of external exchanges, administrative and clinical edits, and identifier validations. Intrusion detection and file change control technology is deployed throughout our security architecture model.

106. Describe the MCO's business continuity, contingency, and recovery planning. Attach a copy of the MCO's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery:

- Operational and system redundancy in place to reduce the risk of down-time.
- System and operational back-up sites.
- Contingency and recovery planning including resumption of operations.
- Prioritized business functions for resumption of operations and responsible key personnel.
- Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable.
- Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith.
- Testing approach and regular schedule to improve and update the plan over time. *3 pages, excluding sample plan*

As detailed in Attachment 19 Q106 Sample Business Continuity Disaster Recovery Plan, we have comprehensive emergency management, business continuity and disaster recovery plans (BC-DR) to safeguard ongoing customer and provider services through any type of emergency. Our ER&R program includes policy, processes and controls to protect the business of UnitedHealth Group; the life and safety of our workforce; and resources of the organization. Locally, chief operating officer Sean Jones oversees business continuity planning. Consistently, over our nearly 20-year history in Nebraska, we have successfully maintained business continuity through natural disasters and other incidents using the tools and processes summarized below.

Operational and System Redundancy

Designed with diverse connectivity and redundant devices, our system configuration allows fault tolerance and automatic failover in the event of any service or hardware failure. The effectiveness of our emergency preparedness has been tested numerous times in a wide variety of conditions and has been proven effective in every circumstance. Key technologies include uninterruptible power supply (UPS) systems, independent backup generators for power outages; multiple data lines (T1, DS3) from different carriers, redundant network appliances in a failover configuration, and clustered servers for key applications in an active/passive mode.

As an added safeguard, our United Command Center (UCC) organization within UnitedHealth Group IT operates a full-time, 24 hours a day, seven days a week, operations team to monitor the health and availability of IT assets.

System and Operational Backup Sites

UnitedHealth Group's data center facilities (DCF) team manages the Minnesota data centers where our systems and data are located. From Minnesota, the DCF team manages our network operations and strategic network of data center facilities. Within each data center, we implement critical systems with a redundant plus-1 approach where hardware is replicated for a seamless cut over to secondary devices. Our network of data centers, which meet or exceed all ANSI/TIA 942-Data Center Tier 1-3 standards, significantly mitigates risk from data center disabling events and confirms availability of key production systems and data 24 hours a day, seven days a week.

Additionally, we employ a national operations center that monitors call volume enterprise-wide to coordinate work volumes for our call centers, which are distributed in multiple U.S. locations, and

respond quickly to load balance and offload calls as needed. The latest call center technology (Virtual Queuing) mitigates impacts on regional natural disasters such as the back-to-back central plains winter storms in February 2013 when calls were distributed to other locations without impact to service levels.

Contingency and Recovery Planning

The business continuity plans (BCPs) focus on restoring critical business functions and continuing operations in a prioritized manner. Each BCP has an appointed business recovery team with trained crisis leaders that skillfully facilitate the continuity of our business operations. We use BCPs, updated quarterly, in conjunction with the Event Management and Disaster Recovery plans, for a quick and efficient response to all types of disasters and disruptions.

As a national organization, our business continuity strategies include leveraging resilient, or redundant, operations performed across the country. Supplementing this strategy is remote work capability, full-time work at home (telecommuter) personnel, as well as the ability to relocate staff or offload work to staff at numerous U.S. locations.

Business functions classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed redundant operations and maintain a recovery time objective of 72 hours or less. Our critical business functions include, but are not limited to, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations and core corporate functions. Within four to eight hours after the disruption, the event management team (EMT) provides the following information to MLTC: a summary of the event; the impact to the members and providers; the steps we are taking to provide continued services; and the frequency in which local key contacts will provide ongoing status updates.

After the disaster and as soon as it is safe to do so, care managers immediately initiate contact to members and facilities housing members to determine if they need assistance. If a member is unable to return home, we arrange and authorize facility placement until it is deemed safe to return home. If members have remained at home during the disaster and have post-disaster issues, care managers attempt a face-to-face visit to coordinate necessary services and admission to a facility to confirm the member's uninterrupted access to needed services.

Prioritized Resumption of Operations and Responsible Key Personnel

Effectively managing a crisis through to resolution requires a different decision-making process than is used for normal day-to-day business operations. Our Event Management Plan (EMP) outlines the EMT organization and communication process for facilitating a prioritized and timely response to major events affecting our personnel, business operations or site locations, with the goal of avoiding or minimizing damage to the organization's profitability, reputation or ability to operate, and to continue services to customers and members.

We minimize member and provider impact in a variety of ways. Our call centers, claims processing, clinical support, financial and banking operations are designed for resiliency and are positioned to continue to provide services to our members and providers. As a national company, we have geographically dispersed computing, customer service facilities and health care networks that can support and supplement the work of compromised localities.

Employee and Supplier Preparedness

Locally, Mr. Jones provides communications in accordance with the emergency communications plan outlined in our BCP, which includes outreach to staff, suppliers, media relations liaisons and our MLTC

contacts. Our event management team, the local business continuity planning and emergency coordinator, along with Mr. Jones are responsible for managing the situation and making the critical decisions that drive remediation and coordination with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization. The team also supports execution on the event management decisions and provides central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management. We define critical vendors/third parties in every business continuity plan.

Figure IV.R-10. The *Health4Me* app is available as a free download at the Apple iTunes App Store and the Android Market on Google Play.

Provider Preparedness

We communicate with members and health care practitioners during a crisis using all available and pertinent mediums. Based upon the impact and severity of the event, we use a variety of communications options, including member and provider portals, member and provider call centers, media communications and direct communications by account executives to our national accounts. Our members can reach us by calling the member services number on the back of their medical ID card. Members who have a smartphone can download the free *Health4Me* app, shown in Figure IV.R-10, which provides instant access to their ID card, network care providers, their personal health benefits and more.

Our critical member and provider Internet and telephone-based IVR and information functions are available to the applicable system users 24 hours a day, seven days a week, except during periods of scheduled systems unavailability as agreed upon by MLTC and UnitedHealthcare. The UCC team closely monitors availability.

We use our member and provider communication channels to disseminate emergency preparedness instructions for providers. When providers close or relocate their offices or practice, the change in the status of their practice is available to provider services and member services so they can provide referrals to members for alternate providers whose offices are still open. We retain claims history and can release the information to the member's alternate provider after the member gives legal consent. Members can make the initial request for claims history by calling member services. Nebraska Medicaid providers can contact the local provider services during an emergency for assistance with questions and issues.

Testing Approach and Improving the Plan

Our ER&R program staff annually test the BCPs by using a variety of real-life scenarios and exercise formats that may include tabletop discussion, functional or partial plan implementation, and full-scale or live drills including emergency response.

Formal exercise reports identifying necessary BCP enhancements are published and BCPs are remediated. Appropriate executive leadership then certifies the BCPs. The ER&R Program Steering Committee monitors the annual certification process. All data security controls are reviewed as part of our annual SOX audits and subject to regular audits.

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IV.S. Claims Management

107. Describe the MCO's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the MCO's strategy for identifying problem areas, and how the MCO will ensure rapid response. *2 pages*

As an incumbent with nearly 20 years of Nebraska Medicaid claims processing experience, we have an established structure and are ready to comply with all with timeliness and accuracy requirements identified in Section IV.S.2—for current physical health and vision claims, as well as the new BH and pharmacy claims services. Over the life of our contracts, our local team has performed multiple implementations for MLTC; most recently, we completed Hospice and Non-Emergent Ambulance benefit implementations without any "noise" in the marketplace.

UnitedHealthcare is committed to processing and paying provider claims for services rendered to members in the most timely and cost-effective manner possible. Nationally, we have 33 years of Medicaid experience in the successful processing of claims. This extensive experience combined with our state-of-the-art technology infrastructure and efficient claims-paying solutions give us the capabilities to process and pay claims as set forth in MLTC's requirements and in compliance with all state and federal regulations including members on restricted services. We also have extensive experience in providing behavioral health (BH) Medicaid claims-payment services across the country, and our claims system ensures flexibility in processing limited services, fee-for-service (FFS) claims, capitated claims and Medicaid administration. For example, in San Diego, we have reached operational excellence by consistently exceeding the performance standard of processing FFS provider claims with 99 percent financial accuracy and 97 percent procedural accuracy.

Claims oversight is led by chief operating officer Sean Jones and supported by health plan performance manager Heather Johnson, and claims administrator Diane Knutson. They are responsible for ensuring claims are processed accurately and in a timely manner.

Strategies to Ensure Claims Processing Readiness

From January 2014 to September 2015, **we processed 99.99 percent of all clean claims for both participating and non-participating providers within 30 days**. These results demonstrate our achievement in consistently exceeding the current Medicaid contractual requirements for claims processing, which is 90 percent of clean claims processed within 30 days. We understand the new RFP timeliness requirements for performance guarantees shift to 90 percent of clean claims within 15 days. To ensure we meet or exceed the new requirements, we will draw upon our current claims processing success in Nebraska and leverage the best practices of our national organization including other state plans that are consistently meeting similar requirements.

Establishing Accurate Claims Processing During Contract Implementation

During contract implementation and post implementation, we will use the following tools and processes to ensure all claims, including new BH and pharmacy claims, are accurately processed.

Tested project management approach. We use the framework of our governance and project management approach to actively monitor and track implementation progress and validate that the quality of our deliverables meet contract requirements. We also implement a continuous improvement process to evaluate implementation performance while maintaining close communication with MLTC stakeholders. Our seasoned approach to project management relies upon a single organizational structure that combines a local, Nebraska-based, implementation model with national resources and support. Using this model, we

are able to create a consistent and proactive process that leverages the resources of our entire implementation team.

Stringent system configuration and testing. While our systems are currently configured for and successfully process Nebraska physical health and vision claims, we will perform system configuration and testing for the new BH and pharmacy claims services and new benefits. To configure our Community Strategic Platform (CSP) system and supporting applications to meet new contract requirements, we produce a standard needs assessment that identifies benefit requirements. Once the needs assessment is complete, configuration work begins to ensure our system meets MLTC requirements. Finally, our implementation team tests the configuration via intensive unit, systems and end-to-end testing and works with providers to perform a series of test scenarios in a test environment to ensure our system is properly configured. Claim edits and reimbursement policies test our system configuration against MLTC's and our reimbursement policies to validate accurate claims adjudication. With the new pharmacy benefit, our pharmacy and implementation teams will work with our collective IT staff to confirm our pharmacy benefit manager (PBM) system is appropriately configured and updated to meet the MLTC benefit requirements. Specific areas of focus for pharmacy readiness include required data elements and reimbursement methodologies, configuration of the Preferred Drug List (PDL) and authorization updates.

Strategy for Identifying Problem Areas and Facilitating a Rapid Response

Post go-live, we have a robust process to monitor all claims to immediately identify any problems, including those associated with the new benefits. We will monitor and manage to a wide variety of performance indicators to verify compliance with regulatory and contractual requirements.

Claims go-live, post-implementation processes. We have a very stringent process for post-implementation that includes: auditing claims to ensure correct processing; using our claims "war room" to quickly identify and remediate issues; and monitoring key metrics, including auto adjudication rates and denial rates.

Consistent progress measurement and internal resource-sharing are facilitated by our daily post go-live performance calls, the results of which are shared via daily and eventually monthly reports to our senior leadership and local health plan leadership teams. This information provides discussion points for trending performance and potential obstacles, along with any additional remediation activities.

We gather information at all key provider touch-points staying in touch with our providers to learn of any issues early. If a claims concern is identified, we determine the root cause of issues and develop appropriate solutions for resolution. We also detect deficiencies through a retrospective review of patterns in provider issues that are logged during calls or claim disputes; proactive review of claims data to identify pattern changes, drilling down into areas of concern and taking action to achieve resolution; and frequent operational meetings with claims, enrollee services and authorization staff.

As the new contract reaches the steady state of claims processing, we will use our recently implemented, enhanced Provider Relationship, Insight and Service Model (PRISM) to identify and rapidly resolve issues. PRISM, with its single intake portal, offers a streamlined approach to issue resolution and also includes analytics and root cause analysis for issue prevention and detection. PRISM integrates information from claims, enrollment, clinical episodes of care and utilization history; identifies gaps in care and compliance with clinical guidelines; and provides clear escalation protocols for a rapid response to critical claims issues.

108. Describe the MCO's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address:

- The process for auditing claims samples.
- Documentation of the results of these audits.
- The processes for implementing any necessary corrective actions resulting from the audit. *3 pages*

Our methodology for achieving claims payment accuracy standards includes a cross-functional claims quality assurance program that applies a combination of automated system checks and manual assessments. Our desire to self-monitor, self-report and improve operations underscores our commitment to comply with the audit and accuracy test requirements stated in Section IV.S.13, Section IV.C.12, Section IV.O.11 and Section IV.Z.18.

Monitoring Claims Processing Accuracy and Auditing Claims Samples

To monitor both physical health and BH claims processing accuracy, we use multiple quality audits and programs to verify adherence to claims processing standards. The claims payment and accuracy metrics we track include: financial accuracy rate (the percentage of dollars paid correctly against the total billed amount); dollar accuracy rate (the percentage of dollars paid correctly against the total paid amount); procedural accuracy rate (the percentage claims without non-financial errors); overall accuracy rate (the percentage of claims without financial or procedural errors); and claims payment accuracy (the percentage of claims paid correctly without financial errors).

Our approach to claims monitoring and quality efforts includes pre-disbursement review, post-disbursement review and prevention, including root cause analysis and resolution. As just one example, our core transaction processing system, CSP, programmatically reconciles and reports on enrollment file discrepancies for revenue reconciliation—mitigating situations where claims are not paid or are paid incorrectly due to issues with the enrollment data.

Our quality management team, separate and independent from our claims operations, performs continuous and comprehensive internal audits to verify integrity in the audit oversight process. Our quality audit personnel have broad experience in claims processing, possess strong analytical skills and work closely with our claims department and other applicable internal subject matter experts to address issues identified from the audits. This collaboration supports performance improvement by letting us make corrections to the system, develop remediation plans and provide feedback and mentoring for processors.

Our PBM processes pharmacy claims using an innovative auditing system that evaluates every electronic claim at the time of submission—identifying errors and potential fraud before a claim is processed and paid. Our real-time audit program checks all claims against a series of filters or edits to assess the eligibility of the claim for payment. Initial edits include: correct format, pharmacy network, member eligibility and PDL status. Claims that comply with all pre-programmed edits are validated and sent on for further processing, whereas claims that fall outside set algorithms are rejected. Once a claim has been approved, it is compared to the reimbursement of the pharmacy's billed amount and reimbursement we have previously agreed upon through our contracted dispensing rate and Maximum Allowable Cost (MAC) listing price described more fully in Q98 of this response.

Achieving Claims Payment Accuracy – Sampling and Reporting System

To maintain a high level of claims payment accuracy, we use our multi-faceted claims management and reporting system to extract a stratified sampling.

System-Generated and Smart Audit Master System (SAM) Edit Reviews

Pre-Disbursement Review: During the claims processing review process, claims are subject to a number of systematic reviews to identify unanticipated claim billing patterns or potential questionable billing practices.

- Review is conducted by the claim system and will flag a processor to review any suspect claims or concerns
- Processor is required to review each of these warnings and apply the appropriate claim processing guidelines, to determine the appropriate outcome for each claim reviewed

Pre-Disbursement Review Example: iCES Editing Tool

We use iCES, an editing tool embedded in CSP, to rigorously review all claims before payment. We manage provider reimbursement policies applied to professional and institutional claims through its editing capabilities. iCES is equipped with a knowledge base that contains up-to-date code sets, updated regularly as rules and codes change, as well as current industry standard guidelines for many codes and claim situations. Among other edits, iCES screens for unbundled codes; up-coded, invalid and duplicate codes; code fragmentation; member age; member gender; place of service; pre- and post-operative intervals; and modifiers.

Random Sampling Review

Post-Disbursement Review: Once claims processing is completed, we use the SAM system to randomly sample the processed claims. Claim auditors access the selected claims within SAM and review the claims to determine processing accuracy. Our process is outlined below:

- Review is a stratified and weighted selection of processed claims
  - Claims are divided into eight categories called strata based upon the dollar amount paid; a fixed number of claims are randomly selected for review; and the number of claims selected per strata is based upon the percent of paid dollars per strata
- The metrics we produce as part of the quality audit include weighted dollar accuracy, weighted financial accuracy, weighted claim payment accuracy, weighted procedural accuracy and weighted overall accuracy. By using the weighted and stratified approach, our results are a statistically valid representation of the claim processing accuracy of the full population of processed claims with a confidence interval of 95 percent +/- 3 percent
- Review is conducted daily, and results are tabulated on a monthly basis

Individual Processor Review

- Random sample selection based upon work completed by each individual processor
- Designed to drive individual contributor's accountability, verifies the processor meets or exceeds quality standards and ensures consistent understanding of claim processing across the organization
- Performed weekly, results scored monthly (e.g., auditor validation is a program to examine samples of auditors' work to confirm consistency in quality review procedures)

Focused Reviews

- Focused audits are performed for specific problematic topics to identify patterns and root cause. Focused auditing is done as needed, and typically looks at a defined range of claims
- Audit could be driven by service types, providers that have recently experienced disruptions or any other characteristic/demographic that requires additional review. A clinical review of the claims may also be requested, based upon initial findings of the review. Post-training quality review is used to review processors' payment accuracy and identify training gaps/opportunities

Documentation of Audit Results

In accordance with Section IV.S.9.e, Claims Payment Accuracy, documentation of the results of testing will include, at a minimum:

- Results of each attribute tested for each claim selected
- Amount of any overpayment or underpayment for claims processed or paid in error
- Explanation of the erroneous processing for each claim processed or paid in error
- Determination of whether any error is the result of keying errors or errors in the configuration or table maintenance of the claims processing system
- Documentation that any claims processed or paid in error have been corrected
- Claims payment accuracy percentage reports based upon audits conducted in compliance with the requirements of the RFP for claims processed by any subcontractor

Implementing Necessary Corrective Actions Resulting from Audits

Reports with the audit findings and control charts are distributed to senior leadership weekly. Monthly reports, automatically generated after audits for the sampled claims are finalized, are also scrutinized. These reports include monthly quality metrics. Reports can also be manually generated to obtain details on the defects identified. The claim detail reports will be reviewed monthly by Six Sigma Black Belts and used for defect analysis quality improvement projects.

The manager of claims operations, along with the claims team, allocates resources to focus on and correct key issues. When involvement is needed from other departments, cross-functional teams are established to perform analysis and determine corrective action. Remediation activities are presented to our Quality Assurance and Performance Improvement Committee (QAPIC) to verify issues are being addressed and corrected.

We use focused audits to audit contract terms against facility paid claims on a monthly retrospective basis. We perform claim payment accuracy audits by validating system configuration against contract terms. Audits include a review of the accuracy of the claims paid against the new contract installation to catch errors early in the lifecycle of new contract loads. Defect remediation follows Six Sigma processes and triggers additional audits upon resolution.

Provider Claims Submission Process

Our Provider Early Warning System also supplements our audit efforts by identifying areas of risk in the claims process. The system not only alerts us to the risk of claims denied in error, but also to fluctuations in claims receipts, rejected claims and cash flow paid to providers to give us an end-to-end view of the claims process and expand our vision to additional areas that can improve provider satisfaction with claims payment. This system is specifically designed to identify issues in a manner that leads to rapid investigation and corrective actions and greatly reduces the time it takes to discover system errors along with the volume of claims impacted.

In addition to our internal claims audit process, PRISM works directly with providers to confirm claims are processed according to contractual requirements. PRISM performs analytics and root cause analysis for issue prevention. Additional features include, but are not limited to, reduced provider issue volume over time; enhanced cross-functional reporting and analytics; and predictably high-quality design and deployment of provider-related fixes and adjustments to data, processes and systems. We meet with key providers to assess their accounts receivable days against our payment timeliness and accuracy and identify issues around gaps or discrepancies in processing.

109. Describe in detail how the MCO will verify that services were actually provided including:

- Minimum sampling criteria to ensure a representative sample.
- How results of monitoring will be reported to the State quarterly. *3 pages*

We have a robust process for monitoring and enforcing claims payment accuracy at all levels, and believe our members can provide great insight into situations that we cannot discover using claims data alone.

Meeting Minimum Sampling Criteria

We have a process in place that meets the RFP requirements. We currently mail service verification notices to a random, sample group of Nebraska Medicaid members on a monthly basis to verify services were actually provided to our members. To comply with the new requirements, we will select, at a minimum, a 2 percent sampling of claims per month, including BH and pharmacy claims. The statistically valid random sample of paid claims shall include all provider specialties and claim types proportionally represented in the sample pool per the requirements set forth in Section IV.S.7 and Attachment 6. Also in compliance, the service verification notices will be sent within 45 calendar days of our claim payment date.

Our notices will clearly and simply specify the description of the service provided, the name of the provider of service, the date of service and the amount paid for the service in a manner that complies with 42 CFR 455.20 and 433.116(e). In addition to the service verification notice, we currently enclose a bilingual Medicaid Tip Sheet with 10 tips on fraud, waste and abuse (FWA) awareness. Our notices request the member to contact UnitedHealthcare's member services department if he/she has any questions about the procedure or care received based upon the claims detail in the service verification notice.

Nebraska Service Claims Verifications

In State Fiscal Year 2015, we:

- Mailed 11,400 service verification notices
- Received phone calls from 76 members questioning the service detailed in their letter
- Forwarded eight claims to our compliance and fraud and abuse departments for formal investigation

Our service verification process includes additional analysis and verification by cross-functional teams—member services, member outreach, care management and compliance—to validate services were provided to our members. If a member disagrees with a service identified on the service verification notice, our member services advocate reviews the claims data with the member. In some cases, the member will recall the claim; in other cases, he/she will not. For those members who do not recall the service, our member outreach specialist will conduct additional follow-up. Members who state no services were received are reported to our compliance and fraud and abuse departments for additional investigation. A dedicated fraud, waste and abuse investigations team then employs a variety of methods to determine if the service or item was actually provided. These cases are tracked through our FWA monitoring report. We also will refer these cases and results to MLTC within three business days of identification.

Additionally, we will complete quarterly audits to identify services paid after the recipient's death or incarceration and home-based services. This audit will include prescription drugs, therapies or medical supplies, received by the patient while that patient was hospitalized, or living in or treated in a setting reimbursed at an all-inclusive rate. The quarterly audit will supplement a current retrospective algorithm run on a monthly basis to identify claims we paid to providers for members who later were disenrolled for either terminating from the plan or death.

Reporting Monitoring Results to the State

All members who contact us in response to the service verification notice are included in our Service Claims Verification Summary Report provided quarterly to MLTC.

In accordance with Section IV.S.7.f, we will continue to report service verification results to MLTC on a quarterly basis. Any instances of identified fraud are also promptly reported to MLTC and appropriate action is taken. Our report to MLTC will include the following:

- Month of the claims service
- Total number of service verification notices mailed to members for validation
- Date the notices were mailed
- Total number of surveys completed
- Total number of services requested for validation
- Number of services validated by members in response to the notices
- Action taken in response to the member's feedback, including the number of potential fraud cases identified and the number that are forwarded for review and investigation
- Analysis of interventions related to complaints or other issues

Program Integrity Meetings

We conduct quarterly program integrity meetings with officials from Nebraska Medicaid Program Integrity that are attended by DHHS staff, attorneys from the MFPAU, Nebraska plan leadership, and national members of our FWA teams. One standing item during these meetings is a discussion of service verification reports, including details on the number of inquiries generated from the monthly mailings and information on any tips made as a result. Cases that are generated from service verification activity are then reflected on the quarterly FWA report that is also discussed during these meetings.

Service Notifications Create Opportunities for Care Management Services and Member Education

When our member outreach specialist reviews the claims in question with the member, the member outreach specialist may discover issues unrelated to the initial service verification call. Because our outreach specialists are highly experienced, they recognize the opportunity to provide additional services to the member. At times, these issues warrant care management services, e.g., a member may mention he/she is having difficulty controlling a chronic condition or managing a child's disability. Our member outreach specialist then refers the member to care management for a care manager to reach out to the member. A specific example of this scenario is described below. This also provides an opportunity for education. For instance, a member may be unaware of a transportation benefit, or a new mom may be unaware of the Baby Blocks value-added benefit. Our member outreach specialist always listens for opportunities to educate members about their benefits and refers them to care management or other areas, if necessary, so they receive the care and services they need.

Member Story: Care Management and Education from Claims Service Verification Call

Due to information obtained during a claims verification call, our bilingual member outreach specialist contacted a member with diabetes complications who only spoke Spanish. The member wanted to be healthy and compliant with her medications and preventive care, but language barriers and socioeconomic factors hindered her ability. Our Spanish-speaking member outreach specialist identified that this member needed additional follow up due to her health condition and desire for improvement. We offered the member an opportunity to work with one of our care managers and she agreed.

Our assigned care manager, with the assistance and use of our telephonic interpreter service, discovered and resolved several issues the member was facing, including:

- The member, who had recently moved to Nebraska from California, was not aware of SNAP benefits for food assistance. Our care manager provided her with the phone number to apply for SNAP (food assistance).
- The member relied on her son's schedule to take her to medical appointments, as she was not aware of the transportation benefit. Our care manager educated her on her transportation benefit and provided the phone number.
- The member's PCP had ordered her a walker and shower chair, but the durable medical equipment (DME) provider had not notified her that the order was ready. Our care manager coordinated with the DME provider for receipt of the walker and chair.
- The member had been paying for her diabetes supplies out-of-pocket. Our care manager educated the member that these items are covered in full, and all she needs is her Medicaid ID card; she also contacted the pharmacy to relate the issue.

We made a follow-up call to the member to confirm she had received her walker and shower chair. The member reported she had and additionally stated that her glucose levels were improved, as she was now aware of the right medications, dose/quantity and purpose of her prescriptions. The member had changed her PCP and she was very happy with his care. We also provided her with additional resource information, such as the NurseLine and League of Human Dignity. The member was very grateful for all the assistance and resources provided by our care manager. She has now been educated on her benefits, which will facilitate reaching her health goals and compliance with medication and preventive care.

110. Describe the drug reference database used in pharmacy claims processing, and the update schedule, including term dates, obsolete dates, and rebate status. *2 pages*

Drug Reference Database Description

OptumRx, delivers pharmacy benefits through more than 67,000 community and retail pharmacies nationwide and uses the Medi-Span Master Drug database file to keep product and pricing information up-to-date. The file includes price updates, product updates and new drug information for all drugs, including specialty drugs. Medi-Span has provided comprehensive drug information to the health care industry for more than 30 years. We adopted Medi-Span because it is widely considered to be the leading industry source for drug pricing information. **Our current processes, policies and procedures apply the Medi-Span files to the claim system twice weekly, exceeding MLTC's minimum requirement for updates every seven days.**

OptumRx reports are generated from the file update process, reviewed and verified. If there are any issues identified in the reports, our team works together to validate the information if necessary, documenting the issue on the Medi-Span and Clinical Operations log for tracking and follow up with Medi-Span for research and resolution. Upon resolution from Medi-Span (if required), OptumRx initiates and completes the project to apply the updated information to the system.

Claims with an active Medi-Span National Drug Code (NDC) will have a corresponding Medi-Span average wholesale price (AWP) that is effective when the claim is adjudicated. The drug pricing information also easily integrates into our existing software applications. We exclusively use Medi-Span as our source for AWP to adjudicate claims and for guarantees preventing our retail pharmacies from submitting adjusted AWP to maximize their discounted ingredient costs. We obtain Medi-Span updates daily and enter relevant product changes in our claim system. Therefore, a full file update is not required.

Update Schedule

We will review and update our pharmacy files daily and perform system updates within two business days. We will conduct ad hoc internal audits to verify that all NDCs in the files we receive from MLTC are appropriately programmed into the system. Our system will provide for an automated update to the NDC file including all product, packaging, prescription, pricing and rebate information. The system will maintain a history of the pricing schedules and other significant reference data.

111. Describe how the State Medicaid PDL will be integrated into the MCO pharmacy claims system. *2 pages*

Integrating Nebraska's Medicaid PDL into Our Claims System

Our affiliate health plans currently manage pharmacy benefits in 20 states across the nation. We have implemented state preferred drug list (PDL) in four states including Florida, Kansas, Ohio and Texas; three are common PDLs; and we have successfully implemented UnitedHealthcare's PDL in the remaining 13 states. Each state approached the integration differently based upon the specific needs and requirements of the state. We will leverage the experience and resources of our parent organization, UnitedHealthcare Community & State, MLTC pharmacy specialists and our local and affiliate health plan experts to establish and implement a comprehensive pharmacy program.

We look forward to working with MLTC to integrate the pharmacy benefits into our Heritage Health program including the integration of the PDL into our claims system to better serve our members. We will integrate, follow and enforce MLTC's PDL through our established processes, policies, procedures and technology for provider education; utilization management including prior authorization, prospective, concurrent and retrospective review and psychotropic medication monitoring; care management and claims management. We will follow the Nebraska Medicaid regulations that require ordering and prescribing providers to obtain a Nebraska Medicaid Provider Identification number issued by the state of Nebraska.

We will provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and will submit our policies and procedures for complying with the PDL to MLTC within 60 days prior to implementation. Our goal is to further our current partnership with MLTC by developing a robust pharmacy management program that facilitates meeting the needs of our members in the Heritage Health program through a robust new benefit build, seamless transition from the existing fee-for-service (FFS) program and ongoing management of the pharmacy benefit.

System *Setup*

Our current systems are scalable and flexible. The systems will support the integration of MLTC's PDL into our claims system prior to implementation. It is our experience that this type of integration can be achieved through a high degree of engagement and collaboration with state partners to assure an accurate and timely data exchange. We will collaborate with MLTC to establish sound workflows and processes that will adhere to defined drug inclusions and exclusions of coverage.

Drugs and drug classes that are included in the program will be defined in the system at a therapeutic class level as a covered class, which allows the system to recognize a class of drugs as eligible for coverage and automatically recognizes new additions to that drug class. Drugs that are excluded from coverage will be clearly defined and blocked from processing and overrides. System setup at an even more defined level determines precise PDL coverage and specific coverage rules, facilitating the flexibility to guarantee access to covered medications while also applying drug benefit management.

We will load pharmacy benefits as defined by MLTC including the PDL, member benefits, prior authorization (PA) criteria including non-preferred drugs, utilization management (UM) edits, quantity edits, age edits and specialty drug designations. Weekly review of Medi-Span in conjunction with ongoing collaboration with the Pharmacy and Therapeutics (P&T) Committee will assure our members have access to the medications they need for their conditions.

System *Updates*

We will work with MLTC to create a policy for ongoing formulary updates to address the receipt of routine updates to the formulary/PDL files from MLTC on a regular basis. Changes to the file will be

itemized and translated into a system coding request. The coding request will be reviewed for accuracy prior to submission to the benefit operations team. Our benefit operations team will complete the system coding request and, once approved, the coding update will migrate into production.

We also will maintain policies to address post-production monitoring, including review of daily claims processing activity to make sure paid and rejected claims are appropriate and a remediation strategy for inappropriate rejects, including investigation for root causes, completion of system coding updates, analysis of member impact and possible inclusion of outbound calls to providers to reprocess claims.

We will collaborate with MLTC on the following types of new policies:

- Building an accurate benefit infrastructure within our PBM including coverage of all required classes
- Adhering to MLTC's rebate requirements
- Assuring coverage by place of service such as nursing facilities
- Receiving and loading files accurately
- Collaborating with MLTC on an ongoing basis

We also will support administrative simplification for our provider network through standardization of forms and processes, easy access to the PDL, initial and ongoing training on the PDL, user-friendly technology and processes for prior authorization, timely communication of PDL changes and the availability of peer-to-peer consultations on the PDL and PA processes. To further maximize the effectiveness of the PDL, we also will have a robust drug utilization review program.

Our members will have access to all drugs covered in the Heritage Health benefit and also comply with requirements for data reporting for the Federal Drug Rebate Program. We will use the CMS Drug File as a reference to identify the medications that are covered and verify we are in compliance with medication access requirements.

Interaction with MLTC's Pharmacy & Therapeutics Committee

Our pharmacy director will participate on the MLTC P&T Committee to assure a seamless transition to our pharmacy program for our members, make sure our pharmacy program continues to meet MLTC requirements and collaborate with MLTC on ways in which we can improve the delivery of medications to our members. This also will provide a vehicle for two-way sharing of information for recommended changes to the PDL based upon nationally recognized research, best practices and local practice patterns.

112. Describe the MCO's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the MCO proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor. *5 pages*

Longstanding Record
In accordance with Section IV.S.10, we have consistently met or exceeded the required monthly encounter acceptance rate for, minimally, the past 20 months.

UnitedHealthcare recognizes that accurate, timely and complete encounter data submissions are evidence that we are fulfilling our responsibilities to MLTC, allowing use of the data as the foundation for evaluating performance and quality and determining premium payments in the future. As an incumbent, we will continue our compliance with all requirements for submission of complete, accurate and timely medical, BH, vision and pharmacy-related encounter data to MLTC in accordance with all federal requirements and as specified in Section IV.R, Section IV.S.10(a-x) and Section IV.C.17. For example, we will continue our:

- Submission of encounter data accurately, meeting the MLTC established data quality standard of correct encounters
- Submission of all available claims data to MLTC without alteration or omission when a provider claim is denied for reimbursement
- Actions to address 90 percent of reported errors within 30 calendar days, and 99 percent of reported errors within 60 calendar days
- Generation of encounter data files following MLTC's payment cycle requirements (e.g., within two business days of the end of a payment cycle, etc.); this will be a change to currently compliant processes, where claims extracts are done on a monthly basis
- Submission of a weekly claim-level detail file of pharmacy encounters to MLTC that includes individual claim level detail information on each pharmacy claim dispensed to a Medicaid patient

Under the leadership of Mr. Jones, the encounter data quality coordinator, Rob Steffens, and claims administrator, Diane Knutson, meet regularly to review reports on encounter submission trends and completeness as well as discuss correction opportunities throughout the payment and encounter submission process.

Approach to Submitting Timely and Accurate Data

UnitedHealthcare has substantial experience and a proven track record in submitting timely and accurate encounter data. Our unparalleled encounter reporting capability is cultivated from our experience in managing Medicaid managed care programs in 24 states; many of which include the integration of physical health, BH and long-term care populations. We have procedures and processes in place to confirm that we submit timely, accurate, complete and required data elements for subsequent transmission to MLTC. This includes encounters for our subcontractors who are under the direct oversight of our dedicated national encounter process team. We believe accurate encounter data begins with accurate claims. All new claims are subject to a series of reviews to confirm we have all of the data needed to process the claim and produce accurate encounters.

CSP houses our claims data, which serves as the main data source for encounter data extracts. Based upon adjudicated claims data from CSP, we collect encounter data in HIPAA transaction formats and code sets through our National Encounter Management Information System (NEMIS). We have extensive local and national experience submitting and receiving all encounters in standard HIPAA transaction formats as required by MLTC including, but not limited to, 837P (professional claims), 837I (institutional claims) and NCPDP (pharmacy) file formats for electronic transactions. We comply with CMS and HIPAA

standards for electronic submission, security and privacy, and verify that our subcontractors adhere to the same standards.

While we are very familiar with HIPAA transaction and code set regulations, we acknowledge the importance of using MLTC's encounters companion guide, or other required documents to achieve a successful encounter program. We plan to conduct comprehensive end-to-end testing before the operational start date. Successful end-to-end testing with MLTC will be dependent upon understanding and deploying the specific requirements.

Monitoring Data for Completeness

National Encounters Management Information Systems

We use NEMIS throughout the end-to-end encounters process from submission and tracking to error corrections and resubmission. The NEMIS infrastructure is equipped with a centralized repository to store and submit encounter submission data in various formats to MLTC, as required. Although Medicaid encounter submission, tracking and reconciliation are the primary functions of the system, NEMIS supports most X12 formats (837I/P/D, NCPDP), Medicare RAPS format and proprietary layouts. It is also flexible enough to accommodate any future changes as required by MLTC.

NEMIS is designed to accommodate multiple data sources including our claims and enrollment systems. Claims data from contracted vendors is loaded into NEMIS on a bimonthly basis. To confirm timeliness of data collections, vendor transmissions are scheduled and monitored by our media tracker database.

NEMIS also provides our encounter business team and local health plan with reports necessary to track encounter submittal success rates, investigate and correct submittal errors, and make business decisions regarding the processes involved.

Encounter Submission Process

Our encounter data collection and submission process, shown in Figure IV.R-11, confirms all data provided to MLTC has first been tested for accuracy, completeness, logic and consistency. We submit encounter data in the HIPAA-standard approved by MLTC, using files generated in NEMIS. We comply with CMS and HIPAA standards for electronic submission, security and privacy, and we verify our subcontractors adhere to these standards as well.

The collection and submission process presented below validates accurate processing and timely submission of encounter data files due to checkpoints included in the process.

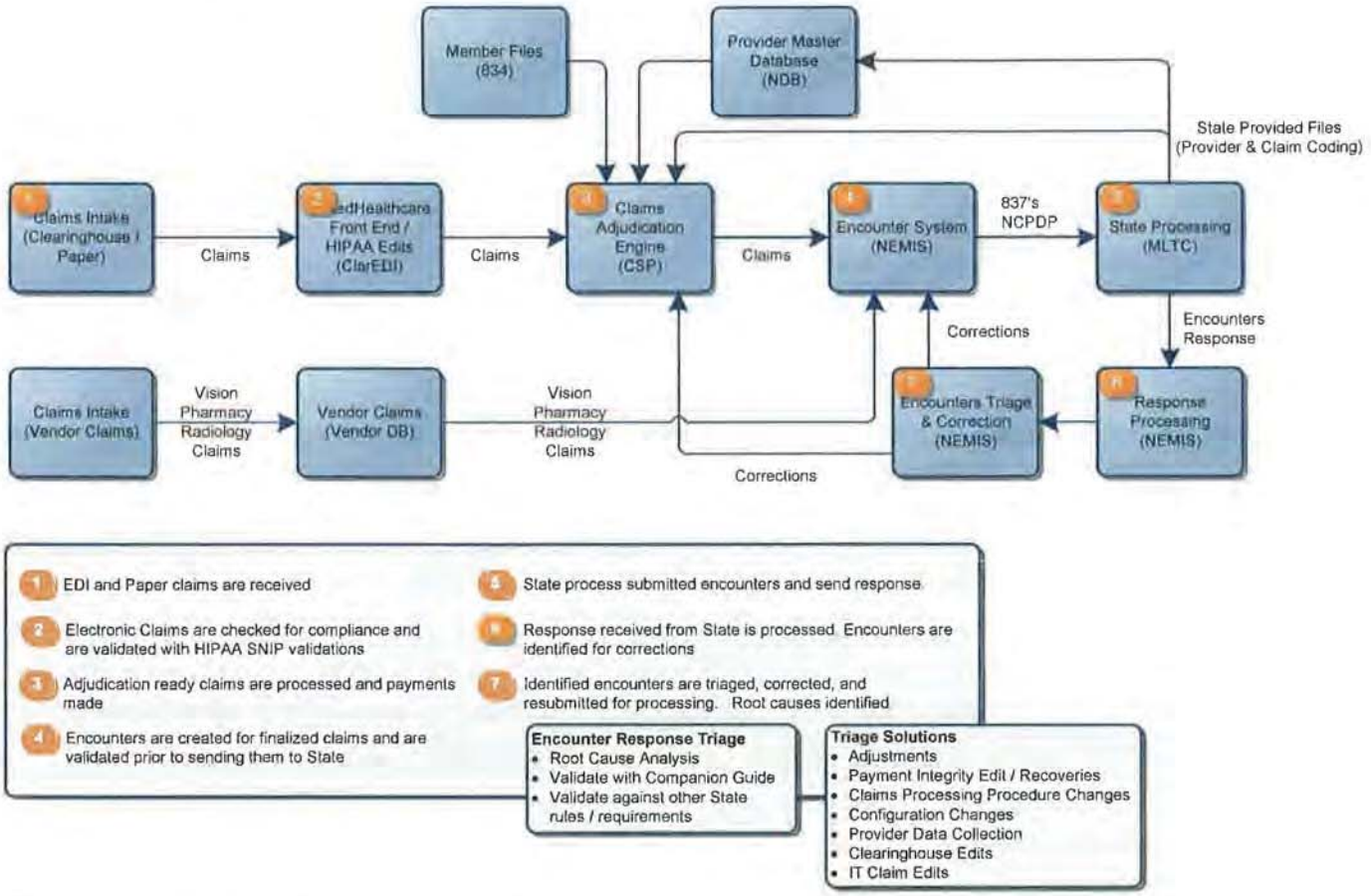

Figure IV.R-11. Encounters Flow. Our encounter data collection and submission process confirms all data provided to MLTC has first been tested for accuracy, completeness, logic and consistency.

As required, an attestation to the truthfulness, accuracy and completeness of all encounter data submitted will be included. We will configure our submission to meet the 10,000 per day encounter claim limitation.

Claims Data Acquisition

All required data elements are retained in claims history for use in creating the encounter submissions. Our claim extract program identifies all paid, denied and adjusted claims from the claims system to be included in our NEMIS repository. Claims from our subcontracted providers are pulled into NEMIS through our vendor database. All paper claims are converted to electronic data, which are populated in the claims system. The claims system assigns unique document control numbers to link the claim to the original image. Once in the claim system, the claim is processed in the same manner regardless of how it was submitted to us.

Data Validation

NEMIS performs automated edits and HIPAA validations on all claims to confirm the accuracy and completeness of encounter data (e.g., presence of provider IDs, national provider identifier [NPI], taxonomy and member Medicaid IDs). We submit all claims that pass these validations, and certify HIPAA transaction readiness. Claims that do not pass these validations receive an error and are set aside for research by the encounters management team. The team collaborates with functional operating teams, including subcontracted vendors, to resolve and submit those encounters.

We test NEMIS to verify it is configured appropriately to meet the requirements set forth by MLTC. This includes validation that certain data elements are required on the encounters; the encounters are validated against national code sets and that encounters comply with required reimbursement methodologies.

Subcontractor Data Validation

UnitedHealthcare has several mechanisms in place to safeguard the submission of accurate and complete provider and subcontractor encounter data, including operating agreements, dedicated encounters staff, statistics and reports, governance calls and audits. Our provider and subcontractor agreements obligate providers to submit timely and accurate claims. Payments are contingent on the provider or subcontractor meeting all contractual obligations, including the claims submission guidelines in our *Provider Administrative Guide*. We monitor rejection and denial volumes to identify providers in need of additional education by our provider relations advocate team or other department experts.

Our encounters team verifies claim data is received from our subcontractors as contracted. Using NEMIS, the encounters team employs validation edits and lag reports to monitor encounter data collection from subcontracted providers. The verification process confirms the file is not a duplicate and that primary service dates or claim postdates fall within expected ranges. We validate original input filename, expected received date, actual received date, insert date, batch load ID, number of claim header and detail records, number of claims accepted into encounter claims processing system and number of claims failing initial edits. If any anomalies are seen, we work with the subcontractor to understand and resolve.

We have a Delegation Vendor Oversight Committee responsible for the review of activities performed by delegated subcontractors. This committee meets quarterly and is made up of key management from throughout the company. In addition, our contracts with subcontractors stipulate that subcontractors must follow MLTC's accurate and timely submission requirements. To confirm subcontractors' adherence to MLTC standards, we report results to the QAPIC for review, analysis and any recommendations for corrective action.

Response File Process

NEMIS receives the MLTC encounter submission response files with acceptance detail and posts a response status. The encounters management team researches all rejected encounters as identified by the denial code list within MLTC's encounters companion guide, or other required documents. The team collaborates with functional operating teams, including subcontracted vendors, to resolve and resubmit timely the rejected encounter as replacements, adjustments or voids. If errors are found by MLTC or subcontractors that require encounters to be adjusted or voided, we will complete within the required timeline. NEMIS also generates encounter post submission completeness reports that provide our encounters management team with detailed insight into the process with key checkpoints that verify all transactions are balanced and reported.

In the event we realize a claim needs to be resubmitted or updated, paper or electronic, our provider advocates work with the provider on resubmission, and any refresher training needed for recurring claim issues is offered.

Continuous Quality Improvement

UnitedHealthcare continuously reviews current encounter requirements and processes for opportunities to improve encounter quality. Rejected encounter reports are reviewed for the top issues experienced. For the short term, mitigation plans are developed to correct identified issues before the next submission. For the long term, edits are identified and developed to improve future results. Additionally, we monitor encounter rejections to identify all providers in need of additional claim billing education. We welcome

collaborative work sessions with MLTC on encounters as our experience shows they are very effective in improving quality. When we identify provider education trends, we will engage the local provider relations team to work on prevention of errors and correction of any issues identified through our internal quality control processes.

Managing Non-Submission of Encounter Data by a Provider or Subcontractor

Our team of professionals dedicated from each functional business units monitors claims and encounter reporting and submission. Our strategies consist of active monitoring/early warning and ongoing provider support and education. Overall activities include, but are not limited to, the following:

- ***Encounter Volume Control Chart Monitoring:*** Encounter completeness can also be monitored by examining the following metrics:
  - Encounter rate per enrollee for inpatient services
  - Encounter rate per enrollee for outpatient services
  - Encounter rate per enrollee for professional services
  - Encounter rate per enrollee for pharmacy services

  Once the metrics are calculated by type of claims for each month, a control chart is created to include the average or acceptance range as determined by standard deviation statistics. This control chart will be particularly useful to examine encounter completeness for the special needs populations. Any observed deviation, as suggested from the control chart, will be raised and investigated with an action plan developed to mitigate the issues.
- ***Provider-Level Monitoring:*** We calculate utilization metrics (per 1,000 members per year) for member physician office visits and other key services like clinics, ER and hospital inpatient services. In particular, we measure the office visits if they are rendered by the assigned PCPs, generalists within the medical practice (e.g., nurse practitioners, physician assistants, delegated physicians covering for an out-of-office PCP, etc.) and other specialists. Overall, these measures are used to examine if members are being seen on a routine basis. Since percentile ranking statistics are calculated for each measure for each provider, this method allows identification of certain providers with potential under-reporting issues (e.g., overall office visit less than one visit for disabled members). More importantly, we can also use this method to examine providers with special status. If under-reporting trends are detected consistently for the providers during our quarterly monitoring, they are contacted by our provider services team.

113. Describe the MCO's proposed processes for coordination of benefits for dually-eligible members. *2 pages*

Processing Medicare Crossover Claims

We have significant experience coordinating coverage with Medicare Parts A, B and D and state Medicaid programs through our support of more than 228,334 dual-eligible members and our data-sharing and copayment arrangements with the 14 states where they reside.

In compliance with Section IV.S.16, we will continue to provide a list of known third party liability information, in the Nebraska required format, on a monthly coordination of benefit (COB) file that is delivered via our program integrity officer, Tim Langdon.

Savings from Dual-Eligible COB Activities
Nationally, we save, on average, 11 percent of medical spend due to savings generated from coordination of benefit activities. Decreasing our medical spend ultimately benefits the MLTC.

In compliance with Section IV.S.17, we will coordinate copayments, coinsurance and applicable deductibles remaining after Medicare or commercial payment on behalf of members with Medicare or commercial coverage, up to the Medicaid allowable. Under no circumstances shall the combined Medicaid-Medicare payment or the combined commercial-Medicaid payment equal more than the amount Medicaid would have paid as the sole payer. We efficiently process Medicare crossover claims with our Medicare crossover claims processing methodology. To reduce the administrative burden on providers, we require them to submit the claim one time to the Medicare intermediary for Medicare and Medicaid processing of the claim. In addition, we automatically:

- Identify Medicare enrollees through the Medicare intermediary and CMS
- Load third party liability (TPL) data into CSP to improve claims processing speed
- Create crossover claims in CSP based upon the original Medicare claim, providing timely processing of the Medicaid portion of crossover claims

Our Medicare crossover claims process:

- Begins by establishing a trading partner agreement with the Medicare intermediary allowing us to share data with them
- Identifies enrollees who have Medicare as the primary payer through the multiple sources used to collect TPL data, such as UnitedHealthcare Medicare and commercial plans and CMS
- Automatically loads TPL data into CSP for each enrollee identified as having Medicare
- Allows providers to submit Medicare claims once to the Medicare intermediary for Medicare and Medicaid processing
- Allows us to receive an HIPAA 837-compliant claim file of claims processed by the Medicare intermediary for enrollees with dual membership
- Verifies we provide timely adjudication and payment of crossover claims using CSP through active monitoring of claim queues to prevent claims from aging beyond established metric targets
- Confirms we submit Medicare crossover claim encounter data according to CSP requirements

CSP creates crossover claims automatically by generating the Medicare and Medicaid claims from the original claim. If the enrollee has UnitedHealthcare Medicare, we pay the Medicare claim as primary and process and pay the Medicaid claim. If the enrollee has Medicare coverage with another carrier, we coordinate the primary Medicare payment with the other carrier and process and pay the Medicaid claim.

We can configure CSP to pay Medicare coinsurance or deductible amounts. For services denied by Medicare (other than Medicaid-only covered services), we use the Medicare crossover claim file carrier explanation of benefits (EOB) to determine secondary liability. If Medicare has denied the service for administrative reasons, we deny the claim and instruct the enrollee to work through the Medicare appeals process if he/she disagrees with the Medicare denial.

CSP can store other carrier information and has built-in edits to allow for COB processing. We configure CSP to meet CSP-specific requirements to coordinate the Medicare allowable or to process and pay only the Medicare copays. We also keep an audit trail of all crossovers claims, and they are recorded and tracked as COB adjustments in our system.

We submit encounters in the HIPAA 837I and 837P formats and populate the primary payer identifiers in the Other Payer Name loop and primary payer payment information in Other Subscriber Information loop, according to the HIPAA implementation guides.

Network Provider Agreement Responsibilities

In accordance with Section IV.S.17, we will continue to establish written agreements with all Nebraska network providers that include required benefit provisions. Our Medicaid provider agreements also state that if a TPL exists, payment of claims will be determined in accordance with MLTC requirements. Unless UnitedHealthcare otherwise requests assistance from the provider, we will be responsible for third party collections conducted in accordance with MLTC guidelines.

Additionally, we work closely with providers to educate them on claim submission requirements when they know a member has TPL coverage, which includes submission of the primary carrier's EOB. We inform providers of our TPL processes and their obligations using several tools, including:

- Provider agreement
- *Provider Administrative Guide*
- Provider newsletters
- Provider services representatives
- Provider portal

We target providers who are identified as consistently noncompliant with TPL claims and recovery activities for targeted education.

IV.T. Reporting and Deliverables

IV.T. Reporting and Deliverables

114. Provide an example of dashboards that the MCO will use to track MCO performance for MCO leadership and the QAPI Committee.

We proactively manage our performance and develop strategies for improvements, measuring and analyzing our performance on a daily, weekly, monthly and annual basis. With substantial experience producing reports and dashboards that track plan performance for our leadership and the Quality Assurance and Performance Improvement Committee (QAPIC), our QAPIC provides program direction and oversight of quality improvement (QI) activities related to the unique needs of Nebraska Medicaid members and network providers in the areas of clinical care, service operations, satisfaction, patient safety, compliance and practitioner credentialing.

If dashboard or scorecard measures trigger thresholds requiring further research, we have extensive health data analytics capabilities through our robust, integrated reporting and data analytics solution, including our Strategic Management Analytic Reporting Tool (SMART). This comprehensive reporting solution gives us the flexibility to produce any type of operational, management or ad hoc report that might be useful in examining and strengthening our procedures and program outcomes. It enables us to maximize plan effectiveness, meet MLTC reporting requirements and empower providers and care for our members. It integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce all reporting and analytics needed to conform to MLTC's requirements.

In addition to standard reports, SMART power users can use predesigned templates and drill down features to analyze high-level trends that pinpoint potential root causes. This helps our management understand business performance and develop effective action plans that address changing business needs. Using our existing dashboards, functional area scorecards and the flexibility of our analytical tools, our team can track and monitor business performance, provide early warning of variation in the business and quickly determine drivers of change.

Dashboards and Scorecards

Below are some examples of our dashboards and scorecards used by leadership and QAPIC. The areas of focus include:

- Clinical care
- Service operations
- Member and provider satisfaction
- Patient safety
- Compliance
- Practitioner credentialing

Clinical Care

Utilization Management Scorecard

We submit our Utilization Management Scorecard to MLTC quarterly. This scorecard, a callout of which can be seen in Figure IV.T-1, compares prior year data against current year goals for utilization management (UM) metrics, admits, days and average length of stay. The Utilization Management Scorecard has an easy-to-use interface that provides multiple views of the data. The data are claims-based driven and refreshed monthly. The reports provide additional detail on inpatient utilization metrics by various case categories and trend information on readmissions.

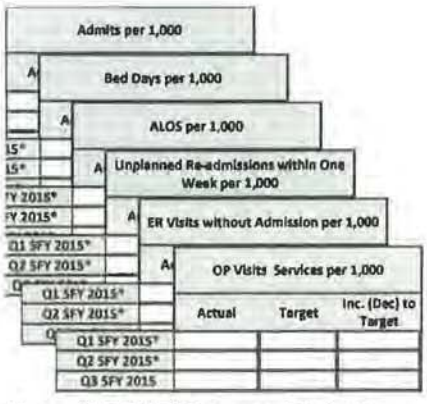

Figure IV.T-1. UM Scorecard Callout

Quality Metrics Scorecard

We report quality metrics on a scorecard, seen in Figure IV.T-2 Quality Metrics Scorecard, to facilitate analysis and development of necessary improvement plans. This is reported to QAPIC on a quarterly basis. In Nebraska, our comprehensive quality scorecard is one of many tools we use to systematically identify opportunities for improvement. On this scorecard, we monitor critical HEDIS measures that are specific to our population and the gaps in care that we are focused on driving gap closure and care improvements. The scorecard provides a snapshot of all incentives in place for these focused measures. We have shared this scorecard with MLTC, and it was well received.

In addition, we monitor CAHPS. This survey asks consumers and patients to report on and evaluate their experiences with health care. We currently complete three surveys, and the scorecard documents our progress toward improvement in five key categories and our member satisfaction initiatives.

For all quality initiatives, we monitor and evaluate opportunities that may result in performance improvement projects (PIPs) or other formal or informal quality improvement activities. These activities focus on improving the quality, timeliness or appropriateness of our care and service delivery.

UNITEDHEALTHCARE COMMUNITY PLAN, NEBRASKA
QUALITY METRICS SCORECARD
Quality improves when you measure...

HEDIS		HEDIS is the Healthcare Data & Information Set is a quality measurement tool developed by the National Committee for Quality Assurance (NCQA). There are 93 metrics across five dimensions such as preventive care, chronic care, service, access/availability, and utilization. Data is presented on the HEDIS year.							Member Incentives						
abbr.	Plan Critical Measures--selected to monitor effectiveness of care across the population allowing for targeted interventions.	HEDIS 2012 rate (Final)	HEDIS 2013 rate (Final)	HEDIS 2014 rate (Final)	HEDIS 2015 Rate (Final)	2015 % Change	2016 Goal	HEDIS 2016 Interim Rate	Annual Prevent Letter	Automated EPSDT Calls	EPSDT Post card	Automated Silverlink Calls	Live Calls	Post Care Post Card	Baby Blocks Baby Showers
AWC	Adolescent Well-Care Visits														
W34	Well Child Visits in 3, 4, 5, 6 year olds														
CDC	Comprehensive Diabetes Care (HbA1c Testing)														
CDC	Comprehensive Diabetes Care (Eye Exam)														
CDC	Comprehensive Diabetes Care (Monitor nephropathy)														
CDC	Comprehensive Diabetes Care (Controlling Blood Pressure <140/90)														
LSC	Lead Screening														
CIS	Childhood Immunization Status--Combo 2														
IMA	Adolescent Immunization Status--Combo 1														
HPV	Human Papillomavirus Vaccine for Female Adolescents (new in 2012)														
PPC	Timeliness of Prenatal Care														
PPC	Frequency of Prenatal Care >=81%														
PPC	Postpartum Care														
W15	Well Child Visits 1st 15 months: six or more visits														
BCS	Breast Cancer Screening														
CCS	Cervical Cancer Screening														
CHL	Chlamydia Screening in Women (Total)														
AAP	Adults' Access to Preventative/Ambulatory Health Services (total)														
SPR	Use of Spirometry Testing in the Assessment & Diagnosis of COPD														
ABA	Adult BMI Assessment														
CBP	Controlling Blood Pressure (new in 2012)														
ASM	Use of Appropriate Meds for People with Asthma														
MPM	Annual Monitoring for Patients on Persistent Medications (new														

CAHPS	CAHPS is the Consumer Assessment of Healthcare Providers and Systems survey. This survey asks consumers and patients to report on and evaluate their experiences with health care.							Member Satisfaction Initiatives					
Measure	ADULT		CHILD w CCC GP		CHIP w CCC GP								
Measurement Year	2014	2015	2014	2015	2014	2015							
Getting Needed Care													
Getting Care Quickly													
Customer Service													
Rating of All Health Care													
Rating of the Health Plan													

NCQA Accreditation Status	Health plans accredited by NCQA are required to prove themselves against a rigorous test of quality. The care and service the plan provides have been evaluated against NCQA's high standards. Because the plan met or exceeded the standards, it achieved NCQA Accreditation.	NCQA Accreditation Status						
		Calendar Year	Standard Year	Standards	HEDIS	CAHPS	Total	Status
Denied, Interim, Provisional Accredited, Commendable, Excellent	UHCCP Nebraska Health Plan Status:							
Recertification Date								

Figure IV.T-2. Quality Metrics Scorecard.

A future enhancement of the Quality Metrics Scorecard will include our provider satisfaction key metrics and initiatives in place to improve our results.

Service Operations

Contractual Monitoring Dashboard

In our review with leadership and through QAPIC, we leverage several of the key metrics from the operational area, such as customer service metrics, to ensure contractual metrics are met on a month-to-month basis. See Figure IV.T-3 Contractual Monitoring Dashboard below. In addition, we discuss any variances identified on this dashboard to ensure contractual requirements continually are met.

Operational Benchmarks Type		Benchmark	12 mo Avg	Sep-15
Member Call	PG	30 ASA	#	#
	PG	</= 3% Abandonment	#	#
Provider Call	PG	30 ASA	#	#
	PG	</= 3% Abandonment	#	#
Medical Claims	PG	90% clean claims adjudicated within 15 days	#	#
Pharmacy Claims	PG	90% clean claims adjudicated within 7 days	#	#
Encounters	PG	98% or greater acceptance rate for each monthly encounter submission	#	#
Appeal Resolution	PG	95% resolution within 30 days	#	#
Grievance Resolution	PG	95% resolution within 30 days	#	#
PDL Compliance	PG	95% dispense medications in PDL categories compliant with NE State PDL each QTR	#	#

PG- Performance Guarantee

Figure IV.T-3. Contractual Monitoring Dashboard.

Provider Network Access Dashboard

This report, seen in Figure IV.T-4 Provider Network Access Dashboard below, provides a full comparison of specific provider type locations in relation to member locations to demonstrate the provider network coverage is in compliance with the access standards and measures for members' access to care. Provider types measured include PCPs, acute care hospitals, high-volume specialists (cardiologist, neurologist, obstetrician, gynecologist, oncologist and orthopedics), urgent care centers and federally qualified and rural health centers. This dashboard also identifies PCPs with open panels to new members.

	Provider				
	% Member Access by County				
	Cardiology	Neurology	Oncology	OB/GYN	Orthopedic
County	**1 within 60 miles**	**1 within 60 miles**	**1 within 60 miles**	**1 within 60 miles**	**1 within 60 miles**
Cass					
Dodge					
Douglas					
Gage					
Lancaster					

	Provider				
	% Member Access by County				
	Cardiology	Neurology	Oncology	OB/GYN	Orthopedic
County	1 within 60 miles	1 within 60 miles	1 within 60 miles	1 within 60 miles	1 within 60 miles
Otoe					
Sarpy					
Saunders					
Seward					
Washington					

Figure IV.T-4. Provider Network Access Dashboard.

Provider Network Adequacy Dashboard

Figure IV.T-5 Provider Network Adequacy Dashboard below provides a full comparison of home health and durable medical equipment (DME) provider locations in relation to member locations to demonstrate the provider network coverage is in compliance with the access standard of one provider located within 60 miles of a member's location.

	Provider							
	% Member Access by County							
	DME				Home Health Agency			
	1 within 60 miles				1 within 60 miles			
County	Q1-15	Q2-15	Q3-15	Q4-15	Q1-15	Q2-15	Q3-15	Q4-15
Cass								
Dodge								
Douglas								
Gage								
Lancaster								
Otoe								
Saunders								
Sarpy								
Seward								
Washington								

Figure IV.T-5. Provider Network Adequacy Dashboard.

Availability Dashboards

Quarterly, UnitedHealthcare gathers information regarding the current status of the network as it relates to PCPs and high-volume specialists. Availability standards are established, and performance against those standards is measured to verify the network has sufficient numbers and types of primary care, specialty care and behavioral health practitioners.

Figure IV.T-6 Availability Dashboards provides results of the ability of PCPs, prenatal providers and high-volume specialists (cardiologists, neurologists, oncologists and orthopedists) to meet MLTC standards for timely access to care and services, taking into account the urgency or need for services.

Table II: Numeric Availability of Primary and High Volume Specialty Practitioners

	Numeric Target Ratio Goal 1: X	Actual 1: X	Goal Met/Not Met
Primary Care Provider Type			
Family Practice	1:1000		
General Practice	1:1000		
Internal Medicine	1:1000		
Pediatrics	1:1000		
Total Adult PCP	1:1000		
Specialty Care Practitioner Type			
Orthopedics	1:2000		
Ophthalmology	1:2000		
ENT	1:4000		
Dermatology	1:8000		
Allergy	1:10000		
OB/GYN	1:2000		

Where state requirements are more stringent than those in this policy, the state requirements take precedence.

Table III: Geographic Availability of Primary and High Volume Specialty Practitioners

Primary Care	Goal	Goal Met or Not	Large Metro 1 in 5 miles	Metro 1 in 10 miles	Micro 1 in 20 miles	Rural 1 in 30 miles	CEAC 1 in 60 miles
Family/General Practice							
Internal Medicine							
Pediatrics							
Total Adult PCP							
High Volume Specialists							
Ophthalmology							
Orthopedics							
High Volume Specialists	**Goal**	**Goal Met or Not**	**Large Metro 1 in 10 miles**	**Metro 1 in 30 miles**	**Micro 1 in 45 miles**	**Rural 1 in 60 miles**	**CEAC 1 in 100 miles**
Dermatology							
High Volume Specialists	**Goal**	**Goal Met or Not**	**Large Metro 1 in 15 miles**	**Metro 1 in 30 miles**	**Micro 1 in 60 miles**	**Rural 1 in 75 miles**	**CEAC 1 in 110 miles**
Allergy							
ENT							
OB/GYN							

** CEAC- Counties with Extreme Access Consideration*

Figure IV.T-6. Availability Dashboards.

Appointment Availability Dashboard

An assessment of routine care, urgent care and after-hours care appointment availability, shown in Figure IV.T-7 Appointment Availability Dashboard, is conducted via a telephone survey, on a quarterly basis by DialAmerica, and provides analysis for appointment availability.

Physician Type	Availability (AV) Standard	Total Providers	Minimum Random Samples to be Taken	Number of Providers Contacted	Sample Acceptance	# of Providers That Met the AV Standard	% of Providers That Met the AV Standard	% of Providers That Did Not Meet the AV Standard
PCP								
Emergency	24 hours/ day, seven days/week							
Urgent Care	2 calendar days							

Physician Type	Availability (AV) Standard	Total Providers	Minimum Random Samples to be Taken	Number of Providers Contacted	Sample Acceptance	# of Providers That Met the AV Standard	% of Providers That Met the AV Standard	% of Providers That Did Not Meet the AV Standard
Routine	14 working days							
Specialists (High-Volume)								
Routine	30 working days							
Prenatal								
First Trimester	14 working days							
Initial Second Trimester	7 working days							

Figure IV.T-7. Appointment Availability Dashboard.

Member and Provider Satisfaction

Member Satisfaction

Assessment of member experience is performed annually to identify opportunities for improvement and to develop plans to correct process deficiencies and improve experiences, as seen in Figure IV.T-8 Member Action Plan. The review is accomplished using two main data sources:

- Member reported issues (complaints, appeals and grievance data)
- Consumer Assessment of Healthcare Provider and Systems (CAHPS 5.0H®[5])

Results from CAHPS surveys are also incorporated into the member experience analysis. The 2014 CAHPS surveys were fielded in the first half of 2014 using the CAHPS questionnaires and NCQA protocols. Surveys were mailed to random, statistically valid samples of eligible members in the health plan, with a telephone follow-up of non-respondents.

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Issue	Source: CAHPS, Complaints, Appeals	Priority: High, Medium, Low	Interventions
Access – (UR Determinations, medical necessity)	Appeals	Medium	
Billing and Financial (Balance Billing)	Complaints	Medium	
Customer Service	CAHPS CHIP	High	
Health care overall	CAHPS Adult Child	Medium	
Rating of Specialist and personal doctor	Adult CHIP	Low	

Figure IV.T-8. Member Action Plan.

Provider Satisfaction

The purpose of the 2015 UnitedHealthcare provider satisfaction survey report is to evaluate the overall satisfaction with local plan performance and key areas of service related to customer service, appeals, claims processing, care management, specialist satisfaction and provider relations with participating providers with UnitedHealthcare. Assessment of provider experience is performed annually to identify opportunities for improvement and to develop plans to correct process deficiencies and improve experiences, as seen in Figure IV.T-9 Provider Action Plan.

WorkPlan

2015 Provider Satisfaction Survey - Areas for Improvement

Nebraska

Deliverables and Milestones Tracking Sheet

Task #	Deliverables / Milestones	Owner	Status	Start	Planned End	Actual End	Comments
1							
2							
3							
5							
6							
7							
8							
9							
10							
11							
12							

Figure IV.T-9. Provider Action Plan.

Net Promoter Score

Net Promoter Score is a tool that measures a consumer's likelihood to recommend our health plan to others. UnitedHealthcare Community & State uses NPS as a component of loyalty and satisfaction with consumers. The Year-to-Date NPS Summary, Figure IV.T-10 and the NPS Monthly Overview, Figure IV.T-11 enable us to measure, track and improve the loyalty of the members as we continuously work to provide high quality services, identify and address issues proactively and provide innovative solutions.

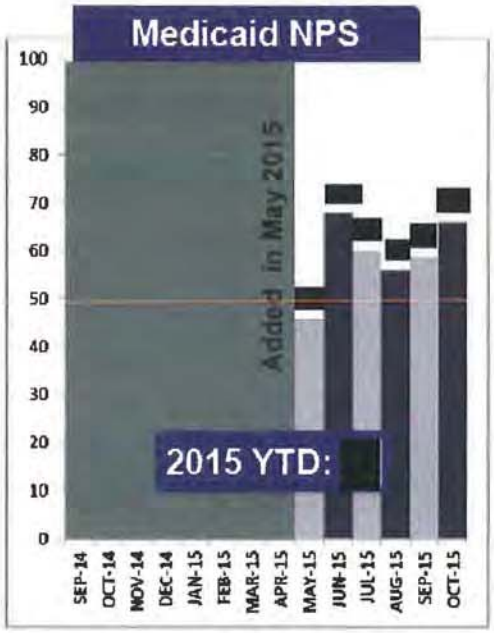

Figure IV.T-10. Year-to-Date NPS Summary.

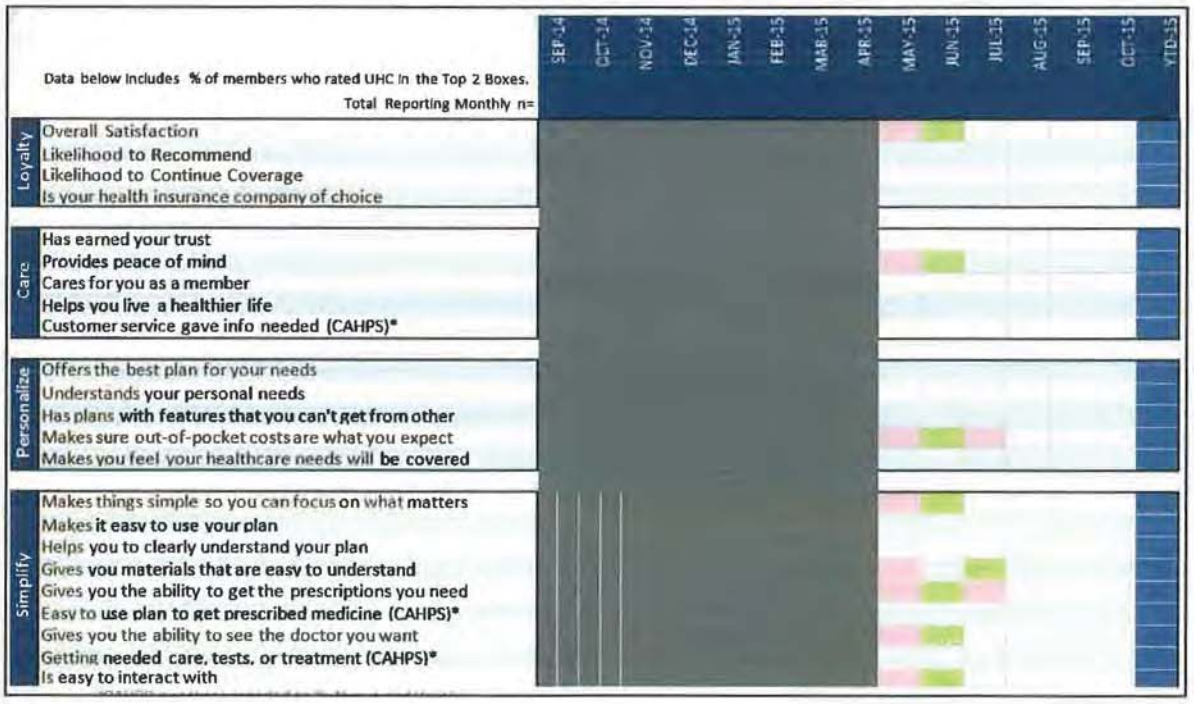

Figure IV.T-11. NPS Monthly Overview.

Patient Safety

Leapfrog Group

UnitedHealthcare continues as a health plan partner of the Leapfrog Group (LFG). LFG is the leading national nonprofit organization taking action to change the way health care is purchased and delivered. They are an employer-based coalition advocating for improved transparency, quality and safety in hospitals. As part of our Patient Safety Program, we monitor key aspects of patient safety and identify opportunities to promote safe patient care by analyzing and evaluating Leapfrog Hospital Survey Data. See Figure IV.T-12 National Leap Frog Annual Safety Reporting. UnitedHealthcare also continues to promote adoption of LFG's focused pillars, transparency in health care, standardized measurements and incentives and rewards. We also promote completion of the annual hospital LFG survey with all participating facilities.

LFG Reporting Year	2010	2011	2012	2013	2014
% of Participating Hospitals					

LFG Reporting Year	Reporting Hospitals	Total Hospitals	Rate of Participation
2013			
2014			
Difference			
Percentage of Change			
Rate Increase			

Figure IV.T-12. National Leap Frog Annual Safety Reporting.

Compliance Scorecard

We have developed a standardized internal scorecard that is used by each state plan, including Nebraska. The scorecard includes both subjective and objective measures on all aspects of the program including, but not limited to, program oversight; training and education; privacy and security; policies and procedures; performance monitoring of operational metrics; fraud waste and abuse (FWA) activities; including referrals to MLTC and regulatory enforcement activity, including correction action plans (CAPs).

The measures listed in the scorecard below, Figure IV.T-13 Corporate Responsibility and Compliance Scorecard, are examples and are modified periodically to meet emerging compliance trends or issues. Additionally, as we implement processes that result in consistent high scores, we look for new, more stringent measures to improve our overall compliance profile. QAPIC is key to reviewing the compliance scorecard in an effort to generate discussion and action to ensure a continued high level of compliance.

Corporate Responsibility & Compliance - Nebraska Quarterly Performance - Q1 2015						
Compliance Program Lead:		**Business Lead:**				
	Structure / Process	**Nebraska**	Points Q1	Q2	Q3	Q4
1	Program Oversight and Governance					
2	Standards, Policies & Procedures					
3	Training, Education and Communication Awareness Strategy					
4	Risk Assessment and Monitoring Strategies					
5	Reporting Mechanisms and Prompt Response to Detected Offenses					
	Standard Outcomes	**Nebraska**	Points Q1	Q2	Q3	Q4
1	Compliance Audit Results					
2	Privacy & Security Disclosures					
3	Compliance Training Completion					
4	Vital Signs Survey - Ethical Compliance Standard					
	Focused Outcomes	**Nebraska**	Points Q1	Q2	Q3	Q4
1	Regulatory Enforcement Actions					
2	Regulatory Standing					
3	Performance Monitoring of Operational Metrics					
4	Program Integrity					
	EVALUATION KEY:	**TOTAL:**				

Figure IV.T-13. Corporate Responsibility and Compliance Scorecard.

Practitioner Credentialing

Credentialing/Recredentialing

UnitedHealthcare completes credentialing and recredentialing to verify that practitioners and organizational providers that provide care and services to a UnitedHealthcare member meet established standards. Figure IV.T-14 Nebraska Credentialing Report represents the initial credentialing for the CPAC to review and approve. Figure IV.T-15 Annual Delegated Credentialing Audit Report represents the annual credentialing audit / preassessment performed to assess the credentialing compliance of our delegated entities. The report is also used as evidence to our regulators of our oversight of the delegated entities.

	CREDENTIAL TYPE	MKT	PHYSICIAN'S LAST NAME	PHYSICIAN'S FIRST NAME	DGR	SPECIALTY	CITY	ST	MEDICAL DIRECTOR DECISION	MPIN	TAX ID	MARKET #	STREET	ZIP	ZIP + 4	COUNTY	NPI	COMMITTEE APPROVAL DATE
2	INITIAL	COMMUNITY & STATE - NEBRASKA	LAST NAME	FIRST NAME	OD	SPECIALTY	CITY	ST	APPROVED	0000000	000000000	00000	STREET ADDRESS	ZIP	ZIP+4	COUNTY	0000000000	00/00/0000
3	INITIAL	COMMUNITY & STATE - NEBRASKA	LAST NAME	FIRST NAME	OD	SPECIALTY	CITY	ST	APPROVED	0000000	000000000	00000	STREET ADDRESS	ZIP	ZIP+4	COUNTY	0000000000	00/00/0000
4	INITIAL	COMMUNITY & STATE - NEBRASKA	LAST NAME	FIRST NAME	OD	SPECIALTY	CITY	ST	APPROVED	0000000	000000000	00000	STREET ADDRESS	ZIP	ZIP+4	COUNTY	0000000000	00/00/0000
5	INITIAL	COMMUNITY & STATE - NEBRASKA	LAST NAME	FIRST NAME	OD	SPECIALTY	CITY	ST	APPROVED	0000000	000000000	00000	STREET ADDRESS	ZIP	ZIP+4	COUNTY	0000000000	00/00/0000
6	INITIAL	COMMUNITY & STATE - NEBRASKA	LAST NAME	FIRST NAME	OD	SPECIALTY	CITY	ST	APPROVED	0000000	000000000	00000	STREET ADDRESS	ZIP	ZIP+4	COUNTY	0000000000	00/00/0000
7	INITIAL	COMMUNITY & STATE - NEBRASKA	LAST NAME	FIRST NAME	OD	SPECIALTY	CITY	ST	DENIED	0000000	000000000	00000	STREET ADDRESS	ZIP	ZIP+4	COUNTY	0000000000	00/00/0000
8																		
9																		

Initial | Recred Pracs | Medical Director Review | Reconsiderations | DNMC | Components | Components DNMC

Figure IV.T-14. Nebraska Credentialing Report.

Delegation Audit Findings

Preassessment Audit: Reviewed LIP's only

Annual Audit: Reviewed LIP's and Components

File Methodology Used: ☐ 10 Credentialing / 10 Recredentialing ☐ NCQA 8/30 Rule

If Applicable, Note Accreditation Type and Name on Certificate (if Different)

Delegate's Name: **Delegate's Name**

Sub-Delegate's Name: **Sub-Delegate's Name** — **NCQA Certified CVO - VeriPoint/CreDentals**

Date of Audit: January 00, 0000
States(s) supported by delegate: NE
Product(s) supported by delegate: Medicaid
Auditor: Name/Title
Person Responsible for Credentialing: Name/Title
Auditor Comments and Recommendations: **Comments/Recommendations**

Annual Delegation Oversight Audit was performed using both the current UnitedHealthcare Credentialing Plan and the NCQA Credentialing standards. Desktop document review was performed. Please see below for your score.

☐ **Recommend Delegation/Continued Delegation** Correct any identified Opportunities within 6 months; however no written response to United required. We will review your corrections at the next annual audit. Recommend Continued Delegation.

☐ **Does Not Meet All Criteria, requires Improvement Action Plan (IAP).** You must submit a written plan that describes your Action Plan, Responsible Party and Date to be Completed for each Opportunity Identifed below. Kindly submit that response within the next 30 days to <INSERT ACCT MGR EMAIL ADDRESS>. You may reach me at <XXX-XXX-XXXX> with questions.

☐ **Does not meet UnitedHealthcare Criteria for Continued Delegation, Recommend Termination**

Current Status	# of PCPs / # of SCPs Contracted	NCQA Medicare Audit Tool Score	NCQA State Audit Score	NCQA Medicaid Audit Score	NCQA TRICARE Audit Tool Score
	00/00				
Delegated / Preassessment for Medicaid	# of practitioners cred/recred in audit period	N/A	0%	0%	N/A
	00/00				
Opportunities Identified					

Figure IV.T-15. Annual Delegated Credentialing Audit Report.

Performance at a Glance Dashboard

As a result of wanting to be more customer-focused, we developed the Performance at a Glance Dashboard in 2010, seen in Figure IV.T-16. We currently provide Performance at a Glance with our quarterly report submissions. It provides a summary of key performance metrics in the required quarterly reports. We include prior and current reporting periods to allow for MLTC to see trends at a glance.

Nebraska State Dashboard	Q2 SFY 2015 (Oct, Nov, Dec)	Q3 SFY 2015 (Jan, Feb, Mar)	Q4 SFY 2015 (Apr, May, Jun)	Q1 SFY 2016 (Jul, Aug, Sept)
Utilization Management				
Bed Days /1000 Members				
Outpatient Services / 1000 members				
Unplanned Re-admissions within 1 wk / 1000				
ER visits w/o admission / 1000 members				
Average Length of Stay				
Admits / 1000 Members				
Case Management				
Total High Risk Assessments				
Total Receiving Case Management*				
Dx Receiving CM - Asthma				
Dx Receiving CM - Diabetes				
Dx Receiving CM - Obesity				
Dx Receiving CM - Hypertension				
Dx Receiving CM - Elevated Lead				
Client Grievance (appeal)				
Total actions issued				

Nebraska State Dashboard	Q2 SFY 2015 (Oct, Nov, Dec)	Q3 SFY 2015 (Jan, Feb, Mar)	Q4 SFY 2015 (Apr, May, Jun)	Q1 SFY 2016 (Jul, Aug, Sept)
Client Grievance (expedited appeal)				
Expedited appeals filed				
Expedited appeals resolved in 3 days or less				
Provider Appeals (combined with complaints prior to Q1-16)				
Total Appeals Filed				
Total resolved in < 45 days				
Provider Complaints (combined with appeals prior to Q1-16)				
Total Complaints Filed				
Total resolved in < 90 days				
PCP Access by County, 2 within 30 miles				
10 County Service Area				
PCP Timely Access Report - Appointment Availability				
Urgent Care 2 calendar days				
Routine Care 14 calendar days				
Timely Access Report - Hours of Operation				
Hours of Operation - all standards				

* Adjusted

Figure IV.T-16. Performance at a Glance Dashboard.

We welcome working with MLTC and the other awarded MCOs to establish a meaningful all-MCO scorecard for measuring performance.

115. Provide examples of the following reports:

- Member Grievance System
- Performance Improvement Projects
- Care Management

How will the MCO use required reports in its day to day management and operations?

Reports, whether internal dashboards or external, required reports, are a vital component of monitoring our performance, continually identifying opportunities for improvement, and improving outcomes for members and the customer experience for providers. We currently meet all contractual and regulatory obligations for reporting information monthly, quarterly and annually to MLTC. Over the last 20 years, we have invested significant time into developing required reports and templates, some of which were used to establish standardized report forms for all MCOs. In addition to required reports, we make use of multiple dashboards in day-to-day management and operations. These dashboards, discussed in detail in our response to Question 114, cover all areas of our work including quality, care and utilization management, compliance, provider relations, contractual guarantees and more. Taken together, our use of required reports and also internal dashboards helps us meet and exceed the expectations of members, providers, MLTC and other regulatory or accrediting bodies.

Member Grievance System Report

The Member Grievance System Report is prepared quarterly. This report provides a summary of member grievances, appeals and State Fair Hearings filed in the reporting quarter, including summary data of all complaints and detailed data submitted for complaints that have been unresolved for more than 90 days. Appeals and expedited appeals also are listed, including description and resolution time frames. This report enables us to identify appeals, State Fair Hearings and complaint trends along with areas for improvement.

Identifying Trends, Resolving Issues and Making Improvements from Report Analysis

Care management uses the appeals and expedited appeals metrics to trend providers and types of services for areas of provider education or the need to expand upon the amount of network providers. State Fair Hearings enable us to track and trend providers with education opportunities, further analysis of authorization processes and utilization needs.

The following is an example of how we identified a trend through recent appeals and provided an immediate resolution to facilitate timely and appropriate services to our members. Upon analysis, we identified pediatric members who needed a specialized insulin pump and assigned a care manager to work directly with the members, physicians and DME company to coordinate timely delivery of equipment to members. The providers reached out to the care manager who then assisted with processing the authorizations. As the point person in this process, the care manager was able to verify prompt delivery of the equipment, provide education and follow up with members and parents about their disease and equipment, and give feedback to the provider offices.

Another example of an improvement made based upon data analysis associated with the Member Grievance System Report pertains to appeals submitted by providers that should have included additional information not presented before the appeal. Oftentimes, this additional information supports the medical necessity of the service, enabling us to overturn the appeal. We determined for the 12 months prior that 59 percent of overturns are related to this issue. As a result, we have developed a clinical reconsideration process that will allow providers to request a reconsideration for a medical necessity review online, over

the phone or by mail and will be reviewed based upon Medical Clinical Guidelines by claims review staff. This process is being implemented to improve provider satisfaction.

Once the review is complete, we will share the outcome with the provider. If the information provided allows for a claim adjustment, we will send the payment and remittance to the provider. If the information provided still results in a claims denial, the provider will receive a letter explaining the reason for uphold. Importantly, the providers are then able to exercise their appeal rights if they are unsatisfied with the outcome of the clinical reconsideration request, and the time frame for requesting a clinical dispute/appeal remains the same.

This process will reduce the overall receipts for post service appeals. We are expecting a reduction of approximately 22 claim disputes that result in overturns each month. This, in turn, will likely lower the number of formal claim disputes. As mentioned, we expect provider satisfaction to increase as providers will be able to easily submit a clinical reconsideration request online electronically and upload all pertinent medical necessity attachments with the clinical reconsideration request.

Please refer to Attachment 19 Q115-1 Member Grievance System Report.

Performance Improvement Projects Reports

We continually endeavor to find areas of our operations to modify so we can improve the quality of services we provide to members and providers. Performance improvement projects, also known as quality improvement projects, are designed for the entire Nebraska population or a targeted population or subgroup. We identify and establish PIPs to improve our program performance. Our PIP studies are designed to include measurement of performance, interventions, performance improvement and systematic and periodic follow-up on the effect of the interventions. Performance improvement indicators are objective, clearly defined, based upon current clinical knowledge or care management research, and capable of measuring outcomes such as changes in health status, functional status, member satisfaction or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement.

Member Outreach Improved Overall Breast Cancer Screening Rate

The plan completed a breast cancer screening PIP that included a targeted member incentive, member education and provider communication. The results of this PIP showed an 11.33 percentage point increase in the number of members receiving their breast cancer screening. The member outreach incentives were determined to be effective in lifting the overall screening rate and therefore improving the care of these members. This resulted in a process improvement that continues for these members.

As we are required to show demonstrable and sustained improvement toward meeting MLTC performance targets, we report our results of measuring or assessing outcomes and quality, and incorporate these performance indicators into our PIPs. The QAPIC reviews and approves the results of evaluations and recommendations at least annually.

We have attached samples of two PIP reports we submit to MLTC:

- Attachment 19 Q115-2 PIP Report – Improving Screening and Follow-up for Adolescent Depression
- Attachment 19 Q115-3 PIP Report – Reducing Non-Emergent Emergency Department Visits

Care Management Reports

The Care Management Report includes summary data on the number and percent of members offered and receiving care management services during the reporting quarter. The accompanying narrative analysis

includes a comparison of the previous year's monthly and quarterly data, suggestions for areas of improvement and any actions implemented by care management.

We use this report to identify the member cohorts that are using care management services. The care management team is able to pull additional claims data and perform outreach to members based upon utilization trends, disease management needs or referrals. This report helps us track and monitor member populations, monitor and help improve coordination of care and ultimately make sure members receive the right care at the right time and in the right setting.

Please see Attachment 19 Q115-4 Care Management Report.

Monthly Case Review Assists in Avoiding a Potential Health Risk to a Member

During a recent monthly review of cases, a pharmacist indicated a member was being prescribed a large dose of Adderall. Our medical director outreached to the prescribing physician to review the current medications, compliance and potential needs of the member. After reviewing the case, they discovered a psychiatrist also was involved in the care of the member. A care conference was scheduled immediately to heighten the awareness between all collaborating parties about the member's needs and the potential health risks due to the combination of medications. An action plan was developed that centered around the member's needs, both physically and emotionally. The case was assigned to a care manager who outreached to the member to provide care management services. The care manager will continue to follow this member to help navigate the member through the health system and make certain the member receives appropriate and timely services.

Required Reporting Package

We produce numerous reports in all functional areas of our business to assist in the day-to-day management of our work and members, including, but not limited to, the required reports we submit to MLTC. We analyze the information from these reports and identify trends or opportunities for improvement.

We have been diligent in making sure our reports provide substantial details and keep MLTC well-informed of any updates. In addition, we have been timely in filing with MLTC per the contract requirements.

We will expand our monthly, quarterly and annual reporting to include the required reports in Attachment 6 that we do not currently generate and submit to MLTC within the specified time frames and in an MLTC-provided template or a format approved by MLTC.

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IV.X. Transition and Implementation

116. Describe how the MCO will coordinate the initial transition of individuals in the follow situations to ensure continuity of care:

- From another MCO.
- From FFS, including specific approaches for the aged and disabled populations who are new to managed care.

Include processes for engaging existing providers in the transition. *5 pages*

We are an established plan with significant experience and success in Nebraska providing transition and implementation services over the years. We know how to perform transitions and implementations for complex populations. We have successfully transitioned members from fee-for-service (FFS) in Nebraska several times. We did so initially in 1996 and again in 2010, adding seven counties. We do so whenever a new Class of Service (COS) is added, such as the Katie Beckett waiver-eligible population. On July 1, 2015, we worked closely with MLTC on a successful hospice implementation plan that led to MLTC recognition of a "no noise" implementation. Barbara Palmer, case management administrator, personally visited each hospice provider to educate them on our process as well as providing her information and serving as the point of contact for MLTC. For this implementation, we have already visited 161 organizations across the state for behavioral health (BH), intellectual and/or developmental disability (I/DD) including BH, I/DD, homeless, school-based, faith-based, provider, advocacy and service provider organizations, to be sure we understand and address concerns. We have also presented to organizations, such as the Arc of Nebraska board, to answer questions and address concerns, and we will continue to do so. We fully understand that implementation is not just about systems, it is about making sure that we exceed member and MLTC expectations. We plan to replicate these best practices with the new contract.

Our service model and approach to delivery will continue to provide Nebraska with a rich resource of Nebraska-based partners with the necessary skill and competency to meet program needs—now and in the future. Our primary focus is on efficiently and compassionately transitioning to the future Heritage Health program and ensuring continuity of care. Based upon our existing relationship with MLTC, we have a special understanding of the needs and concerns of Nebraska's Medicaid and CHIP enrollees and their families who may be transitioning to a new program. In the past three years, we have implemented new contracts that provided services for new or expanded State populations of approximately 1,055,100 members across 18 states. Our transition process is a multifaceted, member-centered approach that achieves transition success. We focus on goals encompassing risk mitigation, coordination, communication and continuity of care for all stakeholders. We implement a continuous improvement process to evaluate implementation performance while maintaining close communication with MLTC stakeholders. We allow members to see all current providers on their approved LTC plan of care by extending their authorizations when they initially enroll with us, whether the provider is in or out-of-network. This will continue until we receive or complete an LTC plan of care and the member agrees to any change or the issue is resolved through the appeals or fair hearing process and change is implemented.

Transition and Implementation Planning

We understand the need to confirm that medically necessary services continue with no disruption and that we support the continuity of care transitions for every member's physical and behavioral health care needs, including impacts to pharmacy transitions. Our approach to continuity of care verifies that we coordinate the member's care transition and exchange the information required to confirm the uninterrupted delivery of services needed to support the ongoing needs of transitioning members. We place special emphasis on coordinating care for individuals with complex and comorbid needs,

particularly those with frequent exacerbation of chronic conditions that require high use of medical services (e.g., uncontrolled diabetes or behavioral health recovery services). Our transition and implementation project team, led by Mr. Sean Jones, chief operating officer, will support a timely and effective Jan. 1, 2017, implementation.

Transitioning of Managed Care Members and Operations

No matter the transition circumstance, reason or method of first contact, we put member needs first and collaborate with all persons, providers and organizations throughout the care transition process. Our goal is to contact members early and often to establish relationships and assuage any concerns about the transition. We train our staff, network providers and stakeholders within the community on our "no wrong door" approach to delivering services that focuses on safety and quality. For members transitioning to UnitedHealthcare, their first experience with us may be during the new member welcome call. Members new to UnitedHealthcare or new to managed care often have a number of common questions the first month of enrollment, ranging from basic questions on benefit coverage to assistance with changing PCPs. Our new member welcome team conducts outbound calls to new members. During the welcome call process, we use innovative tools and scripting to provide validated information, to answer any immediate questions, to address any concerns our new members may have about access to care or UnitedHealthcare-related questions and to:

- Welcome the member and verify demographic information.
- Offer an overview of the member's covered benefits and services including the promotion of value-added services and preventive care, (e.g., no copays and adult immunizations).
- Confirm the member's PCP assignment, discuss the importance of the PCP/member relationship, assist with PCP appointment scheduling and, as needed, secure transportation services for the PCP appointment, address PCP-access issues and offer to help the member change his/her PCP, if necessary.
- Conduct the health risk screening during the call to identify care management needs, offering to reschedule screening for a time that is more convenient for the member, as necessary.
- Discuss a member's active treatment plan and receipt of any covered, medically necessary and authorized services.
- Discuss the importance of EPSDT screenings with members or their families and assist members who need to complete EPSDT screenings that are due or overdue.
- Review how to access pregnancy programs and resources, (e.g., referrals to Healthy First Steps, *Text4baby* and Baby Blocks, as needed).
- Review how to access carved-out services (e.g., dental services, non-emergent transportation and waiver services).
- Document information in our clinical management system, CommunityCare, providing care managers, care navigators and community health workers (CHWs) with access to up-to-date, member-specific information to facilitate the care coordination process.
- Confirm the member has received written materials, including receipt of a welcome packet.
- Inform members that our public website (*uhccommunityplan.com*) is available in English and Spanish and that they have the option to print their own ID card and access their benefits and claims information via the link to the secure member website (*myuhc.com*).
- A member services advocate (MSA) makes three outbound call attempts at different times of day to welcome the member and conduct the health risk screening. If an MSA cannot reach the

member by telephone, we send a postcard reminder asking the member to call us. Members identified on the enrollment file as having special health care needs are channeled into care management for outreach by a care manager, CHW or care navigator (depending on the member's needs) to ensure continuity of care and to address any unmet needs.

- As an innovative initiative, we are working to contract with Continuum of Care (CoC) providers and HUD providers of homelessness services to match homeless management information systems (HMIS) data against our membership data to identify joint members. This effort will assist us in locating members who are homeless and who are using homelessness services. Once matched, we will engage with the homelessness service agency to conduct a warm introduction between the member and a CHW or BH specialist who will conduct the health risk screening. We will help the member get connected to a PCP, services he/she may need and resolve barriers to care, such as job assistance, food, housing and other needs.
- We document health risk screening results in the member's record. We score the health risk screening and refer members whose score indicates they are at-risk via our care management system to our care management team for further review.

Establish a Command Center and Dedicated Member Care Transition Team

For this implementation, we will provide a health-plan command center located and staffed locally, so that we can monitor day-to-day operations for a successful transition. A dedicated local team is prepared to help new members transition successfully to us. This member-care transition team is interdisciplinary and monitors members for continuity of care and appropriate care. The team monitors our welcome strategy process, including use of the health risk assessment, continuity of care and resolution of escalated issues. Prior to the transition period, the team may conduct daily team calls to monitor progress and to identify and expedite resolution of transition of care issues. Our goal is to identify and mitigate transition issues prior to issues occurring. When issues do arise, this cross-functional team moves quickly to identify root causes and implement solutions. In many cases, issues are resolved within hours or days of discovery. This solution demonstrates our commitment to resolving remaining issues as quickly as possible to meet the needs of MLTC, our members and providers.

Coordinating Care with Other Health Plans During Managed Care Transitions

Collaboration and coordination are required when members transition between health plans. This approach benefits our members by making sure medically necessary care is not disrupted during care transitions. Today, we coordinate services when our members transition from one plan to another or when members enroll with us for medical services and another carrier for BH services. As pharmacy and BH services are carved into our contract, our ability to provide seamless member transitions will only be enhanced, as we will have access immediately to the member's continuum of care. We have formed collaborative relationships with other health plan peers as well as with providers and stakeholder entities, to effectively deliver and coordinate care.

Clinical Information Sharing

Collaboration between health plan managers occurs on a regular basis to share eligibility information or to facilitate member transition of care. A best practice we propose to institute includes a daily check-in call or meeting between clinical health plan managers. This level of collaboration and communication between plans minimizes any potential barriers that could arise when transitioning members between health plans. As the receiving managed care organization (MCO), we are responsible for (including but not limited to) notification to the new PCP (if applicable) of the member's selection of provider. We are also responsible for initiation of the request of transfer for the member's medical files (unless the member

has already arranged for the transfer of his/her medical records) arrangement of medically necessary services (if applicable) and all other requirements for new members during the transition period. If we have not received the member's record within 10 business days of the request, we will follow up with the relinquishing plan to resolve the issue. Using our Accountable Care Population Registry, clinical and claims data received is made available to the PCP to facilitate continuity of care and continuation of medically necessary services. As necessary, we are available to make direct in-person or telephonic contact with providers to facilitate the care transition process.

Coordinating Continuous Care

We coordinate continuous care as necessary for all members transitioning to UnitedHealthcare. We place special emphasis on coordinating care for individuals with complex and comorbid needs, particularly those with frequent exacerbation of chronic conditions that require high utilization of medical services (e.g., uncontrolled diabetes or asthma and BH recovery services). We will honor existing authorizations when a member transitions to us from another source of coverage for covered benefits for up to 90 calendar days without regard to whether such services are being provided by contract or non-contract providers.

MLTC Data and Process

To confirm continuation of services for new members, we request MLTC consider providing MCOs (or requiring other MCOs to provide) the following member-related information:

- An identifier for the relinquishing MCO on the 834 enrollment file for all members transitioning from one MCO to another
- Members with open authorizations
- Members awaiting a transplant or who had a recent transplant
- Members currently enrolled in any type of care/case management
- Members who are pregnant
- Member PCP listing
- Members currently enrolled in chronic case management and their plans of care
- Pharmacy claims history. If two years is not feasible, then at a minimum, we request six months of history, including any prior authorization that the FFS program granted. To facilitate transition, we request the data prior to the go-live date
- Members for whom we do not have contact information

In addition, a census for our new members hospitalized on the member's effective start date will allow us to begin appropriate discharge planning and to prevent any lapses in a member's care that might result in an unnecessary readmission. In other states, we have worked collaboratively with other managed care plans to develop file formats to allow for the exchange of information directly between the plans.

Care Transitions from Fee-for-Service

We recognize our members with special health care needs, including ABD, dual-eligible, and individuals in institutions and waiver programs may have the most pressing ongoing needs; our transition process is applicable and scalable for all of our transitioning members. Our dedicated member care transition team monitors transition volumes, confirms ongoing data sharing and communication with other entities and resolves any escalated issues. We have worked diligently to fine-tune our approach to coordination of care during member transitions so that we can achieve a seamless transition experience for all of our MLTC members, verifying they experience no interruption in services or care as well as continuity of care. We

monitor unique situations and inform the MLTC, as appropriate. Prior to a new transition, we conduct provider outreach to prevent service gaps, work with community stakeholders, and address non-traditional services and therapies, as appropriate. We are confident in our ability to conduct a smooth transition of services during implementation based upon the following relevant experience transitioning individuals from FFS programs to UnitedHealthcare:

- In Texas in summer 2014, we transitioned 30,000 individuals into our LTSS, ABD and I/DD program and in March 2015, we transitioned 9,000 individuals to the State's new nursing home benefit.
- In Delaware in January 2015, we transitioned 59,000 individuals to our LTSS, ABD, TANF and CHIP programs.
- In Kansas in 2013, we successfully transitioned 117,000 new TANF, CHIP and ABD members, including individuals requiring LTSS to managed care from FFS as part of the statewide implementation of KanCare.

Processes for Engaging Providers in the Transition

We plan to offer focused training events and workshops through regional town halls and will perform individual office visits for training, as needed. We supplement these visits with virtual provider trainings using conference calls assisted by Web-based training tools for practices with Internet access. We train network providers, including PCPs, specialists, BH providers, hospitals and pharmacies on our transition processes. We post our continuity of care and transition policies and procedures in the *Provider Administrative Guide* and on our website. We contractually obligate and monitor all network providers to confirm they actively participate in the transition process and cooperate with our dedicated member implementation team, other providers, the state agency, other MCOs and community-based stakeholders, as needed, to confirm continuous quality of care is delivered to the member throughout the transition phase. If the member's PCP or specialist is not in our network, we make every reasonable attempt to contract with that provider. If the provider does not wish to contract with us, we will work with the member to choose another provider and transition the member to the preferred in-network provider. As necessary, we will work with the provider to establish a single case agreement to provide services to this member for a specified payment rate. We will abide by all MLTC requirements and, as such, will pay out-of-network providers 100 percent of Medicaid FFS for 90 days post go-live.

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IV.Z. FFS Claims Management and Processing

117. Provide a detailed description of the MCO's approach to implementing the necessary functionality to support FFS claims processing.

We understand MLTC is in the process of replacing its Medicaid Management Information System (MMIS) and MLTC is looking to enter into a service agreement with a managed care organization (MCO), such as UnitedHealthcare, to process Nebraska Medicaid fee-for-service (FFS) claims. This is a highly innovative strategy that will enable MLTC to use existing technology to meet its FFS claims processing needs, and alleviate the State's need to own and maintain a separate claims system. We welcome the opportunity to serve as MLTC's claims broker and support FFS claims processing. As a known and trusted partner with 33 years of Medicaid experience, we have proven methodologies, processes, policies and procedures in place to execute high-quality processing of Nebraska Medicaid FFS claims.

In partnership with Optum, we offer the breadth and depth of resources and technology unmatched by our competitors. With a team of more than 12,000 technology professionals, we implement and maintain the full range of IT systems needed across the entire health system to improve care delivery, quality and cost-effectiveness. The UnitedHealth Group Information Technology (IT) team supports the implementation of government mandates and industry best practices across UnitedHealthcare and Optum enterprises with a unique blend of business and information technology along with program management, business testing, communications and training, continuous improvement, operational readiness and program analytics. We are a nimble, innovative health care information technology organization that can scale to help our clients implement new approaches that drive positive change. We consistently deliver high complexity technology projects on time and on budget.

In addition to UnitedHealthcare's strong track record in claims processing for MLTC, Optum also demonstrated consistent success in IT projects delivered directly to states. Optum recently completed mission critical systems implementations for both the federal and state governments. In October 2013, we took responsibility for leading site improvements for *healthcare.gov*, after the website experienced well-publicized problems during the implementation of the Affordable Care Act. When failure was not an option, CMS turned to Optum based on our unique experience in managing large, complex health care IT projects. Through a collaborative effort we led involving other vendors, healthcare.gov achieved substantially improved functionality, improved customer experience and significant increases in online enrollments. Following our success at the federal level, Optum assisted several state exchanges that experienced similar challenges and turned around their system performance.

To provide continuity, we will use the same implementation approach and team used for the Heritage Health implementation, which will be supplemented by Optum's MMIS-knowledgeable staff to support the FFS implementation and ongoing operations. The methodology and team structure is common to all other large growth program implementations. Adam Gillund, our senior implementation director, will work with leaders from operational and functional areas within UnitedHealthcare to serve as Nebraska's claims broker. To support ongoing FFS claims operations, the various functional segments (e.g., member services, provider services, technology, operations) will receive customized training on supporting both the UnitedHealthcare Heritage Health members and eligible FFS members. If MLTC requires our system to be certified as an MMIS by CMS, we have staff experienced in that process.

Determining System Requirements

The process of defining a project starts with requirements—working toward a better understanding of the problem and analyzing and documenting the parameters of success. Well-constructed requirements are concise, unambiguous, measurable, testable and traceable. Requirements and Solution Analysis (RSA) is our process for defining requirements. It enables us to capture the technology enhancements required by our contracts to confirm we meet contract and customer expectations. RSA contributes to a reduction in test-related defects, contributes to a reduction in change controls, identifies unnecessary IT spend before the work is committed and improves IT development estimates.

Requirements and Solution Analysis introduces new development techniques by:

- Explicitly separating business requirements from solutions
- Collaborating between business and technology teams to evaluate solutions against measurable business requirements
- Acknowledging the iterative process between requirements identification and solution analysis
- Performing thorough inspections on project deliverables to improve quality

Through the RSA process, we will work with you to define the additional functionality to process FFS claims that is currently not required of the MCOs. Based upon this understanding, we will identify the best Facets instance to support those FFS-specific requirements, which will be on either our stand-alone instance using Optum Business Services Platform (OBSP), or our integrated Facets Community Strategic Platform (CSP) instance. The Optum Platform provides the following options should MLTSS' FFS business needs or CMS requires these:

- OBSP is designed to align with Medicaid Information Technology Architecture's (MITA) Seven Conditions and Standards should CMS require compliance.
- OBSP is designed to meet requirements for CMS certification, based on guidance from the recently released regulation pertaining to Medicaid eligibility and enrollment systems.
- OBSP can be operated completely separately from UnitedHealthcare, while still leveraging Facets, the same technology that is paying managed care claims for you today.

For purposes of the proposal, we describe the integrated Facets CSP instance.

Platform Overview

Our best-in-class CSP is currently operational by UnitedHealthcare in Nebraska. We are well versed implementing claims processing platforms for our state partners. For example, our teams have successfully implemented CSP for 17 of our state Medicaid clients over the past four years. With this experience, we are acutely aware of all the tasks, tests, action steps and deliverables involved in a timely implementation.

The integration of a health care delivery system is no small undertaking. We recognize the challenges of developing and integrating health care delivery systems, including working with external partners and providers with various levels of expertise and different, often incompatible, technologies and interfaces. We have significant experience working with regional and statewide partners in numerous states in assuring effective implementation, self-sustainability and adoption of new technologies.

Our CSP core transaction system is flexible; configurable to accommodate unique payment rules, benefit designs and contracted rates for claims adjudication; set up to accept electronic payments; and will be used to successfully and promptly pay for services provided to Nebraska Medicaid members.

CSP provides eligibility, enrollment, claims processing, benefits configuration, capitation and reporting capabilities, and provides the source data for other system applications, such as our encounter data submission system. In compliance with Section K Subcontracting Requirements, we hold our affiliated providers such as OptumRx, Superior Vision and IntelliRide, to the same management information systems (MIS) requirements for which we are responsible by using contracts, internally set standards, penalties for non-performance and established policies and procedures.

Required Modifications or Updates

With CSP, there are a number of integration points with core UnitedHealthcare enterprise technology assets and systems that are leveraged in the overall operating model and solution. Our managed care information system applications work in concert with CSP to provide care coordination, encounter data submission capabilities, online provider and member support solutions and reporting and analytics capabilities. Our systems are fully interoperable and fluidly exchange information, allowing us to adapt to support current and future MLTC requirements. Our implementation effort consists of a configuration and direct integration effort with MLTC, except for development of MLTC-specific integration points and requirements.

To support our role as the Nebraska claims broker, the FFS requirements will be configured in CSP as a separate and distinct program from the Heritage Health program. This will allow us to separate the two member populations and apply specific FFS benefits, rules, edits, policies and procedures.

As a current MLTC contractor, we accept and process daily enrollment files and monthly enrollment and disenrollment reconciliation files via HIPAA-compliant 834 transactions in the 5010 format. Using Eligibility Enrollment Management System (EEMS), we have the ability to distribute eligibility updates to multiple destinations within our IT environment. The overall effort includes:

- Setup of group, plan and product structure to segregate FFS members
- Setup of FFS provider network and fee schedules
- Integrate the eligibility system with MLTC
- Map our product structure for all of our interfacing systems including clinical, financial, encounters, interactive voice response (IVR), portals, etc. and perform end-to-end testing
- Configure and test our interfaces with OptumRx, MLTC and other external parties
- Build required operational and analytical reporting to manage and report on the FFS population, including payment reconciliation reporting

Our proposed solution eliminates duplication of effort by applying enrollment data as appropriate for FFS separate from managed care.

Claims Broker Services

Nationwide in 2014, we received and processed nearly 15 million claims using our established CSP core transaction processing solution. This advanced infrastructure provides for effective, accurate and efficient claims processing and payment procedures that adjudicates and settles provider claims for covered services filed within the time frames specified by the contract.

Any reference to claims in this section is inclusive of FFS adjustments, recoupments, voids and financial transactions. We understand MLTC will pay for claims broker services separately from managed care capitation payments.

If selected as the claims broker, we understand MLTC will reimburse UnitedHealthcare for claims broker services based on a per-claim administrative fee, and that the fee will be adjusted yearly based upon the administrative expense for the FFS claims processing. Each year, we will report the per-member-per-month (PMPM) costs for FFS claims by the following categories:

- Provider Services
- Care Coordination/Service Authorizations
- Member Customer Services
- Data Capture
- Claim/Adjustment Processing and Adjudication
- TPL/COB
- Grievance and Appeals

As a value-add, we will build an MLTC Reporting Tool that gives health plan and designated MLTC staff access to actionable information. Designed and developed as an end-user interface, this reporting tool will pull data from our custom Medicaid data warehouse, the Strategic Management Analytic Reporting Tool (SMART). Using the reporting tool, MLTC can perform sophisticated, data-intensive analysis such as the ability to compare utilization patterns of different providers and provider groups, without impacting our transaction databases.

Reimbursement for Claims Broker Fee-for-Service Payments

As the claims broker, we will make payments for all FFS claims to providers. We agree to submit to MLTC a reconciliation report of all funds expended and received with remaining balance to be reimbursed for FFS payments. We understand we may submit a funding request to MLTC on a weekly basis to cover the FFS claims payments. We will submit the required report with each funding request to justify the request.

Implementation Time Frame

We are well-positioned to provide high-quality FFS claims broker services to Medicaid members throughout Nebraska because we can leverage the breadth and depth of UnitedHealth Group IT resources. UnitedHealth Group has more than 10,000 technology professionals across the United States. Our local and national IT teams will work with MLTC to identify the specific target date for when we will begin providing claims broker services. We understand that date will occur during the second year of the contract. Please refer to our response to Question 122, which details a timeline for implementation including the number of months it will take to be ready to pay FFS claims.

Functionality

CSP is our TriZetto Facets claims platform and is the heart of our architecture with interfaces that optimize the exchange of information to other key systems. The FFS functionality will be set up as a separate product within Facets. CSP provides eligibility, enrollment, claims processing, benefits configuration, capitation and reporting capabilities and provides the source data for other system applications, including our encounter data submission system, National Encounter Management Information System (NEMIS). Our core systems employ relational data model in their database architectures using relational database management systems (RDBMSs) and can therefore support structured query language (SQL). Our systems will interoperate where needed with MLTC systems and will conform to appropriate standards and specifications set by MLTC and by the industry.

Our system provides processing solutions that include, but are not limited to, retroactive member eligibility. CSP will maintain functionality to process claims for services that require unique provider and member reimbursement methodologies that differ from standard processing protocols.

We reconfigure our flexible interface architecture to support current and future requirements. As federal or MLTC standards for FFS claims processing change, we will conform to future standards within 60 calendar days of the notification by MLTC. We understand recoupment of erroneous payments made to providers is our responsibility as the claims broker. Additionally, we understand MLTC will not reimburse us for uncollected recoupments for claims paid in error.

We will provide view-only access to our key systems for designated MLTC staff, as appropriate. We anticipate MLTC's primary access will be met with view-only access to CSP over a permanent virtual private network (VPN) channel or via our secure Citrix Gateway. This access will enable authorized MLTC personnel to have real-time, remote connectivity to our systems and, with training, provide the ability to view 837 claims data and 834 member and eligibility data. In addition, we can provide guided access with a UnitedHealthcare employee using screen sharing technology to provide access to other systems and answer specific questions. Should MLTC choose not to establish a standing VPN, key MLTC employees can be issued RSA SecureID tokens and connect from their own systems or from UnitedHealthcare issued laptops. Should state requirements lead us to implement the FFS business on the OBSP instance rather than the CSP instance, then alternate and broader access approaches are possible.

We will provide initial and ongoing training to MLTC staff and other authorized resources on the MLTC Reporting Tool and for the view-only access to CSP. We will use a variety of training methods to train authorized system users, such as facilitated classroom presentations, question-and-answer sessions and computer-based training. UnitedHealthcare subject matter experts will conduct classroom and question-and-answer sessions. Computer-based training modules will be available through a mutually agreeable delivery method. Additionally, our Help Desk will be available 24 hours a day, seven days a week, with live support to provide added support.

Claims Processing

As the claims broker, we will maintain the same claims processing standards for all non-drug FFS claims as required for the Heritage Health managed care claims. We acknowledge the processing of FFS claims includes all types of claims including: medical, vision, behavior health, pharmacy as well as non-emergent and emergent transportation. Requirements for rejected claims, pended claims, adjustments, voids, and timely filing guidelines will mirror those of the managed care requirements.

The CSP captures the claim-received date and assigns a unique claim number for all incoming claims. Incoming claims undergo many data edits to confirm the data are compliant, complete, accurate and appropriate under the terms of the contract. We expect FFS claims will have different editing and payment methodologies than managed care claims, and we will maintain these edits and payment processes separately. CSP will post all applicable edits to denied FFS claims during a single processing cycle.

CSP enables us to achieve efficiency and accuracy in our claim processing operations. It provides a full continuum of claims processing steps and functionality including:

- Maintenance of covered benefits for all eligibility groups
- Maintenance of reference files including
- Claims edits and denial codes
- Claims pricing and adjudication
- Check writing and electronic funds transfer

CPT, HCPCS, ICD-10
- Utilization management, including matching prior authorizations and referrals to claims
- Claims logging and tracking
- Claims aging

(EFT)
- Production of paper and electronic remittance advices
- Claim adjustments and voids
- Production of claims management reports

From January 2014 to September 2015, **we processed 99.99 percent of all clean claims within 30 days**. These results demonstrate our achievement in consistently exceeding the current Medicaid contractual requirements for claims processing, which is 90 percent of clean claims must be processed within 30 days. We understand the new RFP timeliness requirements for performance guarantees shift to 90 percent of clean claims within 15 days. To meet or exceed the new requirements, we will draw upon our current claims processing success in Nebraska and leverage the expertise and best practices of our national organization and our plans in other states that are consistently meeting similar requirements. For example, in Kansas we consistently meet the claims processing requirement 90 percent of clean claims within 14 days, and in Louisiana we consistently meet and significantly surpass the requirement of 90 percent of clean claims within 15 days.

Under chief operating officer Sean Jones, claims administrator Diane Knutson is responsible for all claims management activities, including FFS claims management and processing. Ms. Knutson verifies claims timeliness and accuracy, which will be at the forefront of managing these operations. She holds a weekly meeting with claims staff and if we are selected as the FFS claims broker, she and the team will look at days on hand, prompt pay requirements and various claims audits for both products. Ms. Knutson interfaces with the network team to address contract setup issues resulting from the audits. She tracks and trends claims disputes as a means for improving quality. Should we implement OBSP platform solution, Ms. Knutson will be supported by the Optum MMIS team to monitor operations.

Drug Claims Processing

As the claims broker, we will use OptumRx to process all FFS drug claims. Our PBM, OptumRx, delivers pharmacy benefits through more than 67,000 community and retail pharmacies nationwide and is the first in the country to earn all four "URAC Pharmacy Quality Management" accreditations: PBM, Drug Therapy Management, Mail Service and Specialty Pharmacy. First formed in 1989, they now operate as a subsidiary of UnitedHealth Group, managing benefits for more than 27 million members and processing more than 500 million claims per year.

The pharmacy director has overall responsibility for instituting and coordinating all components of the pharmacy program for the health plan, including overseeing FFS drug claims.

Service Authorization Procedures

As the claims broker, we will develop and administer prior authorization procedures for services paid as FFS in accordance with Nebraska Medicaid policy and the requirements of Section N, Utilization Management of Part IV Project Description and Scope of Work. Our utilization management system is the system of record for medical service authorization data and coordination of BH services. We use member and authorization data based upon authorization transactions processed in our clinical platform and passed back to CSP for claims management. We will pay or deny FFS claims in accordance with FFS authorization policies.

Payments to Providers

We will set up providers serving the FFS population as a separate network from that serving the managed care population. While the two networks will share demographics, tax IDs, NPI, credentialing information and more, setting up a distinct FFS network gives us the ability to apply separate fee schedules while minimizing overall provider data maintenance costs and issues. We will process and pay FFS provider claims on schedule and in compliance with the fee schedule rates set by MLTC.

Remittance Advice

We support the HIPAA 835 remittance format, so providers can choose to receive EFT or 835 remittances, or none. The system automatically sends remittance advices to providers and notices of adverse action to members for denied claims. Our claims management team continually reviews our pended and denied claims inventory to confirm timely adjudication and to identify trends to educate providers.

The claim processing payment cycle generates payments for providers (and members, if applicable) and generates payment reports, including remittance advices for providers. After the payment cycle is confirmed, the system automatically posts payment reports to Web portals where the appropriate documents can be accessed online by providers and members. If configured, the system can also send automated email messages to providers and members when new payment reports post to the portals.

The remittance advice will reflect payments or denials to providers. The FFS specific remit advice statement will provide a summary of the claims paid under the FFS contract, and where a provider participates with us for multiple products, a second version of the remittance advice statement is available summarizing the remittance across all categories of service for all claims included in a payment. Each remittance advice generated by us to a provider will clearly identify the following for each claim:

- Name of the member
- Unique member Medicaid identification number
- Patient claim number or patient account number
- Date of service
- Total provider charges
- Member liability, specifying any coinsurance, deductible, copayment or non-covered amount
- Amount paid by us or the amount denied and the HIPAA-compliant reasons for denial

For FFS providers, we communicate our policies and procedures regarding provider rights for claims disputes with the remittance advice. We will include applicable information on the remittance advice if the claim was denied due to a third party liability (TPL), including but not limited to, TPL carrier information such as carrier code, policy number and mailing address.

Providers can receive either EFT payments or paper checks. The finance department obtains check stock from a secured location and prints paper checks in-house. The finance department also sends EFT files to the appropriate banks. For security purposes, all check stock is physically secured, and only authorized users have the ability to finalize the payment cycle, issue electronic payments and print checks.

If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice will specifically identify all the required information and documentation not submitted. Resubmission of a claim with the necessary

information/documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

In compliance with 42 CFR 455.18 and 455.19, the following statement will be included on each remittance advice sent to providers: *I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and/or state laws.*

Third Party Liability

We have a specialized team and formalized policies, procedures and systems dedicated to TPL identification, validation and recovery. Our TPL staff will make every reasonable effort to determine the legal liability of third parties to pay for services rendered to FFS members. Using CSP, they maintain information regarding TPL on the member file and used during claims payment to confirm that Medicaid is the payer of last resort. We assume responsibility for all TPL requirements as required by federal and state laws.

We use a multi-pronged approach to identify and verify other sources of insurance for Medicaid members. Our goal is to identify other insurance prior to payment, and then allow the system to adjudicate and pay claims correctly, considering other insurance automatically. Rather than pay and pursue, we make every effort to avoid overpayment by gathering and storing details about other insurance sources for each member, and then calculating accurate payment or denying claims accordingly. If other insurance is flagged on a member's enrollment record, the system can automatically deny claims during processing or route claims to a work queue for special handling. If other insurance is indicated when a claim is submitted, then COB documentation is required when the claim is processed. If required documentation is missing, then the system triggers an exception.

Since April 2014, our national provider services center representatives have handled more than 3.4 million provider calls with:

- An average hold time of four seconds, ***exceeding the requirement***
- An abandonment rate of 2.10 percent, ***exceeding the requirement***

Our team also will perform recovery activities for claims paid by Medicaid where third-party coverage was applicable. We will return these payment recoveries to MLTC in full immediately upon receipt. We agree to expend the same level of effort on the recovery and cost avoidance of casualty claims for FFS claims as is expended on managed care claims. We will comply with all MLTC policies and applicable laws regarding denial of FFS claims for TPL coverage. We understand MLTC will retain responsibility for all estate recovery activities.

Member Services

We will cross-train our Nebraska-based member services advocates (MSAs) to provide member services call center activities to all eligible FFS members in the same manner as required for the managed care members. In addition to applying their responsibilities and training to both the Heritage Health and FFS members, the MSA will understand the requirements for using MLTC's interface to verify FFS member eligibility.

Provider Services

We will provide our toll-free line to all providers who render services to FFS members and leverage our existing provider services call center. The Nebraska-based call center will be staffed with live agents Monday through Friday, 7 a.m. to 8 p.m. CST, excluding State-approved holidays. Through our call center, cross-trained provider services agents can give assistance on a wide variety of topics such as:

- Covered services, fee schedules and member eligibility verification
- Prior authorization and referral procedures
- Filing provider complaints, grievances and appeals
- Claims payment and dispute resolution
- Verifying member assignment to the provider's panel
- Referring providers to the fraud and abuse hotline as necessary
- Coordinating the administration of out-of-network services

UnitedHealthcare also has a 24 hours a day, seven days a week live agent solution to respond to prior authorization and pre-certification requests from both managed care and FFS providers. Additionally, we provide a dedicated electronic data interchange (EDI) hotline as a convenient method for providers to receive electronic claims support through our EDI support team.

Notifications, bulletins, newsletters, Frequently Asked Questions and other pertinent information will be available on our provider website (*uhccommunityplan.com*) to providers participating in the FFS programs.

Paid Claims Sampling

As the claims broker, we agree to adhere to the same paid claims sampling requirements for FFS claims as required for Heritage Health managed care claims outlined in Section S, Claims Management of Part IV Project Description and Scope of Work. Our paid claims sampling methodology is explained in detail in our response to Question 108 of the proposal.

Claims Dispute Management

We will adhere to the same claims dispute management requirements for FFS claims as required for the Heritage Health managed care claims outlined in Section S, Claims Management of Part IV Project Description and Scope of Work. We understand FFS claims must be disputed through MLTC fair hearing process. Ms. Knutson will oversee the support of MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC.

Claims Payment Accuracy

As the claims broker, we agree to adhere to the same claims payment accuracy requirements for FFS claims as required for Heritage Health managed care claims outlined in Section S, Claims Management of Part IV Project Description and Scope of Work. Our paid claims sampling methodology is explained in detail in our response to Question 108 of the proposal.

Claims Data

We maintain systems that receive, transmit process and store data in a manner compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), as well as Nebraska state laws. We have implemented a robust regulatory monitoring process to maintain compliance with state and federal laws. Our system fully complies with the HIPAA-compliant standards for information exchange, including the 5010 version. Transaction types we support include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 820 Payroll Deducted/Other Group Premium Payment for Insurance Products
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response (including unsolicited)

- ASC X12N 278 Utilization Review Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- NCPDP Pharmacy Claims
- Proprietary flat-file and XML-based formats, where required

Additional formats may be supported as needed. We agree we will submit all relevant data to adjudication, adjustment and recoupments to the state on at least a monthly basis, and we prefer to use standard HIPAA formats wherever applicable. Claims submissions will be segregated between managed care and FFS, and be identified with the appropriate account code.

Drug Rebates

As the claims broker, we will provide pharmacy claims information to MLTC so MLTC can perform all drug rebate activities, including disputed drug rebates, for FFS drug claims.

Our pharmacy claims processing operates under NCPDP version 5.1 complying with current HIPAA billing standards and accepts billing under NCPDP version D.0. Our system is able to identify pharmacy claims filled by 340B enrolled providers for members to confirm MLTC correctly excludes 340B utilization from CMS rebate invoices to manufacturers.

Audit Requirements

As the claims broker, we will adhere to all audit requirements for managing FFS claims as required for the Heritage Health managed care claims, as outlined in Section S, Claims Management of Part IV Project Description and Scope of Work. We agree to support MLTC by providing claims payment explanations as requested. Our process for auditing claims samples can be found in our response to Q. 108 of the proposal.

118. Describe the level of effort necessary to support Nebraska program and policy changes, including but not limited to new covered services, prior authorization requirements, or additional populations.

Our platforms are based on industry-leading commercial off-the-shelf (COTS) packages that are not only highly configurable but as part of their ongoing maintenance are kept compliant to federal mandates and market changes in the health plan administration marketplace.

We have a rigorous Product Lifecycle Management approach that keeps all components of our solutions up-to-date with the latest updates. Major mandates such as ICD10 compliance are implemented as part of these updates.

Most routine State program and policy changes including, but not limited to, covered service changes, prior authorization changes and waiver programs will be handled by a disciplined business rules configuration change management process that will go through a design, configure, test and implement lifecycle including the appropriate Organization Change Management activities needed to support the change. We provide an overview of the typical scope of work for implementing our systems in our response to Question 117, under the heading "Required Modifications or Updates."

However, the FFS plan varies from a typical managed care implementation. Our plan is to set up the FFS program as an independent product from the managed care product. This distinction results in a higher implementation effort, more intensive requirements discovery, and longer timeline than for the expanded benefits of the managed care product. Since we anticipate an intensive, dedicated requirements discovery process with MLTC for the FFS program, we recommend engagement of a year or more before the start of claims payment. Although our goal is to have a program go-live date in early 2018, there are additional considerations that may extend the timeline further, such as:

- Limited data conversion from the legacy MMIS to accommodate benefit continuity—once-in-a-lifetime procedures and service limit accumulators for authorized services
- Unique FFS considerations—crossover claims, Medicare buy-in, requirements or processes related to CMS certification (if required)
- Additional system interfaces beyond those required for the MCO implementation

We recognize the challenges of developing and integrating health care delivery systems, including working with external partners and providers with various levels of expertise and different, often incompatible, technologies and interfaces. We have significant experience working with regional and statewide partners in numerous states in assuring effective implementation, self-sustainability and adoption of new technologies.

Manpower and Time-Estimating Methods

Our successful implementation experience nationwide uniquely qualifies us to serve FFS members in Nebraska. We have extensive experience confirming our administrative and operational structure is able to accommodate membership growth in a timely and efficient manner. We have a proven record of responding to expanding staffing needs and have an already strong and experienced management team and staff serving more than 59,000 Medicaid, 258,000 commercial, 61,000 military and veterans and 47,000 Medicare Nebraskans statewide. Our robust workforce and stable network is due in part to the following components:

Administrative

Infrastructure Scalability: Our current infrastructure is completely scalable and able to support significant membership changes and growth. We achieve system consistency, stability and performance

through a combination of load balancing software, advanced hardware and virtualization capabilities for our systems.

Workforce Planning: We use a standardized Workforce Management Projection Model that accommodates membership changes and can project the number of full-time equivalent (FTE) personnel required by functional area, to support membership growth. For example, metrics and planning models have been created for member and provider call center, claims, and appeals and disputes, to calculate workforce projections. This model allows us to plan for the hiring, training and location of each required FTE, ensuring we have the resources we need, when and where we need them.

National Resources: We have a national implementation team that can be deployed to assist us on a local level. National resources can be relocated to Nebraska to assist in the implementation process while efforts are undertaken to hire and train our local staff. These national resources also allow our local executives and staff to focus on the members, expansion of our operational infrastructure, and seamless transition of members. Optum will supplement our leadership with MMIS-knowledgeable staff to support the FFS implementation and ongoing operations. If CMS certification is required, Optum also has staff experienced in that process.

Operational

IT Flexibility and Scalability: We have sufficient, scalable, enterprise-wide information technology resources to handle membership growth including backup servers to handle information increases and system redundancy. Server platforms are scalable and allow for the dynamic reallocation of system resources to different applications as necessary to support demand fluctuations. This scalability enables us to add additional members, provider networks, reporting and care management transactions for Nebraska and other markets, without adversely affecting the platform or requiring downtime.

UnitedHealth Group IT has more than 10,000 technology professionals across the United States. Following industry standards, our IT professionals are geographically dispersed to take advantage of the national labor pool and mitigate risks of localized disaster and weather events. Our IT professionals are strategically located around major population centers in six states: Minnesota, Connecticut, California, New Jersey, Wisconsin and Arizona. During implementation, the program will be staffed with resources in these locations as well as Nebraska.

Time-Estimating Methods

We use an Estimating Best Practices Guideline and a software tool called SEER to provide accurate time estimating. SEER is an algorithmic project management software application designed specifically to estimate, plan and monitor the effort and resources required for any type of software development and/or maintenance project. SEER relies on parametric algorithms, knowledge bases, simulation-based probability and historical precedents to allow project managers, engineers and cost analysts to accurately estimate a project's cost schedule, risk and effort before the project is started.

119. Describe how the MCO will maintain a distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system.

Our solution is part of an overall strategic initiative by UnitedHealthcare to consolidate claim platforms across our markets to provide a streamlined and cost-effective solution by using standardized technology. Currently deployed in 17 markets, CSP has the present capacity to manage 6,000 concurrent users and support more than 5.5 million members. It processes more than 275,000 medical claims each day, handles more than 350 million daily database transactions and maintains an average response time of four thousandths of a second (0.004) per database transaction. Our impending platform upgrade to the Oracle X5 platform will raise overall system capacity substantially. By using Facets, we have the flexibility to scale business services and leverage our Facets expertise across both CSP and OBSP. Our team of experienced professionals possesses deep knowledge of both the health care industry and Facets solutions, enabling us to help solve unique business challenges and achieve results more quickly.

We support the MLTC program in a common distributed environment centered around our CSP platform. The platform and all of the surrounding systems are shared across multiple UnitedHealthcare customers, allowing us to scale and operate efficiently while maintaining logical separation between products and customers. This architecture enables us to establish and maintain a distinction between the FFS and managed cared processing rules, claims transactions, providers, members and prior authorizations.

To support our role as the Nebraska claims broker, the FFS requirements will be configured as a separate and distinct product from the Heritage Health program. Segregating FFS using native Facets group, plan and product structure will allow us to separate the two member populations and apply FFS specific benefits, provider network and fee schedules, adjudication (and prior authorization) rules, claims edits, policies and procedures.

This product segregation will flow downstream to all interfaced systems and vendors, allowing the systems and users to treat each population accordingly.

Furthermore, this logical separation of data for the MLTC programs provides options in all systems to secure access to FFS member information where needed, and to identify the population for operational and analytical reporting.

120. Provide an explanation of the MCO's plan and approach for business operations to support the FFS volume vs. the risk-based volume. Will the plan have separate or joint business operations units for some or all processes?

We agree to maintain a level of staffing necessary to perform and carry out all functions, requirements, roles and duties as required and to comply with contractual requirements and performance metrics. Our goal is to support shared business operations between FFS and risk-based volume wherever appropriate based on the additional business FFS business needs that are not currently required of the MCOs.

We are committed to a strong local presence in Nebraska and to delivering high-quality services to our members, providers, communities and MLTC. Regarding our approach for business operations to support the FFS volume versus the risk-based volume, we will develop a staffing plan by modeling our staffing needs using proprietary workforce models and planning tools as a baseline. We have developed these models across our business units, considering the unique and varied needs and requirements of the Nebraska FFS initiative to support efficient managed care operations based on factors such as expected claims volume, anticipated call volumes and contract requirements. We will use staffing ratio guidelines for certain staff functional areas that acknowledge the health needs of the population served. These ratio guidelines provide benchmarks to assess staffing levels and may be adjusted to reflect final contract requirements, or actual changes in member care needs.

Our approach to support business operations is to centralize operations and share services across UnitedHealthcare's health plans wherever it makes sense to do so. This gives us great flexibility in staffing and lowers costs overall. Teams do specialize and support specific products, especially when and where there are specialized operating rules required to support a product. But we also cross-train within and across products and geographic areas to allow us to adjust staffing levels in response to demand—be it claims, pharmacy, prior authorization or call volume. Across the Nebraska health plan, we expect clinical services, benefits operations, customer service, network operations and other areas will share staffing between the FFS and the Heritage Health products, with broader support from cross-trained resources supporting the region to provide resiliency and contingencies for business continuity planning. Should FFS requirements lead us to segregate operations or implement using the OBSP platform, overall staffing levels and segregation will likely be impacted.

When recruiting staff, including subcontractor staff, we focus our activities on individuals with the necessary credentials. We only hire candidates who meet the qualifications outlined for the job. Once hired, these new employees undergo a structured orientation to their job. From the high-performing people we hire, to the health care services we provide, we advocate the possibilities of unique thinking. We are committed to creating an inclusive environment fueled by innovative ideas. Our employees have diverse cultural backgrounds, beliefs, perspectives and lifestyles; however, they have one thing in common—their ability to excel.

We assure MLTC that all staff and other new hires working under the Nebraska FFS contract will have appropriate training and orientation to fulfill the requirements of their positions and provide the highest level of service to enrollees and MLTC. A trainer facilitates our training programs for both current and new staff, using classroom, Web-based, role-playing and adult learning approaches. Nebraska FFS contract training sessions will occur annually for existing staff and will be provided throughout the year for new hires. We also offer numerous tools to help member services advocates while they are on the job.

Training Curriculum

Upon hire, we maintain new employee orientation requirements to confirm compliance obligation awareness and provide tools for all employees to understand and follow the Code of Conduct and

business practice expectations. We will conduct ongoing training for our entire staff, in all departments, so staff is aware of all Nebraska FFS programmatic changes, as well as outline differences with the Heritage Health program and processes. We will develop and deliver curriculums specific to Nebraska FFS functional area responsibility. Training can take many forms including mandatory compliance training, classroom training, on-the-job training, mentoring, newsletters, online, communication handouts and other formats as needed to meet the training goals. We recognize that each state has a unique culture and our curriculum is developed to give our staff the opportunity to truly understand and relate to the specific member populations they serve.

The training curriculum includes a well-defined set of topics to facilitate understanding of each program requirement and of covered services, as well as to provide our staff with a holistic understanding and insight into the cultural and care needs of the populations we serve. Dedicated trainers facilitate our training programs for both current and new staff, using classroom, Web-based, role-playing and person-centered teaching approaches.

Online Training Platform

LearnSource

LearnSource is our company-wide learning management system for our employees. LearnSource focuses on providing training and training tracking for professional development, cultural competency, company policies, state and federal regulations and compliance. This online tool allows employees to register for training (classroom and Web-based), take online or Web-based training and track required and completed training. Course owners can track registration and course completion using automated tools and reports. LearnSource notifies employees and their managers when required training deadlines are approaching.

All employees will have training opportunities through this portal on skill building, policies and procedures, and career development. Each employee has access to an individual LearnSource development plan that identifies and tracks all the training courses the employee is required to complete. Starting with the new employee orientation sessions, all training and education courses are maintained in the system. Supervisors are accountable for employees' compliance with completion of the training sessions. As with all training, if an employee is noncompliant or exhibits performance below UnitedHealth Group's standards, the employee's supervisor takes appropriate action.

Maintenance of Written Policies and Procedures

UnitedHealthcare and our parent company, UnitedHealth Group, are committed to providing MLTC FFS enrollees with access to high-quality medical care while complying with state, federal and local laws, regulations and other requirements of the department. As one of the country's leading health and wellness companies, our reputation ranks high among our most important assets. We understand MLTC expects honesty and integrity in their dealings with us.

Our National Quality Management Oversight Committee (NQMOC) manages the development, maintenance and availability of policies and procedures for each functional area in compliance with the Code of Federal Regulation. There are established policies and procedures pertaining to quality, compliance, medical management, operations, finance, legal, human resources and contracting. Within each of these broad categories, there are subcategories, each with its own set of policies and procedures. Each business segment within UnitedHealth Group is responsible for analyzing its business practices to support compliance with established policies and procedures. Our policies and procedures are documented to provide for consistency across the organization, and serve as a reference tool for

employees. Our compliance and business areas provide training to all employees, as necessary and appropriate for employees to carry out their job function in accordance with these policies and procedures.

Guidelines for Developing Policies and Procedures

Local senior managers are responsible for adopting national policies approved by our NQMOC and following written guidelines for developing, reviewing and approving all policies and procedures. In the event there are state-specific requirements not addressed in the national policy, a rider will be developed and added to the national policy. Only in the event where a state disallows the use of riders may additions or alterations be made to the body of the national policy. All new policies and procedures must follow established development and formatting standards.

Guidelines for Reviewing and Approving Policies and Procedures

The completed policy and procedure is reviewed and approved by the initiating department's senior-most manager prior to forwarding the policy to the next level of review. National policies and riders are brought before our local Quality Assurance and Performance Improvement Committee (QAPIC) for review and acceptance. Review and approval by the QAPIC and legal, when appropriate, is documented in committee minutes.

Approved policies and procedures must then be signed and dated by the appropriate senior manager and all files are maintained by the policy owner and uploaded to the policy and procedure library.

121. Provide an explanation of the significant risks associated with the implementation and ongoing operation of claims broker services, and provide mitigation strategies for those risks.

Any large-scale implementation has levels of risk associated with it. With 33 years of Medicaid experience and currently providing managed care services for more than 5.3 million low income and medically fragile members, including D-SNP, in 24 states plus the District of Columbia, we are familiar with how to identify and mitigate implementation risks. We are one of the nation's leading Medicaid managed care plans, and we have served the members of the Nebraska Medicaid program since 1996.

The significant risks UnitedHealthcare sees associated with the implementation and ongoing operations of the claims broker services for MLTC include:

- The overall implementation and readiness timeline prior to the start date of operations
- Configuring system functionality that is unique to FFS Medicaid and not currently required of MCOs
- This will be a new type of transition for MLTC and UnitedHealthcare's partnership
- Ensuring a seamless transition for members and providers

Implementation Timeline and Collaboration

We have a comprehensive and proven approach to implementation, including the development of a detailed implementation plan in coordination with MLTC for the Nebraska FFS program. The detailed implementation plan will identify the elements for implementing the proposed services including, but not limited to, tasks; staff responsibilities; timelines; and processes to be used to confirm contracted services begin upon the contract effective date. It will be important for MLTC to provide active engagement and resources on the development of the implementation plan and coordination on risk mitigation strategy.

We anticipate using our standard national provider database, and layering on state fee schedules under a FFS network. We would not typically load an entirely separate provider record for such business. The state's definition of network and ours—the hierarchy/taxonomy of NPIs will likely not align 100 percent and require detailed examination and remediation. For the implementation to be successful, it will be important for MLTC to make available subject matter experts. Additionally, collaboration with MLTC to obtain and implement fee schedule changes prior to their effective dates will be critical.

Unique Program Implementation

UnitedHealthcare and MLTC have never completed a claims broker services implementation jointly and there is tremendous amount of scope and detail to be documented related to FFS requirements. That alone is a risk elevator as we do not have the joint history to leverage. There will be a cost consequence for MLTC to stand up this business with UnitedHealthcare or any outside party due to system changes required on both ends. UnitedHealthcare recommends regular (weekly) meetings to commence with MLTC no later than Q4 2016 to prepare for a mutually agreed to program go-live date in 2018. These joint standing meetings will enable UnitedHealthcare and MLTC to meet key milestones for the implementation, have an open channel of communication, resolve open questions and develop and work through risk mitigation strategies in a true partnership. Criteria to understand operational readiness on both sides and timelines for readiness will be critical. We will mitigate this risk by leveraging our business and technology experts who understand FFS businesses in partnership with our teams implementing the managed care business.

We anticipate that MLTC may require us to have our MMIS system certified to receive CMS enhanced matching funds. The services certification requirements and process are currently undefined. Again, we

will mitigate this risk by tapping the knowledge and expertise of our business and technology teams who understand FFS business. We will form a close partnership with CMS and work with representatives from the agency early and often to identify requirements and overcome barriers.

We understand organizational changes can be difficult. We have experience anticipating the challenges associated with a change similar to MLTC's transition from its current FFS environment of managing the work in-house (both IT and business operations) to a fully outsourced service model. To minimize disruptions, we will provide strong organizational change management (OCM) processes to support knowledge transfer, emphasize the new service model, and reinforce MLTC's communication to state staff to alleviate uncertainty. Strong OCM partnership between us and MLTC is required for success.

Member and Provider Transitions

At UnitedHealthcare, transition of care and continuity of care are core competencies. Whether we are coordinating the transition of one person or large groups of members during initial program implementation or anytime thereafter, we deploy long-established, successful processes and apply scalable resources to provide for a consistently smooth transition, continuity of care at all service levels in all care settings and continuation of medically necessary services in compliance with all timelines, exceptions and grandfathering prescribed by our state clients. Our transition process focuses first on those individuals with special health care needs such as someone in ongoing treatment (e.g., chemotherapy), individuals receiving LTSS, individuals with BH dual diagnosis, and individuals with other complex medical conditions.

Prior to program implementation, we will gather as much information as possible from MLTC about the transitioning members, including how many members we should expect to handle, special needs populations to be served (e.g., waiver, LTSS, I/DD, dual eligible), demographics and utilization data. Primary data gathering resources for new members include the state's daily enrollment files, state claims data (e.g., inpatient, outpatient, BH, LTSS), open authorization reports and any available data regarding existing treatment plans, determinations (e.g., Medically Exempt) and assessments that have been performed. Our clinical team will use this data to perform risk stratification on each member to help us prioritize those individuals that are at the highest risk/need.

Ensuring Continuity of Care and Continuation of Services

To allow providers and members time to adjust to a new way of obtaining approvals and receiving services after members first enroll, during year one of the contract we will honor all outstanding PAs and will establish a grace period of 90 days. This grace period includes the relaxation of prior authorizations (PAs) until we are able to contact the treating provider to discuss the care plan and educate them about our care management program. After year one of the contract, we will honor PAs for a minimum of 30 days or if a member qualifies for transition of care/continuity of care conditions. It will be paramount for UnitedHealthcare to understand MLTC's concurrence with this approach and any unique MTLC variations from our standard prior authorization requirements.

Ensuring a Smooth Transition for FFS Providers

We use standard edits and processes for claims adjudication and expect to apply them for the FFS program. We will want to understand Nebraska's FFS reimbursement methodology to all provider types to confirm claims are paid according to MLTC payment structure, including claim edits such as industry standards regarding bundling and global billing policies MLTC may or may not have in place currently.

Provider education, training and timely communication and dissemination of information will be essential to helping providers understand our role in the FFS operations. To help FFS providers transition to a new

process for submitting claims, requesting prior authorizations and reaching out for support, we will use a broad continuum of media for regular and timely dissemination of information and State-provided documents to providers that includes, but is not limited to, the following:

- ***Initial Provider Training:*** We will use our well-developed provider orientation program that includes educational mailings, online seminars and group trainings. Our initial provider training will cover a number of subjects, such as billing and prior authorization requests.
- ***Continuing Provider Education:*** After the initial provider training, our provider relations staff will remain in frequent communication with Nebraska FFS providers by sending periodic mailings, newsletters and fax blasts communicating any program changes or updates and any documents provided by MLTC that are relevant for providers.

Our provider relations team is responsible for coordinating and conducting on-site provider visits; sending periodic mailings, newsletters, and fax blasts about program changes; passing along communications from the State; and meeting with providers one-on-one as needed to offer training refreshers or additional training. Provider relations representatives are locally based field staff assigned to deliver face-to-face support across the state, with providers' offices visited on a regular basis.

122. Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.

We anticipate kicking off the implementation for the FFS claims brokerage functionality in late 2016. Since our plan is to set up the FFS program as an independent product from the managed care product, it will take a longer ramp-up time as illustrated in Figure IV.Z-1.

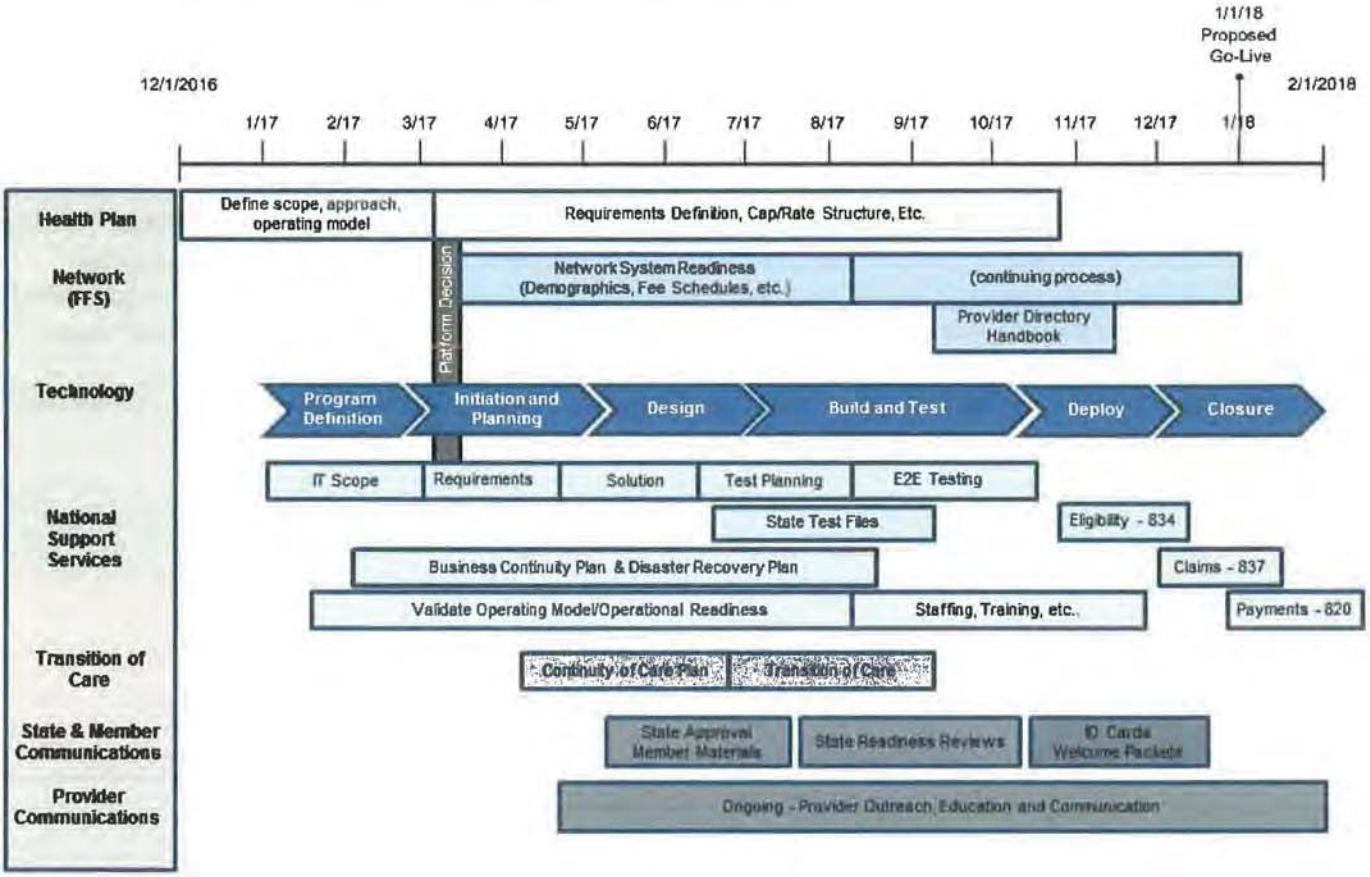

Figure IV.Z-1. FFS Timeline. With our extensive implementation experience, we are acutely aware of all the tasks, tests, action steps and deliverables involved in a timely implementation.

Implementation Approach

We have comprehensive processes for ensuring MLTC has a detailed and complete overview of all implementation and go-live activities. Readiness Review meetings are held on-site at a preferred location to walk through readiness to date alongside plan effective date. The Readiness Review meeting allows the implementation team to review all processes with our state partner and to discuss upcoming milestone dates and activities. Upon notice of award and prior to the contract effective date, we will activate our Command Center model, 24 hours a day, seven days a week, to facilitate rapid resolution of issues identified by our local management team. We have found the use of this approach successfully addresses concerns in a way that builds confidence among key stakeholders. Our entire senior management team, as well as other key personnel, will assist Command Center staff to make sure there is a smooth transition for enrollees and an effective transition for the providers who serve them. At each step in the implementation process, Mr. Gillund and members of the implementation team will be in constant contact with MLTC staff assigned to this project. We maintain full transparency in our processes and progress,

and we welcome close coordination with MLTC, as there are many dependencies that are required for the successful implementation of the FFS brokerage services.

Our system readiness review experience as an incumbent greatly mitigates many of the critical systems readiness challenges and the risks to Nebraska. Major activities related to program readiness include:

- Complete a matrix of contract deliverables with owners and sample test runs
- Project definition and kick-off
- Review of contractual requirements
- Review/confirmation of system design features
- Test run of key provider claim payments
- Quality audits
- Deployment
- Development and internal system testing
- Post-implementation review
- Testing prior authorizations

The major activities related to our systems readiness process will be targeted to FFS program requirements. We confirm that our staff is fully deployed and prepared for the anticipated volume of activity and increase in program functionality.

We suggest collaboratively creating an accountability matrix that clearly articulates key interaction, decision and communication protocols to enable efficient and effective interactions between MLTC and our implementation team.

As indicated earlier, we recommend regular (weekly) meetings to commence with MLTC no later than Q4 2016 to prepare for a mutually agreed to program go-live date in 2018. These joint standing meetings will enable UnitedHealthcare and MLTC to meet key milestones for the implementation, have an open channel of communication, resolve open questions and develop and work through risk mitigation strategies in a true partnership. Criteria to understand operational readiness on both sides and timelines for readiness will be critical.

After implementation, we recommend scheduled periodic meetings to help clarify issues and assess contract compliance. These meetings will assist all parties in resolving concerns or proactively anticipating potential issues.

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Attachment 19 Q2 Regulatory Actions and Sanctions

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This CAP is a result of a previously Independent Review response that was submitted by Health Plan.	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	missing required language	Medicaid
Nov-10	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland:Department of Health and Mental Hygiene	CAP	Required performance improvement program did not meet state requirements.	Medicaid
Nov-10	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	MPRO on behalf of DMAHS will be conducting an annual audit.	Medicaid
Nov-10	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Grievances & Appeals were not resolved within required timeframes	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Nov-10	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	Failure to resolve grievances and appeals in a timely manner	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	39000	Information not sent	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division at the Bureau of TennCare has completed review of the Behavioral Health Deliverables submitted by AmeriChoice for services provided during the second quarter of 2010. It has been determined that benchmarks were not met.	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division at the Bureau of TennCare has completed review of the Behavioral Health Deliverables submitted by AmeriChoice for services provided during the second quarter of 2010.	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Nov-10	AmeriChoice of Connecticut, Inc	CT	Connecticut:Department of Social Services	CAP	Training, network, report, and contract issues	Medicaid
Nov-10	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	In 2Q10, plan advised certain providers would be contracted by 3Q10; this did not occur.	Medicaid
Nov-10	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	4000	Inpatient claims not processed in accordance with timeframes	Medicaid
Nov-10	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	1000	Hancock County Hospital-ABD fine.	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Nov-10	Unison Health Plan of the Capital Area, Inc.	DC	District of Columbia:Department of Health Care Finance	CAP	CAP to monitor and track timely classification of reporting of critical and sentinel events, notification of births of newborns to DHCF within ten business days, delivery of risk assessment and case management services to members.	Medicaid
Nov-10	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	HSAG, on behalf of ODJFS, will conduct a comprehensive review.	Medicaid
Nov-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical Records/doctor's orders missing	Medicaid
Dec-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Dec-10	Unison Health Plan of the Capital Area, Inc.	DC	District of Columbia:Department of Health Care Finance	CAP	DHCF will conduct an onsite review to address case management.	Medicaid
Dec-10	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Extension of NMMRA EQRO Audit Focusing on Performance	Medicaid
Dec-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare's Provider Network completed their review of the November GeoAccess.	Medicaid
Dec-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Dec-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Dec-10	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA has identified non-compliance with contract Attachment II, Exhibit 6.A.6.c. relating to eligibility for Behavioral Health Services for members in Area 6 who are enrolled in a Child Welfare Prepaid Mental Health Plan (CW-PMHP).	Medicaid
Dec-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau has recently communicated to your health plan several critical reporting issues on AmeriChoice's encounter, provider enrollment, and invoice-like files.	Medicaid
Dec-10	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1252500	AHCA has indicated that a CAP and fine are to be submitted within 10 calendar days of receipt, due to non-compliance in authorization determinations for Speech Therapy.	Medicaid
Dec-10	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV submitted an updated CPA report to DCI on 12-20-10 wherein CRA measurement requirements were not achieved.	Medicaid
Dec-10	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	2000	Inpatient claims not processed in accordance with required timeframes	Medicaid
Dec-10	Unison Health Plan of Tennessee, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Information Not Sent	Medicaid
Dec-10	Unison Health Plan of Tennessee, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Jan-11	Unison Health Plan of Tennessee, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Provider Network department at TennCare completed their review of the 4Q10 GeoAccess.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Provider Network division at TennCare completed their review of the 4Q10 GeoAccess.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Provider Network completed the review of the Health Plan's 4Q10 Geo Access.	Medicaid
Jan-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	7228.34	The Plan went above the 2% requirement for dupes.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical records/doctor's order missing	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and the results have been received.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and the results have been received.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and the results have been received.	Medicaid
Jan-11	Unison Health Plan of the Capital Area, Inc.	DC	District of Columbia:Department of Health Care Finance	CAP	Unison is required to develop an Encounter CAP to identify the deficiencies in Unison's encounter data.	Medicaid
Jan-11	Unison Health Plan of the Capital Area, Inc.	DC	District of Columbia:Department of Health Care Finance	CAP	The expiration of Unison's subcontract with MedStar creates an unfavorable position for District Medicaid beneficiaries. It is the District's hope that Unison is able to reach an agreement with MedStar prior to the expiration of the current agreement.	Medicaid
Jan-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	The Plan provided inaccurate information regarding two surgeons.	Medicaid
Jan-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	ID cards mailed out late	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jan-11	UnitedHealthcare Community Plan of Ohio, Inc.	Ohio	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	ID cards were mailed out late due to difficulty in processing 834 file	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	An annual Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review is conducted to determine the extent to which medical providers were in compliance with EPSDT standards.	Medicaid
Jan-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	CAP	CAP for not processing 834 files timely	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	NEMT (non-emergency medical transportation) abandonment rates were reported higher than previously submitted stats due to inclement weather conditions for December 2010.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare is requesting information to our previous responses on the VFC coding requirements.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare is requesting an additional follow-up to our previous responses that have been submitted as requested.	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare previously asked each MCO to provide information relating to policy and coding.	Medicaid
Jan-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	10000	Inpatient claims not processed in accordance with standards	Medicaid
Jan-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Internal Criteria not sent	Medicaid
Feb-11	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Deficiencies identified by ALTSD and HSD/MAD regarding participant assessment records, ISPs, and documentation	Medicaid
Feb-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare completed the CHOICES Enrollee Record Review and Provider Qualification Review for Health Plan in Middle TN in November 2010.	Medicaid
Feb-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	1000	Failure to meet minimum panel requirements	Medicaid
Feb-11	AmeriChoice of Connecticut, Inc	CT	Connecticut:Department of Social Services	CAP	EQR Comprehensive Husky B Audit for YE 2009 and re	Medicaid
Feb-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Failure to achieve EPSDT and Lead Rates for CY2008	Medicaid
Feb-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	7500	Harris SDA - Acute Appealed Claims - adjudicated claims underperformance within 30 days	Medicaid
Feb-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	5000	Travis SDA - BH Clean Claims - adjudicated claims underperformance within 30 days	Medicaid
Feb-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	5000	Nueces SDA - BH Clean Claims adjudicated claims underperformance within 30 days	Medicaid
Feb-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	50000	Failure to complete 2009 Member Assessment for PAS	Medicaid
Feb-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	PDV Survey	Medicaid
Feb-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	35406	A fine in the amount of $35406.00 was assess due to failure to meet compliance levels for EPSDT and Lead rates.	Medicaid
Feb-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Violation of facilitated enrollment procedures when representative reviewed consumer PHI in an open area visible to others.	Medicaid
Feb-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	COB Criteria Incorrectly Identified	Medicaid
Feb-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV received response from the January 2011 Claims Payment Accuracy Results from DCI.	Medicaid
Feb-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received results for the UPRV Claims Payment Accuracy Report for January 2011 and the Data Request for February 2011.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Mar-11	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Adjustments, Payment Delays, Training, Education IHS	Medicaid
Mar-11	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	The State (AHCA) is conducting a review of implement	Medicaid
Mar-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	10000	August 2010 claims not processed on time.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing required language	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information not sent on time	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information not sent on time	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Acceptable provider enrollment file not accepted on time.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices rejected encounters	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	citations missing or incorrect	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	PDV Survey - 4th Qtr 2010	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Provider Data Validation Survey	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Mar-11	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA requires that a CAP be created each year, when the federal screening and/or participation rates are not met.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1672	Proof of Services	Medicaid
Mar-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Failure to meet program requirements for clinical measures	Medicaid
Mar-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	10000	Claims not processed in accordance with regulatory requirements	Medicaid
Mar-11	Unison Health Plan of South Carolina, Inc.	SC	South Carolina:Department of Health and Human Services	CAP	Correct claims payment lag of less than 90% clean claims paid within 30 days	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV submitted the February 2011 Claims Payment Accuracy Reports (CPAR) to the TennCare Division on March 17, 2011 and noted deficiencies have been received.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3720	Proof of Service	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6810	Proof of Services	Medicaid
Mar-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Failure to ensure providers who are sanctioned by OPMC, do not have valid licenses or who are disciplined are removed from our network	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received notification from TennCare, CAP 11144, relating to error rate on CHOICES Group 2 members.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received notification from TennCare, CAP 11143, relating to error rates on CHOICES Group 2 patients.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received notification from TennCare, CAP 11142, relating to error rate on CHOICES Group 2 patients.	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Provider Data Validation Survey	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Approving Services	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of the Bureau of TennCare has completed review of the Behavioral health Deliverables submitted by UHCCP for services provided during 3Q10. UHCCP West did not achieve certain benchmarks as outlined in CRA.	Medicaid
Mar-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	1000	Claims not processed in accordance with requirements	Medicaid
Mar-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	1667	Claims not processed in accordance with requirements	Medicaid
Mar-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Apr-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Unapproved letter relating to prescription restrictions sent to member.	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices Rejected encounters	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices Rejected Encounters	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	monthly provider file not accepted by due date	Medicaid
Apr-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	CAP	Required file not submitted consistently and correctly	Medicaid
Apr-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	DMAHS is requesting a CAP due to a configuration issue causing claims to deny incorrectly according to the contract.	Medicaid
Apr-11	Unison Health Plan of South Carolina, Inc.	SC	South Carolina:Department of Health and Human Services	CAP	The Carolinas Center for Medical Excellence has no	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1st Quarter 2011 GeoAccess analysis of Health Plan's provider network has been completed.	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1st Quarter 2011 GeoAccess analysis of HP's provider network has been completed and deficiencies have been noted.	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1st Quarter 2011 GeoAccess analysis of MCOs provider network has been completed and noted deficiencies have been indicated.	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20000	Claims Payment Accuracy	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Claims Payment Accuracy	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20000	Claims Payment Accuracy	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Claims Payment Accuracy	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Claims Payment Accuracy	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and deficiencies were noted.	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and deficiencies have been noted.	Medicaid

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Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and there were noted deficiencies	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information not sent	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4670	Proof of Service	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Notice Not Sent - Behavioral Health	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical records/doctor's order missing	Medicaid
Apr-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information not sent	Medicaid
Apr-11	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland:Department of Medical Assistance and Health Services (DMAHS)	CAP	Clinical and quality focused audit	Medicaid
Apr-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Plan did not meet the minimum performance standard for the SFY 2010 CFC emergency department diversion performance measure.	Medicaid
May-11	Unison Health Plan of Tennessee, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay	Medicaid
May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Following a review of the information that HP submitted on 12-3-2009, there were noted deficiencies.	Medicaid
May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Following a review of the information the UHCCP provided on 12-3-2009, noted deficiencies were provided.	Medicaid
May-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Grievances and Appeals were not resolved within required timeframes.	Medicaid
May-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	PCP Error rate above 10% standard at 31.1%	Medicaid
May-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	250	Encounter/FSR Reconciliation non-compliant (over 5% variance)	Medicaid
May-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	3000	Provider Recognition Report submitted in incorrect format	Medicaid
May-11	UnitedHealthcare of Texas, Inc.	TX	Texas:Health and Human Services Commission	13000	Evercare failed to comply with implementation of Denial of Nursing Services Letter	Medicaid
May-11	UnitedHealthcare of Texas, Inc.	TX	Texas:Health and Human Services Commission	1000	Provider Recognition Filing in incorrect format	Medicaid
May-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	Grievances and Appeals were not resolved within required timeframes.	Medicaid
May-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Fifteen (15) marketing observations of the health plan were conducted. Monitors identified a problem with two (2) observations. Additionally, there were five (5) No Shows	Medicaid
May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The month of April 2011 GeoAccess analysis of Health Plan's provider network has been completed.	Medicaid
May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The month of April 2011 GeoAccess analysis of Health Plan's provider network has been completed.	Medicaid
May-11	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	AHCCCS announced its annual review of APIPA to inc	Medicaid
May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Health Plan received results for UPRV April 2011 Claims Payment Accuracy.	Medicaid

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May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	information not sent	Medicaid
May-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
May-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Marketing staff member made a "human error" and put the wrong date on the schedule for an event and labeled the location by a different name than the State knows it by.	Medicaid
May-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	1000	Failure to meet the provider panel requirements in the regions for which UnitedHealthcare Community Plan of Ohio, Inc. (UCP) holds a Provider Agreement.	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Claims Payment Accuracy	Medicaid
Jun-11	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	ECS encounters following the CMS allowable rate during a validation study, did not meet the allowed rate.	Medicaid
Jun-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Submitted incorrect prior authorization requests	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	NEMT Prompt Pay - 60 day clean claims	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	NEMT Prompt Pay - 60 days clean claims	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Claim Payment Accuracy	Medicaid
Jun-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Hospital Inpatient not meet requirements	Medicaid
Jun-11	UnitedHealthcare of New England, Inc.	RI	Rhode Island:Department of Human Services	CAP	Annual review of Plan for 2010 Performance Measure	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV submitted the March 2011 Claims Payment Accuracy Reports to TennCare on April 18, 2011.	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Provider Data Validation Survey	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The month of May 2011 GeoAccess analysis of Health Plan's Provider Network has been completed and deficiencies were noted.	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The month of May GeoAccess analysis of Health Plan's Provider Network has been completed and deficiencies were noted.	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices rejected encounters not corrected within 45 days	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices rejected encounters not corrected within 45 days	Medicaid
Jun-11	UnitedHealthcare of New England, Inc.	RI	Rhode Island:Department of Human Services	CAP	UBH provider was inappropriately credentialed	Medicaid
Jun-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Three consecutive quarters identifying five or more provider gaps in Madison County	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Focused audit associated to Quality Assurance and	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Proof of Service	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Jun-11	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	failure to meet per. standards with a dramatic decrease in its rate for EPSDT participation and submit a CAP for eye exams for diabetic members	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity	Medicaid
Jun-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Health Plan received the latest Claims Payment Accuracy request from DCI wherein the medical metrics were not met as outlined in the CRA.	Medicaid
Jun-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	11417	Untimely claims processing for November and December 2010	Medicaid
Jun-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	1000	Timeliness standards not met	Medicaid
Jul-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	CAP	Lack of activity on new restrictions, inaccurate data; internal action plan already in place.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of the Bureau of TennCare has completed review of the Behavioral Health Deliverables submitted by United Health Care for services provided during the 4th quarter of 2010.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of the Bureau of TennCare has completed review of the Behavioral Health Deliverables submitted by United Health Care for services provided during the 4th quarter of 2010.	Medicaid
Jul-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Insurance Department	106.51	Fine due to process application for Commonwealth employee.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	541.04	Directed - Missed Shifts	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q2011 GeoAccess analysis of health plan's provider network has been completed.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q11 GeoAccess analysis of HP's provider network has been completed.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct an audit of al	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q11 GeoAccess analysis of the provider network has been completed for deficiencies have been noted.	Medicaid
Jul-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	23261	Sanction totals $23,261.00 for encounters above the allowable 2% duplicates.	Medicaid
Jul-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	6100	Claims not processed in accordance with timeliness standards	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and deficiencies were noted.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and deficiencies were noted.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare and deficiencies were noted.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Internal Criteria Not Sent	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Internal Criteria Not Sent	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices rejected encounters not being corrected within 45 days	Medicaid
Jul-11	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	CAP	On behalf of HI DHS, Health Services Advisory Group	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	12500	Quality Assurance/Monitoring	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	13500	Quality Assurance Monitoring	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	12500	Quality Assurance/Monitoring	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV submitted the June 2011 Claims Payment Accuracy Reports (CPAR) to TennCare on July 15, 2011 and a deficiency was noted.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	38500	Directed	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV submitted a CHOICES data file to determine compliance with the separate TennCare prompt pay contractual requirements for CHOICES claims and deficiencies were noted.	Medicaid
Jul-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	On December 17, 2010, TennCare issued a CAP to UHCCP pertaining to provider reporting issues on encounter files.	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Grier Notice not sent	Medicaid
Aug-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	5833	Claims timeliness processing standards not met	Medicaid
Aug-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	100000	Two STAR+PLUS members were eligible for waiver services and were denied covered nutritional supplements	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Every year as required by the John B. Consent Decree, TennCare conducts a state wide audit of children's well child visits.	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Each year as required by the John B. Consent Decree, TennCare conducts a state wide audit of children's well child visits.	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Claims Payment Accuracy	Medicaid
Aug-11	AmeriChoice of Connecticut, Inc	CT	Connecticut:Department of Social Services	CAP	2011 EQR Audit was a validation of the 2010 EQR CA	Medicaid
Aug-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Email verification from the Plan confirming that grievances were submitted as appeals.	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	On July 19, 2011, DCI requested certain items including data files of claims processed in July 2011. UPRV transmitted the items timely.	Medicaid
Aug-11	UnitedHealthcare of the Midlands	NE	Nebraska:Department of Health and Human Services	CAP	To resolve currently and on going provider issues. This is regarding errors with members being assigned to open and closed panels.	Medicaid
Aug-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Medicaid disproportionate share hospital (DSH) audit.	Medicaid
Aug-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	Incomplete/ Invalid Information and/ or criteria on required ASH forms	Medicaid
Aug-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare reviewed the Behavioral Health deliverables submitted by UPRV for services provided during the 1st quarter of 2011 and discrepancies were noted.	Medicaid
Aug-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Insurance	CAP	TX Dept. of Insurance HMO Triennial Quality of Car	Medicaid
Aug-11	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	800	Plan filed quarterly report 2 days late in August 2011.	Medicaid
Sep-11	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	200000	Failure to meet minimum performance standards for Children's/Adolescent's Access to PCPs at 12-24 Months and Well Child Visits at 15 Months.	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	13675	Behavioral Health	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay - LTC CHOICES	Medicaid
Sep-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	9067	Claims timeliness requirements not met	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validity Survey	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	There were noted coding deficiencies noted in the adult BH code 15 on the previously submitted monthly provider enrollment file.	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	There were noted deficiencies in adult BH code 15 in the previously submitted monthly provider enrollment file.	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This request is related to the inpatient SA having been incorrectly coded for Adult BH Code 15.	Medicaid
Sep-11	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	25000	EVC sent out a letter not approved by State	Medicaid
Sep-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	391602.26	UHC did not meet the minimum performance standards for Jan - March 2011 for High Risk Case Management	Medicaid
Sep-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	Claims Processing Noncompliance, Encounters, PCP Error Rates	Medicaid
Sep-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	2500	Acute Clean Claims - Clean claims adjudicated underperformance (Nueces)	Medicaid
Sep-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	2500	Acute Clean Claims - Clean claims underperformance (Travis)	Medicaid
Sep-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Health and Family Services	2500	Travis LTC Clean claims - clean claims adjudicated underperformance	Medicaid
Sep-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	7500	Harris LTC Clean Claims - Clean claims adjudicated underperformance	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay	Medicaid
Sep-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	SDOH identified providers that we should have identified and terminated from Plan systems	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Sep-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Encounter Data volume measurements are below minimum	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Claims Payment Accuracy	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Claims Payment Accuracy	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Claims Payment Accuracy	Medicaid
Sep-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1650	Directed - skilled nursing visits	Medicaid
Sep-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	UMTD Files Not Submitted Timely or Correct	Medicaid
Oct-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Health	1000	Claims timeliness standards not met	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Information Not Sent	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	On October 7th, received notification of 3Q2011 GeoAccess Deficiency for 030	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	On October 7th, notification received as it relates to the findings within the 3Q2011 GeoAccess report for West TN region	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	750	Network - Provider Enrollment File Deficient	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	250	Network - Deficient Provider Enrollment File	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	250	Network - Provider File Deficient	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	200	IT - Edifices rejected encounters not being corrected within 45 days	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This CAP results from the recently submitted monthly provider enrollment file to TennCare.	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This CAP is a result of the recently submitted monthly provider enrollment file to TennCare.	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The CAP is in result to the recently submitted monthly provider enrollment file.	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Oct-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	8901	Sanction for duplicates in excess of allowable percentage	Medicaid
Oct-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Oct-11	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	1000	Claims payments did not meet timeliness standards	Medicaid
Oct-11	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Comprehensive Plan review in accordance with contract.	Medicaid
Oct-11	Unison Health Plan of Delaware, Inc.	DE	Delaware:Division of Medicaid & Medical Assistance (DMMA)	CAP	Comprehensive EQRO Review of plan year July 1, 201	Medicaid
Oct-11	UnitedHealthcare of the Mid-Atlantic, Inc.	MD	Maryland:Department of Health and Mental Hygiene	2364846.25	Disincentives for Seven Measures	Medicaid
Nov-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	200	Edifices rejected encounters not being corrected within 45 days (2 enctrs)	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Nov-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	A 100% audit of critical incidents during the month	Medicaid
Nov-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	CY2010 CFC Clinical Performance Measures indicate areas of noncompliance	Medicaid
Nov-11	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	CY2010 ABD CPM indicated areas of noncompliance	Medicaid
Nov-11	Unison Health Plan of the Capital Area, Inc.	DC	District of Columbia:Department of Health Care Finance	CAP	During the months of May and June 2011 DHCF Office	Medicaid
Nov-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Information Not Sent	Medicaid
Nov-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	43363	Duplicate Encounters over 2% submitted	Medicaid
Nov-11	Unison Health Plan of the Capital Area, Inc.	DC	District of Columbia:Department of Health Care Finance	CAP	Non-compliance with requirement to provide mail or telephone reminder to every child who is due or overdue for an EPSDT screening visit	Medicaid
Nov-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Form not completed	Medicaid
Nov-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Information Not Sent	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Member Manuals & Education	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6500	Grier Denial Notice Not Sent	Medicaid
Dec-11	UnitedHealthcare of Texas, Inc.	TX	Texas:Health and Human Services Commission	5300	Encounter to FSR Paid Claims Input Reconciliation Report, Complaint Response	Medicaid
Dec-11	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	70000	LTC Clean Claims	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Dec-11	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	A provider participation rate of 64% was identified which is below the 75% threshold.	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed their review of the Behavioral Health deliverables submitted for services provided during 2Q2011.	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed review of the Behavioral health deliverables for services provided during 2Q2011.	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5960	MCO approved services	Medicaid
Dec-11	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Annual audit of Care and Case Mgmt file document	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Internal Criteria Not Sent	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Form not completed	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Dec-11	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Provider Qualification Review will allow for v	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	CAP for Middle region which details our intended course of action to rectify the identified issues with the Assisted Care Living Facilities Provider Enrollment File.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	CAP for East region which details our intended course of action to rectify the identified issues with the Assisted Care Living Facilities Provider Enrollment File.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 4Q11 GeoAccess analysis of the Health Plan's provider network / provider enrollment file has been completed.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical Records/doctor's order missing	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Based upon feedback in the 1/10/2012 MCC meeting, it was discussed that this MCO did not comply with the directive to implement 5010 for all claims.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Based upon feedback in the 1/10/2012 MCC meeting, it was discussed that this MCO did not comply with the directive to implement 5010 for all claims.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Based upon feedback in the 1-10-2012 MCC meeting, it was discussed that the Health Plan did not comply with the directive to implement 5010 for all claims starting 1-1-2012.	Medicaid
Jan-12	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	1000	Claims not processed in compliance with timelines standards	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	There were 65 records in the sample with invalid telephone numbers creating a 75.8% accuracy rate.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	There were 55 records in the sample with invalid telephone numbers creating a 79.6% accuracy rate.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	There were 74 records in the sample with invalid telephone numbers creating a 72.5% accuracy rate.	Medicaid
Jan-12	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	Performance standards not meeting the benchmarks set.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical records/doctor's order missing	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	As the result of data mining activities, the Office of Program Integrity has uncovered an issue pertaining to encounters submitted by the Health Plan.	Medicaid
Jan-12	UnitedHealthcare of Louisiana, Inc.	LA	Louisiana:Department of Insurance	CAP	recipients have enrolled in UnitedHealthcare Community Plan because they incorrectly believed that their current PCP was in the United network.	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	3Q11 Provider Data Validation Survey	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	3Q11 Provider Data Validation	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	3Q11 Provider Data Validation Survey	Medicaid
Jan-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Other - wrong age listed on denial letter	Medicaid
Feb-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Failure to achieve EPSDT and Lead Rates for CY2009	Medicaid
Feb-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	47707	A fine in the amount of $59,749 was assess due to failure to meet compliance levels for EPSDT and Lead rates.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Feb-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	2000	Failure to meet the provider panel requirements in the regions for which UHCCP holds a Provider Agreement	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Unavailable	Medicaid
Feb-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Annual assessment of the NJ Medicaid Plan performed	Medicaid
Feb-12	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	CAP	Failure to meet minimum performance standards in quarterly reports	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The January 2012 GeoAccess analysis of the Health Plan's provider network / provider enrollment file has been completed.	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The January 2012 GeoAccess analysis of the Health Plan's provider network / provider enrollment file has been completed.	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The January 2012 GeoAccess analysis of the Health Plan's provider network /	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed review of the Behavioral health Deliverables for service provided during 3Q2011	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed review of the Behavioral Health Deliverables for service during 3Q2011	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4200	MCO approved services	Medicaid
Feb-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA has required a CAP because the Claims Aging Report did not include Behavioral Health Claims.	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	CAP developed by the TennCare Bureau as a part of its 2010 Performance	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	CAP developed by the TennCare Bureau as a part of its 2010 Performance	Medicaid
Feb-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	CAP developed by the TennCare Bureau as a part of its 2010 Performance Error Rate Measurement (PERM) review	Medicaid
Mar-12	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	2000	Claims not paid timely	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical Records/Doctor's Order Missing	Medicaid
Mar-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	The plan is required to complete a CAP describing the methods it will take to ensure that complaints are accurately tracked and subsequently reported on the quarterly Complaints, Grievance, and Appeals Report.	Medicaid
Mar-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	10400	The Bureau has determined that the Plan did not accurately report data. The Agency is fining the Plan the sum total of$10,400 as a result of the correct report being 52 days late @ $200/Day.	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Rejected encounter - Edifices	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The February 2012 GeoAccess analysis of the provider network has been completed and deficiencies were noted.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The February 2012 GeoAccess analysis of the provider network has been completed and deficiencies were noted.	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Rejected encounter not submitted within 45 days of rejection from Edifices	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Rejected encounter not submitted within 45 days of rejection from Edifices	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Claims not re-adjusted within timeframe specified by the ORR	Medicaid
Mar-12	Health Plan of Nevada, Inc.	NV	Nevada:Division of Health Care Financing and Policy	CAP	Nevada Division of Health Care Financing and Policy	Medicaid
Mar-12	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	5750	Evercare did not meet the 98% performance standard for STAR+PLUS Member Complaints within 30 calendar days from the date the complaint is received. Appealed claims must be adjudicated to a paid or denied status within 30 days of receipt; below standard.	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect usage of medical necessity	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Compliance - In correct form sent	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Compliance - ASH Audit - Information Deficient	Medicaid
Mar-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Compliance - ASH Audit	Medicaid
Apr-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Banking and Insurance (DOBI)	324000	Specific to timeliness of authorization turnaround time for Medical Day Care	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare will cover procedures pursuant to application	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Information not corrected within 45 days of Edifices rejection	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Information Not Sent	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Validation Survey - Invalid Phone Numbers	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Validation Survey - Incorrect Telephone Numbers	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation - Incorrect Telephone Numbers	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1Q2012 GeoAccess analysis of the Provider Network has been completed and a deficiency was noted.	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1Q2012 Provider Data Validation Report has been completed and deficiencies noted.	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1Q2012 Provider Data Validation Report has been completed and deficiencies were noted.	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1Q2012 Provider Data Validation Report has been completed and deficiencies were noted.	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 1Q2012 GeoAccess analysis of the Provider Network has been completed and deficiencies noted.	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Acceptable Response to ORR not sent timely	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The objective of this audit is to determine contractual standards.	Medicaid
Apr-12	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	CAP	Med-QUEST division (MQD) indicated that the State wanted to review all HCBS reductions prior to implementation. Most recent information from MQD indicates this was a CAP	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Information not sent - Edifices	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices - Redetected Claims not resubmitted with 45 days	Medicaid
Apr-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	State of Tennessee External Quality Review Organizational standards	Medicaid
May-12	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	The IAD letter did not document correct information; What was required on appeal	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The April 2012 GeoAccess analysis has been completed.	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
May-12	Unison Health Plan of South Carolina, Inc.	SC	South Carolina:Department of Health and Human Services	CAP	Annual EQRO conducted by CCME	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Defective Notice	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The submitted report containing 4Q11 data did not meet all benchmark requirements.	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The report submitted containing data for 4Q11 does not meet benchmark requirements.	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The report submitted containing 4Q11 data did not meet all benchmark requirements.	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	30100	Edifices - Information not sent within 45 days	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	16500	Edifices - Information not sent with 45 days	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	126000	Edifices - Information not sent within 45 days	Medicaid
May-12	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	2012 APIPA AHCCCS OFR - Focused on CRS	Medicaid
May-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	36500	Review of the FFY 2010-2011 CHCUP results demonstrated that the plan failed to meet its projected goals of 80% for both the Federal Participation and Screening Rations. The fine is calculated at $100 per day for the 365 days in the year, for a total of $3	Medicaid
May-12	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	Q:Medicaid Regulatory Audit Medicaid PlanArizona	Medicaid
May-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This Audit was used to examine the contractor's co	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incomplete Proof of Directive Compliance	Medicaid
Jun-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	13920	Dup rate exceeded for month	Medicaid
Jun-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	7369	Encounter dupe rate overrun	Medicaid
Jun-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	13135	Encounter Dupe Rate overrun	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jun-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	3399	Encounter Dupe Rate overrun	Medicaid
Jun-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	3136	Capitation Detail Record Denials - overrun	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Jun-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Numerous denial PA for Dental, gastric bypass, occupational therapy and nursing facility care	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The May 2012 GeoAccess analysis has been completed	Medicaid
Jun-12	Unison Health Plan of Delaware, Inc.	DE	Delaware:Division of Medicaid & Medical Assistance (DMMA)	CAP	This is a review of all Information Systems necessary	Medicaid
Jun-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	8846	Encounter dupe Rate overrun	Medicaid
Jun-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	618 ID Cards were not delivered to New Members timely June 1, 2012	Medicaid
Jun-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	618 ID Cards were not delivered to New Members timely June 1, 2012	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Jun-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Appeals and Non-Claims-Related Grievance Statewide Reports showed non-compliance in untimeliness	Medicaid
Jun-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	Appeals and Non-Claims-Related Grievance Statewide Reports showed non-compliance in untimeliness	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare request the Health Plan to perform a systematic review on gaps in administrating the NEMT services regarding transporting recipients with no evidences of services being provided.	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare request the Health Plan perform a systematic review on gaps in administering the NEMT services regarding transporting recipients with no evidences of services being provided.	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The CAP asks the Health Plan to perform a systematic review on gaps in administrating the NEMT services regarding transporting recipients with no evidences of services being provided.	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	600	Information not Sent	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	600	Information Not Sent	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	600	Information Not Sent	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	600	Information Not Sent	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	600	Information Not Sent	Medicaid
Jun-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	600	Information Not Sent	Medicaid
Jul-12	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	50000	A&G Nonperformance	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Information Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q12 GeoAccess analysis of the provider network has been completed with noted deficiencies.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q12 GeoAccess analysis of the provider network has been completed with noted deficiencies.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q12 GeoAccess analysis of the provider network has been completed with noted deficiencies.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q12 GeoAccess analysis of the provider network has been completed with noted deficiencies.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The 2Q12 GeoAccess analysis of the provider network has been completed with noted deficiencies.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical records/ doctor's order missing	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	55500	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	29500	Information Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	24500	Information Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Information Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20500	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Identify Provider missing or Incorrect	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20500	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	21000	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	24000	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Upon review of the NEMT Provider Monitoring Summary Report, it was determined the report was deficient.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Upon review of the NEMT Provider Monitoring Summary, it was determined that the report was deficient.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Upon review of the NEMT Provider Monitoring Summary it was determined that the report was deficient.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	21000	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	24000	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	24000	Grier Denial Not Sent	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	24000	Grier Denial Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Internal criteria not met	Medicaid
Jul-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	5531	Capitation Detail Record Denials - overrun	Medicaid
Jul-12	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland:Department of Health and Mental Hygiene	CAP	Comprehensive EQRO Survey covering the following s	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan submitted the required disclosure submission rate report as required by the CRA.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan submitted the Disclosure Submission Report as outlined in CRA section 2.30.15.4.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan made the submission on the Disclosure Submission Rate Report as outlined in CRA section 2.30.15.4.	Medicaid
Jul-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Other	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	As part of the CMS requirement for CHOICES, the Bu	Medicaid
Aug-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Department of Elder Affairs	CAP	Case file reviews the enrollee visits for PSA-7 to	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan must explain why there are claims paid without information on billing provider's EIN/TIN.	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan must explain why there are claims paid without information on billing provider's EIN/TIN.	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan must explain why there are claims paid without information billing provider's EIN/TIN.	Medicaid
Aug-12	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	UHCCPOH did not submit revised Grievance and Appeals from CAP Timely	Medicaid
Aug-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA will be conducting compliance monitoring review	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Other	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Other	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The July 2012 GeoAccess analysis was performed on the recently submitted provider enrollment files.	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The July 2012 GeoAccess analysis was performed on the recently submitted provider enrollment files.	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The July 2012 GeoAccess analysis was performed on the recently submitted provider enrollment files.	Medicaid
Aug-12	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	CAP	DDD will be conducting an annual review of the health plan.	Medicaid
Aug-12	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	Failure to meet minimum performance standards	Medicaid
Aug-12	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	200000	Failure to meet minimum performance standards	Medicaid
Aug-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Response untimely	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	1Q2012 CHOICES Care Coordination Report	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5799.71	10 days plus cost of care	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	NEMT Call Center Standards	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	NEMT Call Center Standards	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Sep-12	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual site visit	Medicaid
Sep-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	In the Health Plan's prior ORR responses, it was indicated that a transportation provider in West TN, Northwest carriers, did not notify the Health Plan of an incident until the state issued an ORR.	Medicaid
Sep-12	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	United Healthcare of New York, Inc. failed to remove a provider	Medicaid
Sep-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	14100	Financial Remedies--Pharmacy Encounters. Non-timely with pharmacy encounter reporting. (Contract Section II.D.12 General Responsibilities of Health Plan)	Medicaid
Oct-12	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Telephonic verification of participation with health plan	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	3Q2012 Provider Data Validation Report has been completed and deficiencies were noted	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	3Q2102 Provider Data Validation Report has been completed and deficiencies were noted	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	3Q2012 Provider Data Validation Report has been completed and deficiencies were noted	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Achieve Benchmark - incorrect telephone numbers - 80.3% accuracy rate	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Achieve Benchmark - invalid telephone numbers and primary care services	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Achieve Benchmark - invalid telephone numbers	Medicaid
Oct-12	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Access to routine appointments, non urgent 'sick" appointments, and after-hours access was validated	Medicaid
Oct-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Department of Elder Affairs	CAP	Case file reviews the enrollee visits for PSA-11A	Medicaid
Oct-12	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	CAP	HSAG third follow-up review of UHP correction a	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1200	Report deficient	Medicaid
Oct-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	582.08	Missed Shifts	Medicaid
Nov-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA's annual on-site audit on the following contract	Medicaid
Nov-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	118724	Finding Encounter Dupe Rate overrun	Medicaid
Nov-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	271705	Finding Encounter Dupe Rate overrun	Medicaid
Nov-12	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	1083	Cap Detail Line denial rate overrun	Medicaid
Nov-12	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	CAP	DHS QUEST readiness review to ensure plan is in co	Medicaid
Nov-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA, BMHC, Health System Development is conducting	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Nov-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	25000	AHCA states that UHC has failed to submit pharmacy encounter data for DOS in September 2012 by 10/15/12.	Medicaid
Nov-12	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	25000	Plan failed to submit all pharmacy typical and atypical services with dates of service 9/2012-10/15/2012	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed its review.	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed its review.	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed its review.	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed its review.	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed its review.	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division of TennCare has completed its review.	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Nov-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information not sent timely	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Internal Criteria Not Met	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct a routine bi-a	Medicaid
Dec-12	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual on-site visit	Medicaid
Dec-12	UnitedHealthcare of Mississippi, Inc.	MS	Mississippi:Department of Insurance	CAP	A EQR Compliance review of the Plan	Medicaid
Dec-12	UnitedHealthcare of Texas, Inc.	TN	Texas:Health and Human Services Commission	354600	UHC did not meet performance requirements for 3Q SFY2012.	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical records/doctor's order missing	Medicaid
Dec-12	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	24794	Failure to provide home delivered meals	Medicaid
Jan-13	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland:Department of Health and Mental Hygiene	CAP	The EPSDT review is performed to assess the degree	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jan-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	IPRO conducted two focused studies to evaluate car	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare.	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare.	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to TennCare.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Provider Data Validation Survey	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6500	Information Not Sent	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Untimely response to ORR	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Proof of Service	Medicaid
Jan-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	Pursuant to the contract, if the Health Plan does not achieve the 60% screening rate or the 80% federal participation rate, a CAP must be filed by 2/15 annually.	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Personal Care Attendant	Medicaid
Jan-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	UHCCP improperly denied a request for a medication as a plan exclusion.	Medicaid
Jan-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	UHCCP improperly denied a request for a medication as a plan exclusion. Assessed fine, CAP, and 10-pt penalty.	Medicaid
Jan-13	UnitedHealthcare of Louisiana, Inc.	LA	Louisiana:Department of Insurance	CAP	UnitedHealthcare Community Plan (UHC) must maintain an automated Management Information System (MIS) which accepts provider claims, verifies eligibility, validates prior authorization, preprocesses and submits claims data to DHH's Fiscal Intermediary (Mol	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Information Not Set	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	58812	Missed Home Delivered Meals	Medicaid
Jan-13	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	Health plan has a large number of encounters in a pend status, especially more than 120 days.	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical records/doctor's order missing	Medicaid
Jan-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	13000	Information Not Sent	Medicaid
Feb-13	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual Compliance Review (monthly submission)	Medicaid
Feb-13	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual Compliance Review (monthly submission)	Medicaid
Feb-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Failure to notify OMA of the addition and deletion of the MCP subcontractors.	Medicaid
Feb-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	10000	UHC failed to notify OMA of the addition and deletion of MCP subcontractors.	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Feb-13	UnitedHealthcare of the Midlands	NE	Nebraska:Department of Health and Human Services	CAP	Per Sec IV.C.7.e.i of Contract: Inadequate Network of PCPs due to provider termination, Section IV.C.7.f.vii of contract reimbursement of claims	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Untimely Response to VFD	Medicaid
Feb-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	10000	Unable to achieve minimum HEDIS standards	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received Prompt Pay results from January 2013 reporting period.	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received Prompt Pay results from January 2013 reporting period.	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received Prompt Pay results from January 2013 reporting period.	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	14000	2012 AQS Deficient CAP	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	14000	2012 AQS - Deficient CAP	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	14000	2012 AQS CAP Deficient	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Identifying Provider missing or incorrect	Medicaid
Feb-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Did not meet performance measures for nine areas.	Medicaid
Feb-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Did not meet performance measures for three areas.	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Untimely Response	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	COB response untimely	Medicaid
Feb-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	50000	Failure to achieve minimum performance measure standards established in the 2009-2012 Plan Contract	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	552.44	MCO approved	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	17500	Initial Denial Notice not sent	Medicaid
Feb-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Mar-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	5000	The Child Health Check Up CAP was due on 2/15/13, but was not filed until 2/25/13.	Medicaid
Mar-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	5500	Preferred Care Partners, Inc. d/b/a CareFlorida (Plan) has failed to timely file the 2013 CHCUP CAP.	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Mar-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Subsequent to submitting the report for 4th quarter 2012 Table 3C, DMAHS identified cases which exceeded the required 30 day resolution timeframe for multiple Provider complaints. Specifically, 48 pharmacy complaint resolutions were non-compliant due to r	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Mar-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	IPRO will conduct a focused review on those 11 elements	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Form not completed	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Grier Notice Not Sent	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TDCI requests Health Plan to provide a CAP for the East TN grand region for noncompliance with prompt pay requirements.	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Medical Records/doctor's order missing	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Mar-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	HSAG reviewed pharmacy claims that were denied fro	Medicaid
Mar-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	COB criteria incorrectly identified	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Apr-13	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	MCO not meeting minimum performance requirements regarding Encounter data.	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Identify Provider missing or incorrect	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Medical records/doctor's orders missing	Medicaid
Apr-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	Education of Therapy providers impacted by NCCI edits	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received the 1QPDV results for UHCCP.	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received the 1QPDV results for UHCCP.	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received the 1QPDV results for UHCCP	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Provider Data Validation Survey	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Data Validation Survey	Medicaid
Apr-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	DMAHS has issued a Notice of Deficiency (NOD) due to perceived ongoing non-compliance with contractual provisions as outlined in sections 4.S.1, 4.6.4, 4.7.1 and 5.15.1 and 11:24-8 of the N.J.A.C.	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received results from the January Focused Claims Testing Report that was submitted.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received results from submitted report on Focused Claims Testing requirement.	Medicaid
Apr-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	AHCA states that UHC failed to submit the Insolvency Protection report by 4/1/13. Report was submitted timely however a typo was made in the address and report was not received.	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or incorrect	Medicaid
Apr-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	Medical health Plans of Florida, Inc. (Health Plan) has failed to account encounter data for the 2011 IBNR Behavioral Health Annual 80/20 Expenditure Report	Medicaid
Apr-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Board Cited - 2012 Phase 2 Provider Directory Survey - Sample of 80 providers, variety of provider types in all counties. Provider participation of 60%.	Medicaid
Apr-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	CareFlorida (Health Plan) has failed to timely file a complete and accurate audited annual financial report (Report) for 2012	Medicaid
Apr-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	Medical health Plans of Florida, Inc. (Health Plan) has failed to timely file a complete and accurate audited annual financial report for 2012.	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Information Not Sent	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations Missing or Incorrect	Medicaid
Apr-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to meet time frames for telephonic outreach	Medicaid
Apr-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA is requesting a CAP because there appear to be providers missing on the Online Provider Directory	Medicaid
May-13	UnitedHealthcare of Louisiana, Inc.	LA	Louisiana:Department of Insurance	140700	Improper denial of electronic claims for which Medicaid is secondary payer	Medicaid
May-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Requesting to validate PCP network in Davidson County	Medicaid
May-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	Medical Health Plans of Florida, Inc. has failed to file an accurate behavioral health 80/20 expenditure report for 2012.	Medicaid
May-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Resolution of claims that require adjustment and repayment for Washington County-Johnson City EMS	Medicaid
May-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	CareFlorida (Health Plan) has failed to file an accurate 1st Quarter 2013 Unaudited Quarterly Financials Report.	Medicaid
May-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	50000	Medical Health Plans of Florida, Inc. has failed to achieve and/or maintain the financial surplus requirements for the Q1 2013 Unaudited Quarterly Financials Report	Medicaid
May-13	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland:Department of Health and Mental Hygiene	CAP	Delmarva verbally informed the Plan of an EQRO Reg	Medicaid
May-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Qsource, as the state's designated External Quality	Medicaid
Jun-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	One member in 2011 received bariatric surgery at a site not deemed a Center of Excellence	Medicaid
Jun-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	As a CMS requirement for the CHOICES program, the	Medicaid
Jun-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	As a CMS requirement for the CHOICES program, the	Medicaid

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Jun-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Beginning January 1, 2012, the Contractor Risk Agreement (CRA) Section 2.22.7, Monthly Focused Claims Testing, includes additional monthly focused claims testing requirements.	Medicaid
Jun-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Failure to submit an accurate provider network	Medicaid
Jun-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	UnitedHealthcare has improperly denied requests for medications as benefit exclusions, and therefore has failed to provide medically-necessary Medicaid covered services to members.	Medicaid
Jun-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	20000	UnitedHealthcare has improperly denied requests for medications as benefit exclusions, and therefore has failed to provide medically-necessary Medicaid covered services to members.	Medicaid
Jun-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Jun-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Jun-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	UHCNY failed to submit its management contract with CareCore National, LLC. to the Department for renewal at least 90 days prior to its expiration, December 31, 2012	Medicaid
Jun-13	UnitedHealthcare of Washington, Inc.	WA	Washington:Washington State Health Care Authority	CAP	Annual Contract Monitoring audit. Review period 7	Medicaid
Jun-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Jun-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	An NOD was issued to UHCCPNJ citing non-compliance with provisions contained in Articles 4.6.4 and 5.15.1 of the NJ FamilyCare/Medicaid Managed Care Contract regarding continuation of the same level of service while the determination is in appeal.	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received the 2nd Quarter 2013 Provider Data Validation Report results for UHCCP	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received 2nd Quarter 2013 Provider Data Validation Report results for UHCCP.	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are conducted to determine the accuracy of provider information.	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Jul-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	47000	Civil penalties $47K based on possible violation of Insurance Law	Medicaid
Jul-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	The audit will focus on each MCP's compliance with	Medicaid
Jul-13	Unison Health Plan of Delaware, Inc.	DE	Delaware:Division of Medicaid & Medical Assistance (DMMA)	CAP	LTC QCMMR is missing LTC data since April 2013	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Grier Denial Not Sent	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Procedure 6 of this audit - auditors selected 5 no	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jul-13	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	MCO performance not meeting the performance requirements.	Medicaid
Jul-13	UnitedHealthcare of Texas, Inc.	TX	Texas:Health and Human Services Commission	216005	MCO performance not meeting the performance requirements.	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct a routine bi-a	Medicaid
Jul-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	Medica has failed to file an accurate medical loss ratio report for the 2nd quarter of 2012-2013	Medicaid
Aug-13	UnitedHealthcare Community Plan of Ohio, Inc.	Ohio	Ohio:Ohio Department of Job and Family Services (ODJFS)	31000	As of July 1, 2013, UHC does not meet minimum provider panel requirements in 13 areas.	Medicaid
Aug-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Aug-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	23560	Finding Encounter Dupe Rate overrun	Medicaid
Aug-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	64996	Finding Encounter Dup Rate overrun	Medicaid
Aug-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	109226	Finding Encounter Dup Rate overrun	Medicaid
Aug-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	152552	Finding Encounter Dup Rate overrun	Medicaid
Aug-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	57125	Finding Encounter Dup Rate overrun	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1750	Submission did not followed formatting protocol	Medicaid
Aug-13	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Public Welfare	CAP	Review of FWA policies and processes.	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	Medica has failed to timely file a complete and accurate claims aging report for the 2nd quarter of 2013.	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	Medica has failed to timely file a complete and accurate claims aging report for the 2nd quarter of 2013.	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	CareFlorida Reform (Health Plan) has failed to timely file a complete and accurate claims aging report (Report) for the 2nd quarter of 2013	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	CareFlorida (Health Plan) has failed to timely file a complete and accurate unaudited quarterly financial report for the 2nd quarter of 2013	Medicaid
Aug-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	CareFlorida Non-Reform (Health Plan) has failed to timely complete an accurate claims aging report (Report) for the 2nd quarter 2013	Medicaid
Aug-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Disabled Member, United did not handle the replacement of the wheelchair correctly, timely or according to contractual requirements.	Medicaid
Aug-13	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Board Cited Calls test PCP, OB responses to the availability of routine appointments, non urgent "sick" appointments and after-hours access. SOD issued because some providers responded that they did not participate in the plan or exceed the panel size limit.	Medicaid
Aug-13	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	CAP	Annual audit conducted by the EQRO, Health Service	Medicaid
Sep-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	NOD/CAP Request for Failure to Continue Services during Appeal Process and Failure to Provide Accurate Information regarding Denial and Appeal Rights.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8800	Transportation	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8800	Transportation	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8800	Transportation	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4000	Form not completed	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Form not completed	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	NEMT Scheduling After Hours (RFI 020196/CAP 017503)	Medicaid
Sep-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	6500	Submission was not sent timely	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's August 2013.CPAR for East Tennessee Nursing Facility shows a payment accuracy of 93.00% which is below the required contractual rate of 97%.	Medicaid
Sep-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Members age was documented incorrectly in the initial denial letter	Medicaid
Sep-13	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	2500	Submission was not sent timely	Medicaid
Sep-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Claims were reviewed for Medicaid payments made for Suboxone from 1.1.11-12.1.11. 20 prescribing providers were not found on the SAMHSA website as having a certification/waiver for prescribing Suboxone.	Medicaid
Oct-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	53552	Finding Encounter Dup Rate overrun	Medicaid
Oct-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	82415	Cap Detail Line denial rate overrun	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received 3rd Quarter 2013 Provider Data Validation Report results for UHCCP.	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received 3rd Quarter 2013 Provider Data Validation Report results for UHCCP.	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Received 3rd Quarter 2013 Provider Data Validation Report results for UHCCP	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Other	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Oct-13	UnitedHealthcare Integrated Services, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	16660	Preliminary results of Sanctionable pended encounters	Medicaid
Oct-13	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	19610	Quarterly notice of potential sanctions due to the number of pended encounters. Sanctions waived this quarter.	Medicaid
Oct-13	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	12735	Quarterly notice of potential sanctions due to the number of pended encounters. Sanctions waived this quarter.	Medicaid
Oct-13	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	2310	Quarterly notice of potential sanctions due to the number of pended encounters. Sanctions waived this quarter.	Medicaid
Oct-13	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	2000	UHCCP failed to meet Provider Panel requirements in the regions for which UHCCP holds a Provider Agreement.	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	2Q13 CHOICES Care Coordination Report	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	2Q13 CHOICES Care Coordination	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	2Q13 CHOICES Care Coordination Rpt	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Middle TN Nursing Facility payment accuracy 96.80% which is below the contractual rate of 97%.	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	East TN Medical show payment accuracy 96.44% which is below the required contractual rate of 97%.	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Our objective is to determine if United Healthcare	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct in May 2013 an	Medicaid
Oct-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Tennessee Department of Commerce and Insurance (TDCI)	CAP	The TennCare Division of the Department of Commerce	Medicaid
Nov-13	Unison Health Plan of Delaware, Inc.	DE	Delaware:Division of Medicaid & Medical Assistance (DMMA)	CAP	This is the annual external quality review audit w	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Monitoring review	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	During the August 2013 focused claims review TDCI noted that two paid claims from the East Tennessee testing have not been reported to the TennCare Bureau as encounter data.	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	During the August 2013 focused claims review TDCI noted for seventeen of the twenty-five claims selected with a status of denied in the Middle Tennessee testing, there was a significant delay between the date received and the "paid date".	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Claims Payment Accuracy deficiencies	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Oct 2013 CPA Results for UHPRV and Rqst for CAP Matter 13-011	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UHC has been instructed to stop paying parts of claims that are non-compliant since a claim is compliant as a whole and not in parts.	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UHC has been instructed to stop paying parts of claims that are non-compliant since a claim is compliant as a whole and not in parts.	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UHC has been instructed to stop paying parts of claims that are non-compliant since a claim is compliant as a whole and not in parts.	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Other	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid
Nov-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	900	Transportation- Deficient ORR	Medicaid
Nov-13	UnitedHealthcare of Pennsylvania, Inc.	PA	Pennsylvania:Department of Health	CAP	PA Department of Health requests a Plan of Correction from the plan, based upon an August 2013 NCQA survey where QI12: Element F scored less than 80%	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Denial Not Sent	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Denial Not Sent	Medicaid

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Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Denial Not Sent	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Denial Not Sent	Medicaid
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Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Denial Not Sent	Medicaid
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Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Denial Not Sent	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TDCI is requesting for West Tennessee control numbers 12, 21, and 22 where claims are reported with a "denied" status when UPRV paid "$0" as a secondary payer in both the prompt pay data files and the encounter data submitted to Tenncare.	Medicaid
Dec-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	15409	Finding Encounter Dup Rate overrun	Medicaid
Dec-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	10817	Finding Encounter Dup Rate overrun	Medicaid
Dec-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	48483	Finding Encounter Dup Rate overrun	Medicaid
Dec-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	336	Cap Detail Line denial rate overrun	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2938.92	Approving Services	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Claims Payment Accuracy - LTC CHOICES	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20000	Claims Payment Accuracy - LTC CHOICES	Medicaid
Dec-13	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Claims Payment Accuracy - LTC CHOICES	Medicaid
Dec-13	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	DMAHS requested a Corrective Action Plan to address areas of member dissatisfaction identified as a result of the 2013 CAHPS Survey.	Medicaid
Jan-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	UnitedHealthcare has failed to properly utilize available resources for identifying sanctioned/excluded providers.	Medicaid
Jan-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Telephone Survey to ensure Customer Services is providing accurate information to consumers and members.	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10728.8	MCO Approved (Home Health Services)	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Requesting a CAP for East control number 9, where denial reason communicated to provider was "payment adjustment submission/billing error".	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jan-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	AHCA has assessed Liquidated Damages for the unaudited CHCUP report for filing 1 day late.	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	847.56	Deliverable was deficient until fourth submission	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2400	Deliverable was deficient until fourth submission	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1300	Deliverable was deficient until third submission	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to ensure level of care	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to ensure level of care	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Unavailable	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to ensure level of care	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to ensure level of care	Medicaid
Jan-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to ensure level of care	Medicaid
Feb-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	25000	Failure to achieve the required Federal 80% Participation Ratio	Medicaid
Feb-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	25000	Failure to achieve the required Federal 80% Participation Ratio	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Information Not Sent	Medicaid
Feb-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	Failure to timely file the IBNR Behavioral Health Annual 80/20 Expenditure Report for 2012.	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Disclosure Submission Rate Report	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Disclosure Submission Rate Report	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Disclosure Submission Rate Report	Medicaid
Feb-14	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual Compliance Review (Monthly Submission)	Medicaid
Feb-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	SOF being issued as a result of a mbr complaint	Medicaid
Feb-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC did not comply with STAR and STAR+PLUS program requirements for FREW timely checkups for the 2011 reporting period.	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Requesting the following should be addressed in a follow-up related to the incident with NorthWest Tennessee HRA and their driver Gerald Sumkoski	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2699.2	Home Health Missed Shifts	Medicaid
Feb-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Statement of Deficiency - Provider Directory Survey Phase I 2013 - demographic and participation information was inaccurate in the directory	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Documentation of Freedom of Choice/POC timeframe untimely	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Documentation submitted for one member record did not demonstrate review	Medicaid
Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Documentation submitted for one member record did not demonstrate review of the Plan of Care within required timeframes.	Medicaid

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Feb-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Not contacting Group 2 members in nursing facility due for face-to-face within the prescribed timeframe	Medicaid
Feb-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	26270	Finding Encounter Dup Rate overrun	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct a routine bi-a	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare will conduct routine audits in November 2	Medicaid
Mar-14	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual Compliance Review (submission monthly)	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Grier Notice to member did not give at least 10 days advance notice of the reduction/termination	Medicaid
Mar-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	DMAHS reviewed the 4th quarter submission of Table 3A - Provider Grievances and Appeals Report and noted 12 cases as non-compliant with the required resolution timeframe.	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	February 2014 Claims Payment Accuracy Results for East TN Nursing Facilities were below 97% requirement	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Did not submit appropriate denial letter.	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Missing Required Language	Medicaid
Mar-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	VFD was not submitted timely	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	IDL did not state Consumer Directed Personal Care and missing the rule for the CD worker	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey-Invalid Phone Numbers	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey - Invalid Phone Numbers.	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
Apr-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA has required a CAP because the non-pharmacy encounters did not meet accuracy standards.	Medicaid
Apr-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	IPRO will conduct a review of UHCCP's Medicaid open	Medicaid

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Apr-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	CHOICES ERR Report Spring 2013 submitted by UHC-East for month of February, 2014, the percent of Participant Rights compliance for document with actionable changes reviewed was 57%.	Medicaid
Apr-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	71500	UHC failed to achieve minimum performance measure standards for calendar year 2012.	Medicaid
Apr-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	61000	Failure to achieve minimum performance measure standards established in the 2012-2015 Plan Contract	Medicaid
Apr-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	150000	AHCCCS alleges that the Health Plan failed to notify them of a material network change as required by contract.	Medicaid
Apr-14	UnitedHealthcare Integrated Services, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	3000	Arizona HealthCare Cost Containment System (AHCCCS) issued sanction for failing to report a material network change	Medicaid
May-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Annual audit to determine whether or not providers	Medicaid
May-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	In accordance with CMS requirements and Arizona Ad	Medicaid
May-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	The Division of Developmental Disabilities (Division	Medicaid
May-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	AHCA has determined that UHCCP-Florida is out of compliance with provider contract requirements regarding Non-compete clauses that restrict contracted providers from competing with a Managed Care Plan's other subcontractors or network providers.	Medicaid
May-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Office of Medical Assistance (ODM)	5000	Overstated capacity information furnished to the MCPN and ODM	Medicaid
May-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	16224	Failed to provide CHOICES Home-Delivered Meals	Medicaid
May-14	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland:Department of Health and Mental Hygiene	CAP	Delmarva verbally informed the Plan of an EQRO Reg	Medicaid
May-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The CRA requires 25 outreach events per quarter. According to the 1Q14 TENNderCare Report, we only conducted 20 TENNderCare events.	Medicaid
May-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The CRA requires 25 outreach events per quarter. According to the 1Q14 TENNderCare Report, we only conducted 20 TENNderCare events.	Medicaid
May-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Insufficient quantity of TENNderCare outreach events for 1Q2014	Medicaid
May-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4500	Insufficient number of outreach events	Medicaid
May-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	Arizona Health Care Cost Containment System (AHCCC	Medicaid
May-14	UnitedHealthcare of Mississippi, Inc.	MS	Mississippi:Division of Medicaid	CAP	The readiness review process assesses the Vendor's	Medicaid
Jun-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Complaints/grievances regarding access have increased, requiring a CAP which includes the specific steps to be taken to ensure that Quality of Care Referrals improve.	Medicaid
Jun-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Non Compliance with provisions of NYSDOH Title 10 NYCRR & Public Health Law	Medicaid
Jun-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC did not comply with SFY2013 Quarters 1-4 performance requirements.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Reconsideration response failed to include the CHOICES Plan of Care	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jun-14	UnitedHealthcare of Texas, Inc.	TX	Texas:Health and Human Services Commission	330600	UHC did not comply with SFY2013 Quarters 1-4 performance requirements.	Medicaid
Jun-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	An on site focus survey of United Healthcare Community Plan	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8500	Form not completed	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Form not completed	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Member Manuals & Education	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Member Manuals & Education	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Member Manuals & Education	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	9000	Other	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Jun-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	The Case Management Program Description was submitted one day late.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Claims Payment Accuracy - LTC CHOICES	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Incorrect Usage of Medical Necessity Prongs	Medicaid
Jun-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	32000	The plan received the attached fine based on our repeat Statement of Deficiencies (SOD) related to our provider data. The basis for the fine is detailed in the Stipulation.pdf (attached).	Medicaid
Jun-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	10000	AHCCCS alleges that the Health Plan failed to notify them of a material network change as required by contract.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8614	Home Health Missed Shifts - Meals	Medicaid
Jun-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	The New York State Department of Health will be conducting their annual Article 44/49 audit of the New York Health Plan. This will be a comprehensive review of all New York Health Plan operations.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	MFP Transitions	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	MFP Transitions	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	MFP Transitions	Medicaid
Jun-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	39655	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Jun-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	13555	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Jun-14	UnitedHealthcare Integrated Services, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	19395	We received our LTC Pended Encounter Sanction for quarter ending Dec 2013 this afternoon. Our preliminary results identified 3,189 encounters pended over 120 days. AHCCCS reviewed our challenges and reduced the Sanctionable encounters to 2,153.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	For all three claims that UPRV identified as errors, they were indicated that the claim was processed and the authorization were not on file.	Medicaid
Jun-14	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	9780	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Jun-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	The Ohio Department of Medicaid (ODM) review.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	16000	Failure to Complete and Submit New LOC Assessment	Medicaid
Jun-14	UnitedHealthcare of Washington, Inc.	WA	Washington:Washington State Health Care Authority	CAP	Annual Comprehensive Contract audit. Review period	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7500	Failure to Submit LOC Assessment and Failure to Disenroll	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	1Q2014 CHOICES CC Report - Failure to meet any timeframe regarding care coordination	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	1Q2014 CHOICES CC Report - Failure to meet any timeframe regarding care coordination.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to Complete and Submit New LOC Assessment.	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to Complete and Submit New LOC Assessment	Medicaid
Jun-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Citations missing or incorrect - Failure to include the out of network exclusion rule.	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	LTC Functional Assessment not submitted for HHA appeal	Medicaid
Jul-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	Missed Services Report due to AHCA was not submitted timely due to FTP Site security changes which restricted UHC's access to the FTP. Issue was correct late the same day however, due to changes within UHC FTP access protocols, staff was unable to upload	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	11500	Untimely Response to Prior Authorization Request.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	2Q2014 PDV - failure to reach accuracy rates - Invalid Phone Numbers.	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Untimely Response to Prior Authorization Request for Occupational Therapy.	Medicaid
Jul-14	UnitedHealthcare of Mississippi, Inc.	MS	Mississippi:Division of Medicaid	CAP	The Carolina Centers for Medical Excellences will	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	External Quality Review Organization (EQRO), will	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Matter 14-002 Prompt Pay Data Integrity Issue -significant number of unadjusted first submission claims.	Medicaid
Jul-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Insurance	CAP	The Texas Department of Insurance (TDI) has scheduled	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to Complete and Submit a New LOC Assessment (PAE)	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7500	Failure to Complete and Submit a New LOC Assessment (PAE)	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Complete and Submit a New LOC Assessment (PAE)	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to Complete and Submit a New LOC Assessment (PAE)	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation (PAE)	Medicaid
Jul-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to Complete and Submit a New LOC Assessment (PAE)	Medicaid
Jul-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Insurance	CAP	In accordance with 28 TAC Section 11.303(a) and TIC Section 843.156, the Texas Department of Insurance (TDI) is opening a triennial examination to determine UnitedHealthcare Community Plan of Texas' compliance with quality of care requirements. The examination will consist of document and file review covering the period from January 6, 2011 through April 7, 2014.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Spring 2014 ERR - Deficient Document; no service authorizations or other documentation provided to indicate discontinuance of service.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Spring 2014 ERR - Deficient Document - Incongruence between POC and notice relating to IHR	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Complete and Submit a New LOC Assessment	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Complete and Submit a New LOC Assessment	Medicaid
Aug-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	AHCA states that UHC failed to submit the Unable to Locate report timely, report was due 8/5 and received 8/7.	Medicaid
Aug-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	5500	AHCA indicated that Q1 Performance Measure Follow up for Grievances has a due date of 7/18 and not received until 7/30.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Aug-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	AHCA indicated that UHC reported inaccurate information in the Q1 Performance Measure report.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Complete and Submit a New LOC Assessment	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This is the first audit that the Bureau of TennCare will conduct for CHOICES Group 2 or 3 members who were admitted to a nursing facility. This will be a desk audit occurring at the Bureau's Nashville office that will evaluate the MCO's adherence.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct routine audits	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Bureau of TennCare will conduct a routine bi-a	Medicaid
Aug-14	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Qtr 1, Geo Access Report #55 indicated transportation access standard deficiencies in the rural county of Chaves and frontier counties of Catron, Cibola, Colfax, DeBaca, Guadalupe, Harding, Sierra, and Quay.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4054	Failure to provide home delivered meals - 8 days.	Medicaid
Aug-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	An audit of each Contractor's Drug List. The audit was completed to ensure that the medications listed on the AHCCCS MRPDL were also on the Contractors list. There were drugs that were not found on the contractors list.	Medicaid
Aug-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	AHCCCS conducted an audit to ensure that the medications listed on the AHCCCS MRPDL were included on our formulary. Gaps were identified.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6500	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4000	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Pick-up and Delivery Standards	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Pick-up and Delivery Standards	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	Information Not Sent	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV submitted the July 2014 CPA reports to the TennCare Division on August 18, 2014.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	As noted in the UPRV focused claims testing memo for the month of June 2014, TDCI is requesting a CAP for East TN claims issued identified by UPRV.	Medicaid
Aug-14	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	High monthly average of member transportation grievances. Specifically, ground non-emergency transportation.	Medicaid
Aug-14	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Untimely, inaccurate and incomplete state reports.	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Pick-up and Delivery Standards	Medicaid
Aug-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Pick-up and Delivery Standards	Medicaid
Sep-14	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	During the month of July 2014, Human Services Department (HSD) will conduct a desk audit of care coordination processes as part of its oversight responsibilities.	Medicaid
Sep-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	17500	Failure to Complete and Submit a New LOC Assessment	Medicaid
Sep-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	AHCCCS received a large volume of provider complaints related to claims payment, contract load, authorizations, incorrect reimbursements, and audit process. UHC has not demonstrated the ability to address and solve provider complaints timely.	Medicaid
Sep-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	11000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Sep-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	SOD for Provider Directory Survey Phase 2 2013	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Sep-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	40000	An internal system error caused incorrect claims denials for Assistive Care Services. As a result of the system issue, processing and reimbursement for Assistive Care Service providers were not accurate for May, June, July and August 2014.	Medicaid
Sep-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	833	Fine imposed due to excess denied capitation encounters.	Medicaid
Sep-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	22	Fine imposed due to excess denied capitation encounters.	Medicaid
Sep-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	17855	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Sep-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Banking and Insurance (DOBI)	CAP	A market conduct examination of AmeriChoice New Je	Medicaid
Sep-14	UnitedHealthcare of Texas, Inc.	TX	Texas:Health and Human Services Commission	25300	UHC did not comply with SFY2014 Quarters 1 & 2 performance requirements.	Medicaid
Sep-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	NJ mbrs received a letter that was intended for mbrs in Kansas State. NJ mbrs should not receive any mbr materials that have not been prior reviewed and approved by DMAHS. Note: There was no PHI mishap-all letters received by a mbr had that mbr's info.	Medicaid
Sep-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	17725	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Sep-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	47475	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Sep-14	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	20330	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Sep-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	2500	AHCA states that UHC failed to submit two Critical Incidents timely, reports were 1 day late in one instance and a second 4 days late	Medicaid
Sep-14	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Untimely and incomplete case documentation to address health and safety concerns.	Medicaid
Sep-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	SOD re. Sanctioned Providers 4Q13	Medicaid
Sep-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	SOD re. Primary Care Provider Verification/Niagara County	Medicaid
Sep-14	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	450000	Contractor sanction based on Quality Performance Measures that did not meet the contractual Minimum Performance Standards or demonstrated a statistically significant decline from the previous measurement year.	Medicaid
Sep-14	UnitedHealthcare of New England, Inc.	RI	Rhode Island:Department of Human Services	CAP	Annual performance goals audit conducted by the EO	Medicaid
Sep-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's August 2014 CPARs for East Tennessee NEMT show a payment accuracy of 96% which is below the required contractual rate of 97%.	Medicaid
Sep-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's August 2014 CPARs for West Tennessee NEMT show a payment accuracy of 94%, which is below the required contractual rate of 97%.	Medicaid
Sep-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	A critical incident was reported to United Healthcare of Florida, Inc. on September 17, 2014. It was not reported to AHCA timely.	Medicaid
Sep-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Transportation - Failure to perform the required Post-accident NEMT drug test.	Medicaid
Sep-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Information Not Sent	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Sep-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Stmt of Deficiency	Medicaid
Oct-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	1412	Fine imposed due to excess denied capitation encounters.	Medicaid
Oct-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	50000	UHC has failed to comply with claims processing as described in the contract. United has not processed and reimbursed claims to providers for DME services for May, June, July, August and September 2014.	Medicaid
Oct-14	UnitedHealthcare of New England, Inc.	MA	Massachusetts	CAP	Noncompliance as to the contract measure surrounding signed service plans	Medicaid
Oct-14	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Statement of Deficiency - the Plan is in violation NYCRR Section 360-10.8(d)(2) Fair hearings	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV Survey - Invalid Phone Numbers	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV - Failure to achieve accuracy rates - invalid phone numbers	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	PDV - Failure to achieve accuracy rates - invalid phone numbers.	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards.	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Oct-14	UnitedHealthcare of Wisconsin, Inc.	WI	Wisconsin:Department of Health Services	CAP	Multiple Encounter Issues	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Claims Payment Accuracy for Sep 2014	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	900	9 rejected encounters were not submitted with 45 days of rejection from Edifices.	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	400	4 rejected encounters that were not resubmitted within 45 days of rejection from Edifices.	Medicaid
Oct-14	Arizona Physicians IPA, Inc	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	The Arizona Health Care Cost Containment System (	Medicaid
Oct-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	United was assessed $1000 Liquidated Damages for late submission of a LTC Critical Incident received on 10/24/14 and submitted on 10/27/14.	Medicaid
Oct-14	UnitedHealthcare of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	1400	Late Healthtrack Complaint Resolution Fine	Medicaid
Oct-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Assuring the member arrives to their appointment on time and receives care as needed.	Medicaid
Oct-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	United was assessed $1000 Liquidated Damages for late submission of a LTC Critical Incident received on 10/24/14 and submitted on 10/27/14.	Medicaid
Nov-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	IPRO (on DMAHS' behalf) will conduct an audit of	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to comply with approval and scheduling time frames and the pick up and delivery standards.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3600	Deficient Report - 1Q2014 NEMT Post Transportation Validation Checks Report.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to comply with the approval and scheduling timeframes; and Failure to comply with pickup and delivery standards.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to Complete and Submit New LOC Assessment.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	NEMT CPA - Failure to meet the required 97% benchmark - reported 96% for September 2014.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	NEMT CPA - Failure to meet the required 97% benchmark - reported 96% for August 2014.	Medicaid
Nov-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	3000	United was assessed $3,000 Liquidated Damages for late submission of a LTC Critical Incident received on 10/29/14 and submitted on 11/05/14.	Medicaid
Nov-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1500	United was assessed $1,500.00 for late submission of an LTC Critical Incident received 11/4/2014 but not reported until 11/7/2014. AHCA Case #: 2014011156	Medicaid
Nov-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	5000	Failure to meet Provider Panel requirements	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	NEMT CPA - Failure to meet the required 97% benchmark - reported 94% for August 2014.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	11500	Failure to Complete and Submit New LOC Assessment.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20500	Failure to ensure that a level of care (i.e., PAE) and supporting documentation submitted with the level of care is accurate and complete.	Medicaid
Nov-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	237948	For SFY2011 - STAR and STAR+PLUS program FREW timely checkups - UHC did not meet threshold measures to earn incentive paid and did not meet requirements	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	East Tennessee NEMT shows a payment accuracy below the required contractual rate.	Medicaid
Nov-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	United was assessed $1,000 Liquidated Damages for late submission of an LTC Critical Incident received on 11/18/14 and not reported until 11/21/14	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT - Failure to comply with pick up and delivery standards	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT - Failure to comply with pick up and delivery standards.	Medicaid
Nov-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT - Failure to comply with requirements regarding urgent trips.	Medicaid
Nov-14	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	1200000	Multiple UHC reports did not comply with one or all reporting requirements such as timeliness, accuracy and/or completeness.	Medicaid
Dec-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Job and Family Services (ODJFS)	CAP	Surveys for the Drug Utilization Review (DUR) and	Medicaid

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Dec-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	UHC submitted over 110 providers with same/very similar addresses and capacity amounts multiple times to the MCPN System.	Medicaid
Dec-14	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	5000	UHC submitted over 110 providers with same/very similar addresses and capacity amounts multiple times to the MCPN System.	Medicaid
Dec-14	Unison Health Plan of Delaware, Inc.	DE	Delaware:Division of Medicaid & Medical Assistance (DMMA)	CAP	Readiness Review will include 6 tracks to prepare for 1/1/2015 new contract start.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	45000	NEMT Claims Payment Accuracy - Failure to Meet Benchmark	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	25000	Nurse Triage Line - Failure to meet benchmark to answer within 30 seconds.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	25000	Nurse Triage Line - Failure to meet benchmark to answer within 30 seconds.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	25000	Nurse Triage Line - Failure to meet benchmark to answer within 30 seconds.	Medicaid
Dec-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	671	Fine imposed due to excess denied capitation encounters.	Medicaid
Dec-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	94162	Finding Encounter Dup Rate overrun	Medicaid
Dec-14	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	832	Fine imposed due to excess denied capitation encounters.	Medicaid
Dec-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	The Provider Termination & New Provider Notification Report was submitted late for 1 day Case # 2014011954. Liquidated Damages for a total of $500.00 were received for late submission of the Provider Termination and New Provider Notification report by one day. Case # 2014011954. Check was mailed overnight UPS on 12/19/2014.	Medicaid
Dec-14	UnitedHealthcare of Arizona, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	16210	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Dec-14	UnitedHealthcare of Arizona, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	925	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Dec-14	UnitedHealthcare of Arizona, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	16945	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards.	Medicaid
Dec-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	Few Medicaid Managed Care Texas Health Steps, Medical Checkups Report (SFY 2011) must be submitted on time, accurate, and complete.	Medicaid
Dec-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	750	The file submitted on 12/1/14 did not follow formatting protocol and therefore failed to import successfully.	Medicaid
Dec-14	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Health and Family Services	3460	For SFY2014 Q3 UHC did not meet the performance standards for Financial Statistical Reporting to Encounter Data Reconciliation for STAR and CHIP.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Claims Payment Accuracy results for Nov 2014 reporting requirement.	Medicaid
Dec-14	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards.	Medicaid

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Dec-14	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	1000	An Ad-Hoc Report required as per Policy Transmittal 14-05 requested Health Plan Financial and Encounter Data to be submitted by 11/12 and was not provided until 11/14, plan was assessed $1,000.00 Liquidated Damages	Medicaid
Dec-14	UnitedHealthcare of Arizona, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	2090	Notice of sanctions due to the number of pended encounters outstanding after 120 days as of 6/30/2014.	Medicaid
Dec-14	UnitedHealthcare of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	804897	The Bureau of Managed Care (BMC) is imposing a monetary sanction in the amount of one quarter of one percent of the current month's premium payment for each quality measure where UHC did not meet the minimum performance standard.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	250	Provider Enrollment File not accepted by 5th of month - 1 day late	Medicaid
Jan-15	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	15537	Finding Encounter Dup Rate overrun	Medicaid
Jan-15	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	CAP	Incomplete implementation of EVV system.	Medicaid
Jan-15	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Regulator, OQA noticed a concerning increase in non-compliance for cases reported on 3rd Quarter Table 3A.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Quarterly telephone surveys are routinely conducted to determine the accuracy of provider data submitted to the Bureau of TennCare.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	NEMT Claims Payment Accuracy for 11/2014 - Failure to meet the required 97% benchmark.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Validation Survey Report - failure to reach accuracy rates - Invalid Phone numbers.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Validation Survey Report - failure to reach accuracy rates - Invalid Phone numbers.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Provider Validation Survey Report - failure to reach accuracy rates - Invalid Phone numbers.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4584	Failure to Provide Approved Services (Personal Care).	Medicaid
Jan-15	UnitedHealthcare Insurance Company	HI	Hawaii:State of HI Department of Human Services	CAP	Problems related to contract loading, claims payment accuracy and recoupment.	Medicaid
Jan-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	250	The Provider Network File was due to AHCA on 1/5/15. UnitedHealthcare of Florida, Inc. did not submit the file until 1/6/15. Case No: 2015000443	Medicaid
Jan-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	This is a situation where UHC did not monitor the supply of product, ensure timely approval of the product for delivery before the current supply ran out, and did not communicate information to the parent or the provider.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Because your organization achieved 61% of your annual goal, and did not reach 85% of your transition goal in 2014 we are asking you to submit a Corrective Action Plan (CAP).	Medicaid

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Jan-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	5000	Failure to assist a member in accessing needed services in a timely manner.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Incorrect responses by member services staff between 10/15 and 11/6/14	Medicaid
Jan-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	3000	As of 1/12/2015, UHC did not meet the minimum provider requirements for Guernsey (dentist), Fulton (dentist), and Wood (orthopedists).	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to Meet Timeframe Regarding Care Coordination.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7000	Failure to meet any timeframe regarding care coordination and Failure to comply with the requirements regarding documentation.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to meet any timeframe regarding care coordination and Failure to comply with the requirements regarding documentation.	Medicaid
Jan-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Jan-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC reporting capabilities do not allow encounters to be reported by Financial Arrangement Code (FAC) after the encounter submission.	Medicaid
Feb-15	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual Compliance Review (Monthly Submission)	Medicaid
Feb-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	United was assessed $500 Liquidated Damages for late submission of an LTC Critical Incident received 1/14/15 and not reported until 1/16/15.	Medicaid
Feb-15	UnitedHealthcare of New York, Inc.	NY	New York:Department of Health and Mental Hygiene	CAP	Statement of Deficiency for 4th Quarter HCS Complaint Summary Submission	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to Complete and Submit a New LOC Assessment.	Medicaid

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Feb-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	UnitedHealthcare was assessed $500.00 for the late submission of an Ad-Hoc report, the report was due 12/15/2015 and was not received until 12/23/2015.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Requesting confirmation on number of trips and number of un-duplicated members for wheelchair and stretchers are correct by due date.	Medicaid
Feb-15	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	Regulator, OQA noticed a concerning increase in non-compliance for cases reported on 3rd Quarter Table 3B.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	As a CMS requirement for the CHOICES program, the Bureau of TennCare is required to conduct a statistically valid Enrollee Record Review (ERR) twice each year for each MCO. The ERR assesses compliance with CRA reqs related to CHOICES elements.	Medicaid
Feb-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	AHCCCS conducted Secret Shopper Survey focused on routine and urgent dental appointment availability. The survey focused on appointment availability in urban and rural settings, members with special health care needs and Spanish speaking members.	Medicaid
Feb-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	UHC failed to comply with a Corrective Action Plan issued 12/1/2015. Inaccurate reporting to the Managed Care Provider Network (MCPN) System and the Ohio Department of Medicaid (ODM).	Medicaid
Feb-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	10000	UHC failed to comply with a Corrective Action Plan. Inaccurate reporting to the Managed Care Provider Network (MCPN) System and the Ohio Department of Medicaid (ODM).	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT Failure to Notify TennCare of an Accident/Incident within the specified timeframe.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to Complete and Submit a New LOC Assessment.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to comply with the requirements regarding urgent trips.	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Feb-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request.	Medicaid
Feb-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	11535	Pended encounter sanction. UHC is required to resolve all pended encounters within 120 calendar days of the processing date. 828 final sanction number pended encounters (after review of encounters UHC LTC advised were result of AHCCCS errors)	Medicaid
Feb-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	1595	Notice of sanctions due to the number of pended encounters outstanding after 120 days. This is for the CRS product	Medicaid
Feb-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	16335	Notice of sanctions due to the number of pended encounters outstanding after 120 days. Specific to UHC Acute	Medicaid

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Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT Failure to Comply with Rqmts Regarding Urgent Trips.	Medicaid
Mar-15	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	1871	Fine imposed due to excess denied capitation encounters.	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Denial Notice not issued within 21 days.	Medicaid
Mar-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	United was assessed $500.00 for late submission of an LTC Critical Incident which was received 10/3 and not reported until 10/6	Medicaid
Mar-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Health and Family Services	13000	UHC did not meet performance requirements for SFY2014 Q4.	Medicaid
Mar-15	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	CAP	IPRO will conduct a focused review on those 7 elements identified with a Not Met finding as a result of the comprehensive audit completed in 2013.	Medicaid
Mar-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC did not comply with STAR and STAR+PLUS program requirements for FREW timely checkups for SFY2012	Medicaid
Mar-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	AHCCCS identified several significant encounter data issues while performing data analysis and validation for critical and time-sensitive projects.	Medicaid
Mar-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC did not comply with STAR and STAR+PLUS program requirements for FREW timely checkups for SFY2012.	Medicaid
Mar-15	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	150	Statutorily required annual fee to renew Certificate was not received timely	Medicaid
Mar-15	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	3000	Statutorily required annual fee to renew Certificate was not received timely	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	13000	NEMT-Failure to comply with pick-up and delivery standards.	Medicaid
Mar-15	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	2825	Notice of sanctions due to the number of pended encounters outstanding after 120 days for the quarter ending 9/30/2014.	Medicaid
Mar-15	UnitedHealthcare Insurance Company of Ohio	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	On January 7, 2015 UnitedHealthcare (UHC) sent a request for approval of a Medicaid Expansion Focus Group survey, welcome letter and discussion guide. The BMC responded to the submission on January 16, 2015. The response asked for clarification and expressed concern with some of the survey questions but did not give an approval of the submission. UHC responded to the initial questions on January 22, 2015. On February 2, 2015 the BMC notified UHC that we were still discussing some of the survey questions. The same day, February 2, 2015, UHC asked if they could start the survey calls. Again, no approval was given for the submission. However, in an email dated February 20, 2015 from Amy Swanson it was confirmed that UHC had started making the survey calls using the survey that was not approved. The Provider Agreement, Appendix C.22, states "the MCP is responsible for ensuring that all MCP marketing and member materials are prior approved by ODM before being used to share with members or potential members." UHC failed to obtain ODM approval before using the Expansion Focus Group survey.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation of CHOICES Transition Request	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	7500	Failure to Complete and Submit a New LOC Assessment	Medicaid
Mar-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	Ohio MMP failed to meet required service level for the month of January, 2015.	Medicaid
Mar-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	UHC average speed of answer for January was 63 seconds which exceeds the standard of less than or equal to 30 seconds. UHC abandonment rate for January was 5.4% which exceeds the standard of less than or equal to 5%.	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV February 2015 claims payment accuracy reports(CPAR) for the East Nursing Facilities and West NEMT show payment accuracy rate of 94% and 95% respectively below contractual rate of 97%	Medicaid
Mar-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	10000	UHC average speed of answer for January was 63 seconds which exceeds the standard of less than or equal to 30 seconds. UHC abandonment rate for January was 5.4% which exceeds the standard of less than or equal to 5%.	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1412.5	Home Health Missed Shifts	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5575	Home Health Missed Shifts	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT Failure to Comply with Approval & Scheduling Timeframes	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request.	Medicaid
Mar-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT Failure to comply with the approval and scheduling timeframes.	Medicaid
Mar-15	Health Plan of Nevada, Inc.	NV	Nevada:Division of Health Care Financing and Policy	CAP	Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the Nevada Division of Health Care Financing and Policy (DHCFP), will be conducting a review of the Medicaid managed care organizations (MCO) compliance with state and federal standards.	Medicaid
Mar-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	UHC did not meet the 4th quarter pharmacy PA TAT.	Medicaid
Mar-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	500	United was assessed $500 Liquidated Damages for late submission of an LTC Critical Incident received and due to AHCA by 3/12/15 and not reported until 3/16/15.	Medicaid
Mar-15	UnitedHealthcare of New England, Inc.	MA	Massachusetts:Executive Office of Health and Human Services	CAP	This fulfills a CMS request of the Massachusetts regulator to complete an annual SCO/FEW Contract attestation of all SCO plans in MA.	Medicaid
Apr-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	CAP	If the Federal and State CHCUP required ratios are below the standards, plans must submit to the Agency a corrective action plan for approval and implementation. UnitedHealthcare of Florida's Child Health Checkup (aka CHCUP or EPSDT) report indicated that the plan is below the Federal and State standards, therefore a CAP must be submitted for approval and implemented.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Abacus Matter 15-002 Initial Prompt Pay results were received for February 2015.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Abacus Matter 15-002 UPRV Initial Prompt Pay results were received for the month of January 2015.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	8000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Complete and Submit a New LOC Assessment	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Results were received from the 1Q15 provider data validation report.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	11000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	18000	Failure to Complete and Submit a New LOC Assessment	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20000	PDV - Failure to achieve accuracy rates for elements reported on provider enrollment file.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Failure to meet 97% benchmark for NEMT Claims Payment Accuracy.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Insufficient Documentation for CHOICES Transition Request	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Discrepancies between the pickup and delivery standards in comparison cross-reference with the member complaint report.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Failure to comply with claims processing requirements.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Failure to Comply with Claims Processing Requirements	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT Failure to Comply with Rqmts Regarding Urgent Trips	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	400	NEMT Deficient Complaint Report	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT Failure to Comply with Appr/Scheduling Timeframes	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to Comply with Pick-up and Delivery Standards	Medicaid
Apr-15	UnitedHealthcare of New Mexico, Inc.	NM	New Mexico:New Mexico Human Services Department (HSD)	25000	The State will provide monthly notice of sanctions for prior periods where the Plan submitted inaccurate, incomplete or untimely reports or failed to complete an ad hoc deliverable.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This is a CAP that covers a wide scope of functional business areas within the Health Plan.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	This CAP covers several functional business areas within the Operations of the Health Plan.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Failure to meet required benchmark for January 2015 CHOICES Prompt Pay.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Failure to meet required benchmark for February 2015 CHOICES Prompt Pay.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan received the results for the March 2015 Claims Payment Accuracy monthly report.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to adhere to contract requirements related to notification of fatality of NEMT driver.	Medicaid
Apr-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to disenroll and failure to provide timely notification of a member's death.	Medicaid
Apr-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	3000	As of April 1, 2015, United HealthCare did not meet minimum provider panel requirements for Guernsey (dentist), Fulton (dentist), and Clinton (pcp).	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Qsource, as the state's designated External Quality Review Organization (EQRO), will be conducting the onsite portion of the 2015 TennCare Annual Quality Survey (AQS) between March 3, 2015 and May 8, 2015 to evaluate each Managed Care Contractor's (MCC) compliance with the appropriate TennCare Contractor Risk Agreement and other applicable documents. Pre-Site Deliverables due 2/16/15 with the exception of the EPSDT file which is due to Qsource January 22, 2015.	Medicaid
May-15	AmeriChoice of New Jersey, Inc.	NJ	New Jersey:Department of Medical Assistance and Health Services (DMAHS)	5579	Finding Encounter Dup Rate overrun	Medicaid
May-15	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	1020.53	Completed Data Validation Studies A and B for services in 2012.	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT Failure to comply with approval and scheduling timeframes	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6000	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT Failure to comply with approval and scheduling timeframes	Medicaid
May-15	Great Lakes Health Plan, Inc.	MI	Michigan:Michigan Department of Health and Human Services	CAP	Annual Compliance Review (Monthly Submission)	Medicaid
May-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	1000	UHC did not meet performance requirements for FREW for SFY2014 Q3 and 4, SFY2015 Q1.	Medicaid
May-15	UnitedHealthcare Insurance Company, (UHIC)	MD	Maryland	CAP	Delmarva verbally informed the MD Health Plan (during the DHMH QALC meeting held 9/9/14) that its onsite audit (to review activity for calendar year 2014) will be held January 21 - 22, 2015. Delmarva posted Orientation Manual and Standards & Guidelines to portal 9/10/14.	Medicaid
May-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	UnitedHealthcare failed to meet the data quality standard of 100% for dental encounters.	Medicaid
May-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	120345	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid
May-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	20725	Notice of sanctions due to the number of pended encounters outstanding after 120 days.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
May-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	50540	Notice of sanctions due to the number of pended encounters outstanding after 120 days	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's April 2015 claims payment accuracy report (CPAR) for the East Tennessee Grand Region Nursing Facilities shows a payment accuracy rate of 93% which is below the statewide contractual rate of 97%.	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2000	Failure to Comply with Pickup and Delivery Standards	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to initiate disenrollment of member not receiving TennCare-reimbursed long-term care services	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to Comply with Approval and Scheduling Timeframes	Medicaid
May-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6727.24	Failure to Provide Approved Service Timely	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	On April 17, 2015, TDCI requested files that contained claims processed during the month of April 2015.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	16500	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	20000	Claims Payment Accuracy - Failure to Meet Benchmark	Medicaid
Jun-15	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	11300	Notice of sanctions due to the number of pended encounters outstanding after 120 days for the quarter ending 12/31/2014	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to Comply with Approval and Scheduling Timeframes	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Deficient NEMT Roster Report	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	11500	Deficient NEMT Roster Report	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1600	Deficient NEMT Roster Report	Medicaid
Jun-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	80000	AHCA determined that UnitedHealthcare of Florida, Inc. did not meet the minimum standards for HEDIS performance for CY 2013.	Medicaid
Jun-15	Medica Health Plans of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	10000	AHCA determined that Medica did not meet the minimum standards for HEDIS performance for CY 2013.	Medicaid
Jun-15	Preferred Care Partners, Inc.	FL	Florida:Agency for Healthcare Administration	10000	AHCA determined that Preferred Care Partners did not meet the minimum standards for HEDIS performance for CY 2013	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The QO Division at TennCare reviewed and denied submission.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Quality Oversight Division at the Bureau of TennCare requests submission, by UHC, information related to MCO DIDD Coordination of Benefits.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT Failure to comply with Pick Up and Delivery Standards	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT Failure to comply with Requirements Regarding Urgent Trips	Medicaid
Jun-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	50000	Settlement of Unison unpaid interest/penalties resulting from the Unison overpayment.	Medicaid
Jun-15	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	United member expressed difficulty receiving approval for the Group 3 wheelchair that was appropriate to meet his needs.	Medicaid

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Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	Procedure 6 of this audit requires the auditor to select 5 nonpharmacy providers associated with a health care plan to verify whether notice of the right to appeal adverse decisions affecting services is displayed in a public area.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT - Failure to notify TennCare of an incident.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to provide requested documentation.	Medicaid
Jun-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	250	United was notified on 1/27/15 that the Provider Network File submitted on 1/15/15 did not demonstrate compliance with network ratios, specifically for Otolaryngologists. Upon significant discussion and research,the actual LD was levied on 6/23/15.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT - Failure to Notify of Accident/Incident.	Medicaid
Jun-15	UnitedHealthcare of Washington, Inc.	WA	Washington:Washington State Health Care Authority	CAP	The Washington Health Care Authority (HCA) will assess managed care organizations (MCO) compliance with managed care contract and state and federal regulation requirements.	Medicaid
Jun-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Defective Notice of Adverse Action	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT - Failure to ensure the member receives the appropriate level of service.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to Comply with Pick-up and Delivery Standards	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay - Failure to Achieve Benchmark	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The CPA percentage rate was below the benchmark requirements as noted within the CRA.	Medicaid
Jul-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC did not meet performance requirements for FSR to Encounter Data, untimely encounter submissions and claims processing requirements for Behavioral Health clean claims.	Medicaid
Jul-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Department of Health and Family Services	31250	UHC did not meet performance requirements for FSR to Encounter Data, untimely encounter submissions and claims processing requirements for Behavioral Health clean claims.	Medicaid
Jul-15	UnitedHealthcare of Mississippi, Inc.	MS	Mississippi:Division of Medicaid	CAP	The CAP is relating to rural health clinic rates. This is a recurring issue. When receiving similar complaint in April 2015, UHCCP of MS responded with the following: configuration issues with the updated FQHC and RHC pmt appendix for Medicaid delayed submission of HQHC's and RHc's in MS. The Medicaid schedules could not be created and Networks could not load contracts without having the identifying schedule. The configuration is now completed and Networks can resume contracting FQHC's and RHC's in the market. UHC was provided the 2015 RHC rates via email on 1-12-15 followed by CD for loading to the UHC system. In addition, the RHC rates were provided on the DOM website.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3500	Failure to submit complete and accurate data pertaining to MFP.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	6000	Failure to submit complete and accurate data pertaining to MFP.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan received Prompt Pay results from the State on 6-23-15.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	On a quarterly basis, TennCare has its extension quality review organization, QSource, conduct quarterly telephone surveys.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	PDV - Failure to achieve accuracy rates for elements reported on provider enrollment file.	Medicaid
Jul-15	UnitedHealthcare of Wisconsin, Inc.	WI	Federal:CMS Central Office	CAP	Allegation that segment N104 of loop 1000B is being populated with TIN instead of NPI. NPI must be used for all providers who have them.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TennCare reviewed the GeoAccess report based on the July 5, 2015, provider enrollment file submissions.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Deficient Report	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Deficient Report	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Deficient Report	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	4000	Untimely Response to Prior Authorization Request	Medicaid
Jul-15	UnitedHealthcare of New England, Inc.	RI	Rhode Island:Executive Office of Health and Human Services	CAP	Annual performance goals audit conducted by the EOHHS, the State's Medicaid Agency	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to provide determination for Prior Authorization within 21 days	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	45000	Failure to Achieve Benchmark - NEMT Claims Payment Accuracy	Medicaid
Jul-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	The Arizona Health Care Cost Containment System (AHCCCS) will conduct a Focused Operational Review in May 2015 for Acute. The purpose of this review will be to determine compliance with contract YH14-0001.	Medicaid
Jul-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	The Arizona Health Care Cost Containment System (AHCCCS) will conduct a Focused Operational Review in May 2015 for CRS. The purpose of this review will be to determine compliance with contract YH12-0002.	Medicaid
Jul-15	Arizona Physicians IPA, Inc.	AZ	Arizona:Arizona HealthCare Cost Containment System (AHCCCS)	CAP	The Arizona Health Care Cost Containment System (AHCCCS) will conduct a Focused Operational Review in May 2015 for LTC. The purpose of this review will be to determine compliance with contract YH12-0001.	Medicaid
Jul-15	UnitedHealthcare of Mississippi, Inc.	MS	Mississippi:Division of Medicaid	CAP	Division of Medicaid ("DOM") requested that UnitedHealthcare Community Plan ("UnitedHealthcare") complete a formal Corrective Action Plan ("CAP") worksheet for its alleged failure to meet the screening rate requirements set forth in Section 6.10 of the December 1, 2012 contract between DOM and UnitedHealthcare for children ages 0-11 months.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's June 2015 report fell below the contractual requirement of 97%.	Medicaid
Jul-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	8000	As of July 6, 2015, UHC did not meet minimum provider panel requirements.	Medicaid
Jul-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	TDCI reviewed the Monthly Focused Claims Testing report that includes additional monthly focused claims testing requirements.	Medicaid

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Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	11500	Failure to submit complete and accurate data pertaining to MFP.	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	10000	Prompt Pay - Failure to Achieve Benchmark	Medicaid
Aug-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	CAP	UHC did not meet performance requirements for BH clean claims, inaccurate Pharmacy Encounters to FSR.	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	13516	Failure to Provide Approved Personal Care Services	Medicaid
Aug-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	The Ohio Department of Medicaid (ODM) contracted with Health Services Advisory Group, Inc. (HSAG) to perform an evaluation of each MyCare Ohio Plan's (MCOP's) compliance with care management program requirements, including the provision of waiver service coordination, as outlined in the 3-way agreement, the MCOP Provider Agreement, and the 1915(b) Home and Community Based Services (HCBS) waiver. The evaluation performed by HSAG will also provide an opportunity to collect data that will be used to calculate waiver assurance performance measures for which ODM is required to report to the Centers for Medicare and Medicaid Services (CMS).	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	2500	NEMT - Failure to Comply with Urgent Trips and Approval/Scheduling Requirements	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	NEMT - Failure to comply with approval and scheduling requirements.	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	15000	Claims Payment Accuracy - Failure to Achieve Benchmark	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1000	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
Aug-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	10000	Failure to meet care management requirements for the following six standards: Risk Stratification, Comprehensive Assessment, Individualized Care Plan, Waiver Service Provision, Care Manager/Care Management Team, and Beneficiary Interaction.	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Claims Payment Accuracy - Failure to Meet Required Benchmark	Medicaid
Aug-15	UnitedHealthcare Community Plan of Texas, L.L.C.	TX	Texas:Health and Human Services Commission	46574	UHC did not meet performance requirements for BH clean claims, inaccurate Pharmacy Encounters to FSR.	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	Failure to meet timeframe regarding care coordination for CHOICES members	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	THE CPA percentage rate was below the benchmark requirements as noted within the CRA	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	NEMT - Incorrect/Deficient June 2015 Accidents and Incidents Report	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	NEMT - Incorrect/Deficient June 2015 Accidents and Incidents Report	Medicaid
Aug-15	UnitedHealthcare of New York, Inc.	NY	New York:New York State Department of Health	CAP	Telephone calls are periodically placed to network providers to verify their participation	Medicaid
Aug-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	600	The Bureau of Managed (BMC) did not receive the above submission by the specified due date.	Medicaid
Aug-15	UnitedHealthcare of New England, Inc.	MA	Massachusetts:Executive Office of Health and Human Services	CAP	Contractual requirement that the plan must have a Medical Loss Ration (MLR) of at least 80%. The plan's current MLR is 78.6%.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	30000	NEMT Claims Payment Accuracy - Failure to Meet Required Benchmark	Medicaid
Aug-15	Arizona Physicians IPA, Inc.	AZ	Arizona:AZ Department of Economic Security (DES), Division of Developmental Disabilities (DDD)	20765	Notice of sanctions due to the number of pended encounters outstanding after 120 days for the quarter ending 3/31/2015.	Medicaid
Aug-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	CAP	MCPs are required to report alerts to the ODM Alerts Mailbox within 24 hours of any incident that meets the definition of an alert. For the fourth quarter of CY 2014, UHC was an outlier compared to other MCPs for alerts reported. Of the 292 alerts reported to ODM, UHC accounted for only 9 alerts. UHC had the lowest per member per month calculation at .7 with the highest plan at 12.1. PCG is obligated to approve prevention plans. Therefore, MCPs are required to enter all incidents into PCG's electronic incident management system. In reviewing the data for May through November, 2014, it appears that UHC only reported certain incidents. Of the 702 reported, UHC reported only 9.	Medicaid
Aug-15	UnitedHealthcare Community Plan of Ohio, Inc.	Ohio	Ohio:Ohio Department of Medicaid (ODM)	10000	Failure to report incidents and alerts timely	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	2Q12 PDV - Failure to achieve accuracy rate for telephone numbers	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	2Q12 PDV - Failure to achieve accuracy rates - Telephone Numbers	Medicaid
Aug-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	2Q12 - PDV Survey Failure to meet telephone percentage	Medicaid
Aug-15	UnitedHealthcare of Florida, Inc.	FL	Florida:Agency for Healthcare Administration	25000	Failure to Achieve the minimum screening rate of 60%	Medicaid
Sep-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	10000	UHC did not have a Medicaid-specific Bank Identification Number/Processor Control Number combination by the July 1, 2015 deadline	Medicaid
Sep-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT - Failure to comply with pick-up and delivery standards	Medicaid
Sep-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's August 2015 Claims payment accuracy report shows the following percentage rates which are below the contractual rate of 97%.	Medicaid
Sep-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Meet Accuracy Rate of NEMT Claims Payment Accuracy Report	Medicaid
Oct-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	5000	Fine for not meeting provider panel requirements	Medicaid
Oct-15	UnitedHealthcare Community Plan of Ohio, Inc.	OH	Ohio:Ohio Department of Medicaid (ODM)	5000	Fine for not meeting provider panel requirements	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	QSource conducted their quarterly analysis of the Health Plan's Aug 2015 provider enrollment files.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT - Failure to comply with the requirements regarding urgent trips.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	Failure to comply with the requirements regarding urgent trips.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	700	Deficient NEMT No Show Report for August 2015	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	700	Deficient NEMT No Show Report for August 2015	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	700	Deficient NEMT No Show Report for August 2015.	Medicaid

Date	Legal Entity	State	Regulator	Penalty Type	Description	Product
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	1500	NEMT - Failure to comply with the requirements regarding urgent trips.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	500	NEMT - Failure to comply with pickup and delivery standards.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	200	Failure to submit a complete and acceptable response to a NEMT Complaint ORR.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	3000	NEMT - Failure to comply with pickup and delivery standards.	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	The Health Plan received Prompt Pay results from the State	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	CAP	UPRV's September 2015 claims payment accuracy report (CPAR) show the following payment accuracy rates which are below the contractual rate of 97%:	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	100	Edifices rejected encounters not being corrected within 45 days of initial rejection	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to Meet Accuracy Rate of NEMT Claims Payment Accuracy Report	Medicaid
Oct-15	UnitedHealthcare Plan of the River Valley, Inc.	TN	Tennessee:Department of Finance and Administration - Bureau of TennCare	5000	Failure to comply with time frames for providing Member Newsletters.	Medicaid

Attachment 19 Q11
Certificate of Authority

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

UNITEDHEALTHCARE OF THE MIDLANDS, INC.

DOMICILED IN THE STATE OF NEBRASKA

IS HEREBY AUTHORIZED AND LICENSED IN NEBRASKA TO TRANSACT THE BUSINESS AS A HEALTH MAINTENANCE ORGANIZATION (HMO) IN THE STATE OF NEBRASKA AS DESCRIBED BY CHAPTER 44 OF THE INSURANCE STATUTES OF NEBRASKA:

149483	May 1, 2015	April 30, 2016
NEBRASKA IDENTIFICATION NUMBER	**DATE ISSUED**	**DATE EXPIRES**

SIGNED AT LINCOLN, NEBRASKA

GREAT SEAL OF THE STATE OF NEBRASKA
MARCH 1ST 1867

Bruce R. Ramge
DIRECTOR OF INSURANCE

Attachment 19 Q26
Pharmacy Preliminary
Implementation Work Plan

Task #	Task Name	Health Status	% Complete	Start	Finish	Duration	Resource Names	Functional Area	Notes (dates subject to change based on bid award notification)
	Pharmacy Milestones	Gray	0%	1/1/2016	1/1/2017		Pharmacy Project Manager	Pharmacy	
1.0	**Define Pharmacy Development requirements**	Gray	0%	1/1/2016	3/1/2016		Regional Pharmacy Director	Pharmacy	
1.1	- Create detailed work plan based on development requirements (if applicable)	Gray	0%	3/1/2016	7/1/2016		Pharmacy Project Manager	Pharmacy	
1.2	- Development Work Team(s) oversight meetings (if applicable)	Gray	0%	4/1/2016	12/31/2016		Pharmacy Project Manager	Pharmacy	
1.3	- Idenitfy staffing needs (if applicable)	Gray	0%	1/1/2016	2/25/2016		Regional Pharmacy Director	Pharmacy	
1.4	- - requisition and hire (if applicable)	Gray	0%	5/1/2016	10/1/2016		Regional Pharmacy Director	Pharmacy	
1.5	- - onboard and training (if applicable)	Gray	0%	10/1/2016	12/31/2016		Regional Pharmacy Director	Pharmacy	
2.0	**C&S Formulary: Determine if standard will be used or state formulary**	Gray	0%	1/1/2016	3/1/2016		Regional Pharmacy Director	Pharmacy	
2.1	- If non standard formulary - create coding request (if applicable)	Gray	0%	3/1/2016	9/1/2016		Pharmacy Operations	Pharmacy	
2.2	- Submit & test coding request (if aplicable)	Gray	0%	9/1/2016	12/15/2016		Pharmacy Operations & PBM	Pharmacy	
3.0	**C&S Clinical Guidelines: Determine if Standard will be used or state guidelines**	Gray	0%	1/1/2016	3/1/2016		Regional Pharmacy Director	Pharmacy	
3.1	- Develop clinical guidelines (if applicable)	Gray	0%	3/1/2016	9/1/2016		Pharmacy Clinical Team	Pharmacy	
3.2	- If non standard ; create code request(s) clinical guidelines	Gray	0%	9/1/2016	12/1/2016		Pharmacy Operations	Pharmacy	
3.3	- Submit & test coding request (if aplicable)	Gray	0%	9/1/2016	12/15/2016		Pharmacy Operations & PBM	Pharmacy	
4.0	**Pharmacy Network Readiness**	Gray	0%	1/1/2016	1/1/2017		Regional Pharmacy Director	Pharmacy	Standard or Value Network
4.1	- Network Geo Access	Gray	0%	1/1/2016	3/1/2016		PBM	Pharmacy	
4.2	- Network contracting - Gap fill (if applicable)	Gray	0%	4/1/2016	12/31/2016		PBM	Pharmacy	
4.3	- Draft and facilitate Pharamcy Network Notices incldning Web based, fax etc	Gray	0%	9/1/2016	12/31/2016		Regional Pharmacy Director & PBM	Pharmacy	
5.0	**MTM Program**	Gray	0%	1/1/2016	1/1/2017		Regional Pharmacy Director	Pharmacy	
5.1	- Idenitfy deliverables and determine non-standard requirements (if applicable)	Gray	0%	3/1/2016	5/1/2016		Regional Pharmacy Director	Pharmacy	
5.2	- Add NE to MTM Contract	Gray	0%	6/1/2016	7/1/2016		Regional Pharmacy Director	Pharmacy	
5.3	- Idenity non-standard deliverbale and reporting requirements and facilitate development (if applicable)	Gray	0%	3/1/2016	12/1/2016		Regional Pharmacy Director	Pharmacy	
5.4	- Implement MTM	Gray	0%	tbd	tbd		Regional Pharmacy Director	Pharmacy	minimally requires one quarter's worth of Pharmacy claims data
6.0	**DUR Program**	Gray	0%	4/1/2016	1/1/2017		Regional Pharmacy Director	Pharmacy	
6.1	- Idenitfy deliverables and determine non-standard requirements (if applicable)	Gray	0%	3/1/2016	5/1/2016		Regional Pharmacy Director	Pharmacy	
6.2	- Notify PBM & Rx Clinical Team of development requirements (if applicable) and implement	Gray	0%	5/1/2016	12/31/2016		Regional Pharmacy Director	Pharmacy	
6.3	- Submit & test coding request (if aplicable)	Gray	0%	9/1/2016	12/15/2016		Pharmacy Operations & PBM	Pharmacy	
7.0	**PBM set up**	Gray	0%	4/1/2016	7/1/2016		Pharmacy Lead	Pharmacy	
7.1	- Rx Benefit configuration	Gray	0%	10/1/2016	12/15/2016		Pharmacy Lead	Pharmacy	

7.2	- Draft, Obtain Approval & load Rx Operational Letters	Gray	0%	7/1/2016	11/1/2016		Pharmacy Lead	Pharmacy	
7.2	- Confirm Prior Authorization, Clinical Guidelines & DUR in Place	Gray	0%	11/1/2016	12/15/2016		Pharmacy Lead	Pharmacy	
7.3	- Eligibility file testing	Gray	0%	10/1/2016	11/30/2016		Pharmacy Lead	Pharmacy	
7.4	- Production Eligibility files to ORx	Gray	0%	12/1/2016	12/20/2016		Pharmacy Lead	Pharmacy	
7.5	- Load historical pharmacy & PA data from the state (if available)	Gray	0%	12/20/2016	12/31/2016		Pharmacy Lead	Pharmacy	
8.0	**Go live oversight**	Gray	0%	12/15/2016	tbd		Regional Pharmacy Director	Pharmacy	
8.1	- Request go live reports	Gray	0%	12/15/2016	12/30/2016		Regional Pharmacy Director		
8.2	- Schedule go live team meetings	Gray	0%	12/15/2016	12/30/2016		Project Manager		
8.3	- Roll out standard Pharamcy Training	Gray	0%	12/15/2016	12/30/2016		Regional Pharmacy Director		
8.4	- Monitor Reports to inlcude (PA, Claims paid/denied, TATs etc)	Gray	0%	1/1/2017	tbd		Regional Pharmacy Director	Pharmacy	
8.4	- Facilitate Go live Meetings	Gray	0%	1/1/2017	tbd		Regional Pharmacy Director	Pharmacy	
9.0	Operationalize	Gray	0%	tbd					
9.1	- Move to standard Operations	Gray	0%	tbd					

Baby Blocks Brochure

Personal Empowerment Program

Health Talk – Member Newsletter

THE KEY TO A GOOD LIFE IS A GREAT PLAN

HealthTALK

UnitedHealthcare®
Community Plan

DID YOU KNOW?

Flu season can actually last for three seasons: fall, winter and spring. You can prevent seasonal flu all year long with a flu vaccine. Anyone age 6 months and older should get a flu vaccine each fall. There is no cost to you if you get it at your PCP's office.

Help us help you

Have you taken a Health Assessment?

UnitedHealthcare Community Plan offers special benefits and programs to help improve your health. The Health Assessment tells us which services can help you. By answering just a few questions, you can be matched with the right programs for you.

We ask new members to take a Health Assessment within 60 days of joining the plan. If you have been a member for longer, it's not too late.

Taking a Health Assessment is easy. It only takes a few minutes. Just visit the secure member website at **myuhc.com/CommunityPlan**. Or, call **1-800-641-1902 (TTY 711)** and complete it over the phone. You can also ask that a paper copy be mailed to you.

It's private. Your answers are confidential. They will not reduce your health care coverage in any way.

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United Health Group

UnitedHealthcare Community Plan
2717 North 118th Street, Ste. 300
Omaha, NE 68164

Attachment 19 Q35 Member Education Materials

Stay healthy

Preventive care is covered.

It's important for people of all ages to get regular preventive care. Preventive care aims to keep you healthy. It helps you avoid serious health problems later.

Preventive care is covered when you use a network provider. There is no cost to you. Covered services include:

- **CHECKUPS FOR CHILDREN AND ADULTS**
- **STANDARD IMMUNIZATIONS**
- **WELL-WOMAN CARE.** This includes a yearly woman's health visit. Screenings include Pap tests and testing for sexually transmitted diseases. Family planning and prenatal care are also covered.
- **SCREENINGS.** For children, this includes standard newborn testing and lead testing. Obesity and developmental screenings are also covered. For adults, this may include blood pressure, cholesterol and diabetes screenings. Screenings for problems with tobacco, alcohol and depression are also covered.

COVERED: PRE-TEEN VACCINES

11- to 12-year-olds need three vaccines:

- tetanus, diphtheria and pertussis (Tdap)
- human papillomavirus (HPV)
- meningococcal (MCV4)

In addition, teens need a booster of MCV4 at age 16.

What do you need? Many more preventive services are covered. Ask your primary care provider (PCP) about the screenings, exams, counseling and shots needed for your age and sex.

Sharing our results

UnitedHealthcare Community Plan has a Quality Improvement Program. It works to give our members better care and services. Each year we report our results.

HEALTH RESULTS

In 2014, our goals included increasing the number of members who had:

- infant, child and teen well visits
- breast cancer screenings
- pap smears
- lead screens

In 2015, we found that more children were receiving lead screenings. Also, more women were getting mammograms. Plus, many more members were having their body mass index (BMI) measured. However, we found that not enough children ages 3–6 years old were having annual well visits.

In 2015–2016, we will keep encouraging our members to get needed services. We want to see more:

- annual well visits for infants and young children.
- prenatal and postpartum visits for women.

MEMBER SATISFACTION RESULTS

UnitedHealthcare Community Plan welcomes your feedback to improve our services and programs. We do this through member satisfaction surveys. They show how well we are meeting our members' needs. Our 2015 surveys showed improvement in several measures. These include how our members rated their specialists, their medical care and their health plan. We are trying to improve our customer service. We now have specific people who help members who call more than once about a problem.

Get it all. Want to know more about our Quality Improvement Program? Call toll-free **1-800-641-1902 (TTY 711)**.

Baby showers

Helping people live healthier lives

Thank you for being a UnitedHealthcare Community Plan member. Our mission is "Helping People Live Healthier Lives." We are in your community sharing resources and providing education.

UnitedHealthcare Community Plan has partnered with community organizations to sponsor baby showers. We invite expecting mothers and new parents to attend. A guest speaker informs the families of the importance of prenatal visits, postpartum exams, baby's well-child care and immunizations. Expectant moms and new moms meet with health experts and community partners to get answers to questions about their pregnancy. They get tips for taking care of their babies.

During the baby shower, families can participate in a drawing for prize items that include baby-care items and health care resource materials. Every family also leaves with a gift bag to help baby get started.

Baby Blocks. Baby Blocks is a free online wellness incentive program for pregnant women and new moms. Members get email appointment alerts and wellness-related text messages. They can ask questions to maternity nurses. Moms can even earn reward gifts for keeping doctor appointments. Visit **UHCBabyBlocks.com** for more information.

Healthy First Steps

Whether you're expecting your first baby or your third, Healthy First Steps can help. Get personal support to stay healthy before, during and after pregnancy. While you're pregnant, your personal nurse can help you:

- find ways to reduce tobacco, alcohol and drug use
- eat well
- exercise safely
- prepare for labor

Your support doesn't end after you have your baby. Your nurse can help you for up to six weeks after delivery to:

- get postpartum care (and make your appointment)
- choose a doctor for your baby
- find local resources such as Women, Infants and Children (WIC)

Expecting? For a happy and healthy pregnancy, enroll today. Call **1-877-813-3417**, Monday–Friday, 8 a.m.–5 p.m. Central time. Healthy First Steps is already part of your benefits, so there's no extra cost to you.

Resource corner

Member Services If you do not speak English, Member Services will connect you with an interpreter.
New hours: Monday–Friday, 7 a.m.–7 p.m.
1-800-641-1902 (TTY 711)

NurseLine Get advice from a nurse, including help deciding the best place to get care, 24/7.
1-877-543-4293 (TTY 711)

Healthy First Steps Get pregnancy and parenting support. Join the Baby Blocks rewards program (toll-free).
1-877-813-3417 (TTY 711)
UHCBabyBlocks.com

Behavioral Health Services
1-800-424-0333 (TTY 711)

Superior Vision
1-800-879-6901

Care Management Nurse care managers are available Monday–Friday, 8 a.m.–5 p.m.
1-877-856-6351 (TTY 711)

Our website Look up a provider, print your ID card or read your Member Handbook.
myuhc.com/CommunityPlan

ACCESSNebraska Call if you change your address or phone number or become pregnant.
1-855-632-7633 (TTY 711)
402-473-7000 in the Lincoln area
402-595-1178 in the Omaha area

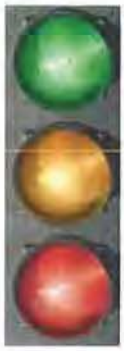
IntelliRide Arrange for transportation services.
1-844-531-3783
402-401-6999 in the Omaha area
IRideNow.com

KidsHealth Get answers to your questions about children's health.
UHCCommunityPlan.com/NEKids

In the zone

Your asthma action plan

If you have asthma, work with your doctor to create an asthma action plan. It will help you control your asthma. It explains your medications. It tells you what to do when your symptoms get worse. It tells you when you may need to add a medication, call your doctor or go to the hospital. An asthma action plan has three zones:



- **GREEN:** You feel well. Keep taking your long-term control medications.
- **YELLOW:** You are having asthma symptoms. You may be coughing or wheezing. Your chest could feel tight. You might be having trouble working or exercising. Slow down and take your quick relief medicine.
- **RED:** You are having severe symptoms. Your quick relief medicine is not helping enough. Get immediate medical attention.

Join us. We offer disease management programs. They help people with asthma, diabetes and other conditions manage their health. You can get advice from a nurse and reminders about your care. To learn more, call toll-free **1-877-856-6351 (TTY 711)**.

HEALTH4ME

UnitedHealthcare Community Plan has a new member app. It's called Health4Me. The app is available for Apple or Android tablets and smartphones. Health4Me makes it easy to:

- find a provider
- call Nurseline
- view your ID card
- contact Member Services

Connect. Download the free Health4Me app today. Use it to connect with your health plan wherever you are, whenever you want.

Scan to download mobile app.

Attachment 19 Q35 Member Education Materials

Rincón de recursos

Servicios para miembros Si no habla inglés, Servicios para miembros le comunicará con un intérprete. Nuevo horario: de lunes a viernes, de 7 a.m. a 7 p.m.
1-800-641-1902 (TTY 711)

Línea de enfermería (NurseLine) Obtenga consejos de una enfermera, incluida ayuda para decidir cuál es el mejor lugar para recibir atención, las 24 horas del día, los siete días de la semana.
1-877-543-4293 (TTY 711)

Healthy First Steps (Primeros Pasos Saludables) Obtenga asistencia durante el embarazo y sobre paternidad. Inscríbase en el programa de recompensas Baby Blocks (llamada gratuita).
1-877-813-3417 (TTY 711)
UHCBabyBlocks.com

Behavioral Health Services
1-800-424-0333 (TTY 711)

Superior Vision
1-800-879-6901

Administración de atención Nuestras enfermeras administradoras de casos están disponibles de lunes a viernes de 8 a.m. a 5 p.m.
1-877-856-6351 (TTY 711)

Nuestro sitio web Busque un proveedor, imprima su tarjeta de identificación de miembro o lea su Manual para miembros.
myuhc.com/CommunityPlan

ACCESSNebraska Llame si cambia de dirección o número de teléfono, o si se embaraza.
1-855-632-7633 (TTY 711)
402-473-7000 en el área de Lincoln
402-595-1178 en el área de Omaha

IntelliRide Coordine servicios de transporte.
1-844-531-3783
402-401-6999 en el área de Omaha
IRideNow.com

KidsHealth Reciba respuesta a sus preguntas acerca de la salud infantil.
UHCCommunityPlan.com/NEKids

En la zona

Su plan de acción contra el asma

Si tiene asma, hable con su médico para crear un plan de acción contra el asma que le ayude a controlarla, le explique sus medicamentos, le diga qué hacer cuando sus síntomas empeoren y cuándo puede ser necesario añadir otro medicamento, llamar a su médico o acudir al hospital. Un plan de acción contra el asma tiene tres zonas:

- **VERDE:** Se siente bien. Siga tomando sus medicamentos de control a largo plazo.
- **AMARILLO:** Tiene síntomas de asma. Puede tener tos o sibilancia o sentir opresión en el pecho. Podría tener problemas para trabajar o hacer ejercicio. Relájese y tome su medicamento de alivio rápido.
- **ROJO:** Tiene síntomas graves. Su medicamento de alivio rápido no le ayuda lo suficiente. Busque atención médica de inmediato.

Únase. Ofrecemos programas de control de enfermedades que ayudan a las personas con asma, diabetes y otras afecciones a controlar su salud. Puede obtener consejos de una enfermera y recordatorios sobre su tratamiento. Para obtener más información, llame gratis al **1-877-856-6351 (TTY 711)**.

HEALTH4ME

UnitedHealthcare Community Plan tiene una nueva aplicación para los miembros. Se llama Health4Me. La aplicación está disponible para tabletas y teléfonos inteligentes Apple y Android. Health4Me hace que le sea más fácil:

- encontrar un proveedor
- llamar a la línea de enfermería (NurseLine)
- ver su tarjeta de identificación
- ponerse en contacto con Servicios para miembros

Conéctese. Descargue hoy la aplicación gratuita Health4Me. Úsela para comunicarse con su plan de salud dondequiera que esté, cuando lo desee.

Escanee para descargar la aplicación móvil.

Manténgase sano

La medicina preventiva tiene cobertura.

Es importante que las personas de todas las edades obtengan atención médica preventiva de manera habitual. La atención médica preventiva tiene por objetivo mantenerlo sano y ayuda a evitar problemas de salud graves más adelante.

La atención médica preventiva está cubierta si usa un proveedor de la red. Esto no tiene costo para usted. Los servicios cubiertos incluyen:

- **CONTROLES DE RUTINA PARA NIÑOS Y ADULTOS**
- **VACUNAS ESTÁNDAR**
- **CONTROL DE MUJER SANA.** Incluye una consulta médica anual. Los exámenes de detección incluyen citología y exámenes de detección de enfermedades de transmisión sexual. La planificación familiar y los cuidados prenatales también tienen cobertura.
- **EXÁMENES DE DETECCIÓN.** Para los niños incluyen pruebas estándar para recién nacidos y exámenes de detección de plomo. Los exámenes de obesidad y desarrollo también tienen cobertura. Para los adultos pueden incluir exámenes de presión arterial, colesterol y diabetes. Los exámenes de detección de problemas con tabaco, alcohol y depresión también tienen cobertura.

CON COBERTURA: VACUNAS PARA PREADOLESCENTES

Los niños entre 11 y 12 años necesitan tres vacunas:

- tétano, difteria y tos ferina (Tdap)
- virus del papiloma humano (VPH)
- meningocócica (MCV4)

Además, los adolescentes necesitan un refuerzo de la MCV4 a los 16 años.

¿Qué necesita? Muchos otros servicios preventivos tienen cobertura. Pregunte a su proveedor de atención primaria (PCP) sobre los exámenes de detección, otros exámenes, orientación y vacunas necesarios para su edad y sexo.

Compartimos los resultados

UnitedHealthcare Community Plan ofrece un programa de mejoramiento de calidad que sirve para ofrecer a nuestros miembros una mejor atención y mejores servicios. Cada año informamos los resultados.

RESULTADOS DE SALUD

En 2014, entre nuestras metas estaba aumentar la cantidad de miembros que se realizaran:

- controles preventivos de bebés, niños y adolescentes
- exámenes de detección de cáncer de seno
- Papanicolaou
- exámenes de detección de plomo

En 2015, descubrimos que una mayor cantidad de niños se realizaron exámenes de detección de plomo. Asimismo, más mujeres se realizaron mamografías. Y muchos más miembros solicitaron la medición de su IMC. Sin embargo, nos dimos cuenta de que una cantidad insuficiente de menores entre 3 y 6 años se realizaron sus controles preventivos anuales.

En 2015–2016 seguiremos incentivando a nuestros miembros para que reciban los servicios necesarios. Queremos ver más:

- controles preventivos anuales para bebés y niños.
- consultas prenatales y posparto.

RESULTADOS DE SATISFACCIÓN DE LOS MIEMBROS

En UnitedHealthcare Community Plan agradecemos sus comentarios para mejorar nuestros servicios y programas. Lo hacemos a través de nuestras encuestas de satisfacción de los miembros. Estas demuestran nuestro desempeño en cuanto a la atención de las necesidades de nuestros miembros. Nuestras encuestas del año 2015 demostraron una mejora en varias medidas. Estas incluyen cómo calificaron nuestros miembros a sus especialistas, su atención médica y plan de salud. Estamos intentando mejorar nuestro servicio al cliente. Ahora contamos con personas especializadas en ayudar a los miembros que llaman más de una vez debido a un problema.

Obténgalo todo. ¿Quiere saber más sobre nuestro Programa de mejoramiento de calidad? Llame gratis al **1-800-641-1902 (TTY 711)**.

Baby showers

Ayudar a las personas a vivir una vida más saludable

Gracias por ser miembro del UnitedHealthcare Community Plan. Nuestra misión es "Ayudar a las personas a vivir una vida más saludable". Estamos en su comunidad para compartir recursos y ofrecer educación.

UnitedHealthcare Community Plan se ha asociado con organizaciones comunitarias para patrocinar baby showers. Invitamos a las madres embarazadas y a los nuevos padres a que asistan. Un orador invitado enseña a las familias la importancia de las visitas prenatales, los exámenes posparto, los controles preventivos para bebés y las vacunas. Las embarazadas y las nuevas madres se reúnen con expertos en salud y socios de la comunidad para obtener respuesta a sus preguntas acerca del embarazo y reciben consejos para cuidar a sus bebés.

Durante el baby shower, las familias pueden participar en un sorteo de premios como artículos para el cuidado del bebé y recursos para el cuidado de la salud. A cada familia también se le entrega una bolsa de regalo para ayudar con los primeros días del bebé.

Baby Blocks. Baby Blocks es un programa en línea de incentivos de bienestar para mujeres embarazadas y nuevas mamás. Los miembros reciben alertas de sus citas por correo electrónico y mensajes de texto sobre bienestar. Pueden hacer preguntas a las enfermeras de maternidad. Las mamás incluso pueden ganar obsequios por acudir a sus citas con el médico. Visite **UHCBabyBlocks.com** para obtener más información.

Healthy First Steps

Ya sea que esté esperando a su primer o tercer bebé, Healthy First Steps puede ayudarle. Obtenga apoyo personal para mantenerse su salud antes, durante y después del embarazo. Durante su embarazo, su enfermera personal puede ayudarle a:

- encontrar formas para reducir el consumo de tabaco, alcohol y drogas
- comer bien
- hacer ejercicio de manera segura
- prepararse para el parto

Su apoyo no finaliza después de que dar a luz. Su enfermera puede ayudarle por un periodo de hasta seis semanas después del parto a:

- recibir cuidado posparto (y programar sus citas)
- elegir un médico para su bebé
- encontrar recursos locales, como Mujeres, Bebés y Niños (Women, Infants, and Children, WIC)

¿Está embarazada? Para disfrutar de un embarazo feliz y sano, inscríbase hoy. Llame al **1-877-813-3417,** de lunes a viernes de 8 a.m. a 5 p.m., hora central. Healthy First Steps ya forma parte de sus beneficios, de modo que no tiene costo adicional para usted.

LA CLAVE PARA UNA BUENA VIDA ES UN GRAN PLAN

HealthTALK

UnitedHealthcare® Community Plan

¿SABÍA USTED QUE...?

La temporada de influenza en realidad puede durar tres temporadas: el otoño, el invierno y la primavera. Puede evitar contraer esta enfermedad todo el año si se vacuna contra la influenza. Todas las personas a partir de los seis meses de edad deben vacunarse cada otoño. No hay ningún costo para usted si vacunarse en el consultorio de su PCP.

Ayúdenos a ayudarle

¿Se ha realizado una Evaluación de Salud?

UnitedHealthcare Community Plan le ofrece beneficios y programas especiales que le permiten mejorar su salud. La Evaluación de Salud nos indica qué servicios pueden ayudarle. Al responder tan solo algunas preguntas, se le puede relacionar con los programas adecuados para usted.

Pedimos a los miembros nuevos que llenen una Evaluación de Salud dentro de los siguientes 60 días de unirse al plan. Si ha sido miembro durante más tiempo, aún no es demasiado tarde.

Llenar una Evaluación de Salud es fácil. Solo tardará algunos minutos. Simplemente visite el sitio web seguro para miembros en **myuhc.com/CommunityPlan**. O bien, llame al **1-800-641-1902 (TTY 711)** y respóndala por teléfono. También puede pedir que le envíen por correo una copia impresa.

Es privada. Sus respuestas son confidenciales. No reducirán su cobertura de atención médica de ninguna manera.

Asthma Mailer

Asthma Mailer – Spanish

Diabetes Mailer

Diabetes Mailer – Spanish

KidsHealth Flyer

Multilingual Welcome Card

2015 - 2016

UnitedHealthcare
Community Plan

Welcome to UnitedHealthcare Community Plan. Please take time to read your Member Handbook and review your benefits.

Important Telephone Numbers and Websites:

- **:mber Services** **1-800-641-1902**
  Y for the hearing impaired **711**
  Interpreter services are available.
  Available Monday - Friday, 7:00 a.m - 7:00 p.m.
- **24/7 NurseLine℠** **1-877-543-4293**
  Interpreter services are available.
- **Care Management** **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **Baby Blocks™** ..... **www.uhcbabyblocks.com**
- **Vision** **1-800-879-6901**
- **Transportation: IntelliRide (iridenow.com)** **1-844-531-3783**
  in Omaha **402-401-6999**

UnitedHealthcare Community Plan provides rides to and from WIC appointments, prenatal and pregnancy classes, approved exercise and nutrition classes, nutrition counseling, and Alcoholics Anonymous meetings.

www.myuhc.com/communityplan

UnitedHealthcare
Community Plan

Bienvenido a UnitedHealthcare Community Plan. Tómese unos minutos para leer su Manual para miembros y analizar sus beneficios.

Números de teléfono importantes:

- **Servicios para Miembros** **1-800-641-1902**
  TTY para personas con problemas de audición **711**
  Se encuentran disponibles servicios de intérprete.
  Disponible de lunes a viernes de 7 a. m. a 7 p. m.
- **Línea de enfermería NurseLine℠** **1-877-543-4293**
  Se encuentran disponibles servicios de intérprete.
- **Administración de la Atención Médica** **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **Baby Blocks™** ..... **www.uhcbabyblocks.com**
- **Vision** **1-800-879-6901**
- **Transporte: IntelliRide (iridenow.com)** **1-855-531-3783**
  En Omaha **402-401-6999**

UnitedHealthcare Community Plan brinda traslados para asistir a citas del programa Mujeres, Bebés y Niños (Women, Infants and Children, WIC), clases prenatales y para embarazadas, clases aprobadas de ejercicio y nutrición, asesoramiento nutricional y reuniones de Alcohólicos Anónimos.

Spanish **www.myuhc.com/communityplan**

UnitedHealthcare
Community Plan

ပက္ခဲမှာဘဉ်နၤဖဲ ယူဉ်နဲးတဲးတၢ်အိဉ်ဆူဉ်အိဉ်ရူဟၣ်ကွၢ်တဲ့ ပှၤတခၢဟၣ်တိာ်ကျဲၤ (UnitedHealthcare Community Plan) လီၤ. ဝဲသးစုၤဟီးနွံတၢ်ဆၢကတိၤလၢနၤကဖးနၤ ကရၢဖိုဆလံာ်နဉ်ကျဲ (Member Handbook) ဒီးကွၢ်ကဒါကုၤနတၢ်နွံဘျုးတဖဉ်နွဉ်တက့ၢ်.

လီတဲစိနိဉ်ဂ်ၢ်လၢဆရူဒိဉ်တဖဉ် -

- ကရၢဖိတၢ်မၤစၢၤတဖဉ် **(Member Services)** **1-800-641-1902**
  TTY လၢတၢ်နၢ်ဟူတဂုၤတဖဉ်ဆဂီၢ် **711**
  ပှၤတဲဘကျိုးထံတၢ်မၤစၢၤတဖဉ်စ့ၢ်ကီးဆိဉ်ဝဲလီၤ.
  ဂ့ၢ်ထိဉ် မ့ၢ်တနံၤ - မ့ၢ်ယါနံၤ, ဂီၤခီ ၇း၀၀ - ဟါခီ ၇း၀၀ နွဉ်လီၤ.
- **/7 NurseLine℠** **1-877-543-4293**
  ပှၤတဲဘကျိုးထံတၢ်မၤစၢၤတဖဉ်စ့ၢ်ကီးဆိဉ်ဝဲလီၤ.
- တၢ်ပၢဆုၤတၢ်ကွၢ်တဲ့ **(Care Management)** **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **Baby Blocks™** ..... **www.uhcbabyblocks.com**
- **Vision** **1-800-879-6901**
- ဝံစိ်ာ်တီဆုၤ - **IntelliRide (iridenow.com)** **1-844-531-3783**
  လၢဆိဉ်မ့ာ်ဟဉ် **(Omaha)** အပူၤ **402-401-6999**

ယူဉ်နဲးတဲးတၢ်အိဉ်ဆူဉ်အိဉ်ရူတၢ်ကွၢ်တဲ့ ပှၤတခၢတၢ်တိာ်ကျဲၤ (UnitedHealthcare Community Plan) တအုၤ ထိဉ်ဆုၤလီၤစၢၤတၢ်ဆူWIC တၢ်သ့ဉ်နဲၤစးသိတမဉ်ဆဂီၢ်. တဖျးဆိဉ်ဖျဲဉ်ဒီးတၢ်ဆိဉ်ဒီးဟုးသးတၢ်မၤလိတဖဉ်. နွဲ်ဖိတၢ်ဟူတၢ်ဂၤလၢတၢ်ဆုဉ်ကီၤဒီၤတခဉ်ဒီးတၢ်ဆိဉ်နွဉ်ဂ်ၢ်နွဉ်ဘါတၢ်မၤလိတဖဉ်. တၢ်ဟူဉ်ကွဉ်ဟဉ်ပးတၢ်ဆိဉ်နွဉ်ဂ်ၢ်နွဉ်ဘါတဖဉ်. ဒီး တၢ်ပတ့ဉ်သး (Alcoholics Anonymous)တၢ်ဆိဉ်စိုဉ်ဟၣ်လိၢ်တဖဉ်နွဉ်လီၤ.

Karen **www.myuhc.com/communityplan**

UnitedHealthcare
Community Plan

مرحبًا بك في الخطة الصحية UnitedHealthcare Community Plan. يرجى قراءة دليل الأعضاء ومراجعة المزايا التي تستطيع الحصول عليها.

أرقام هاتفية مهمة:

- خدمات الأعضاء **1-800-641-1902**
  خط الهاتف النصي (TTY) الخاص بضعاف السمع أو النطق **711**
  خدمات الترجمة الفورية متاحة.
  متاح من الإثنين إلى الجمعة، من 7 صباحًا إلى 7 مساءً.
- خط التمريض **NurseLine℠** المتاح على مدار الساعة وطوال أيام الأسبوع **1-877-543-4293**
  خدمات الترجمة الفورية متاحة.
- إدارة الرعاية **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **Baby Blocks™** ..... **www.uhcbabyblocks.com**
- **Vision** **1-800-879-6901**
- النقل: **IntelliRide** (iridenow.com) **1-855-531-3783**
  في أوماها **402-401-6999**

توفر الخطة الصحية UnitedHealthcare Community Plan وسيلة نقل من وإلى مواعيد WIC والفصول التوجيهية لرعاية الحمل وما قبل الولادة والفصول التوجيهية المعتمدة للتمارين والتغذية واستشارات التغذية واجتماعات مجموعة مدمني الكحول المجهولين (Alcoholics Anonymous).

Arabic **www.myuhc.com/communityplan**

UnitedHealthcare
Community Plan

Chào mừng quý vị đến UnitedHealthcare Community Plan. Xin dành chút thời giờ để đọc Cẩm Nang Hội Viên và duyệt qua các quyền lợi của quý vị.

Những Số Điện Thoại Quan Trọng và mạng lưới:

- **Dịch Vụ Hội Viên** **1-800-641-1902**
  TTY cho người lãng tai **711**
  Có sẵn dịch vụ thông dịch.
  Có mặt Thứ Hai - Thứ Sáu, 7:00 sáng - 7:00 tối.
- **24/7 NurseLine℠** **1-877-543-4293**
  Có sẵn dịch vụ thông dịch.
- **Ban Quản Lý Chăm Sóc** **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **`aby Blocks™** ..... **www.uhcbabyblocks.com**
- **sion** **1-800-879-6901**
- **Chuyên Chở: IntelliRide (iridenow.com)** **1-855-531-3783**
  tại Omaha **402-401-6999**

UnitedHealthcare Commmunity Plan cung cấp chuyên chở đến và về cho các buổi hẹn WIC, các lớp học về tiền sản và thai nghén, các lớp thể dục và dinh dưỡng được chấp thuận, cố vấn về dinh dưỡng, và các buổi họp Nghiện Rượu Ẩn Danh (Alcoholics Anonymous).

Vietnamese **www.myuhc.com/communityplan**

UnitedHealthcare
Community Plan

UnitedHealthcare Community Plan အဖွဲ့အစည်း အစီအစဉ်မှ ကြိုဆိုပါသည်။ သင်၏အဖွဲ့ဝင်လက်စွဲစာအုပ် နှင့်အကျိုးခံစားခွင့်များကို အချိန်ယူပြီး ဖတ်ရှုစစ်ဆေးပါ။

အရေးကြီးတယ်လီဖုန်းနံပါတ်များ နှင့်ဝဘ်ဆိုဒ်များ -

- အဖွဲ့ဝင်ဝန်ဆောင်မှုများ **1-800-641-1902**
  နားမကြားသောသူများအတွက် TTY **711**
  စကားပြန်ဝန်ဆောင်မှု ရရှိနိုင်သည်။
  တနလ်ာနေ့မှ သောကြာနေ့တိ - နံနက် 7:00 နာရီမှ ညနေ 7:00 နာရီအတွင်းရရှိနိုင်ပါသည်။
- 7/24 သူနာပြုလိုင်း℠ **1-877-543-4293**
  စကားပြန်ဝန်ဆောင်မှု ရရှိနိုင်သည်။
- စောင့်ရှောက်မှုစီမံခန့်ခွဲရေး **1-877-856-6351**
- **Healthy First Steps®** **1-877-813-3417**
- **Baby Blocks™** ..... **www.uhcbabyblocks.com**
- **Vision** **1-800-879-6901**
- သယ်ယူပို့ဆောင်ရေး- IntelliRide (iridenow.com) **1-855-531-3783**
  Omaha အတွင်း **402-401-6999**

UnitedHealthcare Community Plan အဖွဲ့အစည်း အစီအစဉ်မှ WIC ရက်ချိန်း၊ မီးဘယာပေးနှုံ့ ကိုယ်ဝန်ဆောင် ပညာပေးသင်တန်းများ၊ သင့်မှတ်လွေးကျင့်ခန်းနှင့် အာဟာရဆိုင်ရာ သင်တန်းများ၊ အာဟာရဆိုင်ရာ အကြံပေးချက်နှင့် အမြဲမမော်လိုသော အရက်သောက်သုံးသူ တွေ့ဆုံမှုများအတွက် သယ်ယူပို့ဆောင် ပေးသည်။

Burmese **www.myuhc.com/communityplan**

Recordatorios útiles sobre sus beneficios:

Es importante cumplir con las visitas de bienestar regulares. Concierte una cita con su proveedor de atención primaria (Primary Care Provider, PCP). Si necesita cancelarla, llame al menos 24 horas antes.

- Siempre lleve su tarjeta de identificación de UnitedHealthcare Community Plan y su tarjeta azul de Medicaid del estado a sus citas médicas y cuando vaya a una farmacia.
- Llame al consultorio de su PCP siempre que necesite atención de urgencia. También puede acudir a clínicas que atiendan fuera del horario normal o centros de atención de urgencia participantes.
- Los Servicios para Miembros se encuentran disponibles de lunes a viernes, de 7 a. m. a 7 p. m. Se encuentran disponibles servicios de intérprete. Llame para obtener información sobre sus beneficios o para encontrar y cambiar su PCP. Contamos con intérpretes telefónicos para usted si su proveedor no habla su idioma.
- Visite nuestro sitio web en **www.myuhc.com/communityplan** para obtener más información sobre su plan de Medicaid. Inicie sesión en el sitio web para imprimir una nueva tarjeta de identificación, consultar sus beneficios y reclamaciones o encontrar un proveedor u hospital.
- Si tiene una emergencia, llame al 911 para pedir ayuda o diríjase a la sala de emergencias más cercana.
- **Para informar cualquier cambio o si queda embarazada, llame a ACCESSNebraska al 1-855-632-7633. Si se encuentra en el área de Lincoln, llame al 402-473-7000. Si se encuentra en el área de Omaha, llame al 402-595-1178.** Llame también a Servicios para Miembros al **1-800-641-1902 o TTY 711 para personas con problemas de audición.**

UnitedHealthcare Community Plan

Spanish

Helpful Reminders About Your Benefits:

It's important to have regular wellness visits. Make an appointment with your Primary Care Provider (PCP). If you need to cancel, please call at least 24 hours in advance.

- Always bring your UnitedHealthcare Community Plan ID card and your blue State Medicaid card to your medical appointments and pharmacy visits.
- Call your PCP office anytime for urgent care needs. You can also use a participating after hours clinic or urgent care center.
- Member services is available Monday - Friday, 7:00 a.m - 7:00 p.m. Interpreter services are available. Call for information about your benefits or to find and change your PCP. We have telephonic interpreters for you if your provider does not speak your language.
- Visit our website at **www.myuhc.com/communityplan** for more information about your Medicaid plan. Log into the website to print a new ID card, see your benefits, claims, or to find a provider or hospital.
- If you have an emergency call 911 for help, or go to the nearest emergency room.
- **To report any changes or if you become pregnant, call ACCESSNebraska at 1-855-632-7633. If in the Lincoln area, call 402-473-7000. If in the Omaha area, call 402-595-1178.** Please also call Member Services at **1-800-641-1902 or TTY: 711 for the hearing impaired.**

UnitedHealthcare Community Plan

رسائل تذكيرية مفيدة عن المزايا التي لتستطيع الحصول عليها:

من المهم القيام بزيارات دورية للاطمئنان على صحتك. حدد موعدًا مع مقدم الرعاية الأولية (Primary Care provider, PCP) المتابع لك. إذا كنت مضطرًا لإلغاء الموعد، فيرجى الاتصال قبل الموعد بـ 24 ساعة على الأقل.

- احرص دائمًا على إحضار بطاقة هويتك الخاصة بخطة UnitedHealthcare Community Plan وبطاقتك الزرقاء State Medicaid في مواعيدك الطبية وعند زيارات الصيدلة.
- اتصل بمكتب مقدم الرعاية الأولية (PCP) في أي وقت عند الحاجة الطارئة للرعاية. وكذلك يمكنك استخدام العيادات أو مراكز الرعاية الطبية الطارئة المشاركة بعد ساعات العمل الرسمية.
- خدمات الأعضاء متاحة من الإثنين إلى الجمعة، من 7 صباحًا إلى 7 مساءً. اتصل للاستعلام عن المزايا أو عن كيفية العثور على مقدم الرعاية الأولية وتغييره. يتوفر مترجمون لتزويدك بخدمات الترجمة الفورية عبر الهاتف إذا كان مقدم الخدمة لديك غير ناطق بالعربية.
- تفضل بزيارة موقعنا الإلكتروني **www.myuhc.com/communityplan** لكي تحصل على المزيد من المعلومات حول خطة Medicaid بك. قم بتسجيل الدخول إلى الموقع الإلكتروني لطباعة بطاقة هوية جديدة أو للاطلاع على المزايا التي تتمتع بها أو المطالبات أو لإيجاد موفر خدمة أو مستشفى.
- في حالات الطوارئ، عليك الاتصال بالرقم 911 للحصول على المساعدة أو التوجه إلى أقرب قسم طوارئ.
- للإبلاغ عن أي تغييرات، أو إذا أصبحتِ حاملاً، يجب الاتصال بـ **ACCESSNebraska** على الرقم **1-855-632-7633**. إذا كنت في منطقة لينكولن، فاتصل بالرقم **402-473-7000**. إذا كنت في منطقة أوماها، فاتصل بالرقم **402-595-1178**. كما يرجى الاتصال بخدمات الأعضاء على الرقم **1-800-641-1902** أو الهاتف النصي: **711** الخاص بضعاف السمع أو النطق.

UnitedHealthcare Community Plan

Arabic

တက်ဒုးသွဉ်ထိဉ်လ၊အကဲဘျုးဘဉ်ယးဒီးနတက်နှဉ်ဘျုးတဖဉ် –

အရှဒိဉ်လ၊နကလဲးဒီးသမံသခိးကွံၤနတက်အိဉ်ဆူဉ်အိဉ်ရူထီဘိနှဉ်လီၤ. မ၊တ၊သုဉ်ဆ၊ဖးကတိၤလ၊တ၊ထိဉ်လိာ်အိဉ်သကိး ဒီး နပုၤဟှဉ်ဂ်ၢ်ဒိဉ်ထံအံၤကွၤ်ထွဲ (Primary Care provider -PCP) နှဉ်တကွၤ်. ဝဲသးစုၤကိးဆီပုၤအစုၤကတၤ်လ၊ ၂၄ နာ်ရံဉ်အတိၤ်ပူၤတကွၤ်.

- ထီဘိဟဲစိာ် နယူဉ်နဲးဖဲးကၤ်အိဉ်ဆူဉ်အိဉ်ရူတၤ်ကွၤ်ထွဲ ပုၤတ၁၊တၤ်တိာ်ကျဲး (UnitedHealthcare Community Plan) လံာ်ဆူဉ်သးခးကွဲးန State Medicaid ခးကွးလဲပာ် ဆူနတၤ်ကူစါယါဘျါတၤ်သုဉ်နံၤဖးသိတဖဉ်အဂီၢ်ဒီးန ဟဲဆုကသံဉ်ဒးတဖဉ်အခါန္ဉ်တကွၤ်.
- ကိး နှ PCP ဝဲၤဒးတဘျိလ်လ် လ၊တ၊ကွၤ်ထွဲအဆိအရူတ၊လိဉ်ဘဉ်တဖဉ်အဂီၢ်နှဉ်တကွၤ်. နစူးကါ တ၊မ၊သကိးတ၊ ဖဲကသံဉ်ဒး မ့တမ့ၢ် တ၊ကွၤ်ထွဲအဆိအရူစဲထၢ်ဉကးတံ်သးဝံၤအလိၢ်ဓံ သ့စ့ၢ်ကိးနှဉ်လီၤ.
- တ၊မၤန့ၢ် ကဏ္ဍဖိုးတ၊မ၊ဒ၊တဖဉ်သ့ဖဲ မ့ါတနံၤ – မ့ါယဲာ်နံၤ, ဂီၤခီ ၇း၀၀ – ဟါခီ ၇း၀၀. ပုၤတဲကျိုးထံတ၊မ၊စ၊၊တဖဉ် အိဉ်ဝဲနှဉ်လီၤ. ကိးလ၊နကခဲဉ်အါထိဉ်တဂ့ၢ်တ၊ကျိၤ တ၊ဂ့ၢ်တ၊ကျိၤဘဉ်ဃးဒီး နတ၊နှဉ်ဘျုးတဖဉ် မ့တမ့ၢ် တ၊ဃုသ့ဉ်ညါဒီး ဆီတလဲ နှ PCP ဒၢဂိၢ်နှဉ်တကွၤ်.
- လဲၤကွၢ်ဖဲပမ့ာ်ယဲၤသန့ ခဲ **www.myuhc.com/communityplan** လ၊တ၊ဂ့ၢ်တ၊ကျိုးအါထိဉ်ဆဂိၢ် ဒီး နှ Medicaid တ၊တိာ်ကျဲးအဂီၢ်နှဉ်တကွၤ်. လဲၤနှာ်ကွၢ်လ၊ဟုာ်ယဲၤသန့အပူၤ လ၊နကခဲကျိုးထုးထိဉ် လံာ်ဆုဉ်ဆီအဂိၢ်, ကွၢ်နတၤ်ရှဲဘျုးတဖဉ်, တ၊ပတံထိဉ်တဖဉ်, မ့တမ့ၢ် လ၊နကဃုတွၢ်ပုၤဟှဉ်တ၊မ၊စ၊၊ မ့တမ့ၢ် တ၊ဆါဟံဉ်တဖဉ်အဂိၢ်နှဉ်တကွၤ်.
- နမ့ၢ်အိဉ်ဒီးဂ့ၢ်ဂိၢ်အုနှဉ် ကိး 911 လ၊တ၊မ၊စ၊၊အဂိၢ်, မ့တမ့ၢ် လဲၤဆူဂ့ၢ်ဂိၢ်ဆူတ၊ဟှဉ်ကသံဉ်ဒး၊လ၊အဘူးကတၤ်ဒီးနှာနှဉ်တကွၤ်.
- လ၊နကတ်ဖျါထိဉ်တ၊ဆိတလဲတဖဉ်အဂိၢ်, မ့တမ့ၢ် နမ့ၢ်အိဉ်ထိဉ်ဒီးဟုးသးနှဉ်, ကိး **ACCESSNebraska** ခဲလိတဲ ခီနှဉ်ဂၤ် **1-855-632-7633** နှဉ်တကွၤ်. နမ့ၢ်အိဉ်လ၊ လ့ဝၢ်ဂ့ၢ် **(Lincoln)** လံာ်ကစီး၊အဂူးတခီ, ကိးခဲလိတဲခီနှဉ်ဂၤ် နှဉ်တကွၤ်. နမ့ၢ်အိဉ်ခဲ အိဉ်ပဉ်ဟဉ် **(Omaha)** လံာ်ကစီး၊အဂူးတခီ, ကိးလိတဲခီနှဉ်ဂၤ် **402-595-1178** နှဉ်တကွၤ်. ဝဲသးစုၤကိးတရၢ်ပိတၢ်မ၊စ၊၊တ၊မ၊တခုဉ် (Member Services) ခဲလိတဲခီနှဉ်ဂၤ် **1-800-641-1902** မ့တမ့ၢ် ကိး **TTY: 711** လ၊တ၊နှာ်ဟူတ၁၊ဘဉ်တဖဉ်အဂိၢ်နှဉ်တကွၤ်.

UnitedHealthcare Community Plan

Karen

သင့်အကျိုးကျေးဇူးနှင့် ပတ်သက်ပြီး အထောက်အကူပေးမည့် သတိပေးချက်များ-

ကျန်းမာရေးစစ်ဆေးခြင်းသို့ ပုံမှန်သွားရောက်ရန် အရေးကြီးသည်။ သင့်အား အခြေခံ ပြုစုပေးသော ဆရာဝန် (PCP) နှင့် တွေ့ဆုံခိုင်ရန် ချိန်းဆိုမှုများ ပြုလုပ်ပါ။ ချိန်းဆိုမှုကို ပယ်ဖျက်လိုပါက အနည်းဆုံး ၂၄ နာရီကြိုတင်၍ ခေါ်ဆိုပါ။

- ဆေးပါးကုဝသူအတွက် ချိန်းဆိုထားသည့်အတိုင်း သွားရောက်တွေ့ဆုံသည့်အခါနှင့် ဆေးဝါး ကျွမ်းကျင်သူနှင့် တွေ့ဆုံသည့် အခါတိုင်း သင့် UnitedHealthcare Community Plan စီစစ်ရေးကဒ်ပြား နှင့် အပြာရောင် Medicaid ဆေးဝါးကုသမှုကဒ်ပြားကို ယူဆောင်သွားပါ။
- အရေးပေါ် စောင့်ရှောက်မှုလိုအပ်ပါက PCP ရုံးသို့ အချိန်မရွေးခေါ်ဆိုပါ။ ရုံးချိန်နောက်ပိုင်း အရေးပေါ်စောင့်ရှောက်မှုလိုအပ်ပါက ပါဝင်သော အရေးပေါ်စောင့်ရှောက်ရေးဝင်တာကို အသုံးပြုနိုင်ပါသည်။
- စကားပြန်ခန့်ဆောင်မှုများ ရရှိနိုင်သည်။ သင့်အကျိုးခံစားခွင့် သို့မဟုတ် သင့် PCP ကို ရှာဖွေရန်နှင့် ပြောင်းလဲရန်တို့နှင့် ပတ်သက်သောအချက်အလက်များအတွက် ခေါ်ဆိုပါ။ သင့်အား ပုံပြေးပေးသူသည် သင်၏ဘာသာစကားကို ပြောဆိုသူ မဟုတ်ပါက သင့်အတွက် အသံအသုံးပြုသည့်စကားပြန်များ ကျွန်ုပ်တို့တွင် ရှိပါသည်။
- သင့် Medicaid အစီအစဉ်နှင့် ပတ်သက်သော သတင်းအချက်အလက်များ ထပ်မံရယူ လိုပါက www.myuhc.com/communityplan တက်ဆိုင်သို့ ဝင်ကြည့်ပါ။ စီစစ်ရေးကဒ်ပြား အသစ်အား ပရင့်ထုတ်ရန်၊ သင့်အကျိုးခံစားခွင့်များကို ကြည့်ရန်၊ ဆေးရုံးများကို ကြည့်ရန်၊ ဆေးဝါးဆိုင်များ သို့မဟုတ် ပုံပြေးသူ သို့မဟုတ် ဆေးရုံကိုရှာဖွေရန် ဝင်ဆိုင်းအတွင်းသို့ ဝင်ရောက်ပါ။
- အရေးပေါ်လိုအပ်ပါက အကူအညီရယူနိုင်ရန် 911 ကို ခေါ်ဆိုပါ၊ သို့မဟုတ် အနီးစပ်ဆုံး အရေးပေါ်အခန်းသို့ သွားပါ။
- ပြောင်းလဲမှုများ သို့မဟုတ် သင်သည် ကိုယ်ဝန်ဆောင်ခြင်းရှိလာပါက ဝင်ပြီးရန် ACCESSNebraska သို့ 1-855-632-7633 ကို ခေါ်ဆိုပါ။ Lincoln ဧရိယာအတွင်းဖြစ်ပါက 402-473-7000 သို့ ခေါ်ဆိုပါ။ Omaha ဧရိယာအတွင်းဖြစ်ပါက 402-595-1178 သို့ ခေါ်ဆိုပါ။ နားမကြားစေသာသူများအတွက် အခွဲခွဲ ဝန်ဆောင်မှုများပြုလုပ်ရန်သို့ 1-800-641-1902 သို့မဟုတ် TTY: 711 သို့လည်း ကျေးဇူးပြု၍ ခေါ်ဆိုပါ။

UnitedHealthcare Community Plan

Burmese

Nhắc Nhở Hữu Ích về Quyền Lợi của Quý Vị:

Điều quan trọng là khám sức khỏe thường xuyên. Lấy hẹn với Người Chăm Sóc Chánh (Primary Care provider, hay PCP) của quý vị. Nếu quý vị cảm thấy muốn hủy bỏ, xin gọi ít nhất 24 tiếng đồng hồ trước.

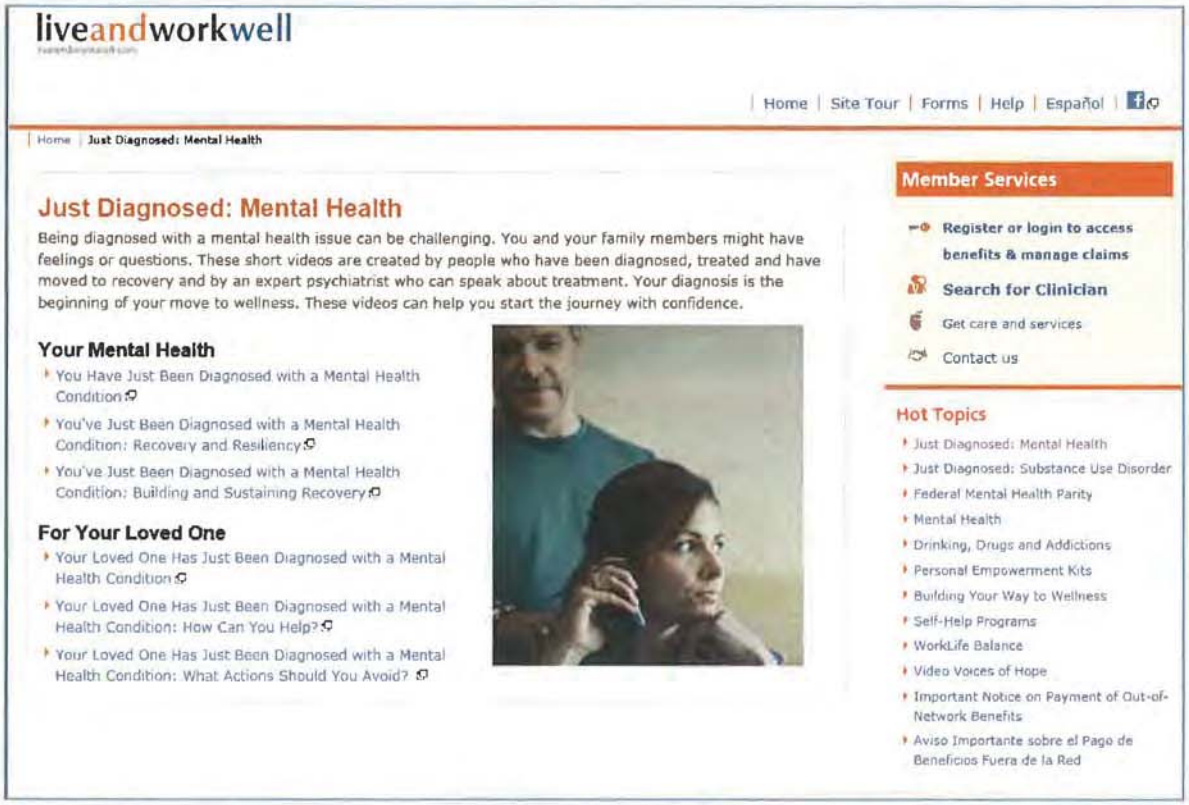
- Luôn luôn mang thẻ ID UnitedHealthcare Community Plan của quý vị và thẻ Medicaid màu xanh da trời của Tiểu Bang khi đến hẹn y tế và đến dược phòng.
- Xin gọi đến văn phòng PCP của quý vị vào bất cứ lúc nào cho các nhu cầu chăm sóc cần gấp. Quý vị cũng có thể sử dụng các bệnh xá hoặc trung tâm chăm sóc cần gấp có tham gia sau giờ làm việc.
- Dịch Vụ Hội Viên có sẵn từ Thứ Hai - Thứ Sáu, 7:00 sáng - 7:00 tối. Có sẵn dịch vụ thông dịch. Gọi để biết thêm thông tin về quyền lợi của quý vị hoặc để tìm và thay đổi PCP của mình. Chúng tôi có thông dịch viên qua điện thoại cho quý vị nếu người chăm sóc không nói ngôn ngữ của quý vị.
- Viếng mạng lưới của chúng tôi tại **www.myuhc.com/communityplan** để biết thêm thông tin về chương trình Medicaid của quý vị. Đăng nhập vào mạng lưới để in thẻ ID mới, xem quyền lợi của quý vị, đơn xin bồi hoàn, hoặc tìm người chăm sóc hoặc bệnh viện.
- Nếu gặp trường hợp khẩn cấp, xin gọi 911 để được giúp đỡ, hoặc đến phòng cấp cứu gần nhất.
- **Để báo cáo bất cứ thay đổi nào hoặc nếu quý vị thụ thai, xin gọi ACCESSNebraska theo số 1-855-632-7633. Nếu quý vị ở trong khu vực Lincoln, xin gọi 402-473-7000. Nếu quý vị ở trong khu vực Omaha, xin gọi 402-595-1178.** Quý vị cũng có thể gọi cho Dịch Vụ Hội Viên theo số **1-800-641-1902 hoặc TTY: 711 cho người lãng tai.**

UnitedHealthcare Community Plan

Vietnamese

Liveandworkwell.com
Screen Shots

The web content illustrated below, and the embedded video links, are accessible at https://www.liveandworkwell.com/public/content/showHotTopic.asp?hid=19&lang=1



liveandworkwell

Home | Site Tour | Forms | Help | Español

Home | Just Diagnosed: Mental Health

Just Diagnosed: Mental Health

Being diagnosed with a mental health issue can be challenging. You and your family members might have feelings or questions. These short videos are created by people who have been diagnosed, treated and have moved to recovery and by an expert psychiatrist who can speak about treatment. Your diagnosis is the beginning of your move to wellness. These videos can help you start the journey with confidence.

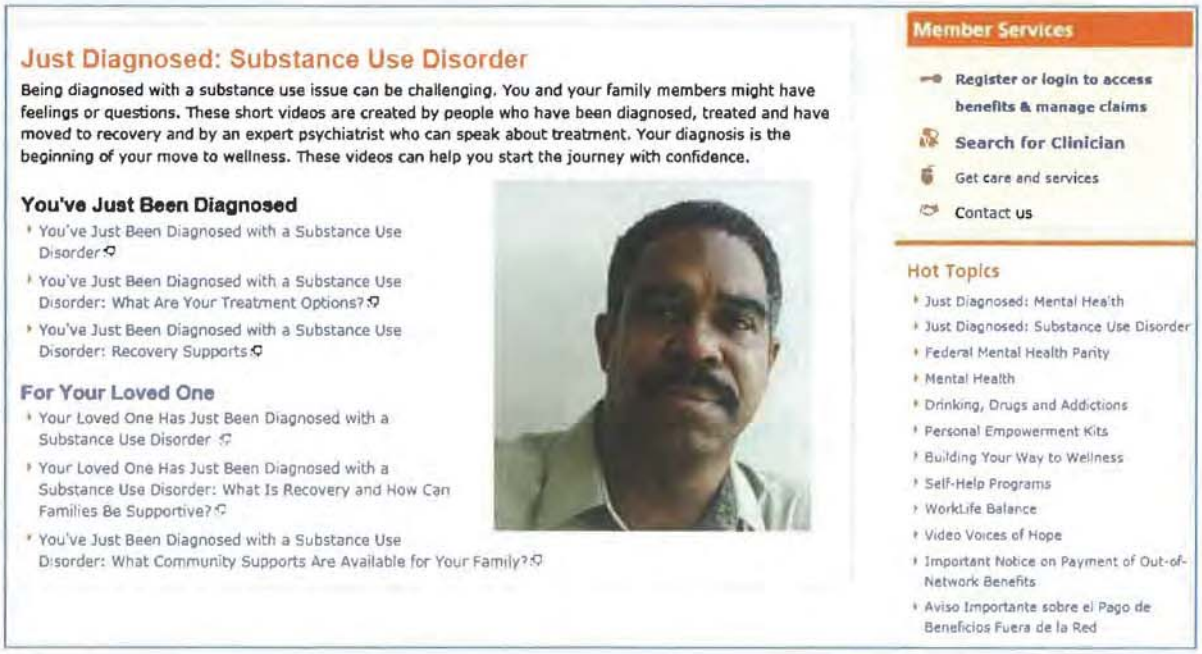
Your Mental Health

- You Have Just Been Diagnosed with a Mental Health Condition
- You've Just Been Diagnosed with a Mental Health Condition: Recovery and Resiliency
- You've Just Been Diagnosed with a Mental Health Condition: Building and Sustaining Recovery

For Your Loved One

- Your Loved One Has Just Been Diagnosed with a Mental Health Condition
- Your Loved One Has Just Been Diagnosed with a Mental Health Condition: How Can You Help?
- Your Loved One Has Just Been Diagnosed with a Mental Health Condition: What Actions Should You Avoid?

The web content illustrated below, and the embedded video links, are accessible at https://www.liveandworkwell.com/public/content/showHotTopic.asp?hid=20&lang=1



Just Diagnosed: Substance Use Disorder

Being diagnosed with a substance use issue can be challenging. You and your family members might have feelings or questions. These short videos are created by people who have been diagnosed, treated and have moved to recovery and by an expert psychiatrist who can speak about treatment. Your diagnosis is the beginning of your move to wellness. These videos can help you start the journey with confidence.

You've Just Been Diagnosed

- You've Just Been Diagnosed with a Substance Use Disorder
- You've Just Been Diagnosed with a Substance Use Disorder: What Are Your Treatment Options?
- You've Just Been Diagnosed with a Substance Use Disorder: Recovery Supports

For Your Loved One

- Your Loved One Has Just Been Diagnosed with a Substance Use Disorder
- Your Loved One Has Just Been Diagnosed with a Substance Use Disorder: What Is Recovery and How Can Families Be Supportive?
- You've Just Been Diagnosed with a Substance Use Disorder: What Community Supports Are Available for Your Family?

Attachment 19 Q47-2
NE Provider Town Hall
Session Presentation

2014 Fall Town Hall

Provider Relations, Iowa/Nebraska

October 2014

UnitedHealthcare®

Meeting Format

UnitedHealthcare

- *Meetings will be held monthly*
- *You may attend as many times as you wish.*
- *For every meeting, we will provide:*
  - *Topics we find may be useful*
  - *An open forum for the provider community to ask questions*
- *Please log in to WebEx at least 5 minutes before the start time.*
- *All participants are currently in listen-only mode, however, there will be an opportunity to ask questions.*
- *A chat window will be left open after the session to type questions.*
- *An electronic survey will be sent out afterwards to obtain your feedback.*

Chat feature

Meeting Format

- *Meetings will be held monthly*
- *You may attend as many times as you wish.*
- *For every meeting, we will provide:*
  - *Topics we find may be useful*
  - *An open forum for the provider community to ask questions*
- *Please log in to WebEx at least 5 minutes before the start time.*
- *All participants are currently in listen-only mode, however, there will be an opportunity to ask questions.*
- *A chat window will be left open after the session to type questions.*
- *An electronic survey will be sent out afterwards to obtain your feedback.*

Agenda

UnitedHealthcare

- Physician Advocates & Network Management
- Credentialing Overview
- Notifications/Prior Authorizations
- Reconsideration versus Appeal
- ICD-10
- Market Specific Topics
- Product Updates (All Savers/Navigate)
- Optum Cloud (Laura Rapoff)
- Contact Information
- Questions

UnitedHealthcare

Advocates & Network Management

Janee' Fisher
Manager of Provider Relations

What is a Provider Relations Team?

UnitedHealthcare®

- ❑A UnitedHealthcare navigational specialist
- ❑Product expert, represents all
- ❑Externally focused – interacts with the provider community and has a direct line of sight to the challenges experienced by local practices.
- ❑Relationship manager – builds collaborative working relationships and communicates changes to physicians in a timely way

Responsive, Proactive, Reliable and Simplistic!

Nebraska_PR_Team@uhc.com or
Iowa_PR_team@uhc.com

Network Account Management

UnitedHealthcare

Your Partner for Contract Needs

- ❑ Contract negotiations and management
- ❑ Contract interpretation questions
- ❑ Fee schedule inquiries
- ❑ Credentialing inquiries
- ❑ Product offerings and amendments

To find your Network Account Manager

www.unitedhealthcareonline.com > Contact Us > Select Your State

UnitedHealthcare

Credentialing Overview

Doug Moats
Provider Relations Advocate

UnitedHealthcare Requirements to begin the Credentialing Process

UnitedHealthcare

- To request participation for UnitedHealthcare and its Affiliate Companies, practitioners and/or facilities may contact the National Credentialing Center by calling the United Voice Portal @ 877-842-3210, and choosing telephone prompts Other Professional Services, then Credentialing, then Join the Network.

- At the time of the initial call the following information is required to search for a practitioner in our system, or set up a new record if needed.
  - Practitioner's name and degree
  - Date of birth, NPI (if applicable) and Social Security number
  - Practicing Specialty
  - Tax Identification number and legal name of the owner of the TIN as it appears on the W-9
  - Primary place of service address with phone and fax numbers
  - Billing address with phone and fax numbers
  - Credentialing address, if different, with phone and fax numbers.

Required Elements

UnitedHealthcare

- Active licensure in the state they will be practicing. Temporary license is not acceptable.
- Active DEA(s) registered in the state(s) they will be practicing, and/or CDS, if required by the state
- Active Professional Liability Insurance
- Active Hospital Privileges or Admitting Arrangements with a Participating Provider, if required for the specialty
- If the practitioner is a MD, DO or DPM, they must complete a Residency or Fellowship Program in their designated specialty

Process

UnitedHealthcare

- CAQH's Universal Credentialing Data Source
- Initial Call
- Credentialing Application Process
- For facility types handled by the NCC, we will send the appropriate application to the organization with instructions on the required supporting documents and where to submit the complete application.

Process continued…

UnitedHealthcare

- Primary Source Verification.
- UHC Credentialing Criteria Review
- Credentialing Committee

Recredentialing Process

UnitedHealthcare

- Providers need to be recredentialed at least every 36 months
- Illinois: State law determines when the credentialing outreaches can occur based on provider's SSN, so there are only specific timeframes within that 3 year cycle that we can contact physicians in IL for credentialing information

UnitedHealthcare

Prior Authorization/Notification Enhancements

Amy Lapaczonek: Provider Relations Advocate

Enhanced Automated Decision Functionality

UnitedHealthcare

- During Q3 2014, UnitedHealthcare is enhancing the functionality of the submission process by expanding and evolving the existing automated capabilities to include additional services.

Date of Deployment:

- **October 1, 2014**

Deployed to the following products in our Market:

- **UHC Employer & Individual Business (Fully Insured & ASO)**
- **UHC Medicare & Retirement**

Specialty Categories

UnitedHealthcare

The following specialty categories are being added to the auto decisioning logic:

- Bariatric Surgery
- Cosmetic & Reconstructive
- Spinal Stimulator for Pain Management
- BRAC Genetic Testing
- Orthognathic Surgery
- Breast Reconstruction – Non Mastectomy
- Spinal Surgery
- Sleep Studies
- Vein Procedures
- Durable Medical Equipment (DME) - greater than $1000
- Joint Replacement

Automatic Decisioning Process

UnitedHealthcare

- When a provider submits a prior authorization request for a service within the specialty category, the provider has an option to access a questionnaire.

- Based on the information provided while completing the questionnaire, the provider will either receive an automated approval or will be informed that additional clinical information is needed to review.

Sample of "Questionnaire"

UnitedHealthcare

Here are some questions a provider may be asked when submitting a request for vein surgery:

Vein Surgery Questionnaire [CPT Codes 36475, 36478, 37718, 37722, 37700, 37780]

INSTRUCTIONS: Please answer the questionnaire **below. Select "Save and Exit" above to** return and complete the notification/prior auth**orization submission request.**

1 *Which extremity will be treated?

- Left
- Right
- Both left and right

2 *Based on the extremity being treated, is there documentation that the patient has any of the following? (select all that apply)

- ☐ Leg pain
- ☐ Leg swelling
- ☐ Bleeding from varicose veins
- ☐ Thrombosis (clot)
- ☐ Skin ulcerations related to varicose or perforator veins
- ☐ None of the above
- ☐ Unknown

Additional Online Training

UnitedHealthcare

- 1st Wednesday of the month (1:00 pm central)
- www.unitedhealthcareonline.com > Tools & Resources > Training & Education

UnitedHealthcare

Reconsideration versus Appeal

Reconsideration vs. Appeal

UnitedHealthcare

UnitedHealthcare

UnitedHealthcare Claim Reconsideration Request Form

Instructions: This form is to be completed by UnitedHealthcare – contracted physicians, hospitals or other health care professionals to request a claim reconsideration for members enrolled in commercial benefit plans administered by UnitedHealthcare and Medicare plans administered by SecureHorizons® and Evercare®.
Mail address: Send all Claim Reconsideration requests to the address on the back of the member's identification card (ID), or the address on the EOB or PRA. **NOTE: If you are receiving the consolidated 835, you may verify the member's correspondence address using the eligibility search function on UnitedHealthcareOnline.com.**

☐ Physician ☐ Hospital ☐ Other health care professional (Lab, Durable Medical Equipment (DME), etc) Date form completed:

No new claims should be submitted with this form. Please submit a separate form for each claim.

Member information

Member ID:	Control / Claim #:	Date(s) Of Service:	Billed Amount:
Member Name: Last:		First:	MI:
Street Address:		State:	Zip:
Patient Name: Last:		First:	MI:

Physician/health care professional information

Tax Identification Number (TIN):	Phone Number:	Email address:

Physician Name (as listed on Provider Remittance Advice (PRA) / Explanation of Benefits (EOB)):

Last:	First:	MI:
Street Address:	State:	Zip:
Facility/Group Name:	Contact Person:	

Option amount owed:

Reason for request

☐ 1. Previously denied / closed as "Exceeds Filing Time" *What should I submit as evidence of timely filing?*
Electronic claims – include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
Paper claims – include a copy of a screen print from your accounting software to show the date you submitted the claim.
The accounting software information must also include proof that the claim is for the correct patient and the correct visit.
• Proof of timely filing could also include other insurance carrier's denial/rejection, EOB, letter indicating termination of coverage, exit or plan participation, etc.
☐ 2. Previously denied / closed for "Additional Information" *(provide description and/or requested documents)*
☐ 3. Previously denied / closed for "Coordination of Benefits" information *(attach primary carrier's EOB)*
☐ 4. Resubmission of a corrected claim *(explain correction below)*
☐ 5. Previously processed but contractual rate applied incorrectly resulting in over/underpayment *(explain below)*
☐ 6. Reactivation of "Prior Notification Information" (including notification information)
☐ 7. Reactivation of "Overdue claim" (including all supporting information)
☐ 8. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare to close UnitedHealthcare's portion of this claim in your practice management system, including dollar amounts if possible.

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a letter of appeal and receipt of a response from UnitedHealthcare. To submit a formal appeal, submit a letter outlining your dispute, any supporting documentation, including our response to the reconsideration request, and the date your reconsideration stage was completed to:

UnitedHealthcare Provider Appeals P.O. Box 30559 Salt Lake City, UT 84130-0559

Required attachments:

• Copy of PRA or EOB • Claim form (with corrections if necessary) • Other required attachments as listed above.

You may have additional rights under state law. For review of claims for members enrolled in other benefit plans, please refer to one or more of the following for information on requesting claim reviews: the website for the entity listed on the member's health care ID card, the EOB for the applicable claim or UnitedHealthcareOnline.com. You may also call the telephone number on the member's health care ID card for information on how to request claims reviews.

Step 1: Claim Reconsideration
Step 2: Claim Appeal

If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may submit a formal appeal request to:

UnitedHealthcare Provider Appeals
P.O. Box 30559
Salt Lake City, UT 84130-0575

You must submit your appeal to us within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review. Our decision will be rendered based on the materials available at the time of formal appeal review.

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a letter of appeal and receipt of a response from UnitedHealthcare. To submit a formal appeal, submit a letter outlining your dispute, any supporting documentation, including our response to the reconsideration request, and the date your reconsideration stage was completed to:

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ICD-10

International Classification of Diseases

ICD-10 Implementation: Moving Forward to October 1, 2015

Prepared For: 2014 Provider Community TownHall

Presented By: Sue Peterson

CMS News Release: July 31, 2014

UnitedHealthcare

Deadline for ICD-10 allows health care industry ample time to prepare for change

The U.S. Department of Health and Human Services (HHS) issued a rule today finalizing Oct. 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. **This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.**

UnitedHealthcare and the Delay

How does this delay specifically impact the UnitedHealthcare ICD-10 implementation plan?

A. UnitedHealthcare is committed to meeting the requirements for the implementation of the ICD-10 and we have assessed how to best adjust our own operations, processes and testing timelines. The extended timeframe will allow us more time to continue with our preparation for ICD-10 and to work with our provider partners to ensure a smooth transition.

What does the new compliance date mean for business partner testing?

A. UnitedHealthcare will explore the opportunity of 'pilot' business partner testing with one or more providers to verify test process, tools and preliminary results.

Will UnitedHealthcare be prepared to accept ICD-10 coded claims on the previous compliance date of Oct.1, 2014 from providers who can generate ICD-10 coded claims?

A. A. Under the law, the HHS cannot adopt the ICD-10 code set until at least Oct. 1, 2015, so no claims may be processed with ICD-10 codes before this date. In fact, CMS has issued guidance about the new ICD-10 compliance date and has stated it will specifically mandate the use of ICD-9 code through September 30, 2015 for all HIPAA covered entities.

Provider Readiness vs. Testing

UnitedHealthcare

Recommendations for providers to be ready for ICD-10 on Oct. 1, 2015:

Seize the Opportunity

The additional year provides an opportunity for providers to re-evaluate their ICD-10 readiness plans and address gaps.

Get Into a State of Readiness

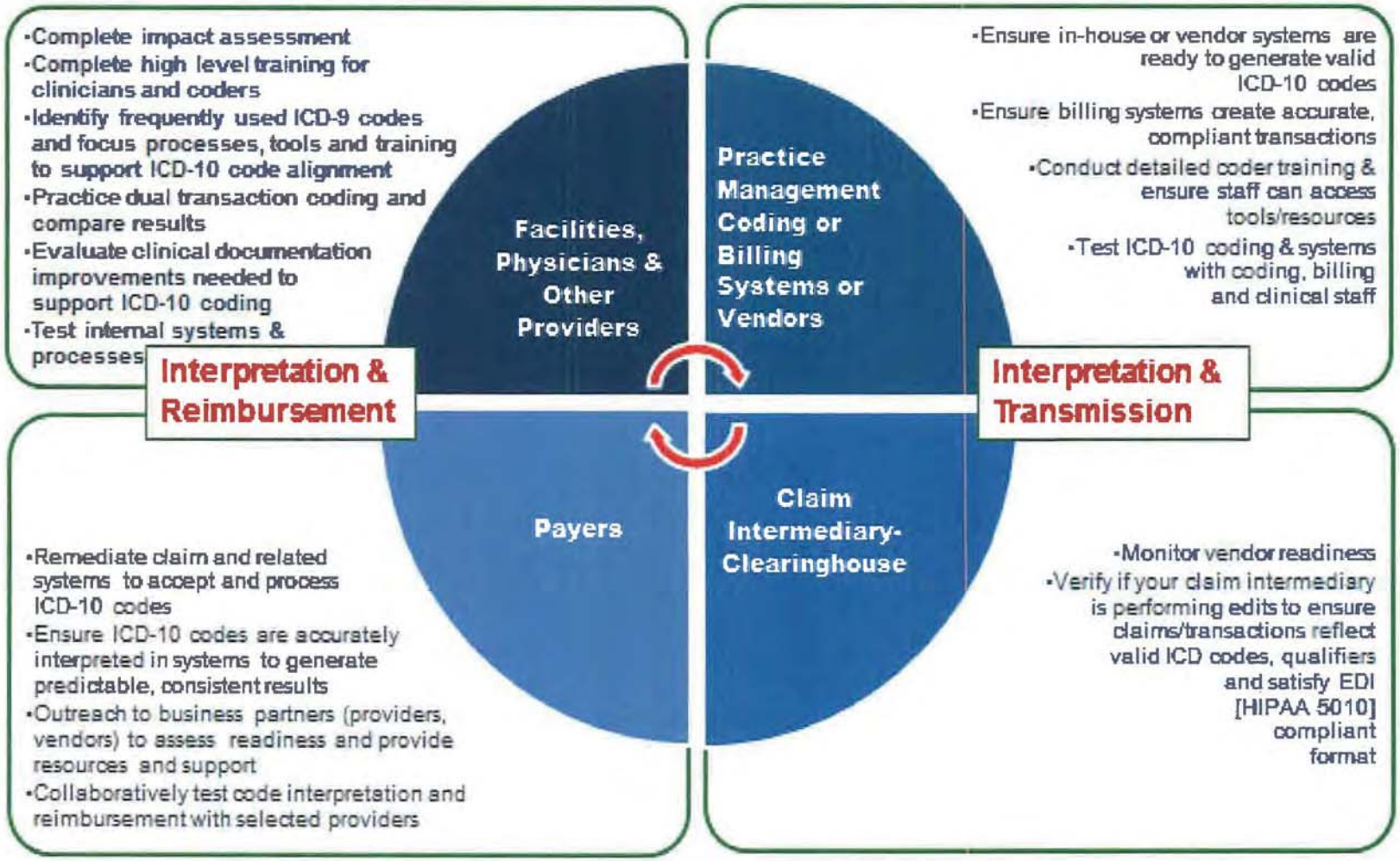
Providers are ***currently*** focused on "Testing" and we should be preparing them for "Readiness.

Focus Areas for Successful ICD-10 Implementation:

1. Interpretation and Reimbursement
2. Interpretation and Transmission
3. Transmission of Compliant ICD-10 Transactions

Effective Provider Readiness Preparation

UnitedHealthcare

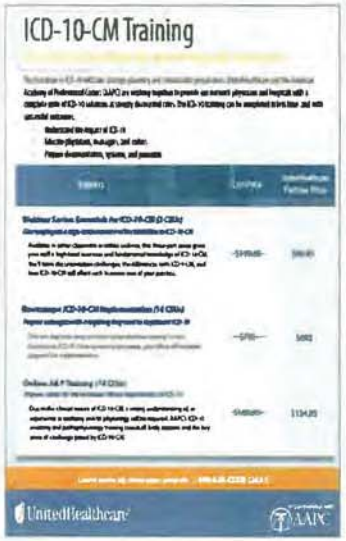


Transmission of Compliant ICD-10 Transactions

UnitedHealthcare's ICD-10 Website

UnitedHealthcare's ICD-10 website allows our delivery-side partners to receive information when they need it.

Go to: www.unitedhealthcareonline.com



It provides access to:

- **Education**
  - –On-demand education module and PowerPoint presentations
- **Tools**
  - –FAQs and ICD-10 readiness assessment solution tool
- **Resources**
  - –ICD-10 focused website links
- **Partnerships**
  - –AAPC

UnitedHealthcare

Market Updates

Meagan Weese: Hospital & Facility Advocate

September Network Bulletin

UnitedHealthcare

- Delay of New Outpatient and Professional Therapy Functional Reporting Requirement
- Prior Authorization Requirement for Outpatient Injectable Chemotherapy for Commercial Members
- Discontinuation of the ANN Form and Changes to the *Charging Customers for Non-covered Services* Protocol
- Electronic Payments & Statements is Expanding (1st Quarter 2015)
- UnitedHealthcare's Medicare Advantage Part B Specialty Drug Prior Authorization Program Terminated

Market Specific Topics

UnitedHealthcare

- Nebraska: A04 Update
- Nebraska: Inpatient DRG claims

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UnitedHealthcare

Product Updates

All Savers & Navigate

Becky Natsis: Provider Relations Advocate

Product Overview

- **All Savers Insurance Company (ASIC)**, a UnitedHealthcare Company, offers health insurance to small employers and is administered by UnitedHealthcare Services, Inc.

- **UHC Provider Admin Guide, 2014**
  https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/100-6088_UHC_Admin_Guide_2014_hires.pdf

- **Provider Network –**
  All Savers plans have access to the UnitedHealthcare Choice Plus network.

- **All Savers Customer Service Phone Number-** (800) 291-2634
- **Claims Address –**
  AMS
  PO Box 31375
  Salt Lake City, UT 84131-0375

- **Electronic Payer ID number -** Payer ID # 81400

- All Savers Quick Reference Guide

Sample Member ID Cards

UnitedHealthcare

All Savers Fully Insured (All Savers Insurance Company) Member ID Card Sample

All Savers Alternate Funding Member ID Card Sample

Navigate (Iowa)

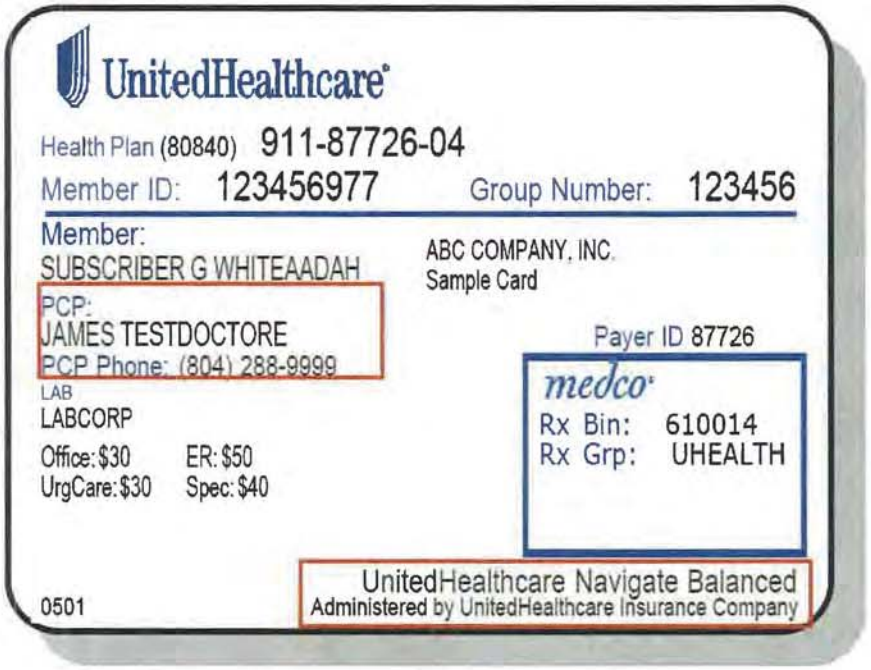
What is UnitedHealthcare Navigate?

UnitedHealthcare®

- Primary care-focused product suite
- Plan design options for choice and flexibility
- Referrals to network specialists
- Broad national network with narrowed networks in some states
- Efficient care & lower costs

Navigate Health Care ID Cards

UnitedHealthcare



This sample ID card is for illustration only.
Actual information varies depending on payer, plan and other requirements.

Navigate Educational Sessions

UnitedHealthcare

- Mid-November & December-
  - Weekly webinar training sessions on Tues/Wed
- January 2015-
  - Weekly webinar training sessions on Tues

➢ Invitations will be coming out shortly

UnitedHealthcare

Optum Cloud

Laura Rapoff

UnitedHealthcare Provider Relations and Service Team

UnitedHealthcare

Your Partner for Claims and Service Needs:

Nebraska_PR_Team@uhc.com or Iowa_PR_team@uhc.com

Navigational specialist

One contact for all UnitedHealth Group companies

Assistance with education; self-service tools

Help with service issues

Works to maximize the ability of practices to interact with UnitedHealthcare

Questions?

Thank you for attending!

Nebraska Quick Reference Guide Updated May 2015

	UnitedHealthcare Commercial	UnitedHealthcare Medicare Solutions	UnitedHealthcare Community Plan Dual Complete	UnitedHealthcare Community Plan	UnitedHealthcare TRICARE
Logos	UnitedHealthcare	UnitedHealthcare Medicare Solutions	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan	UnitedHealthcare MILITARY & VETERANS
Payer ID	87726	87726	87726	87726	99726 (If you use Emdeon, please use SCWI0 for professional and 12C01 for institutional)
Member Website	myuhc.com	myuhc.com	myuhc.com UHCCommunityPlan.com	myuhc.com UHCCommunityPlan.com	uhcmilitarywest.com
Member Services	800-357-0978	Refer to ID card	866-480-1086	800-641-1902	877-988-9378
Provider Website	UnitedHealthcareOnline.com	UnitedHealthcareOnline.com	UHCCommunityPlan.com	UHCCommunityPlan.com	uhcmilitarywest.com
Provider Services	877-842-3210	877-842-3210	877-842-3210	866-331-2243	877-988-9378
Claims Address for Medical	P.O. Box 740800 Atlanta GA 30374-0800	Refer to ID card	P.O. Box 31350 Salt Lake City, UT 84131-0350	P.O. Box 31365 Salt Lake City, UT 84131	P.O. Box 7064 Camden, SC 29021
Claims Address for Pharmacy	Refer to the member's ID card	Refer to ID card	P.O. Box 29045 Hot Springs, AR 71903	P.O. Box 31365 Salt Lake City, UT 84131	Express Scripts, Inc PO Box 52132 Phoenix, AZ 85082
Phone Number For Pharmacy	Refer to the member's ID card	Refer to ID card	Refer to ID card	888-306-3243 (Durable Medical Equipment only)	877-363-1303 (Express Scripts) express-scripts.com/TRICARE
Advance Notification, Admission Notification and Prior Authorization	Phone: 877-842-3210 Fax: 866-756-9733	Refer to ID card	Phone: 877-842-3210	Phone: 866-604-3267 Fax: 866-622-1428	Routine Fax: 877-890-9309 Urgent Fax: 877-890-8203
Notification of Inpatient Admission	Notification requirement within 24 hours of admission or on the next working day following a holiday or weekend admission. For more information, please call the number on the back of the member's ID card.				Notification requirement within 24 hours of admission or on the next working day following a holiday or weekend admission. Fax: 877-578-2738
Radiology Notification/ Prior Authorization	Prior notification for certain outpatient imaging procedures by: • Phone: 866-889-8054 • United Voice Portal Line: 877-842-3210 (select radiology) • Fax: 866-889-8061	Prior notification for certain outpatient imaging procedures by: • Phone: 866-889-8054 • United Voice Portal Line: 877-842-3210 (select radiology) • Fax: 866-889-8061	Prior notification for certain outpatient imaging procedures by: • Phone: 866-889-8054 • United Voice Portal Line: 877-842-3210 (select radiology) • Fax: 866-889-8061	Please refer to UHCCommunityPlan.com for prior authorization list. Phone: 866-889-8054 Fax: 866-889-8061	Not Applicable
Cardiac Notification/ Prior Authorization	UnitedHealthcareOnline.com Phone: 866-889-8054	UnitedHealthcareOnline.com Phone: 866-889-8054	UnitedHealthcareOnline.com Phone: 866-889-8054	Phone: 866-889-8054 Fax: 866-889-8061	Not Applicable
Provider Portal	UnitedHealthcareOnline.com	UnitedHealthcareOnline.com	UnitedHealthcareOnline.com	UnitedHealthcareOnline.com	uhcmilitarywest.com mytricare.com
Online Eligibility and Claim Status	Yes	Yes	Yes	Yes	Yes
Online Referral Number Availability	Yes	Yes	Yes	Yes	Yes
Online Claim Cost Estimator	Yes	Yes	Yes	Yes	No

Subject to change, please consult UnitedHealthcareOnline.com or 877-842-3210 for updated information.

PCA16666_20150526

Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

Provider Network and Education

Overview

Attachment 19 Q47-5 2015 NE Provider Advocate Presentation

UnitedHealthcare®

Our Provider Network

UnitedHealthcare

UnitedHealthcare provides education in many different ways, to a diverse network of care providers.

- The Provider Relations Team is a pivotal part of the provider network and includes:
  - Two Hospital/Facility Advocates
  - Three Physician Advocates

- Advocate specialties include:
  - Federally Qualified Health Centers
  - Rural Health Clinics

Physician Advocate Role

UnitedHealthcare

- ✓ Represents all UnitedHealthcare benefit plans
- ✓ Interacts with medical groups or individual physicians to assist and simplify doing business with us
- ✓ Builds collaborative working relationships and communicates information to medical groups or physicians in a timely manner

Physician Advocate Roles and Responsibilities

UnitedHealthcare

Key Supports You Can Expect from Your Physician Advocate

- Member Issue Resolution
- Provider Set Up and Demographics
  - -Open/Closed Status Panels
  - -Contact Information
- Provider Trainings/Education
- Reimbursement
- Division of Financial Responsibility Issues
- Risk Pool Settlements Special Reimbursement Programs/Indemnification
- Multiple Product offerings within products
- Quoting of Reciprocity/Rider Contracts
- Directory Reviews
- Delegation of Key Operational Functions
  - -Claims Payment
  - -Utilization Management
  - -Quality Management

Proactive Engagement of your Advocate

UnitedHealthcare

- ✓ Report operational changes within your organization that may impact claim processing, EDI transactions, etc.
- ✓ Report trends in processing errors
- ✓ Participate in UnitedHealthcare surveys to monitor your satisfaction with UnitedHealthcare and the Physician Advocate

Provider Relations and Service Team

UnitedHealthcare

Our Provider Relations and Service Team can help you with any immediate claims or service needs.

Contact via email: Nebraska_pr_team@uhc.com

Our team offers one contact for all UnitedHealth Group companies.

They can help you with:

- Assistance with education; self-service tools
- Help with service issues

Communications Resources

UnitedHealthcare

Personal interaction with your Physician Advocate

- Telephone, email or in-person
- Point of contact for change, updates and/or notifications

Direct Mailings – Requires you identify a Communication Liaison

Provider Relation Inquiry Mailbox

UnitedHealthcareOnline.com

- Primary source of communication

Link

- Your new gateway to UnitedHealthcare's online tools

Network Bulletin

- Monthly publication; alerts you to changes in policies or procedures and Administrative Guide updates.

UnitedHealthcareOnline.com

Attachment 19 Q47-5 2015 NE Provider Advocate Presentation

Introduction to Link

UnitedHealthcare

As health care continues to move into virtual online environments, Link supports a diverse collection of applications and services.

- Created to support the way you work, based on feedback from users who face your same challenges
- Provides access to UnitedHealthcare websites and applications from one location
- Quickly move between apps and customize your screen so your most common tasks are just a click away
- For demonstrations, please contact your assigned Advocate, if you do not have an Advocate please submit a Link Training Request though our PR Mailbox: **Nebraska_pr_team@uhc.com**

UnitedHealthcare®

Thank you!

Attachment 19 Q49-2
NE PA Guidelines

Advance Notification Requirements for Nebraska Effective June 1, 2015

UnitedHealthcare Community Plan

General Information

This list represents our prior authorization review requirements for UnitedHealthcare Community Plan of Nebraska. Please use the following to obtain a prior authorization review for coverage:

- **Phone** 866-604-3267 **//Fax** 866-822-1428
- **Online:** http://www.uhccommunityplan.com
- Services rendered by a non-contracted physician, facility or other health care provider must receive prior authorization.
- Non-emergency Inpatient Admissions, including planned surgeries, require prior authorization
- *The use of the Universal Referral Form (URF) does not constitute authorization by UnitedHealthcare Community Plan.*

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Abortion	Prior Notification needed from the state of Nebraska	
Bariatric Surgery Inpatient and outpatient bariatric surgery and specific obesity-related services		43644 43645 43647 43648 43659 43770 43771 43772 43773 43774 43775 43842 43843 43845 43846 43847 43848 43860 43865 43881 43882 43886 43887 43888 64590 95980 95981 95982 0312T 0313T 0314T 0315T 0316T 0317T
Bone Growth Stimulator Electronic stimulation or ultrasound to heal fractures		20974 20975 20979 E0747 E0748
BRCA Genetic Testing		81211 81212 81213 81214 81215 81216 81217
Breast Reconstruction (Non Mastectomy) Reconstruction of the breast except for after mastectomy		19316 19318 19324 19325 19328 19330 19340 19342 19350 19357 19361 19364 19366 19367 19368 19369 19370 19371 19380 19396 L8600
Cochlear and Other Auditory Implants A medical device within the inner ear with an external portion to help persons with profound sensorineural deafness achieve conversational speech		69710 69711 69714 69715 69717 69718 69930 92601 92602 92603 92604 L8614 L8615 L8616 L8617 L8618 L8619 L8621 L8622 L8623 L8624 L8627 L8628 L8690 L8691 L8692 L8693
Cosmetic and Reconstructive		11920 11922 11960 11971 15820 15821 15822 15823 15830 15847 15877 17106 17107 17108 17999 21137 21138 21139 21172 21175 21179 21180 21181 21182

UnitedHealthcare Community Plan

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Cosmetic and Reconstructive (Continued) Cosmetic procedures that change or improve physical appearance without significantly improving or restoring physiological function Reconstructive procedures that treat a medical condition or improve or restore physiologic function		21183 21184 21230 21235 21256 21260 21261 21263 21267 21268 21275 21280 21282 21295 21740 21742 21743 28344 30540 30545 30560 30620 40500 67900 67901 67902 67903 67904 67906 67908 67909 67911 67912 67914 67915 67916 67917 67921 67922 67923 67924 67950 67961 67966 69320 Q2026 Q2027
Durable Medical Equipment (DME) - Greater Than $500 DME with a retail purchase or a cumulative rental cost of more than $500	Prosthetics are not DME *(see Prosthetics and Orthotics)*	A9274 A9279 A9900 A9999 E0193 E0194 E0265 E0266 E0296 E0297 E0300 E0302 E0304 E0328 E0329 E0445 E0450 E0457 E0460 E0461 E0463 E0464 E0470 E0471 E0472 E0485 E0486 E0601 E0636 E0637 E0638 E0641 E0642 E0650 E0651 E0652 E0656 E0666 E0667 E0668 E0669 E0670 E0671 E0672 E0673 E0675 E0691 E0692 E0693 E0694 E0745 E0782 E0784 E0786 E0947 E0948 E0984 E0986 E1002 E1003 E1004 E1005 E1006 E1007 E1008 E1009 E1010 E1011 E1018 E1030 E1035 E1036 E1085 E1086 E1089 E1090 E1130 E1140 E1161 E1220 E1226 E1229 E1230 E1231 E1232 E1233 E1234 E1235 E1236 E1237 E1238 E1239 E1250 E1260 E1285 E1290 E1310 E1825 E1830 E1840 E2100 E2204 E2227 E2228 E2230 E2310 E2311 E2312 E2321 E2322 E2325 E2327 E2328 E2329 E2330 E2331 E2343 E2351 E2370 E2373 E2375 E2376 E2510 E2511 E2512 E2599 E2614 E2616 E2620 E2621 E2626 E2627 E2628 E2629 E2630 E8000 E8001 E8002 K0005 K0007

UnitedHealthcare Community Plan

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans			
Durable Medical Equipment (DME) - Greater Than $500 (Continued)		K0008	K0011	K0013	K0014
		K0108	K0606	K0609	K0730
		K0800	K0801	K0802	K0806
		K0807	K0808	K0812	K0821
		K0822	K0823	K0824	K0825
		K0826	K0827	K0828	K0829
		K0830	K0831	K0836	K0837
		K0838	K0839	K0840	K0841
		K0842	K0843	K0848	K0849
		K0850	K0851	K0852	K0853
		K0854	K0855	K0856	K0857
		K0858	K0859	K0860	K0861
		K0862	K0863	K0864	K0868
		K0869	K0870	K0871	K0877
		K0878	K0879	K0880	K0884
		K0885	K0886	K0890	K0891
		K0898	K0899	Q0479	Q0480
		Q0481	Q0482	Q0483	Q0484
		Q0488	Q0489	Q0490	Q0491
		Q0495	Q0496	Q0502	Q0503
		Q0504	Q0506	T1999	T5999
		V2786	V5268	V5281	V5282
		V5283	V5284	V5285	V5286
		V5287	V5288	V5289	V5290
Enteral Services In home nutritional therapy either enteral or through a gastrostomy tube		B4034	B4035	B4036	
		B4102	B4103	B4104	B4149
		B4150	B4152	B4153	B4154
		B4155	B4157	B4158	B4159
		B4160	B4161	B4162	B9000
		B9002	B9998		
Experimental or Investigational		36514	54240	55866	61863
		61864	61867	61868	61886
		62264	62290	62291	62292
		64555	64566	64722	65767
		66180	95250	95251	95965
		95966	95967	95978	96002
		0191T	0262T	0269T	0270T
		0271T	0282T	0283T	0285T
		A4638	A9274	A9276	A9277
		A9278	E1831	S0810	S2102
		S3652	S8262	S9988	S9990
		S9991			
Femoroacetabular Impingement Syndrome (FAI)		29914	29915	29916	
Home Health Care		99503	G0151	G0152	G0153
		G0154	G0155	G0156	G0157
		G0158	G0159	G0160	G0161

UnitedHealthcare Community Plan

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Home Health Care (Continued)		G0162 G0163 G0164 S9122 S9123 S9124 S9127 S9128 S9129 S9131 S9474 T1000 T1002 T1003
Injectable Medications		**Acthar** J0800 **Botox** J0585 J0586 J0587 J0588 **Cerezyme** J1786 **Elelyso** J3060 **IVIG** 90284 J1459 J1556 J1557 J1559 J1561 J1566 J1568 J1569 J1572 J1599 **Makena** J1725 J2675 **Synagis** 90378 **Xolair** J2357
Joint Replacement Outpatient and inpatient joint and total hip and knee replacement procedures		23470 23472 23473 23474 24360 24361 24362 24363 24370 24371 27120 27122 27125 27130 27132 27134 27137 27138 27412 27446 27447 27486 27487 29867 J7330 S2112
Non-Emergent Air Ambulance Transport		A0430 A0431 A0435 A0436 S9960 S9961
Orthognathic Surgery Treatment of maxillofacial (jaw) functional impairment		21121 21122 21123 21125 21127 21141 21142 21143 21145 21146 21147 21150 21151 21154 21155 21159 21160 21188 21193 21194 21195 21196 21198 21199 21206 21208 21209 21210 21215 21240 21242 21244 21245 21246 21247 21248 21249 21255 21296 21299 30465

UnitedHealthcare Community Plan

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans			
Orthotics and Prosthetics – Greater Than $500 Orthotics and prosthetics with a retail purchase or cumulative rental cost of more than $500.		L0112	L0170	L0430	L0456
		L0458	L0460	L0462	L0464
		L0470	L0480	L0482	L0484
		L0486	L0488	L0491	L0624
		L0629	L0631	L0632	L0634
		L0635	L0636	L0637	L0638
		L0639	L0640	L0700	L0710
		L0810	L0820	L0830	L0859
		L1000	L1005	L1200	L1300
		L1310	L1499	L1500	L1510
		L1520	L1680	L1685	L1686
		L1690	L1700	L1710	L1720
		L1730	L1755	L1832	L1834
		L1840	L1843	L1844	L1845
		L1846	L1860	L1932	L1945
		L1950	L1951	L1970	L2000
		L2005	L2010	L2020	L2030
		L2034	L2036	L2037	L2038
		L2060	L2106	L2108	L2114
		L2116	L2126	L2128	L2132
		L2134	L2136	L2350	L2510
		L2525	L2526	L2627	L2628
		L2999	L3000	L3010	L3020
		L3031	L3160	L3201	L3202
		L3203	L3204	L3206	L3207
		L3212	L3213	L3214	L3215
		L3216	L3217	L3219	L3221
		L3222	L3230	L3250	L3251
		L3252	L3253	L3265	L3649
		L3671	L3674	L3720	L3730
		L3740	L3763	L3764	L3765
		L3766	L3900	L3901	L3904
		L3905	L3960	L3961	L3962
		L3967	L3971	L3973	L3975
		L3976	L3977	L3978	L3999
		L4000	L4010	L4020	L4631
		L5000	L5010	L5020	L5050
		L5060	L5100	L5105	L5150
		L5160	L5200	L5210	L5220
		L5230	L5250	L5270	L5280
		L5301	L5312	L5321	L5331
		L5341	L5400	L5420	L5460
		L5500	L5505	L5510	L5520
		L5530	L5535	L5540	L5560
		L5570	L5580	L5585	L5590
		L5595	L5600	L5610	L5611
		L5613	L5614	L5616	L5639
		L5640	L5642	L5643	L5644

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Orthotics and Prosthetics – Greater Than $500 (Continued)		L5645 L5646 L5647 L5648 L5649 L5651 L5653 L5661 L5673 L5679 L5681 L5682 L5683 L5700 L5701 L5702 L5703 L5705 L5706 L5707 L5716 L5718 L5722 L5724 L5726 L5728 L5780 L5781 L5790 L5795 L5811 L5812 L5814 L5816 L5818 L5822 L5824 L5826 L5828 L5830 L5840 L5845 L5848 L5930 L5950 L5960 L5961 L5962 L5964 L5966 L5968 L5973 L5976 L5979 L5980 L5981 L5982 L5984 L5986 L5987 L5988 L5990 L5999 L6000 L6010 L6020 L6050 L6055 L6100 L6110 L6120 L6130 L6200 L6205 L6250 L6300 L6310 L6320 L6350 L6360 L6370 L6380 L6382 L6384 L6400 L6450 L6500 L6550 L6570 L6580 L6582 L6584 L6586 L6588 L6590 L6623 L6624 L6686 L6687 L6689 L6690 L6692 L6693 L6694 L6695 L6696 L6697 L6704 L6707 L6708 L6709 L6711 L6712 L6713 L6714 L6715 L6880 L6881 L6895 L6900 L6905 L6910 L6915 L7007 L7008 L7009 L7499 L8035 L8040 L8041 L8042 L8043 L8044 L8045 L8046 L8047 L8499 L8500 L8605 L8609 L8610 L8612 L8631 L8659 V2623 V2627
Proton Beam Therapy Focused radiation therapy using beams of protons (tiny particles with a positive charge)		77520 77522 77523 77525
Rhinoplasty Treatment of nasal functional impairment and septal deviation		30400 30410 30420 30430 30435 30450 30460 30462
Sinuplasty		31295 31296 31297

UnitedHealthcare Community Plan

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Sleep Apnea Procedures and Surgeries Maxillomandibular advancement and oral-pharyngeal tissue reduction for treating obstructive sleep apnea		21685 41530 42145 41599
Sleep Studies		95805 95807 95808 95810 95811
Spinal Stimulator for Pain Management Spinal cord stimulators when implanted for pain management		63650 63655 63685
Spinal Surgery Inpatient and outpatient spinal surgeries		22100 22101 22102 22110 22112 22114 22206 22207 22210 22212 22214 22220 22224 22532 22533 22548 22551 22554 22556 22558 22586 22590 22595 22600 22610 22612 22630 22633 22800 22802 22804 22808 22810 22812 22818 22819 22830 22849 22850 22852 22855 22856 22861 22864 22865 22899 63001 63003 63005 63011 63012 63015 63016 63017 63020 63030 63040 63042 63045 63046 63047 63050 63055 63056 63064 63075 63077 63081 63085 63087 63090 63101 63102 63170 63172 63173 63180 63182 63185 63190 63191 63194 63195 63196 63198 63199 63200 63250 63251 63252 63265 63267 63268 63270 63271 63272 63286 63300 63301 63302 63303 63304 63305 63306 63307 63308 64553 64570 0092T
Vagus Nerve Stimulation Implantation of a device that sends electrical impulses into one of the cranial nerves		61885 64568 L8680 L8681 L8682 L8685 L8686 L8687 L8688 L8689
Vein Procedures Removal and ablation of the main trunks and named branches of the saphenous veins for treating venous disease and varicose veins of the extremities		36468 36475 36478 37700 37718 37722 37780

UnitedHealthcare Community Plan

Procedures and Services (Outpatient services provided by participating providers)	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Wound Vac		E2402

UnitedHealthcare Community Plan

Additional Advance Notification and Prior Authorization Programs

Procedures and Services	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Behavioral Health Services Behavioral health services through a designated behavioral health network		Many of our benefit plans provide coverage for behavioral health services through a designated behavioral health network. Please call the number on the member's ID card to refer for mental health and substance abuse/substance use services.
Out of Network Services	A recommendation to a provider who is not contracted with UnitedHealthcare	All out of network services require prior authorization.
Part B Specialty Drug (Medical Benefit) Prior Authorization		Authorization is required for outpatient and office services for certain medical benefit specialty drugs. Specialty drugs do not require prior authorization when rendered in an emergency room, observation unit, urgent care center or during an inpatient stay. To request prior authorization, call **877-255-3092**. To see the list of drugs requiring authorization, go to **UHCCommunityPlan.com** > *Pharmacy Program.*
Radiology Prior Authorization		Prior authorization is required for these advanced imaging procedures: CT, MRI, MRA, PET scan, nuclear medicine and nuclear cardiology. The health care professional ordering an advanced outpatient Imaging procedure is responsible for requesting and completing the prior authorization process before scheduling the procedure. To request prior authorization, call **866-889-8054**. For more information, including a list of the CPT codes that require prior authorization, go to **UHCCommunityPlan.com** > *Radiology > 2014 CPT Code List.*
Transplants		For transplant services, call OptumHealth **800-418-4994** or the notification number on the back of the member's ID card 32850 32851 32852 32853 32854 32855 32856 33226 33930 33933 33935 33940 33944 33945 38205 38206 38207 38208 38209 38210

UnitedHealthcare Community Plan

Additional Advance Notification and Prior Authorization Programs

Procedures and Services	Additional Information	Codes for UnitedHealthcare Community Plan Benefit Plans
Transplants (Continued)		38211 38212 38213 38214 38215 38230 38232 38240 38241 38242 44010 44015 44020 44021 44025 44050 44055 44100 44110 44111 44120 44121 44125 44126 44127 44128 44130 44132 44133 44135 44136 44137 44715 44720 44721 47133 47135 47136 47140 47141 47142 47143 47144 47145 47146 47147 48160 48550 48551 48552 48554 48556 50300 50320 50323 50325 50327 50328 50329 50340 50360 50365 50370 50380 50547 54680 60512 0051T 0052T 0053T S2053 S2054 S2055 S2060 S2061 S2065 S2103 S2152 S9975
Ventricular Assist Devices A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow.		Fax OptumHealth at **877-814-0488** or call the notification number on the back of the member's ID card. Q0505 Q0507 Q0508 Q0509 33975 33976 33979 33981 33982 33983

Attachment 19 Q49-3
Link Introduction

Introducing Link – a New Site for UnitedHealthcareOnline.com users

Get the information you need with fewer clicks. This fall, we're introducing Link – your digital health information connection.

Link will replace Optum Cloud Dashboard. It includes many of the same applications as Optum Cloud Dashboard, but with a new interface that can help make your work measurably faster and easier.*

- **Link was created to support the way you work, based on feedback from users who face your same challenges.**
- **Quickly move between apps and even customize your screen to put your most common tasks just one click away.**
- **Next-generation technology will allow enhanced features and new applications.**

Use Your Optum ID

You'll need an Optum ID to access Link. If you use Optum Cloud Dashboard, you already have an Optum ID. If you don't have one or need help, the Link sign-in screens will guide you through the process to:

- **Recover your Optum ID if you have forgotten it.**
- **Reset your password.**
- **Register for an Optum ID if you don't already have one.**

We'll be sending UnitedHealthcareOnline.com and Optum Cloud Dashboard users more details about the transition to Link and Optum ID. Please make sure your email address is current by signing in to UnitedHealthcareOnline.com and selecting My Account to view your user profile.

If you have questions, please call the Optum Support Center at 855-819-5909. Thank you.

* Based on ongoing usability studies using keystroke-level modeling when comparing Link to UnitedHealthcareOnline.com and Optum Cloud Dashboard.

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Doc#: PCA18530_20150903

Attachment 19 Q49-3 Link Introduction

Attachment 19 Q49-6
Link Eligibility - Benefits
Referral Status

Assessment : Access to Care (CHW)

Total Questions : 15

Member Details :

Name: **Altruista ID:**

Date Of Birth: **Home Phone:**

1 Do you know who your primary doctor (PCP) is?

- [ ] Yes
- [ ] No

2 Are you able to gain access to your primary doctor (PCP) when needed?

- [ ] Yes
- [ ] No

3 Has it been more than six months since you've seen your primary doctor (PCP)?

- [ ] Yes
- [ ] No

4 When was the last time you saw your primary doctor (PCP)?

Enter date or approximate time frame

5 Are you able to gain access to specialists (e.g. behavioral health provider, cardiologist, etc.) when needed?

- [ ] Yes
- [ ] No
- [ ] N/A

6 During the past year were you ever unable to pay for or had to do without:

- [ ] Food
- [ ] Medicine
- [ ] Transportation
- [ ] Electricity
- [ ] Heat or Air Conditioning
- [ ] Housing
- [ ] None of the above

7 Do you have reliable transportation to get you to a physician appointment when required?

- [ ] Yes
- [ ] No

8 Do you know how to get your prescriptions filled?

- [ ] Yes
- [ ] No

9 Do you have any difficulties getting your prescriptions filled?

- [ ] Yes
- [ ] No

10 Do you know when and who to call for emergency help?

- ☐ Yes
- ☐ No

11 Do you have any concerns about being safe in your home or your neighborhood?

- ☐ Yes
- ☐ No

12 Do you have any concerns about environmental hazards in your home (rodents/smoking/clean water)?

- ☐ Yes
- ☐ No

13 Is the member self-expressing a need to talk to a clinician?

- ☐ Yes
- ☐ No

14 For DSNP members only: We typically send your plan of care (health action plan) to you and your PCP. Other than your PCP, is there anyone else who assists you with your health needs that you would want a plan of care (health action plan) sent to?

- ☐ Yes

  Prompt: Verify and update the member's care team. Use Quick Links to navigate to Care Team

- ☐ No

15 End of assessment

End of Assessment - Copyright © 2015 UnitedHealth Group. All Rights Reserved. Any use, copying or distribution without written permission from UnitedHealth Group is prohibited. Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical care, 41(11), 1284-1292. Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce , translate, display or distribute.

Assessment : Adult Core

Total Questions : 73

Member Details :
Name: **Altruista ID:**
Date Of Birth: **Home Phone:**

1 **Do you agree to Case Management services?**

- [ ] Yes
- [ ] No

2 **Do you agree to discuss your health information with me today?**

- [ ] Yes
- [ ] No

3 **PROMPT: Verify and update race, ethnicity and language in member details**

Use Quick Links to navigate to Member Details

4 **How would you describe your health?**

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

5 **What concerns do you have regarding your health?**

Enter Concerns

6 **Does your health keep you from doing the things you want?**

- [ ] Yes
- [ ] No

7 **Do you have difficulties (such as transportation, making appointments) that keep you from seeing your PCP or other type of needed provider as frequently as you would like to?**

- [ ] Yes
- [ ] No

8 **If yes, why?**

- [ ] Transportation
- [ ] Difficulty making or getting an appointment
- [ ] Cannot afford copay
- [ ] No PCP
- [ ] Language barrier
- [ ] Other

Describe Other Barrier

9 **Do you have difficulty doing errands alone such as visiting a doctor's office, shopping, using the telephone, managing your medication?**

- [ ] Yes
- [ ] No

10 Do you have the help you need to meet your needs?

- [ ] Yes
- [ ] No

11 In the past 12 months, have you seen your physician for any reason?

- [ ] Yes
- [ ] No

12 How many times in the past 12 months have you stayed overnight as a patient in a hospital?

- [ ] None
- [ ] 1-3 times
- [ ] 4 or more times

13 Was the hospitalization for mental health or substance abuse?

- [ ] Yes
- [ ] No
- [ ] Declined to answer

14 How many times in the past 12 months have you gone to the Emergency Room for care and were not admitted to the hospital?

- [ ] None
- [ ] 1-3 times
- [ ] 4 or more times

15 Was there an ER visit for mental health or substance abuse?

- [ ] Yes
- [ ] No

16 Do you get help from agencies (e.g.. Meals on Wheels, Food Bank, Church) in your neighborhood?

- [ ] Yes
- [ ] No

17 Have you ever been told you have one or more of the following medical conditions?

- [ ] Heart attack, heart bypass surgery, or a stent
- [ ] Heart Failure or enlarged heart
- [ ] High Blood Pressure
- [ ] Asthma
- [ ] COPD, or other breathing problems
- [ ] ESRD or currently on dialysis
- [ ] Sickle Cell Disease
- [ ] HIV/AIDS
- [ ] Hemophilia
- [ ] Diabetes or sugar problems

- [ ] Hepatitis C
- [ ] Obesity/Overweight
- [ ] Depression OR Major Depression
- [ ] Significant Memory Loss or Dementia
- [ ] Eating Disorder
- [ ] Bi-Polar Disorder
- [ ] Schizophrenia or other psychotic disorders
- [ ] Anxiety Disorder
- [ ] SUD (Substance Use Disorder)
- [ ] Intellectual/Developmental Disability
- [ ] Other Conditions
- [ ] None
- [ ] Doesn't know

18 Type of Intellectual/Developmental Disability

- [ ] Neurodevelopmental Disorder
- [ ] Autism Spectrum Disorder
- [ ] Cerebral Palsy
- [ ] Down Syndrome
- [ ] Fetal Alcohol Syndrome
- [ ] Prader Willi Syndrome
- [ ] Spina Bifida
- [ ] Tourette Syndrome
- [ ] Other

Describe Other Intellectual/Developmental Disability

19 Do you have a care manager or support coordinator from another agency?

- [ ] Yes

Enter Information in Care Team

- [ ] No

20 Are you pregnant?

- [ ] Yes
- [ ] No
- [ ] N/A

21 Do you take prescription medications?

- [ ] Yes
- [ ] No

22 Do you take your medications as your doctor has prescribed?

- [ ] Yes
- [ ] No

23 Why do you not take your medications as often as your doctor has told you to?

- [ ] Can't get to pharmacy
- [ ] Can't get approved for coverage or excluded in their plan
- [ ] Can't afford
- [ ] Experiencing side effects or don't like the way it makes me feel
- [ ] Forgets to take almost every day
- [ ] Lack of understanding/knowledge
- [ ] Hard to keep tracks of multiple medications
- [ ] Other

Describe Other Reasons for not taking medications

24 How often do you worry that you don't have enough food for yourself or your family?

- [ ] Never
- [ ] Sometimes
- [ ] Always
- [ ] Declined to answer

25 Do you feel safe at home and in your neighborhood?

- [ ] Never
- [ ] Sometimes
- [ ] Always
- [ ] Declined to answer

26 Over the last two weeks, how often have you been bothered by any of the following problems?

Select one option from each of the following questions

27 Little interest or pleasure in doing things

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

28 Feeling down, depressed or hopeless

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

29 Trouble falling asleep, staying asleep, or sleeping too much

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

30 Feeling tired or having little energy

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

31 Poor appetite or overeating

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

32 Feeling bad about yourself – or that you're a failure or have let yourself or your family down

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

33 Trouble concentrating on things, such as reading the newspaper or watching television

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

34 Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

35 Thoughts that you would be better off dead or of hurting yourself in some way

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

36 Over the last two weeks, how often have you been bothered by any of the following problems ?

Select one option from each of the following questions:

37 Feeling nervous or on edge

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

38 Not being able to stop or control worrying

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

39 Worrying too much about different things

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

40 Trouble relaxing

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

41 Being so restless that it is hard to sit still

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

42 Becoming easily annoyed or irritable

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

43 Feeling afraid as if something awful might happen

- [ ] Not at all
- [ ] Several days
- [ ] More than half
- [ ] Nearly every day

44 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- [ ] Not difficult at all
- [ ] Somewhat difficult
- [ ] Very difficult
- [ ] Extremely difficult

45 Has the member received any of these preventive services?

- [ ] Cervical Cancer Screening (Female)
- [ ] Family Planning Screening

- [ ] Colon Cancer Screening
- [ ] Hearing Test
- [ ] Health Exam in the last year
- [ ] Osteoporosis screening
- [ ] Mammogram Screening (Female)
- [ ] STD Education/Awareness/Protection
- [ ] Annual Eye Exam
- [ ] Blood Pressure Screening
- [ ] Lipid Profile / Cholesterol Screening
- [ ] Dental Exam
- [ ] None of the above

46 Have you received the flu shot within the past year?

- [ ] Yes
- [ ] No
- [ ] Doesn't know
- [ ] NA

47 Have you received the Pneumovax shot? (If the first dose received before the age of 65 and it's more than 5 year, and the Member is now 65 years or older, needs revaccination)

- [ ] Yes
- [ ] No
- [ ] Doesn't know
- [ ] NA

48 Have you had a tetanus shot in the last 10 years?

- [ ] Yes
- [ ] No
- [ ] Doesn't know
- [ ] NA

49 Are you ok if we share the information we discussed today with your doctor and others who may be involved in your care?

- [ ] Yes
- [ ] No

50 What is your employment Status?

- [ ] Employed - Full Time
- [ ] Employed - PartTime
- [ ] Leave of Absence
- [ ] Disabled
- [ ] Retired
- [ ] Student

- [ ] Unemployed
- [ ] Other

51 Are you currently seeking Employment Assistance?

- [ ] Yes
- [ ] No
- [ ] Don't Know

52 Have you ever served in the military?

- [ ] Yes
- [ ] No

53 Describe your ability to get around.

- [ ] Must stay in bed all or most of the time
- [ ] Must stay in the house all or most of the time
- [ ] Need the help of another person getting around inside or outside the house
- [ ] Need the help of some special aid, like a cane or wheelchair, to get around inside or outside the house
- [ ] Do not need the help or another person or a special aid but have trouble getting around freely
- [ ] Not limited in any of these ways
- [ ] Doesn't know

54 Are you deaf or do you have serious difficulty hearing?

- [ ] Yes
- [ ] No

55 Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- [ ] Yes
- [ ] No

56 Do you have serious difficulty concentrating, remembering, or making decisions

- [ ] Yes
- [ ] No

57 Do you have serious difficulty walking or climbing stairs?

- [ ] Yes
- [ ] No

58 Do you have difficulty dressing or bathing?

- [ ] Yes
- [ ] No

59 PROMPT: Enter member height, weight and BMI in health indicators

Use Quick Links to navigate to health indicator:

60 Do you have a plan in place to continue your care in the event of a disaster (such as hurricane, tornado, house fire, flood or snowstorm)?

- [ ] Yes
- [ ] No

Attachment 19 Q59 Initial Health Screening Sample 10

61 What is your plan?

- [ ] Will be staying home
- [ ] Have plan for escape
- [ ] Will be going to stay with family
- [ ] Have generator back up power source
- [ ] Will be going to shelter
- [ ] Other

62 Have you completed any of the following?

- [ ] Advance Directive
- [ ] Psychiatric Advanced Directive
- [ ] Power of Attorney
- [ ] Living Will
- [ ] None of the above

63 Are you interested in receiving some information to review to discuss with your family?

- [ ] Yes
- [ ] No
- [ ] Not Now

64 Do you have any beliefs or preferences that effect the care you receive? (e.g. religious or other feelings and beliefs, such as preference for natural healers)

- [ ] Yes
- [ ] No

65 Do you have the support available to ensure your preferences are met?

- [ ] Yes
- [ ] No

66 Do you know what your health plan covers for you?

- [ ] Yes
- [ ] No

67 Do you find it hard to get help filling out healthcare paperwork?

- [ ] Yes
- [ ] No

68 Do you currently use tobacco products (Cigarettes, chewing tobacco, cigars, pipes, smokeless tobacco)?

- [ ] No, never used tobacco
- [ ] Used to, but have quit
- [ ] Yes, currently
- [ ] Declined to answer

69 Do you use recreational drugs?

- [ ] Never
- [ ] Less than monthly
- [ ] Monthly
- [ ] Weekly
- [ ] Daily or almost daily

70 **"ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member can do the things they need to do to take care of their health? "**

- [ ] Extremely
- [ ] Quite a bit
- [ ] Somewhat
- [ ] A little bit
- [ ] Not at all

71 **"ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member will ask their provider questions and bring up their concerns?"**

- [ ] Extremely
- [ ] Quite a bit
- [ ] Somewhat
- [ ] A little bit
- [ ] Not at all

72 **Trigger Readiness to Change OGI**

- [ ] Next

73 **End of assessment**

End of assessment - PHQ-9: Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9. Journal of General Internal Medicine, 16(9), 606-613. Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.GAD-7: Adapted with permission from Kroenke K, Spitzer RL, Williams JB, et al. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007;146(5):W77. AUDIT-C: Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Archives of internal medicine, 158(16), 1789. "
World Health Organization 2001. This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced, and translated, in part or in whole but not for sale or for use in conjunction with commercial purposes." Copyright © 2014 UnitedHealth Group. All Rights Reserved. Any use, copying or distribution without written permission from UnitedHealth Group is prohibited.

Assessment : PEDS Core

Total Questions : 66

Member Details :

Name: **Altruista ID:**

Date Of Birth: **Home Phone:**

1 Do you agree to Case Management services?

- [ ] Yes
- [ ] No

2 Do you agree to discuss your child's health information with me today?

- [ ] Yes
- [ ] No

3 Does the member or legal guardian give verbal permission to discuss PHI?

- [ ] Yes
- [ ] No

4 Does member or authorized legal representative give verbal permission to share the results of this assessment verbally and/or electronically with members of the healthcare team?

- [ ] Yes
- [ ] No

5 PROMPT: Verify and update race, ethnicity and language in member details

Use Quick Links to navigate to Member Details

6 PROMPT: Enter member height, weight and BMI in health indicators

Use Quick Links to navigate to health indicator

7 How would you describe your child's health?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

8 What concerns do you have regarding your child's health?

Describe Concerns

9 Does your child's health keep him/her from doing the things he/she wants?

- [ ] Yes
- [ ] No

10 Do you have difficulties (such as transportation, making appointments) that keep you from seeing your PCP or other type of needed provider as frequently as your would like to?

- [ ] Yes
- [ ] No

11 If yes, why?

- [ ] Transportation
- [ ] Difficulty making or getting an appointment
- [ ] Cannot afford copay
- [ ] No PCP
- [ ] Language barrier
- [ ] Other

Describe Other Difficulties

12 Do you believe your child's needs are being met through your current support system, i.e. friends, family, faith organization?

- [ ] Yes
- [ ] No

13 Do you feel the primary caregiver is capable and adequately trained to provide necessary care? OR As the primary caregiver, do you feel adequately trained to provide necessary care? (Phrasing dependent on response to Q3)

- [ ] Yes
- [ ] No

14 Caregiving can certainly become overwhelming. What aspects are you finding most stressful lately? (Please select all that apply)

- [ ] Not having enough time for myself
- [ ] Not having enough time with others in my life
- [ ] Controlling my frustration or anger regarding caregiver responsibility
- [ ] Feeling out of control
- [ ] Worsening condition of child
- [ ] Other

Specify Other

15 Do you have any of the following concerns about your child?

- [ ] Change in ability to complete ADLs (in past 90 days)
- [ ] Change in mental status (in past 90 days)
- [ ] Safety in his/ her residence
- [ ] Self-injurious behavior
- [ ] Threatening behavior/ violence toward others
- [ ] Wandering/Elopement
- [ ] None

16 Is your child deaf or do they have serious difficulty hearing?

- [ ] Yes
- [ ] No

17 Is your child blind or does he/she have serious difficulty seeing, even when wearing glasses?

- [ ] Yes
- [ ] No

18 Does your child have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

- [ ] Yes
- [ ] No

19 Does your child have serious difficulty walking or climbing stairs? (5 years old or older)

- [ ] Yes
- [ ] No

20 Does your child have difficulty dressing or bathing? (5 years old or older)

- [ ] Yes
- [ ] No

21 Does your child have difficulty doing errands alone such as visiting a doctor's office, shopping, using the telephone, managing your medication? (15 years old or older)

- [ ] Yes
- [ ] No

22 Does your child take prescription medications?

- [ ] Yes
- [ ] No

23 Does your child take their medication as prescribed by the doctor?

- [ ] Yes
- [ ] No

24 What prevents your child from taking his/her medications as often as prescribed by the doctor?

- [ ] Can't get to pharmacy
- [ ] Can't get approved for coverage or excluded in their plan
- [ ] Can't afford
- [ ] Experiencing side effects or don't like the way it makes me feel
- [ ] Forgets to take almost every day
- [ ] Lack of understanding/knowledge
- [ ] Hard to keep tracks of multiple medications
- [ ] Other

Describe Other

25 What is your child's current living environment?

- [ ] Family Residence
- [ ] Foster Care/Medical Foster Care
- [ ] Group Home
- [ ] Long Term Care Facility
- [ ] Shelter
- [ ] Residential Treatment Center
- [ ] Rehabilitation Facility
- [ ] Other

Describe Other

26 Have you completed any of the following with or on behalf of your child?

- [ ] Advance Directive
- [ ] Psychiatric Advance Directive
- [ ] Power of Attorney
- [ ] Living Will
- [ ] "My Wishes" Booklet
- [ ] N/A
- [ ] None of the above

27 Are you interested in receiving some information to review to discuss with your family/child?

- [ ] Yes
- [ ] No
- [ ] Not Now

28 Do you have any beliefs that impact how care should be provided for your child? (e.g.. religious or other feelings and beliefs, such as blood transfusions)

- [ ] Yes

Describe Beliefs

- [ ] No

29 Do you have the support available to ensure your preferences are met?

- [ ] Yes
- [ ] No

30 Do you know what your health plan covers for you?

- [ ] Yes
- [ ] No

31 Over the past year, how many days did the member miss preschool/school/work because of illness or injury?

- [ ] 0-5 days
- [ ] 6-10 days
- [ ] >10 days
- [ ] N/A (does not attend school or work)

32 What are the reasons the member missed preschool/school/work ?

- [ ] Illness
- [ ] Transportation
- [ ] Skilled nursing unavailable
- [ ] Classroom aide unavailable
- [ ] Parent/Natural Support unable to accompany child
- [ ] Hospitalization
- [ ] Child refusal
- [ ] Disciplinary action
- [ ] Behavioral health issue

- [ ] Scheduled medical/dental appointments
- [ ] Other

Describe Other Reasons

33 During the past week, on how many days did your child exercise or participate in any physical activities for at least 20 minutes?

- [ ] No days per week
- [ ] 1-2 times per week
- [ ] 3 or more times per week
- [ ] Doesn't know
- [ ] Not applicable

34 Does anyone in your household smoke tobacco products?

- [ ] Yes
- [ ] No

35 Does the member smoke or use tobacco products?

- [ ] Yes
- [ ] No
- [ ] N/A

36 Is the member sexually active?

- [ ] Yes
- [ ] No
- [ ] N/A

37 Does the member use alcohol or drugs?

- [ ] Yes
- [ ] No
- [ ] N/A

38 Is baby being breast fed?

- [ ] Yes
- [ ] No
- [ ] N/A

39 Is baby experiencing any problems with feeding?

- [ ] Yes
- [ ] No
- [ ] N/A

40 If yes, specify:

- [ ] Poor nippling, takes too long to eat
- [ ] Problems nursing
- [ ] G-tube fed
- [ ] Problems breathing with feeds, nasal flaring, cyanosis

- [ ] Gastroesophageal Reflux (GERD) - usually on anti-reflux medication

41 Does baby have any breathing problems?

- [ ] Yes
- [ ] No
- [ ] N/A

42 If yes, describe:

- [ ] On supplemental oxygen
- [ ] On apnea monitoring
- [ ] Cyanosis
- [ ] Fast breathing
- [ ] Ventilator / Bipap

43 Has the child experienced or witnessed an event that caused , or threatened to cause, serious harm to him or herself or to someone else?

- [ ] Yes
- [ ] No

44 What was the event?

- [ ] Car or Other Accident
- [ ] Fire
- [ ] Storm
- [ ] Physical Illness or Assault
- [ ] Sexual Assault
- [ ] Other Event

Describe Other Event

45 What age was the member when this event occurred?

Specify Age

46 Child reports more physical complaints such as headaches, stomach aches, nausea when reminded of the event.

- [ ] Not True (as far as you know)
- [ ] Somewhat or Sometimes True
- [ ] Very True
- [ ] Often True

47 Child avoids doing things that remind him/her of the event

- [ ] Not True (as far as you know)
- [ ] Somewhat or Sometimes True
- [ ] Very True
- [ ] Often True

48 Child startles easily (jumps when hears sudden loud noises)

- [ ] Not True (as far as you know)
- [ ] Somewhat or Sometimes True

- [ ] Very True
- [ ] Often True

49 Child gets upset if reminded of the event.

- [ ] Not True (as far as you know)
- [ ] Somewhat or Sometimes True
- [ ] Very True
- [ ] Often True

50 Are your child's well Child check-ups (EPSDT) up to date?

- [ ] Yes
- [ ] No
- [ ] Don't know

51 Are your child's immunizations up to date?

- [ ] Yes
- [ ] No
- [ ] Don't know

52 Does your child see the dentist for routine preventive services every 6 months?

- [ ] Yes
- [ ] No
- [ ] Don't know

53 Have you/ your child received age appropriate Health Education at each visit?

- [ ] Yes
- [ ] No
- [ ] Don't know

54 Do you have a plan in place to continue your care in the event of a disaster (such as hurricane, tornado, house fire, flood or snowstorm)?

- [ ] Yes
- [ ] No

55 If yes, what is your plan

- [ ] Will be staying home
- [ ] Have plan for escape
- [ ] Will be going to stay with family
- [ ] Have generator back up power source
- [ ] Will be going to shelter
- [ ] Other

Describe Other Plan

56 Does your child receive any of the following services in community early intervention program or in the school?

- [ ] Guidance Counseling
- [ ] Personal Care Attendant

- [ ] Medication Administration
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Speech Therapy
- [ ] Respiratory Therapy
- [ ] Behavioral Management Services
- [ ] Individual Behavioral Health Therapy
- [ ] Group Behavioral Health Therapy
- [ ] Homebound Services
- [ ] Extended School Year Program
- [ ] Assistive Technology
- [ ] Autism Resource Services
- [ ] Visual Impairment Support
- [ ] Multiple Disabilities Support
- [ ] Other

Please specify other services through school

- [ ] Doesn't know
- [ ] None of the above

57 Does your child have a formal plan for receiving services in the community/ school?

- [ ] Yes
- [ ] No
- [ ] Doesn't know

58 Which plan does your child have for school services?

- [ ] Individualized Family Service Plan (IFSP)
- [ ] Individualized Education Plan (IEP)
- [ ] 504 Plan

59 What is the name of the coordinator who helped you create the service plan for school or early intervention services?

- [ ] Enter Document name, agency and contact info

Document Name

60 Is your child's primary care doctor involved with the IEP / IFSP/504 Plan?

- [ ] Yes
- [ ] No
- [ ] Doesn't know

61 Are there any concerns you have regarding the services your child receives at school?

- [ ] Yes
- [ ] No
- [ ] Doesn't Know
- [ ] N/A

62 Have you ever been told your child has one or more of the following medical conditions?

- [ ] Allergies
- [ ] Cleft Lip/Palate
- [ ] Cochlear Implant
- [ ] Ear Infections
- [ ] Hearing Impairment
- [ ] Sinus Problems
- [ ] Strabismus/Lazy Eye
- [ ] Throat Infections
- [ ] Vision Impairment
- [ ] Broken Teeth
- [ ] Bruxism
- [ ] Caries
- [ ] Missing Teeth
- [ ] Orthodontia
- [ ] Pain
- [ ] Atrial Septal Defect (ASD))
- [ ] Cardiomyopathy
- [ ] Coarctation of Aorta
- [ ] Double outlet Rt. Ventricle
- [ ] Dysrhythmias
- [ ] Heart Murmur
- [ ] HF
- [ ] Hypertension
- [ ] Hypoplastic Left Heart
- [ ] Primary pulmonary hypertension
- [ ] Tetralogy of Fallot
- [ ] Ventricular Septal Defect (VSD)
- [ ] Asthma
- [ ] Bronchopulmonary Dysplasia (BPD)
- [ ] Bronchiolitis/Bronchitis
- [ ] Cystic Fibrosis
- [ ] Recurrent Pneumonia
- [ ] RSV
- [ ] Tuberculosis
- [ ] Hemophilia
- [ ] HIV/AIDS
- [ ] Immune Globulin Deficiency

- [ ] Rheumatoid Arthritis
- [ ] Sickle Cell Disease
- [ ] Diabetes Type I
- [ ] Diabetes Type II
- [ ] Gigantism/Acromegaly
- [ ] Hypothyroidism
- [ ] Short Stature/ Dwarfism
- [ ] Cerebral Palsy
- [ ] Hydrocephalus/VP Shunt
- [ ] Paraplegia
- [ ] Quadriplegia
- [ ] Seizure disorder/Epilepsy
- [ ] Spina Bifida
- [ ] Spinal Cord Injury
- [ ] Traumatic Brain Injury (TBI)
- [ ] Anorexia
- [ ] Bulimia
- [ ] Eating Disorder
- [ ] Failure to Thrive
- [ ] Gastrostomy Tube
- [ ] Gastrostomy-Jejunostomy Tube
- [ ] Obesity/Overweight
- [ ] Acid Reflux
- [ ] Colostomy
- [ ] Celiac Disease
- [ ] Constipation
- [ ] Crohn's disease
- [ ] Diarrhea
- [ ] GI Motility Disorder
- [ ] Hepatitis
- [ ] Hirschsprungs Disease
- [ ] Irritable Bowel Syndrome
- [ ] Lactose Intolerance
- [ ] Neurogenic Bowel
- [ ] Pyloric Stenosis
- [ ] Enuresis
- [ ] GU Reflux
- [ ] Neurogenic Bladder

- [ ] Recurrent Urinary Tract Infections
- [ ] Renal Failure
- [ ] Urinary Incontinence
- [ ] Pregnant
- [ ] Sexually Transmitted Disease (STD)
- [ ] Amputation
- [ ] Club Foot
- [ ] Congenital Hip Dysplasia
- [ ] Muscular Dystrophy
- [ ] Osteomyelitis
- [ ] Scoliosis
- [ ] Anxiety Disorder
- [ ] Attention Deficit Hyperactivity Disorder (ADHD)
- [ ] Auditory Processing Disorder
- [ ] Autism or Autism Spectrum Disorder
- [ ] Bipolar Disorder
- [ ] Delay in Toilet Training
- [ ] Depression
- [ ] Post Traumatic Stress Disorder
- [ ] Oppositional Defiance Disorder
- [ ] Schizophrenia
- [ ] Substance Abuse
- [ ] Other

Specify Other Condition

63 Are you ok if we share the information we discussed today with your child's doctor and others who may be involved in your child's care?

- [ ] Yes
- [ ] No

64 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member can do the things they need to do to take care of their health?

- [ ] Extremely
- [ ] Quite a bit
- [ ] Somewhat
- [ ] A little bit
- [ ] Not at all

65 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member will ask their provider questions and bring up their concerns?

- [ ] Extremely
- [ ] Quite a bit
- [ ] Somewhat
- [ ] A little bit
- [ ] Not at all

66 End of assessment

End of assessment - CSDC-SF: Adapted with permission of Drs. Saxe and Bosquet. Bosquet Enlow M, Kassam-Adams N, Saxe G. The Child Stress Disorders Checklist-Short Form: a four-item scale of traumatic stress symptoms in children. Gen Hosp Psychiatry. 2010 May-Jun; 32(3):321-7. Copyright © 2015 UnitedHealth Group. All Rights Reserved. Any use, copying or distribution without written permission from UnitedHealth Group is prohibited

Assessment : HFS Initial Leveling Assessment

Total Questions : 40

Member Details :

Name: **Altruista ID:**

Date Of Birth: **Home Phone:**

1 **PROMPT: Notify member the call is being monitored for quality purposes.**

Validate member PHI.

2 **Member eligibility was verified?**

- [ ] Yes
- [ ] No

3 **Does member have any other insurance?**

- [ ] Yes
- [ ] No

4 **Is Maternity covered?**

- [ ] Yes
- [ ] No

5 **Is member interested in Healthy First Step services?**

- [ ] Yes
- [ ] No

Provide explanation as to why member wishes to NOT participate.

- [ ] Not Applicable

Describe Not Applicable

6 **What is member's estimated due date?**

Enter Date (MM/DD/YYYY) or Unknown

7 **Has member attended or scheduled their first prenatal appointment with their doctor or midwife?**

- [ ] Attended

Enter date appointment occurred (MM/DD/YYYY)

- [ ] Scheduled

Enter date appointment is scheduled (MM/DD/YYYY)

- [ ] No

8 **Would member like assistance with scheduling that appointment?**

- [ ] Yes

Enter date appointment is scheduled (MM/DD/YYYY)

- [ ] Member Declined

9 **Is member from state of TN or NJ and a smoker?**

- [ ] Yes for state of TN or NJ member

Remember member is now L3; move to Question 28 to complete assessment.

- [ ] No

10 Is this a state of LA member age 17 or under?

- [ ] Yes

Remember member is now L3; move to Question 28 to complete assessment.

- [ ] No

11 Is this a state of WI member?

- [ ] Yes
- [ ] No

12 (WI ONLY) DO NOT ASK MEMBER - CHECK ELIGIBILITY: Verify whether or not member is enrolled in SSI

- [ ] Yes

Remember member answered Yes to answer question 12.

- [ ] No

13 (WI Only) Is member under the age of 18 and pregnant?

- [ ] Yes

Remember member answered Yes to answer question 13.

- [ ] No

14 (WI Only) Has the member ever had a prior delivery where the birth weight was 5.5lbs or less?

- [ ] Yes

Remember member answered Yes to answer question 14.

- [ ] No

15 (WI Only) Has the member ever had a miscarriage at >20 weeks or a still birth?

- [ ] Yes

Remember member answered Yes to answer question 15.

- [ ] No

16 Did WI member answer Yes to any one of Questions 12 - 15?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

17 Does the member have a history of preterm birth (baby born before 37 weeks)?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

18 Does the member anticipate their current pregnancy to be twins, triplets or greater?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

19 Does the member currently have hypertension (high blood pressure)?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

20 Does the member currently receive, or within the last 6 months has received, mental health treatment or currently has, or has had within last 6 months, mental health needs?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

21 Does the member currently or have ever had problems with the placenta (may use the term placenta previa)?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

22 Does the member have a history of 3 or more pregnancy losses?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

23 Is the member HIV positive?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

24 Has the member ever been told that their baby has any birth defects?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

25 Has the member ever had to take meds to KEEP from going into labor?

- [ ] Yes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] No

26 Does the member currently have any of the following conditions?

- [ ] Diabetes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] Gestational Diabetes

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] High Blood Sugar

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] None

27 Has the member had any of the following issues? (Check all that apply or check None)

- [ ] Clotting

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] Bleeding (does not include bleeding in 1st trimester)

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] Sickle Cell Disease

Remember member is now L3- High Risk Pregnancy; move to Question 28 to complete assessment.

- [ ] None

Remember member is L1; move to Question 28 to complete assessment.

28 (EXCLUDING HI, DE, NY, NJ) Educate member on the Baby Blocks program

N/A

29 Does member wish to be enrolled in Baby Blocks?

- [ ] Yes

Enroll member in Baby Blocks; move to Question 30

- [ ] No

30 Educate member about Text4Baby

N/A

31 Is member in the Delaware (DE) program?

- [ ] Yes
- [ ] No

32 (DE Only) How old is the member?

- [ ] 17yrs old or younger

Refer to Smart Start; move to Question 33

- [ ] 18 - 34 yrs old

Move to Question 33

- [ ] 35 yrs old or older

Refer to Smart Start; move to Question 33

33 (DE Only) Check any of the following that apply to the member:

- [ ] Anemia

Refer to Smart Start; move to Question 34

- [ ] Thyroid condition

Refer to Smart Start; move to Question 34

- [ ] Had four or more pregnancies

Refer to Smart Start; move to Question 34

- [ ] Obesity

Refer to Smart Start; move to Question 34

- [ ] None

34 For all states: Indicate resources member is interested in receiving (Check all that apply)

- [ ] Car seat for baby

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] Crib

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] Diapers

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] Rent

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] Utility Bills

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] WIC

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] Domestic Violence hotline

Advised member to call 211 to obtain information on community based resources in member's area

- [ ] None of the above

35 Indicate resources member is interested in receiving (Check all that apply)

- [ ] Finding a Pediatrician

Advise member to call member services at the number on the back of their ID card or they can visit www.uhccommunityplan.com

- [ ] Dental Benefits

Advise member to call member services at the number on the back of their ID card or they can visit www.uhccommunityplan.com

- [ ] Enrolling their baby in Medicaid

Advise member to call member services at the number on the back of their ID card or they can visit www.uhccommunityplan.com

- [ ] None

36 Is member having transportation issues with getting to doctor's appointments?

- [ ] Yes

Provide member with resources

- [ ] No

37 Is member a smoker? (Do Not ask NJ or TN state member again)

- [ ] Yes for DE

Refer to Smart Start

- [ ] Yes all other states

Give smoking cessation resources

- [ ] No

38 For Level 3 member, attempt warm transfer to RN Case Manager. Is warm transfer successful?

- [ ] Yes
- [ ] No
- [ ] Not applicable, member is Level 1

39 Refer to HFS PCCM Community Health Worker Outreach Process Job Aid for further actions.

Not Applicable

40 End of assessment

End of assessment

UnitedHealthcare

FACILITY NAME
PRIMARY CARE
PROVIDER PROFILE

PROVIDER
ADDRESS
CITY **ST** **ZIP**

UnitedHealthcare Community Plan of INSERT STATE

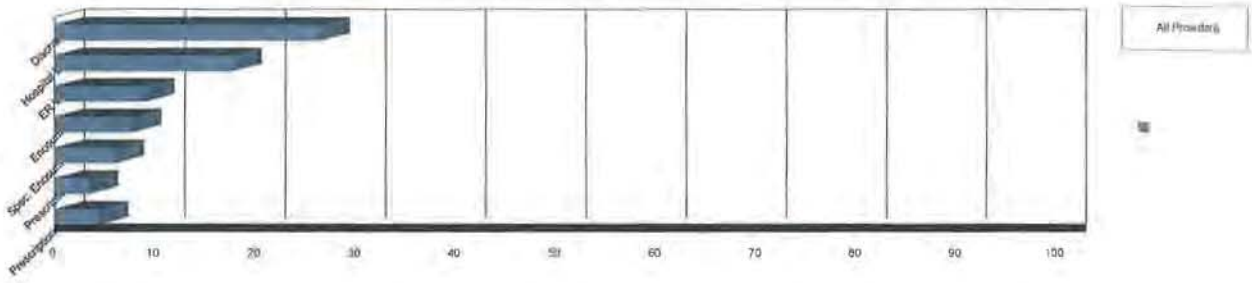
CURRENT DATE: Monday, October 12, 2015 **TAXID:** 0
PROVIDER NUMBER: All Providers All Sites **SPECIALTY:**

Utilization Management Provider Profile

MEMBERS AS OF: 00/00/2015 **MEMBER COUNT:** 0,000
REPORTING PERIOD: 00/00/2015 - 00/00/2015 **MEMBER MONTHS:** 00,000

Measure	Total Medicare	Total Medicaid	Total Dual Eligible	Total Utilization	SITE NUMBER: Indicator	Provider Rate	Plan Rate	Percentile Ranking
Discharges	0	0	0	0	Discharges pmpy	0.00	0.00	0.00
Hospital Days	0	0	0	0	Hosp. Days pmpy	0.00	0.00	0.00
ER Visits	0	0	0	0	ER Visits PMPY	0.00	0.00	0.00
Encounters	0	0	0	0	Encounter PMPY	0.00	0.00	0.00
Spec. Encounters	0	0	0	0	Spec. Enc. PMPY	0.00	0.00	0.00
Prescriptions	0	0	0	0	Prescript. PMPY	0.00	0.00	0.00
Prescription Cost	0	0	0	0	Cost/Prescription	0.00	0.00	0.00
						Overall UM:		00.00

PCP Ranking by Measure



Quality Management Provider Profile

MEMBERS AS OF: 00/00/2015 **MEMBER COUNT:** 0,000
REPORTING PERIOD: 00/00/2015 - - 00/00/2015 **MEMBER MONTHS:** 00,000

Measure	Total Medicare	Total Medicaid	Total Dual Eligible	Eligible Members	Expected Events	Actual Events	HEDIS Provider Rate	HEDIS Plan Rate	HEDIS Expected Rate	Variance from Expected
ADHD Medication - Continuation	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
ADHD Medication - Initiation	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Adolescent Immunization Status	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Adolescent Well Care Visits	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Adult Access - All ages	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Adult BMI Assessment	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
AMM - Effective Acute Phase Treatment	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
AMM - Effective Continuation Phase Treatment	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Dental Visits	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%

A medical director may be contacting you to discuss the results of this profile. An explanatory sheet is attached for your convenience.

Annual Monitoring for Patients on Persistent Med	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on ACE Inhibitors	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on Carbamazepine	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on Digoxin	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on Diuretics	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on Phenobarbital	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on Phenytoin	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Annual Monitoring for People on Valproic Acid	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Appropriate Medications for Asthma	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Child Access – All ages 25 mo to 19 yrs	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Childhood Imms Combo 2	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Completed Mammograms	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Completed Pap Smears	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Controlling High Blood Pressure	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Diabetes Eye Exam	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Diabetes HgbA1c Screening	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Diabetes Nephrophapthy	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Followup After Hosp - Mental Illness 7 Day	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
IET-Initiation of AOD Treatment	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Lead Screening	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Postpartum Exams	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Prenatal Care Visits	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Well Child Visits 0 - 15 mos (0 Visits)	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Well Child Visits 0 - 15 mos (6 Visits)	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%
Well Child Visits 3 - 6 yrs	0	0	0	0	0	0	0.00%	0.00%	0.00%	00.00%

Overall QM: 00.00%

A medical director may be contacting you to discuss the results of this profile. An explanatory sheet is attached for your convenience.

UnitedHealthcare

FACILITY NAME
PRIMARY CARE
PROVIDER PROFILE

UnitedHealthcare Community Plan of INSERT STATE

PROVIDER

ADDRESS

CITY ***ST*** ***ZIP***

Definitions and Descriptions of Standards

Members As Of - End date of the reporting period.
Reporting Period - UM profile is a rolling 12 month period that lags by three months. QM profile always covers a calendar year.
Member Count - Total number of members enrolled with the PCP at any time during the reporting period.
Member Months - Total number of member months of enrollment the PCP had during the reporting period.

Provider Rate - The PCP's measure statistic as calculated for that profile report time span.
Risk Factor - A calculated value determined by averaging all PCP panel-assigned member risk scores, which are derived by a CDPS grouper through claims / encounter experience and diagnoses.
Adjusted Rate - The Provider's Rate divided by the Provider's Risk Factor.
Plan Rate - The rate for that provider's specialty for that measure for that time span. It can be compared to the Provider's rate to show how that provider most closely matches to his peers within the health plan during the reporting time frame.
Percentile Ranking - The Provider's Rate is adjusted using the Risk Factor, then compared to other providers with the same specialty to determine a bell curve percentile ranking. In general, it is good to be >5th percentile or <95th percentile.
Overall UM - An average of the results of all of the percentile rankings for each PCP. PCP encounters are excluded, to be tracked separately.
Overall QM - An average of the Provider Rate column giving an overall average completion of the QM measures.
PCP Ranking by Measure Chart - A visual representation of the provider's percentile ranking as compared to others with the same specialty. Again, it is best to fall between the 5th and 95th percentile, which is <2 standard deviations from the mean.

Utilization Management Measure Definitions
Discharges - Measure of the number of acute inpatient discharges.
Hospital Days - Measure of the associated length of stay for the discharges reported.
ER Visits - Measure of the number of emergency department visits.
Encounters - Outpatient visits to ANY primary care provider of those members assigned to the PCP. Lack of correct encounter submissions will cause major problems to the PCP, especially in the quality management area.
Specialist Encounters - Outpatient visits to any specialist from members assigned to the PCP.
Prescriptions - Prescriptions from members assigned to the PCP.
Prescription Costs - The cost of prescriptions from members assigned to the provider.

Quality Management Measure Definitions
Variance from Expected - (ProviderRate) - (ExpectedRate) / (ExpectedRate) * 100
ADHD Medication - Continuation - Members aged 6-12 years who were dispensed ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase ended.
ADHD Medication - Initiation - Members aged 6-12 years who were dispensed ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
Adolescent Immunization Status - Members aged 13 years who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Adolescent Well Care Visits - Members aged 12 - 21 years who had a comprehensive well care visit with a PCP or OB/GYN within the measurement year.
Adult Access - Members 20 years and older who had an ambulatory or preventtive care visit within the measurement year.
Adult BMI - Members age 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.
AMM - Effective Acute Phase Treatment - Members aged 18 and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on the medication for at least 84 days (12 weeks).
AMM - Effective Continuation Phase Treatment - Members aged 18 and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on the medication for at least 180 days (6 months).
Annual Dental Visits - Members aged 2-21 who had at least one dental visit with a dental practitioner during the measurement year.
Annual Monitoring for Patients on Persistent Medications - Members aged 18 and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year.
Appropriate Medications for Asthma - Members aged 5-64 years of age who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.
Child Access - Members 12 months to 19 years of age that had a visit with a PCP within the measurement year.
Child Immunization Status, Combo 2 - Members aged 2 years who had four DTaP; three IPV; one MMR; three HiB; three HepB, one VZV immunizations (unless contraindicated) by their second birthday.
Completed Mammograms - Female members aged 50 - 74 that had a mammogram performed during the measurement year or within the year prior.
Completed Pap Smears - Female members aged 24 - 64 that had a pap smear performed during the measurement year or within the two

A medical director may be contacting you to discuss the results of this profile. An explanatory sheet is attached for your convenience.

years prior.

Controlling High Blood Pressure - Members aged 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled. (<140/90)

Diabetes Eye Exam - Members aged 18-75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the measurement year.

Diabetes HgbA1c Screening - Members aged 18-75 years with diabetes (type 1 and type 2) who had an HgbA1c Screening in the measurement year.

Diabetes Nephropathy - Members aged 18-75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the measurement year.

Follow-Up After Hospitalization for Mental Illness-7 Day -Discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had a follow up visit with a mental health practitioner within 7 days of discharge.

Initiation of AOD Treatment - Members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Lead Screening - Members that reached age 2 in the measurement year that received a lead-screening test by their second birthday.

Postpartum Exams - Deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Prenatal Care Visits - Deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the plan.

Well Child Visits 0 - 15 Months (0 Visits) - Members aged 0 - 15 months that had zero well child visits with a PCP in the measurement year.

Well Child Visits 0 - 15 Months (6 Visits) - Members aged 0 - 15 months that had six or more well child visits with a PCP in the measurement year.

Well Child Visits 3 - 6 Years - Members aged 3 - 6 years that had a well child visit with a PCP in the measurement year.

A medical director may be contacting you to discuss the results of this profile. An explanatory sheet is attached for your convenience.

Attachment 19 Q77-2
NE HIPR Utilization Summary
Report Template

Attachment 19 Q84 Services Requiring Prior Authorization

Medical Services Requiring Prior Authorization
Abortion – Prior Notification Needed from MLTC
Bariatric Surgery – Inpatient and Outpatient Bariatric Surgery and Specific Obesity-Related Services
Bone Growth Stimulator – Electronic Stimulation or Ultrasound to Fractured Heels
BRCA Genetic Testing
Breast Reconstruction (Non Mastectomy) – Reconstruction of the Breast Except After Mastectomy
Cochlear and Other Auditory Implants
Cosmetic and Other Reconstructive
Durable Medical Equipment – Greater than $500 in Cost
Enteral Services
Experimental or Investigational
Femoroacetabular Impingement Syndrome (FIS)
Home Health Care
Injectable Medications
Joint Replacement
Non-Emergent Air Ambulance Transport
Orthognathic Surgery
Orthotics and Prosthetics – Greater than $500 in Cost
Out of Network Services
Proton Beam Therapy
Radiology Services
Rhinoplasty
Sinuplasty
Sleep Apnea Procedures and Surgeries
Sleep Studies
Spinal Stimulator for Pain Management
Spinal Surgery
Transplants
Vagus Nerve Stimulation
Vein Procedures
Ventriculor Assist Devices
Wound Vac
Behavioral Health Services Requiring Prior Authorization
Mental Health Respite and Hospital Diversion
Inpatient Psychiatric Treatment Facility – Acute and Sub-acute
Psychiatric Residential Treatment Facility – Age 19 and Under
Partial Hospitalization Services
Day Treatment Services
Intensive Outpatient Services
Outpatient Therapy – Greater 75 minutes in duration
Substance Use Disorder – Intensive Outpatient, Residential and Inpatient Services
Rehabilitation – Day Rehabilitation, Secure Residential, Assertive/Alternative Community Treatment, and Psychiatric Residential Rehabilitation
Psychological Evaluation and Testing
Applied Behavioral Analysis
Professional Resource Family Care
Therapeutic Group Home – Services for Adults Age 21 and Over
Social Detoxification
Electroconvulsive Therapy
Ambulatory Detoxification
In-home Psychiatric Nursing
Dual-disorder Residential
Intermediate Residential – Substance Use Disorder

Short-term Residential	
Halfway House	
Therapeutic Community – Substance Use Disorder	
Psychiatric Residential Rehabilitation	
Secure Residential Rehabilitation	
Assertive Community Treatment (ACT) and Alternative (Alt) ACT	
Pharmacy Services Requiring Prior Authorization	
Analgesics, Opiate Long-Acting	▪ BUTRANS (buprenorphine, transdermal) ▪ CONZIP (tramadol extended release) ▪ Hydromorphone ER (generic for Exalgo) ▪ NUCYNTA ER (tapentadol) ▪ Tramadol extended release (generic for Ultram ER)
Analgesics, Opiate Short-Acting	**Oral**
	▪ NUCYNTA (tapentadol)
	Bucccal/Transmucosal
	▪ ABSTRAL (fentanyl transmucosal) ▪ fentanyl transmucosal (generic for Actiq) ▪ FENTORA (fentanyl) ▪ SUBSYS (fentanyl spray)
Antibiotics, Inhaled	▪ TOBI-PODHALER (tobramycin) ▪ CAYSTON (aztreonam lysine) QL
Antiemetics/Antivertigo Agents	**NK-1 Receptor Antagonist**
	EMEND (aprepitant)QL
Antifungals, Oral	▪ Flucytosine (generic for Ancobon) ▪ NOXAFIL (posaconazole) ▪ SPORANOX (itraconazole) ▪ Voriconazole (generic for VFEND)
Antihyperuricemics	▪ COLCRYS (colchicine) ▪ ULORIC (febuxostat)
Antimigraine DrugsQL, Triptans *Quantity Limits for Entire Class	**Oral**
	▪ RELPAX (eletriptan) ▪ Rizatriptan ODT (generic for Maxalt MLT) ▪ Sumatriptan generic oral ▪ AXERT (almotriptan) ▪ FROVA (frovatriptan) ▪ IMITREX oral (sumatriptan) ▪ Naratriptan (generic for Amerge) ▪ Rizatriptan (generic for Maxalt) ▪ TREXIMET (sumatriptan/naproxen) ▪ Zolmitriptan (generic for Zomig/Zomig ZMT)
	Nasal
	▪ IMITREX (sumatriptan) ▪ sumatriptan generic nasal ▪ ZOMIG (zolmitriptan)
	Injectable
	▪ IMITREX (sumatriptan) Pen, Cartridge ▪ Sumatriptan generic Vial ▪ ALSUMA (sumatriptan) ▪ IMITREX (sumatriptan) Vial ▪ Sumatriptan Syringe, Kit ▪ SUMAVEL DOSEPRO (Sumatriptan)
Anti-Parkinson's Drugs (Oral)	▪ MIRAPEX ER (pramipexole) ▪ NEUPRO (rotigotine) ▪ Ropinirole extended release (generic for REQUIP XL)

Bone Resorption Suppression and Related Drugs	▪ FORTEO (teriparatide) Subcutaneous QL
Chronic Obstructive Pulmonary Disease Agents	▪ DALIRESP (roflumilast)
Erythropoiesis Stimulating Proteins * Entire class requires prior authorization when administered outside physician office or hospital	▪ EPOGEN (rHuEPO) ▪ PROCRIT (rHuEPO)
Hepatitis C Treatments * Entire class requires prior authorization based on clinical criteria	**Interferon**
	▪ PEGASYS (pegylated interferon alfa-2a)* ▪ PEG-INTRON (pegylated interferon alfa-2b)* ▪ INFERGEN (interferon alfacon-1)
	Nucleotide Analog Polymerase Inhibitor
	▪ VIEKIRA PAK (ombita/paritap/riton/dasabuvir) ▪ HARVONI (sofosbuvir/ledipasvir) ▪ SOVALDI (sofosbuvir)
	Protease Inhibitor
	▪ OLYSIO (simeprevir)
	Ribavirin
	▪ Ribavirin 200mg tablets/capsules ▪ REBETOL SOLUTION (ribavirin)
Glucagon-Like Peptide-1 Receptor Agonist * Requires metformin trial and diagnosis of diabetes	▪ BYDUREON (exenatide ER) subcutaneous ▪ BYETTA (exenatide) subcutaneous ▪ TANZEUM (albiglutide) ▪ TRULICITY (dulaglutide) ▪ VICTOZA (liraglutide) subcutaneous
Amylin Analog	▪ SYMLIN (pramlintide) subcutaneous
Dipeptidyl peptidase-4 (DPP-4) Inhibitor	▪ JANUMET (sitagliptin/metformin)QL ▪ JANUMET XR(sitagliptin/metformin)QL ▪ JANUVIA (sitagliptin)QL ▪ JENTADUETO (linagliptin/metformin)QL ▪ TRADJENTA (linagliptin)QL ▪ GLYXAMBI (empagliflozin/linagliptin) ▪ KAZANO (alogliptin/metformin)QL ▪ KOMBIGLYZE XR (saxagliptin/metformin)QL ▪ NESINA (alogliptin)QL ▪ ONGLYZA (saxagliptin)QL ▪ OSENI (alogliptin/pioglitazone)QL
Hypoglycemics, Insulin and Related Drugs	▪ Insulin Pens /Cartridges
Hypoglycemics, SGLT2	▪ INVOKANA (canagliflozin) ▪ FARXIGA (dapagliflozin)
Lipotropics, Other (non-statins)	**Treatment of Homozygous Familial Hypercholesterolemia**
	▪ JUXTAPID (lomitapide) ▪ KYNAMRO (mipomersen)
Oncology Agents	▪ AFINITOR DISPERZ ▪ Temozolomide (generic for Temodar)
Ophthalmics, Antibiotics	▪ NATACYN (natamycin)
Pulmonary Arterial Hypertension (Oral and inhaled)	▪ Sildenafil (generic for Revatio) (for PAH only) ▪ ADCIRCA (tadalafil) (for PAH only) ▪ REVATIO SUSPENSION (for PAH only)
Sedative Hypnotics	▪ HETLIOZ (tasimelteon)
Skeletal Muscle Relaxants	▪ AMRIX (cyclobenzaprine) ▪ LORZONE (chlorzoxazone)

	▪ SOMA (carisoprodol)
Stimulants and Related ADHD Drugs	▪ Guanfacine extended release (generic for Intuniv) ▪ Clonidine ER (generic for Kapvay) ▪ Modafanil (generic for Provigil) ▪ NUVIGIL (armodafinil)
Tetracyclines	▪ Demeclocycline

Attachment 19 Q106
Sample Business Continuity
Disaster Recovery Plan

ATTACHMENT 19 Q106
SAMPLE BUSINESS CONTINUITY DISASTER RECOVERY PLAN

This document has been marked confidential/proprietary and appears in the Proprietary binder per the instructions in RFP 5151 Z1, Section III. Terms and Conditions, NN. Proprietary Information.

ATTACHMENT 19 Q115-1
MEMBER GRIEVANCE SYSTEMS REPORT

This document has been marked confidential/proprietary and appears in the Proprietary binder per the instructions in RFP 5151 Z1, Section III. Terms and Conditions, NN. Proprietary Information.

ATTACHMENT 19 Q115-2
PIP REPORT - IMPROVING SCREENING AND FOLLOW-UP FOR ADOLESCENT DEPRESSION

This document has been marked confidential/proprietary and appears in the Proprietary binder per the instructions in RFP 5151 Z1, Section III. Terms and Conditions, NN. Proprietary Information.

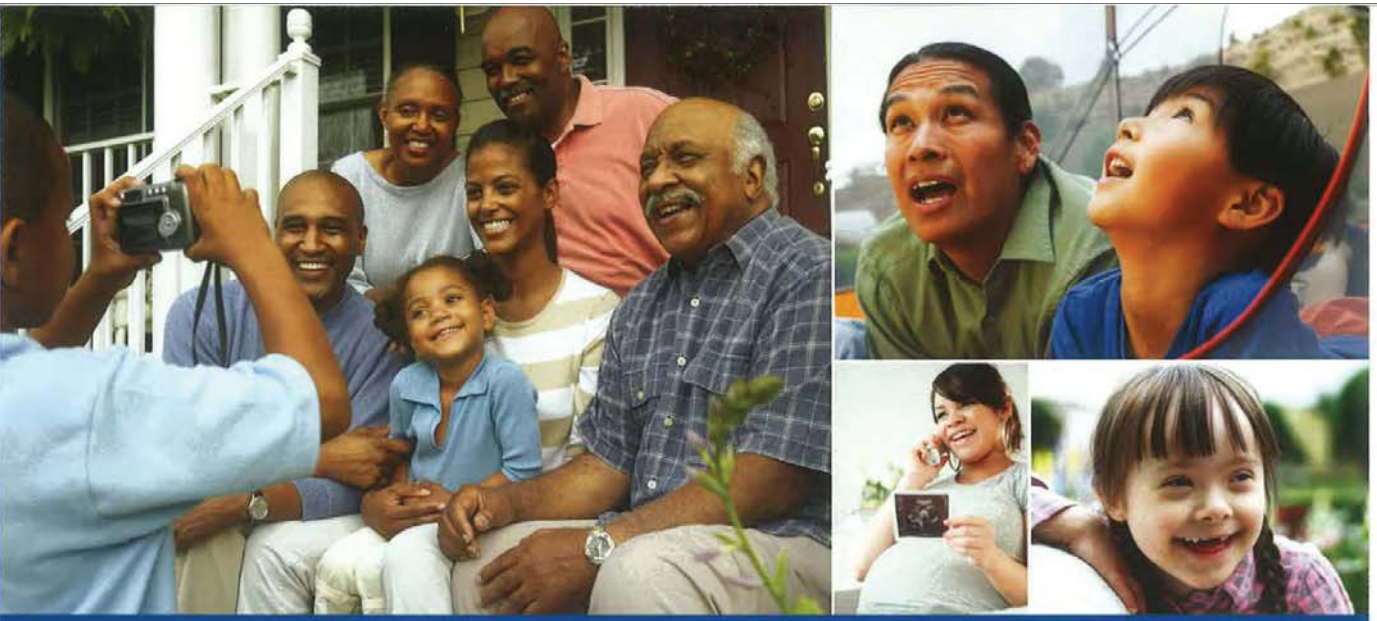
Attachment 19 Q115-3 PIP Report
- Reducing Non-Emergent
Emergency Department Visits

ATTACHMENT 19 Q115-3
PIP REPORT - REDUCING NON-EMERGENT EMERGENCY DEPARTMENT VISITS

This document has been marked confidential/proprietary and appears in the Proprietary binder per the instructions in RFP 5151 Z1, Section III. Terms and Conditions, NN. Proprietary Information.

ATTACHMENT 19 Q115-4
CARE MANAGEMENT REPORT

This document has been marked confidential/proprietary and appears in the Proprietary binder per the instructions in RFP 5151 Z1, Section III. Terms and Conditions, NN. Proprietary Information.



STATE OF NEBRASKA

Request for Proposal for

Nebraska State Purchasing Bureau
Heritage Health

Medicaid Managed Care for Physical Health, Behavioral Health, and Pharmacy Services

Technical Approach

(c. Proposal Deliverables)

Binder 3 of 3

RFP #5151 Z1

ORIGINAL

UnitedHealthcare®
Community Plan

3. TECHNICAL APPROACH

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Attachments
Provider Contract Templates
Network Development Plan
Key Staff Resumes
Preliminary Implementation Plan
Draft Member Handbook

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c. Attachment 5 – Policies, Procedures, and Plans

c. Proposal Deliverables as Listed in Attachment 5 – Policies, Procedures, and Plans

Proposed Rule Implementation Plan

Plan for complying with new CMS Medicaid managed care rules as described in Section IV.C - Business Requirements.

Per 5151 Z1 Addendum 3 - Revisions to RFP, the Proposed Rule Implementation plan is due 90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier), and is therefore not included with this proposal.

Provider Contract Template

Submit provider contract template as described in Section IV.I - Provider Network.

Please find the Provider Contract Templates behind the Provider Contract Templates tab.

Network Development Plan

Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.

Please find the Network Development Plan behind the Network Development Plan tab.

Key Staff Resumes

As possible, submit resumes of proposed key staff as described in Section IV.X - Transition and Implementation.

Please find Key Staff Resumes behind the Key Staff Resumes tab.

Preliminary Implementation Plan

Submit preliminary implementation plan as described in Section IV.X - Transition and Implementation.

Please find the Preliminary Implementation Plan behind the Preliminary Implementation Plan tab.

Draft Member Handbook

Submit a draft copy of the member handbook as described in Section IV.F – Member Services and Education.

Please find the Draft Member Handbook behind the Draft Member Handbook tab.

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Attachment 5-1
Provider Contract Template –
Medical Group
Participation Agreement

Proprietary and Confidential Information

UnitedHealthcare

Attachment 5-1 Provider contract Template – Medical Group Participation Agreement

26 Pages

Attachment 5-2
Provider Contract Template – Sample Facility Participation Agreement

Proprietary and Confidential Information

UnitedHealthcare

Attachment 5-2 Provider Contract Template – Sample Facility Participation Agreement

29 Pages

Attachment 5-3
Provider Contract Template – Sample Ancillary Participation Agreement

Ancillary Provider Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, _____ and the other entities that are United's Affiliates (collectively referred to as "United") and _____ ("Facility").

This Agreement is effective on the later of the following dates (the "Effective Date"):

i) _____ or

ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

United wishes to arrange to make Facility's services available to Customers. Facility wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Payment Policies** are the guidelines adopted by United for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in the Payment Appendix or Payment Appendices to this Agreement. The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Facility's services under this Agreement.

1.7 **Protocols** are the programs and administrative procedures adopted by United or a Payer to be followed by Facility in providing services and doing business with United and Payers under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. The Protocols may change from time to time as discussed in section 4.4 of this Agreement.

1.8 **United's Affiliates** are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II.
Representations and Warranties

2.1 **Representations and warranties of Facility.** Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (a) the organizational documents of Facility, (b) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (c) applicable law.

iv) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Facility has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Facility pursuant to this Agreement constitutes the representation and warranty by it to United that (a) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (b) the charge amount set forth on the claim is the Customary Charge and (c)

the claim is a valid claim.

2.2 Representations and warranties of United. United, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) United is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (a) the organizational documents of United, (b) any material agreement or instrument to which United is a party or by which United or any material part of its property is bound, or (c) applicable law.

iv) United has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III.
Applicability of this Agreement

3.1 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If the service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to the actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility begins providing services at other service locations, at new types of facilities, or under other Taxpayer Identification Number(s), those additional Taxpayer Identification Numbers, new types of facilities or locations, will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges or comes under common ownership with an existing provider that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers). For purposes of this section 3.1, "new types of facilities" include any type of health care provider other than _____.

ii) In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, the payment rates for each of Facility's locations specified in this Agreement and the payment rates for the other provider will be (a) the rates set forth in the other agreement, or (b) the rates set forth in the applicable Payment Appendix to this Agreement, as decided by United with written notice to Facility.

iii) Facility will not transfer all or some of its assets to any other entity during the term of this Agreement, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, without the express written agreement of United. This subsection 3.1(iii) applies to arrangements under which another provider leases space from Facility after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered instead by another provider after the lease takes place.

3.2 **Payers and Benefit Plans.** United may allow Payers to access Facility's services under this Agreement for certain Benefit Plans, as described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

Section 8.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 **Patients who are not Customers.** This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 **Health care.** This Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility's determination of what care to provide its patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility and with Customers and their physicians, and not with United or any Payer.

3.5 **Communication with Customers.** Nothing in this Agreement is intended to limit Facility's right or ability to communicate fully with a Customer and the Customer's physician regarding the Customer's health condition and treatment options. Facility is free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility is free to discuss with a Customer any financial incentives Facility may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement. Facility may also assist a Customer in estimating the cost of a given Covered Service.

Article IV.
Duties of Facility

4.1 **Provide Covered Services.** Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(iv) of this Agreement and, to the extent Facility is subject to

credentialing by United, Facility must be credentialed by United or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 **Nondiscrimination.** Facility will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer.

4.3 **Accessibility.** At a minimum, Facility will be open during normal business hours, Monday through Friday.

4.4 **Cooperation with Protocols.** Facility will cooperate with and be bound by United's and Payers' Protocols. The Protocols include but are not limited to all of the following:

i) For non-emergency Covered Services, Facility will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in United's network, except as authorized by United through United's process for approving out-of-network services for in-network benefits.

ii) As further described in the Protocols, Facility will provide notification and participate in utilization management programs regarding certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information as required by United or Payer.

The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at www.unitedhealthcareonline.com. United will notify Facility of any changes in the location of the Protocols.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if the change is applicable to all or substantially all facilities of the same type and in the same state as Facility (as used in this sentence, examples of a type of facility are an inpatient hospital, SNF, rehab hospital, or ambulatory surgery center). Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

4.5 **Employees and subcontractors.** Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to these services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 **Licensure.** Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement.

4.7 **Liability insurance.** Facility will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance must be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance must be either

occurrence or claims made with an extended period reporting option. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility will submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	Five Million Dollars ($5,000,000.00) per occurrence and aggregate
Commercial general and/or umbrella liability insurance	Five Million Dollars ($5,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility will maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility will provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 **Notice by Facility.** Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or Taxpayer Identification Number.

In addition, Facility will give written notice to United 45 days prior to the effective date of changes in existing remit address(es) and other demographic information.

4.9 **Customer consent to release of medical record information.** Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

4.10 **Maintenance of and access to records.** Facility will maintain medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Facility will provide access to these records as follows:

i) to United or its designees, in connection with United's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility will provide access during ordinary business hours within fourteen days after a request is made, except in cases of a United billing audit involving an allegation of fraud or abuse or the health and safety of a Customer (in which case, access must be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable United to reasonably meet the timelines for determining the appeal or grievance). If records are requested to adjudicate a claim or to make a decision

regarding a request for correction under 6.10, or regarding an appeal, Facility will provide copies of the requested records within fourteen days after the request is made; and

ii) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Facility, United, or Payers.

Facility will cooperate with United on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an interview to review findings, within 30 days after United's request.

If such information and records are requested by United, Facility will provide copies of the records free of charge.

4.11 Access to data. Facility represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Facility that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards).

United recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in so tracking is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to which Facility reported. If the Facility does not report metrics in the public domain, on a quarterly basis, Facility will share these metrics with United as tracked against a database of all discharged, commercial patients (including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers. Notwithstanding the foregoing, Facility agrees that it will participate in The Leapfrog Group's annual patient safety survey if Facility is among the hospitals Leapfrog seeks to survey.

4.12 Compliance with law. Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically. Facility will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by UnitedHealthcare Online® or other online resources as supported for additional products. Facility will use www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Facility that these functionalities have become available for the applicable Customer.

4.14 Implementation of patient safety programs. Facility will implement quality programs recommended by nationally recognized independent third parties on a reasonably prompt basis.

Article V.
Duties of United and Payers

5.1 **Payment of claims.** As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online or upon request. United may change its Payment Policies from time to time, and will make information available describing the change.

5.2 **Liability insurance.** United will procure and maintain professional and general liability insurance, as United reasonably determines may be necessary to protect United and United's employees against claims, liabilities, damages or judgments that arise out of services provided by United or United's employees under this Agreement.

5.3 **Licensure.** United will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable United to lawfully perform this Agreement.

5.4 **Notice by United.** United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 **Compliance with law.** United will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

5.6 **Electronic connectivity.** United will do business with Facility electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those Benefit Plans supported by www.unitedhealthcareonline.com. United will communicate enhancements in www.unitedhealthcareonline.com functionality as they become available, as described in section 4.13 of this Agreement, and will make information available as to which Benefit Plans are supported by www.unitedhealthcareonline.com.

5.7 **Employees and subcontractors.** United will assure that its employees, affiliates and any individuals or entities subcontracted by United to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit United's obligations and accountability under this Agreement with regard to those services.

Article VI.
Submission, Processing, and Payment of Claims

6.1 **Form and content of claims.** Facility must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

6.2 **Electronic filing of claims.** Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that United is able to accept electronically.

6.3 **Time to file claims.** Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by United no more than 90 days from the date of

discharge or from the date outpatient Covered Services are rendered. If Payer is not the primary payer, and Facility is pursuing payment from the primary payer, the timely filing limit will begin on the date Facility receives the claim response from the primary payer.

In the event United requests additional information in order to process a claim, Facility will provide that additional information within 90 days of United's request, unless a longer timeframe is required under applicable law.

6.4 **Payment of claims for Covered Services.** Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable state and federal law.

The obligation for payment under this Agreement is solely that of Payer, and not that of United unless United is the Payer.

6.5 **Denial of claims for not following Protocols, for not filing timely, for Services not Covered under the Customer's Benefit Plan, or for lack of medical necessity.**

i) **Non-compliance with Protocol.** Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under section 6.3 of this Agreement.

In the event payment is denied under this subsection 6.5(i) for Facility's failure to file a timely claim or to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection (i) will be reversed if Facility can show that, at the time the Protocols required notification or prior authorization, or at the time the claim was due:

- Facility did not know and was unable to reasonably determine that the patient was a Customer, and
- Facility took reasonable steps to learn that the patient was a Customer, and
- Facility promptly submitted a claim after learning the patient was a Customer.

A claim denied under this subsection (i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (i) does not preclude United from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being

consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

6.6 **Retroactive correction of information regarding whether patient is a Customer.** Prior to rendering services, Facility will ask the patient to present his or her Customer identification card. In addition, Facility may contact United to obtain the most current information available to United on the patient's status as a Customer.

However, such information provided by United is subject to change retroactively, under the following circumstances, (i) if United has not yet received information that an individual is no longer a Customer; (ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (iv) if eligibility information United receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services will not be eligible for payment under this Agreement and any claims payments made with regard to those services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

6.7 **Payment under this Agreement is payment in full.** Payment as provided under section 6.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, United, Payer or anyone acting on their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether that amount is less than Facility's billed charge or Customary Charge.

6.8 **Customer hold harmless.** Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Facility's failure to comply with the Protocols,

ii) Facility's failure to file a timely claim,

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or

vi) a denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 6.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that United or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against United or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by clause (v) of this section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility may do so only if it first inquires in writing to United as to whether the Payer has defaulted and, in the event that United confirms that Payer has defaulted (which confirmation will not be unreasonably withheld), Facility then gives United 15 days prior written notice of Facility's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 **Consequences for failure to adhere to Customer protection requirements.** If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility will be in breach of this Agreement. This section 6.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

6.10 **Correction of claims payments.** If Facility does not seek correction of a given claim payment or denial by giving notice to United within 12 months after the claim was initially processed, it will have waived any right to subsequently seek such correction under this section 6.10, or through dispute resolution under Article VII of this Agreement or in any other forum.

Facility will repay overpayments within 30 days of written or electronic notice of the overpayment. Facility will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to United within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

Article VII.
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of this Agreement or any term thereof.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII. For Disputes regarding payment of claims, a party must have timely initiated, and completed, the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

Any arbitration proceeding under this Agreement will be conducted in _____. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with a class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VII of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this Article VII. While the arbitration remains pending, the termination for breach will not take effect.

_____

This Article VII will survive any termination of this Agreement.

Article VIII.
Term and Termination

8.1 **Term.** This Agreement will take effect on the Effective Date. This Agreement has an initial term of three years and will renew automatically for renewal terms of one year, until terminated pursuant to section 8.2 of this Agreement.

8.2 **Termination.** This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 180 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party, upon 60 days prior written notice, in the event of a material breach of this Agreement by the other party; the notice must include a specific description of the alleged material breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, termination may be deferred as further described in Article VII of this Agreement;

iv) by either party, upon 10 days prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;

v) by United, upon 10 days prior written notice, in the event Facility loses accreditation; or

vi) by United, upon 90 days prior written notice, in the event:

a) Facility loses approval for participation under United's credentialing plan, or

b) Facility does not successfully complete the United's re-credentialing process as required by the credentialing plan.

8.3 **Ongoing Services to certain Customers after termination takes effect.** In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination of this Agreement takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Circumstances where Payer is required by	As applicable

applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	

Article IX.
Miscellaneous Provisions

9.1 **Entire Agreement.** In order for this Agreement to be binding, a hard copy must be signed by both parties. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter, except that this Agreement does not supersede a national agreement between the parties or their affiliates.

9.2 **Amendment.** This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by United upon written notice to Facility in order to comply with applicable regulatory requirements. United will provide at least 30 days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance.

9.3 **Nonwaiver.** The waiver by either party of any breach of any provision of this Agreement is not a waiver of any subsequent breach of the same or any other provision.

9.4 **Assignment.** This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by United to any of United's Affiliates.

Additionally, if United transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, United may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of United's business.

9.5 **Relationship of the parties.** The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 **No third-party beneficiaries.** United and Facility are the only entities with rights and remedies under this Agreement.

9.7 **Calendar days.** Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

9.8 **Notice procedures.** Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature

portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses.

9.9 Confidentiality. Neither party may disclose to a Customer, other health care providers, or other third parties any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;
ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or
iii) any customer list of the other party regardless of how such customer list was generated.

This section 9.9 does not preclude the disclosure of information by United to a third party as part of the process by which the third party is considering whether to purchase services from United.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

Except as otherwise required by applicable law or stock exchange rule, Facility will not, and will not permit any of its representative affiliates, representatives or advisors to, issue or cause the publication of any press release or make any other public announcement, including, without limitation, any advertisement, with respect to this Agreement without the consent of United.

9.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory appendices. One or more regulatory appendix may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 9.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

_____ as signed by its authorized representative:	**Address to be used for giving notice to Facility under this Agreement:**
Signature: _____	Street: _____
Print Name: _____	City: _____
Title: _____	State: _____ Zip Code: _____
Date: _____	Email: _____

UnitedHealthcare Insurance Company, on behalf of itself, _____ and its other affiliates, as signed by its authorized representative:

Signature: _____
Print Name: _____
Title: _____
Date: _____

Address to be used for giving notice to United under this Agreement: Street: _____ City: _____ State: _____ Zip Code: _____
For office use only: Contract number: 1033879 Month, day and year in which Agreement is first effective: _____

Attachments as of the Effective Date:

X	Appendix 1: Facility Location and Service Listings
_____	Appendix 2: Benefit Plan Descriptions
_____	Additional Manuals Appendix

Payment Appendices:

X	All Payer Appendix(ices)
_____	_____
_____	_____
_____	_____
_____	Other:
	_____
	_____

Regulatory Appendices:

_____	State Regulatory Requirements Appendix (list all states as applicable)
	_____
	_____
	_____
	_____
_____	Medicare Advantage Regulatory Requirements Appendix
_____	Medicaid and/or CHIP Regulatory Requirements Appendix(ices)
	_____
	_____
	_____

Other Attachments:

_____	_____
X	Data Services Appendix
_____	_____

Appendix 1
Facility Location and Service Listings

IMPORTANT NOTES: Facility acknowledges its obligation under section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

The location where Covered Services will be rendered ("Service Location") MUST be listed in this Appendix.

FACILITY LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

Appendix 2
Benefit Plan Descriptions

Section 1. United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- Benefit Plans where Customers are offered a network of participating providers and must select a primary physician, who in some cases must approve any care provided by other health care providers. Such Benefit Plans may or may not include an out-of-network benefit.

- Benefit Plans where Customers are offered a network of participating providers but are not required to select a primary physician. Such Benefit Plans may or may not include an out-of-network benefit.

_____

_____

_____

_____

_____

Section 2. Notwithstanding the above section 1, this Agreement will not apply to the following line items:

- Benefit Plans where Customers are not offered a network of participating providers from which they may receive Covered Services.

_____

- Medicare and Medicaid Enrollees (MME) Benefit Plans.

_____

_____

_____

- Medicaid or CHIP Benefit Plans other than those separately addressed in this Appendix 2.
- Benefit Plans for Medicare Select.
- Benefit Plans for workers' compensation benefit programs.
- Medicare Advantage Private Fee-For-Service Benefit Plans and Medicare Advantage Medical Savings Account Benefit Plans.
- Other Governmental Benefit Plans.
- TRICARE Benefit Plans.

_____

_____

_____

_____

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Facility's participation in a network for such Benefit Plans or Programs.

Section 3. Definitions:

Note: United may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions below regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix will continue to apply to those Benefit Plans as it did previously, and United will provide Facility with the updated information. Additionally, United may revise the definitions in this section 3 to reflect changes in the names or roles of United's business units, provided that doing so does not change Facility's participation status in Benefit Plans impacted by that change, and further provided that United provides Facility with the updated information.

MEDICARE:

- **Medicare Advantage Benefit Plans** means Benefit Plans sponsored, issued or administered by a Medicare Advantage organization as part of:
  i) the Medicare Advantage program under Title XVIII, Part C of the Social Security Act, or
  ii) the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act,
  as those program names may change from time to time.

- **Medicare and Medicaid Enrollees (MME) Benefit Plan** means the CMS sponsored Financial Alignment Demonstration Plan providing integrated care benefits for individuals eligible for both the state Medicaid program and the Medicare program (Parts A, B, C and D). At such time as this Benefit Plan is no longer a demonstration project and is fully implemented in the state, this definition will be interpreted to refer to the fully implemented plan.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Nebraska Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Nebraska that include a reference to "UnitedHealthcare Community Plan for Families" on the identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Nebraska CHIP Benefit Plans** means CHIP Benefit Plans issued in Nebraska that include a reference to "UnitedHealthcare Community Plan for Kids" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Iowa CHIP Benefit Plans** means CHIP Benefit Plans issued in Iowa that include a reference to "UnitedHealthcare Community Plan" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Additional Manuals Appendix

For some of the Benefit Plans for which Facility may provide Covered Services under this Agreement, Facility is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the UnitedHealthcare Administrative Guide; or (2) a United Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Facility on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. United may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if United does so, United will inform Facility.

United may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
No Additional Manuals Apply		
This row intentionally left blank	_____	_____
This row intentionally left blank	_____	_____
This row intentionally left blank	_____	_____

Payment Appendix - All Payer

All Payer Fee Information Document: _____

Unless another Payment Appendix to this Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Payment Appendix apply to Covered Services rendered by Facility to Customers covered by Benefit Plans sponsored, issued or administered by all Payers. Payer will pay claims for Covered Services according to the lesser of Facility's Customary Charge or the applicable fee schedule, and in accordance with Payment Policies.

Facility will submit claims using current CMS 1500 or successor forms for paper claims and HIPAA standard professional format for electronic claims, as applicable, with applicable coding including, but not limited to, ICD, CPT, and HCPCS coding.

_____

Attachment 5-4

Provider Contract Template – NE Medicaid Regulatory Appendix (Provider)

Proprietary and Confidential Information

UnitedHealthcare

Attachment 5-4 Provider Contract Template – NE Medicaid Regulatory Appendix (Provider)

13 Pages

Attachment 5-5
Provider Contract Template – Pharmacy

Proprietary and Confidential Information

UnitedHealthcare

Attachment 5-5 Provider Contract Template – Pharmacy

23 Pages

Attachment 5-6
Provider Contract Template – BH Facility Template

UNITED BEHAVIORAL HEALTH
FACILITY PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned facility provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third-party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Facility-based Provider: A health care professional, who is employed by or under contract or supervision to render MHSA Services to Members. Facility-based Providers include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists, certified registered nurse anesthetists ("CRNAs"), and internists.

Facility Participating Provider: A health care professional, facility, CMHC Supervising Provider, or other organization that has a written Facility Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Service to Members.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance

abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider or Facility-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given. The terms of this section shall prevail over any inconsistent term or condition in the Member's Benefit Plan or other document related to obtaining prior authorization.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

2.9 Credentialing. Provider shall provide UBH with the criteria utilized by Provider to select and credential employed or subcontracted health care professionals and facilities including, but not limited to, Facility-based Providers. UBH shall have the right to audit such criteria upon reasonable advance written notice to Provider.

2.10 Payment of Services. All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Facility-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

2.11 Arrangements for Post-Discharge Follow-up Care. Prior to discharging a Member, Provider shall coordinate post-discharge follow-up care with UBH and assure that the Member has a follow-up plan including a scheduled appointment with the appropriate providers as deemed necessary.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any

applicable Member Expenses; or (b) the fee pursuant to the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date of discharge and 90 days from the date all outpatient MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not

collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

Provider acknowledges that the amounts paid to Provider under this Agreement includes payment for services provided by Provider to Members who are enrolled as Medicare beneficiaries.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the

cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her covered benefits under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider offering acute care services shall procure and maintain, at Provider's sole expense, (a) medical malpractice insurance in the amounts of $5,000,000 per occurrence and in aggregate, and (b) comprehensive general and/or umbrella liability insurance in the amount of $5,000,000 per occurrence and in aggregate. Whereas Provider offering non-acute care services shall procure and maintain, at Provider's sole expense, (c) medical malpractice insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in aggregate, and (d) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain, unless they are covered under Provider's insurance policies, a comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate and medical malpractice or professional liability insurance and comprehensive coverage in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if a Medical Doctor, and $1,000,000 per occurrence and in aggregate if not a Medical Doctor.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims

made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

4.4 Self-Insurance Option. In lieu of compliance with section 4.3 above, Provider may with the prior written approval of UBH, self-insure for medical malpractice liability, as well as comprehensive general liability. Provider shall maintain a separate reserve for its self-insurance. Upon reasonable request by UBH, Provider shall provide a statement, verified by an independent auditor or actuary, that the reserve maintained by Provider for its self-insurance is sufficient and adequate. In addition to maintaining its self-insurance, Provider shall assure that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain adequate medical malpractice insurance unless they are covered by Provider's self-insurance. Failure to maintain adequate self-insurance shall trigger the requirement to obtain and maintain Insurance under section 4.3.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium, or any material adverse change in Provider's financial status which affects its self-insurance;

(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's or any of Facility-based Provider's licenses, certifications or permits by any government or accrediting or regulatory agency under which Provider or Facility-based Provider is accredited or regulated by or authorized to provide health care services;

(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;

(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;

(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;

(g) any occurrence or condition that might materially impair the ability of Provider or Facility-based Provider to perform its duties under this Agreement;

(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Facility-based Provider or Members; or

(i) action taken by Provider to suspend, revoke or allow the voluntary relinquishment of the medical staff membership or clinical privileges of any Facility-based Provider or Facility Participating Provider, unless the action will last 30 days or less.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"),

and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of UBH and Provider;
(b) by Provider at the end of any term, as defined in Section 8.1, upon 120 days prior written notice to UBH;
(c) by UBH upon 120 days prior written notice to Provider;
(d) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(e) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certifications, or loss of insurance or failure to maintain financial reserves sufficient to provide the level of self-insurance required under this Agreement;
(f) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(g) by UBH in accordance with its credentialing plan;
(h) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(i) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9
Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required. Renegotiation of the rates in this Agreement, shall be upon the mutual consent of the parties.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time

to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or

expiration, including without limitation, sections 2.9, 2.10, 2.11, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

Upon the acceptance and execution hereof by both parties hereto, the Effective Date of this Agreement is: _____
(to be completed by UBH only)

UNITED BEHAVIORAL HEALTH
425 Market Street, 14th Floor
San Francisco, CA 94105-2426
Attn: Contract Administration

Signature_____

Deb Adler

Sr. Vice President
Clinical Network Services

Date_____

NAME OF PROVIDER

_____
_____
_____
Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number:_____

Attachment 5-7
Provider Contract Template – BH Individual Template

UNITED BEHAVIORAL HEALTH
INDIVIDUAL PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by UBH. UBH will advise Provider of the then-current Fee Maximums to Provider upon request.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Participating Provider: A health care professional, facility, CMHC Supervising Provider, psychiatrist, psychologist or other behavioral health professional or

organization, that is duly licensed or certified to provide MHSA Services within the state such MHSA Services are provided, and who has a written Individual Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of

Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees and contractors who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations.

Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;

(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government under which Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;

(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;

(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;

(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;

(g) any occurrence or condition that might materially impair the ability of Provider to perform its duties under this Agreement; or

(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to

release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties

knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of UBH and Provider;
(b) by either party upon 90 days prior written notice to the other party;
(c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(d) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certification, or loss of insurance required under this Agreement;
(e) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(f) by UBH in accordance with its credentialing plan;
(g) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(h) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9
Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or

otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans are set for in the Appendices.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision

of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by, in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

NAME OF PROVIDER

_____

_____

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number: _____

Attachment 5-8
Provider Contract Template – BH Group Template

UNITED BEHAVIORAL HEALTH
GROUP PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned group provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth on the signature page of this Agreement or the date of first credentialed Group-based Provider whichever is later (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by UBH. UBH will advise Provider of the then-current Fee Maximums to Provider upon request.

Group-based Provider: A health care professional, CMHC Supervising Provider, psychiatrist, psychologist, therapist or other behavioral health professional who is employed by or under contract or supervision to render MHSA Services to Members.

Group Participating Provider: An entity, organization, group, partnership or affiliation however categorized, consisting of health care professionals, facilities, CMHC Supervising Providers, psychiatrists, psychologists, therapists or other behavioral health professionals that is duly licensed or certified to provided MHSA Services within the state such MHSA Services are provided, and who has a written Group Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated

by UBH or Payor. At the request of a Payor, Provider or Group-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

2.9 Credentialing. Provider shall provide UBH with the criteria utilized by Provider pursuant to its applicable or required criteria to select and credential employed or subcontracted health care professionals, including, but not limited to, Group-based Providers. UBH shall have the right to audit such criteria upon reasonable advance written notice to Provider.

2.10 Payment of Services. All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Group-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses, and in accordance with the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement

and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;

(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government or applicable accrediting or regulatory agency under which Provider is accredited or regulated by or authorized to provide health care services, including without limitation, any action concerning Provider's credentialing criteria or the performance of its employees, contractors or its Group-based Providers; or any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;

(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;

(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;

(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;

(g) any occurrence or condition that might materially impair the ability of Provider or Group-based Provider to perform its duties under this Agreement; or

(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Group-based Provider or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their

authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of UBH and Provider;
(b) by either party upon 90 days prior written notice to the other party;
(c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(d) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's or Group-based Providers licenses or certifications, or loss of insurance required under this Agreement, or failure to materially perform its credentialing and/or supervision of its employees, contractors or Group-based Providers;
(e) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(f) by UBH in accordance with its credentialing plan;
(g) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(h) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

8.5 Termination of Group-based Provider. A Group-based Provider's participation with UBH may be individually terminated under the same conditions Provider's participation may be terminated, as specified above. In addition, a Group-based Provider's participation with UBH may be terminated by UBH (a) immediately upon written notice to Provider due to Group-based Provider loss or suspension of licensure or certification; (b) failure to abide by established criteria as required by section 2.9; (c) loss of insurance as required under this Agreement; or (d) in accordance with UBH's credentialing process.

Furthermore, it is agreed that upon any such termination of a Group-based Provider pursuant to this section 8.5 that UBH shall deliver notice to Provider of such a termination, that Group-based Provider shall not provide MHSA Services to any Member as of the termination date of the Group-based Provider, unless otherwise agreed to by UBH in writing, and that this Agreement shall not be terminated, absent notice otherwise, upon the termination of any Group-based Provider.

ARTICLE 9
Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time

to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or

expiration, including without limitation, sections 2.9, 2.10, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

The Effective Date of this Agreement is: _____
(TO BE COMPLETED BY UBH ONLY)

UNITED BEHAVIORAL HEALTH, INC.
425 Market Street, 27th Floor
San Francisco, CA 94105-2426

Signature_____

Deb Adler

Sr. Vice President
Clinical Network Services

Date_____

NAME OF PROVIDER

_____

_____

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number: _____

UnitedHealthcare®

Community Plan

UnitedHealthcare of the Midlands
UnitedHealthcare Community Plan

Network Development Plan

December 2015

Network Development Plan Requirements

UnitedHealthcare is submitting this network development plan as part of our response to the Request for Proposal (RFP) for the Heritage Health program and for approval by the Division of Medicaid and Long Term care (MLTC). This plan demonstrates our success over 20 years of building and maintaining a robust and compliant network to meet the needs of our Nebraska members and our ability to develop this network to meet the needs of new member populations and benefits. This plan will highlight our track record in Nebraska particularly for Medicaid. This plan also will demonstrate the many efforts we have taken and continue to take to become more familiar and deepening relationships with Nebraska providers.

Demonstrated Network Capability

Network Overview

UnitedHealthcare has a strong and accessible **statewide** provider network that delivers access to MLTC members. Our capability of developing a network in Nebraska is demonstrated by already contracting with nearly 12,500 provider locations statewide, which ensures superior access to health care services for MLTC members. Our statewide Medicaid network has more than 2,800 primary care providers, 3,500 specialists, 102 hospitals, 49 urgent care centers and convenience clinics, 100 percent of the federal qualified health centers (FQHC) and 127 rural health clinics (RHC) throughout the state of Nebraska and border states. We offer expanded access that includes: advanced practice nurses (APNs) and physician assistants (PAs) to enlarge primary care capacity, and telemedicine for expanded and convenient access and collaboration with many community-based organizations to strengthen support services. Beginning in 2014, we started work to expand its Medicaid provider network statewide and focus on the inclusion of border state providers. We have provider contracts in all of Nebraska's neighboring states and have extended many of them to include Nebraska Medicaid.

Numbers and Types of Providers Contracted

To ensure the network contains the number and types of providers required to deliver the covered services, our recruiting efforts focus on meeting the needs of Heritage Health members and complying with the defined access standards. We emphasize contracting with the providers identified by MLTC who have experience providing care to Heritage Health members. We also have existing relationships with many providers in the state through our participation in the Medicaid managed care plan and our commercial, Medicare, and Military & Veterans programs. We continue to expand these relationships while building a statewide Medicaid network of qualified providers.

The following table summarizes the current completeness of our ***statewide*** contracted Medicaid provider network located in the state of Nebraska.

Provider Type	Percent of providers contracted statewide for Medicaid in Nebraska compared to state provider file
PCPs (including extenders)	99%
High Volume Specialists	99%
Hospitals	94%
Urgent Care and Convenient Care	91%
Pharmacy	95%
BH	56%
RHC	94%
FQHC	100%
Vision	95%

Geographic Location of Providers and Members

UnitedHealthcare has a comprehensive network of providers ready to serve Heritage Health members statewide. We have thoroughly evaluated our network's ability to accommodate Heritage Health members in accordance with mandated access standards. A complete GeoAccess analysis will be submitted to MLTC. Outlined below are results from our GeoAccess analysis demonstrating our current access for statewide contracted services based upon the access standards identified in Attachment 2 of the RFP, as superseded by Attachment 38. We have made significant progress in our contracting efforts and we understand the importance of meeting all standards. In some areas of the state an MCO may not be able to meet an access standard due to the lack of a provider type, such as an FQHC in a frontier county.

Provider Type	Urban	Rural	Frontier
PCPs	100%	100%	100%
FQHCs	78%	55%	30%
RHCs	94%	100%	100%
Urgent Care	92%	64%	53%
Hospitals	100%	100%	100%
High Volume Specialists			
Cardiology	95%	95%	95%
Neurology	100%	100%	100%
OB/GYN	100%	100%	100%
Orthopedic	100%	100%	100%
Hematologist/Oncologist	100%	100%	100%
Pharmacy	74%	80%	98%
Behavioral Health			
Inpatient	70%	24%	0%
Outpatient	100%	98%	92%
Vision	99%	99%	99%

Our Plan to Complete the Network

Our network development plan is a detailed approach for developing a statewide provider network sufficient to ensure Heritage Health members have adequate access to all required services. Based upon the requirements outlined by MLTC, our network development plan is designed to continually evolve to address changes in membership, new cultures, unique situations, new benefits, and identified opportunities and concerns.

Our statewide network is developed from statistical analysis consistent with the MLTC assessment methodology and is derived from quantitative data, including appointment standards and availability, eligibility and utilization, network inventory and demographics such as age, gender, race and ethnicity. Our network development plan demonstrates our ability to continue to build upon our current statewide Nebraska Medicaid network to ensure access to all covered services for Heritage Health members. Adequate access to all covered services includes timeliness, amount, duration and scope of services provided in a culturally competent manner, including for those with limited English proficiency and diverse cultural and ethnic backgrounds.

UnitedHealthcare has developed and implemented a strong, comprehensive network in Nebraska. We are committed to delivering this network and partnering with MLTC to achieve the following goals:

- Improved health outcomes
- Enhanced integration of services and quality of care
- Emphasis on person-centered care, including enhanced preventive and care management services
- Reduced rate of costly and avoidable care
- Improved financially sustainable system

Determination of the optimum network composition in Nebraska was made using the following considerations. All requirements and essential community providers identified in the RFP have been included in development of the targeted provider network. Identification of significant traditional providers that have served this population was accomplished by review of the Nebraska Department of Health and Human Services website, use of the Strenuus Network 360 Tool, the Health Resources and Services Administration (HRSA) Primary Health Care website for FQHCs and RHCs, the Indian Health Services website, the Nebraska Primary Care Association member information, and through hospital and other provider community networking. Hospitals that are providing care to this population were identified through historical hospital Medicaid discharge information.

Primary Care Provider Contracting

Following are the PCP clinics enrolled with MLTC that have been identified to complete our statewide network.

PCPs	County	Nebraska Locations	County	Status
McCook Clinic	Rural	McCook	Red Willow	Will engage in contracting once bid is awarded
Hastings Internal Medicine	Urban	Hastings	Adams	Will engage in contracting once bid is awarded
Family Practice Grand Island	Urban	Grand Island	Hall	Will engage in contracting once bid is awarded
Family Medical Center of Hastings	Urban	Hastings	Adams	Will engage in contracting once bid is awarded

UnitedHealthcare has relationships with all physician organizations either through the current Medicaid program, our commercial program, Medicare or Military and Veterans networks. We are continuing positive discussions with all provider organizations and are confident we will complete contracts with these providers to provide services to Heritage Health members.

Federally Qualified Health Centers and Rural Health Centers

We recognize the important role that health safety net providers such as FQHCs and RHCs play in providing access to care for many Nebraska residents. Our hands-on approach and involvement with FQHCs and RHCs has resulted in a strong, collaborative partnership focused on serving Medicaid members. We currently have contracts with **100** percent of all FQHCs and **94** percent of RHCs. We continue active contract discussions with the remaining RHCs and we have commitments from them to work with us once the award is made.

Rural Health Centers Contracting Priorities

The following RHCs enrolled with MLTC have been identified to complete our statewide network. We have nine RHCs remaining in the state with which to secure contracts. Eight will engage in contracting once the bid is awarded and we are in active negotiation with one.

RHC	County	Locations	County	Status
Cherry County Clinic	Rural	Valentine, NE	Cherry	Will engage in contracting once bid is awarded

RHC	County	Locations	County	Status
Curtis Medical Center	Frontier	Curtis, NE	Frontier	Will engage in contracting once bid is awarded
Nelson Family Medical Center	Rural	Nelson, NE	Nuckolls	Will engage in contracting once bid is awarded
Regional West Physicians Clinic	Urban	Morill, NE	Scotts Bluff	Will engage in contracting once bid is awarded
Sidney Regional Medical Center Physicians	Rural	Sidney, NE	Cheyenne	Will engage in contracting once bid is awarded
Superior Family Medical Center	Rural	Superior NE	Nuckolls	Will engage in contracting once bid is awarded
Trenton Regional Medical Center	Frontier	Trenton, NE	Hitchcock	Will engage in contracting once bid is awarded
Valley Medical Clinic of Big Springs	Frontier	Big Springs, NE	Deuel	Will engage in contracting once bid is awarded
Humphrey Medical Clinic	Urban	Columbus, NE	Platte	Active discussions are ongoing

Access to Specialists

UnitedHealthcare currently has 3,500 contracted specialists for the Heritage Health program and we meet or exceed current contractual requirements for access to specialists. Additionally, we have a robust network of specialists contracted for our commercial network. We are in active discussions with these contracted specialists to solicit their participation in our Heritage Health network plan. The existing and longstanding relationships and contracts with Nebraska specialists through our commercial, Medicare, and Military & Veterans products, aid in the recruitment of these providers for the Heritage Health network. We are concentrating on providers with the required specialties needed for the Heritage Health population as set forth in the RFP, including behavioral health (BH) and the intellectual and/or developmental disability (I/DD) population. We will meet or exceed the access standards for specialists by plan readiness review.

Access to Hospitals

UnitedHealthcare currently has 91 contracted hospitals statewide for Heritage Health. We are currently in active negotiations with all the hospitals needed to ensure needed access across Nebraska. We have completed contract negotiations with 94 percent of the hospitals in the state. We have six hospitals remaining to complete contract negotiations. We have 100 percent of the frontier hospitals contracted. Once the bid is awarded we have commitments from these facilities to complete the negotiations.

Hospital Contracting Priorities

The following hospitals enrolled with MLTC have been identified to complete our statewide network.

Hospital System	County	Nebraska Locations	County	Status
Brodstone Memorial Hospital	Rural	Superior	Nuckolls	Will engage in contracting once bid is awarded
Cherry County Hospital	Rural	Valentine	Cherry	Will engage in contracting once bid is awarded
Community Hospital	Rural	McCook	Red Willow	Will engage in contracting once bid is awarded
Great Plains Health	Urban	North Platte	Lincoln	Active discussion
Lexington Regional Health Center	Urban	Lexington	Dawson	Active discussions

Hospital System	County	Nebraska Locations	County	Status
Phelps Memorial Health Center	Rural	Holdrege	Phelps	Will engage in contracting once bid is awarded

Vision

Since 1990, Superior Vision has provided comprehensive vision program management services to managed care organizations and other third party payers across the country. Superior Vision serves as our current subcontractor for routine Medicaid vision services. Additionally, Superior Vision has developed a statewide network consisting of close to 300 vision providers ready to serve Heritage Health members. We also have direct contracts with over 250 ophthalmologists to serve current and future members.

Direct Access to Women's Health Care and Family Planning Services

For all female enrollees, we will ensure direct access to a women's health specialist for covered care necessary to provide women's routine and preventive health care services.

Prenatal Care Services

We have a network in place currently that offers members routine prenatal care, delivery and post-partum care, and needed laboratory services. This network also offers nurse-midwife services that are medically necessary in accordance with their scope of practice as defined by the applicable statutes and regulations.

Other Service Providers

Ancillary providers support members through the provision of diagnostic or therapeutic services administered through a PCP's or specialist's office, a hospital or a freestanding testing facility. Ancillary providers also will include ambulance services for emergencies, durable medical equipment (DME) providers, orthotics, prosthetics, laboratories, radiology, certain supplies and all other providers of services to address member needs for covered benefits. We continue to build upon our national and local commercial contracts to provide key ancillary services, including laboratory, hemodialysis and radiology services as appropriate. We will monitor any gaps in access to care or services and will pursue contracts with additional providers as necessary. Our national relationships and contracts with DaVita help to create a strong hemodialysis network in Nebraska for Medicaid members. We continue to monitor the availability of additional state-based hemodialysis providers and will secure additional contracts for Heritage Health.

Laboratory and Radiology Services

Our current comprehensive network for laboratory and radiology services will accommodate our new Heritage Health membership. Laboratory services are accessible through our national and local laboratory providers, including participating hospitals, PCPs, specialists and reference laboratories throughout the state. Radiology services are accessible through local providers, including participating hospitals, PCPs, specialists and free-standing radiology clinics throughout the state. We continue to evaluate member access and care needs to ensure key ancillary services meet or exceed the access standards for laboratory and radiology services per the RFP requirements.

We also acknowledge all laboratory testing sites providing services under this contract must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

Urgent Care Centers and Convenience Clinic Providers

To supplement our medical provider network, we recruit freestanding urgent care centers to assist our members in obtaining services, especially after hours care. We will make a good faith effort to contract with all urgent care providers.

Across the state there are 54 identified urgent care centers and convenience clinics. In our current 10-county service area we are contracted with 36 out of 38 of these clinics. Statewide we are contracted with 49 clinics.

There are five clinics that are not enrolled in DHHS.

- Concentra (two Omaha clinics, one Lincoln clinic)
- Linc Care/The Physician Network (two Lincoln clinics)

Urgent Care Centers and Convenience Clinic Network

Location	UnitedHealthcare - Participating	UnitedHealthcare – Non Participating	DHHS Not Enrolled	Total
Bellevue	2			2
Columbus		1		1
Council Bluffs	2			2
Fremont	1			1
Grand Island	1	1		2
Gretna	1			1
Hastings	1			1
Kearney	2			2
La Vista	2			2
Lincoln	5	1	3	9
McCook	1			1
Norfolk	1			1
North Platte	2			2
Omaha	20	1	2	23
O'Neill	1			1
Papillion	2			2
Ravenna	1			1
Scottsbluff	2			2
South Sioux City	1			1
Waverly	1			1
York		1		1
Grand Total	49	5	5	59

Non-Emergency Ambulance Transportation

Our network development plan for Heritage Health members also includes non-emergency ambulance transportation for medically necessary services. We have direct contracts with the ambulance providers offering 100 percent access statewide for our members. We will continue to identify local providers as needed for non-emergency ambulance transportation.

Tribal

We have taken a proactive approach to contracting with tribal provider organizations in our current service area and in building relationships with Native American health centers across Nebraska to prepare for an expanded service area. We recognize the need to develop collaborative partnerships with the Native American organizations for members who are tribal members or are eligible for care through Indian Health Services (IHS) or other tribal-funded health and human services programs. We have created strong

partnerships with these providers in our existing 10-county service area and will continue this same strategy with the tribal providers statewide and in border states.

Tribal Contracting Priorities

Following are the tribal facilities enrolled with MLTC that have been identified as necessary to complete our statewide network and providers already under contract.

Tribal Providers	City/State	Status
Carl T. Curtis Health Education Center	Macy, NE	In discussions
Fred LeRoy Health & Wellness Center	Omaha, NE	Contracted
Pine Ridge IHS Hospital	Pine Ridge, SD	Will engage in contracting once bid is awarded
Ponca Hills Health & Wellness Center	Norfolk, NE	Contracted
Ponca Tribe of Nebraska	Omaha, NE	Contracted
Ponca Tribe of Nebraska	Lincoln, NE	Contracted
Rosebud Indian Health Service	Rosebud, SD	Will engage in contracting once bid is awarded
Santee Health Center	Niobrara, NE	Contracted
Wagner IHS Health Center	Wagner, SD	In discussions
Winnebago IHSI Hospital	Winnebago, NE	Will engage in contracting once bid is awarded
Winnebago Tribal Clinic	Winnebago, NE	In discussions

Behavioral Health Provider Network

We have a fully functional BH network in Nebraska for our commercial products and have been building our BH network for Medicaid based upon our commercial network. We have been approaching non-participating providers identified through publically available competitive sources and the MLTC Medicaid provider file. Thus far we are contracted with 56 percent of MLTC BH providers. We have performed outreach to the following provider types that have been identified to complete our statewide network: 600 individual BH providers, including 100 prescribers; 111 groups including RHCs and seven FQHCs; 32 facilities, including CACs with BH services. This proactive recruitment initiative positions us to have a fully contracted network to serve Heritage Health members.

Pharmacy Provider Network

Our pharmacy benefit management (PBM) partner, OptumRx has provided innovative PBM services for more than 20 years. Through their extensive experience serving diverse populations, OptumRx has developed a sophisticated array of high quality, integrated PBM services, including retail pharmacy network claims processing, specialty pharmaceutical management and clinical programs. By focusing on clinical quality and total patient care, they help individuals improve health outcomes while managing overall health care costs. Today, OptumRx manages benefits for nearly 13 million consumers and process more than 370 million claims per year, representing approximately $25 billion in managed drug spend. OptumRx is an affiliate division of UnitedHealthcare. We are contacted with 95 percent of the pharmacy providers listed on the State's Medicaid provider file. We understand that we must obtain an active agreement from a participating pharmacy provider before the start of services for a pharmacist to be considered a network provider, even if the pharmacy has an existing relationship for non-Medicaid services with us.

Transplant Network

Today, we have contracts with more than 160 facilities nationwide for transplant services, including key providers in Nebraska such as Nebraska Medicine. Annually, these 160 plus facilities represent more than 15,000 transplants nationally. Eighteen percent of transplants performed annually for all commercial payers across the country are managed by our transplant network program. Our Transplant Center of Excellence (COE) Program has demonstrated impressive results:

- Twenty-five percent reduction in average length of hospital stays for transplants
- Improved transplant survival rates at Centers of Excellence
  - Three percent reduction in 1-year mortality rates for liver transplants
  - Five percent reduction in 1-year mortality rates for heart transplants
- Sixteen percent reduction in the incident of transplants through application of evidence-based appropriateness

We have built and maintained the network using strict criteria in three areas: transplant program outcomes, structure and program process. The bundled payments encompass all services related to the transplant, including organ acquisition, physician services and hospital services for a certain period of time before and after the transplant. Our inclusive case rates with participating medical facilities include:

- Pre-transplant evaluation
- Hospital and physician fees
- Organ acquisition and procurement, blood/marrow acquisition and donor search charges
- Transplant procedure
- Up to 12 months of follow-up care for transplant-related services

Our bundled transplant payment approach is innovative because most transplant case rates do not include the cost of organ acquisition. Organ acquisition fees are unpredictable costs that can double, triple or quadruple the cost of a transplant. By bundling organ acquisition fees within the case rate, we deliver more predictable transplant costs while holding contracted facilities accountable for the full range of services resulting in improved outcomes. To qualify for bundled payments, providers must demonstrate they can effectively administer this payment methodology through advanced capabilities such as managing and coordinating care across multiple provider participants in the episode. They must also have the ability to submit bundled claims, distribute funds and reconcile payments.

Patient-Centered Medical Home

We promote and facilitate the capability of our providers to deliver patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology (HIT) to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. We foster this effort through implementation of Accountable Care Communities (ACCs). We are committed to expanding the use of PCMHs, both in the numbers of practices we assist and support to transform to this model and in the numbers of our members who are having their health care needs managed by these practice models. In Nebraska, our transformation consultants lead clinical transformation initiatives and help provider practices team achieve the PCMH vision. Transformation consultants work directly with leadership and engage primary practice teams in rapid cycle improvement efforts to successfully integrate PCMH practice components. This includes helping practices build capacity to work with technology tools and data, conduct risk stratification, and develop blueprint processes of care and workflows integrating team roles and evidence-based practices. In Nebraska in our current 10-county service area, **33 percent of PCPs are practicing in a PCMH-recognized or PCMH-like clinic.**

Value-Based Purchasing Agreements

We have begun an aggressive transformation of our provider network and have plans for a significant ramp-up of alternative payment models by 2018. We continue to explore and implement multiple innovative payment and delivery system configuration models based upon varying degrees of provider accountability and ability to assume clinical risk. Our focus is on the Triple Aim of improving population health and patient experience; delivering the best possible quality outcomes; and reducing medical cost and medical trend.

Identifying Measures, Proposed Engagement Strategies and Incentives

We know that there is no single payment model that works for every provider. Each provider has a different appetite for financial risk, and providers are more or less integrated in their care delivery (ranging from solo practitioners to large integrated delivery systems). We recognize the need for a modular set of value-based purchasing (VBP) models that align with a provider's risk readiness and capabilities. In our most progressive value-based contract models where providers share in financial risk, it is imperative that we manage and monitor both provider risk readiness as well as ongoing performance. Before engaging in any shared-risk program with a provider, we conduct an extensive review of their risk readiness, which includes assessment of the provider's financial, structural and cultural capabilities necessary to succeed in a risk-sharing contract. We use a comprehensive quantitative and qualitative approach to engaging provider participation in the most appropriate of our VBP programs. One of the tools used in this evaluation is our VBP Readiness Assessment. This survey gives us insight into providers' organizational structure, HIT infrastructure, level of patient engagement, care coordination capabilities, high-risk patient management, VBP experience with other payers, and willingness or readiness to accept risk.

Used in concert with a review of providers' historical quality performance and management of avoidable medical expense, we collaborate with PCMHs to determine which VBP program suits them best. Next, we require the appropriate safeguards be in place to verify success of the contract. This includes establishing requirements for provider stop loss and reinsurance, as well as establishing financial reserve requirements based upon the level of financial risk and the volume of services where risk is involved. Finally, once provider risk contracts are in place, we actively work with the providers to make certain they succeed under the contract. For our various VBP models, we support providers with appropriate benchmark and ongoing performance reports. For ACOs and PCMH programs, we support providers with clinical consulting. In addition, our strong analytical capabilities, data and reporting tools help our partner accountable care organizations (ACOs) identify areas of improvement. We also can provide clinical support to assist ACOs in developing and/or augmenting clinical programs.

Methodology and Timing for Goal Determination

We offer an array of industry-leading tools and capabilities for our ACO partners. We modify our process regularly if interventions are not successful in helping to attain targets by implementing a solution to address the problem a provider is facing such as supporting the practice with additional outreach resources, such as Clinic Days and health fairs, and additional provider and member education. We also provide service interventions for those providers who are working to meet their VBP targets, but are facing staffing or communication barriers. Finally, as the leading national carrier of Medicare, Medicaid and commercial plans, the size and variation in the population we represent allows us to test our ACO strategy across a more varied population. We produce and share an Interim Scorecard with results from the first six months of the measurement period. A final scorecard is then produced and shared with providers showing results during the full 12 months.

Future Approach to Value-Based Purchasing

We share MLTC's goal to advance VBP and recognize that we must enter into VBP agreements with 30 percent of our provider network by the third year of the contract, and 50 percent of our provider network by the fifth year of the contract. During the first year of the contract, we will submit to MLTC for its review and approval our plan for further advancing and implementing our VBP agreements. We currently have 16 percent of our 10-county provider network contracted in VBP agreements. We have a three-pronged approach to expand our VBP agreements in Nebraska.

First, we plan to continue to advance our current models with new and existing providers in our current geographic footprint, advancing providers to more sophisticated models as our membership grows. We have a special focus on FQHCs, who were among the earliest adopters of VBP initiatives. We believe it is

incumbent upon us to maximize and support the expertise of safety net providers. We have recently executed five Basic Quality Model contracts and have 11 more targeted for 2016. If a provider in the statewide expansion is ready to immediately start a VBP contract with us, we will start them on our BQM model. We designed this model to support PCP practices with more than 150 UnitedHealthcare members to achieve improvement in patient health through closing gaps in care related to preventive screenings and chronic disease monitoring, with an opportunity to be rewarded for their performance. The program encourages PCPs to proactively conduct preventive health screenings, improve HEDIS scores, focus on state quality performance metrics and help members become more informed, engaged patients. Practices may earn incentive payouts in addition to their fee-for-service (FFS) reimbursement for meeting or exceeding quality measure thresholds established at the practice level based upon performance targets and goals.

Second, we are exploring options such as a Pediatric ACO. As we expand to include more provider types, we are exploring a Pediatric Balanced Incentive Model, wherein to further the advancement of our quality and cost goals, we have created a program to reward pediatric providers for their performance against Quality and Affordability goals for our members. Eligible providers will have at least one PCP open to new members, and for the duration of each Program Year, the provider's weekly hours of operation, including availability of PCPs, must be a minimum of 44 hours and include evening hours (after 6 p.m. local time) at least one day per week or weekend hours. Performance bonuses can be based upon Quality Performance, Affordability Performance and/or Clinical Engagement.

Finally, we will expand into the new geography with new providers where we can develop value-based purchasing agreements. Flexible VBP models for new expansion areas of service allow us to accelerate engagement with providers in new geographies. In new geographies, as we recruit providers for network participation, we will identify viable practices for VBP contracting. From the outset, we will develop clinical action plans and begin collaborating with these providers to improve quality outcomes, close gaps in care and reduce avoidable medical expense.

Behavioral Health

We offer the industry's largest tiered network, identifying the best-performing providers through both quality and cost metrics that offer transparent ratings to our members. Metrics that guide our pay for performance reimbursement strategies are derived from our Achievements in Clinical Excellence (ACE) program and are as follows:

Inpatient Metrics	Outpatient Metrics
▪ Seven- and 30-day risk adjusted readmission rate ▪ Seven-day follow-up after mental health hospitalization (HEDIS) ▪ Spending per beneficiary ▪ Peer review rate (a measure of clinical concordance) ▪ Case-mix adjusted average length of stay	▪ Severity adjusted effect size from a member-reported wellness assessment tool—a peer reviewed tool that meets key reliability and validity constructs ▪ Case-mix adjusted average number of visits ▪ Average cost per episode

Clinical Integration Plan - Glide Path Model

Through the Clinical Integration Plan (CIP) - Glide Path Model, we are exploring ways to accelerate engagement with new providers. Selected providers participate for one year as an initial benchmarking period. During this time, we establish a clinical action plan, provide data and collaborate with them to improve performance. In the second year, we review their performance, validate membership eligibility and evaluate what VBP model would be a best fit—advancing the provider up our VBP continuum.

Track Record of Building a Nebraska Network

UnitedHealthcare has a proven track record in Nebraska and nationally of providing access, covered services and managed care programs that achieve financial and clinical outcomes. We bring the expertise

of serving Nebraska Medicaid members for nearly 20 years as well as meeting the network needs of members we serve statewide in commercial, Medicare, and Military & Veterans products. We have demonstrated that we have robust provider relationships and experience in delivering a statewide network that provides patient-centered care for member's needs that includes physical health, BH, transplant and pharmacy services.

We have built upon the strength of our current, fully compliant 10-county Medicaid network, to deliver a statewide network for Heritage Health that is inclusive of border state providers. We demonstrated the capability to develop fully operational networks in 1996 with initial implementation and 2010 for the seven county expansion and will again for 2017. We also understand rural area exception requirements and unique challenges to access high quality care in rural and frontier areas. UnitedHealthcare has extensive experience in rural service areas in other states such as Kansas, Arizona, Mississippi, Pennsylvania and Tennessee. We can, and will continue to, provide local support, national expertise, statewide access and efficiencies for our providers.

We have implemented a network development plan that has delivered a fully contracted statewide network designed to exceed MLTC requirements for both network access and managed care benefit coverage. The steps included in evaluating the provider network needs include assessment of the estimated number of enrollees to be served for each county, the required enrollee to primary care provider ratios, health care services to be provided for Heritage Health, the required standards for distance and travel time for major specialty categories, and the cultural, racial and ethnic characteristics of the population. We prioritize engagement with qualified Medicaid providers that promote culturally sensitive environments and embrace the role of the health care provider in minimizing health care disparities. As a result of these efforts we have a statewide, robust, contracted network that includes essential community providers, safety net providers, FQHCs, RHCs, IHS and other significant, traditional Medicaid providers for this population.

Submission of Provider Development Plan

In addition to submitting for approval the network development plan to MLTC with our proposal, we will comply with all requirements to provide updates on the plan that will detail our network status, including GeoAccess reports. We will describe any provider network gaps and remediation plans from the date of contract award and will continue every two weeks until the contract effective date. We also will provide periodic progress reports as requested by MLTC. Our development plan positions us well to be prepared to offer a fully compliant provider network prior for readiness review Oct. 1, 2016.

Future network development plans will be submitted by Nov. 1 of each contract year. Our network development plan will include documentation of the adequacy and sufficiency of our Medicaid provider network. We also will submit, as needed, an updated plan if a significant change occurs in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, payments, or eligibility of a new population.

Strengthening Provider Relationships

The network development plan is the foundation we will use to strengthen existing and new provider relationships through outreach and providing resources and support to meet the needs of Heritage Health members. It is here that providers will receive education and support to focus on the person-centered care model to help keep members healthy and out of the hospital; it is here that providers will find exceptional quality, compassion and specialized care resources to help members live healthier lives. It is here that our clinical and nonclinical staff provides resources to our provider network to connect members with community resources to remove barriers to health care.

Working with providers and their members, we will focus on implementing a network plan that:

- Demonstrates integrity by proactively identifying and resolving root cause issues
- Exhibits compassion in our focus on quality care for our members and for our physicians, appreciating that the practice of medicine is not easy
- Facilitates relationships to ensure system stability during growth and future enhancements
- Applies innovation and use lessons learned in development and deployment of services
- Establishes flawless performance achieving MLTC requirements operating metrics and deliverables across the state

Provider Partnerships: Supporting the Healing Practice of Medicine

As an existing managed care organization (MCO) in Nebraska we have developed partnerships with providers across the state and have demonstrated that we have worked with providers to meet the needs of Nebraska members. We collaborate with our Clinical Provider Advisory Committee (CPAC), statewide provider associations, regional health systems and independent providers to address access and service needs. We receive feedback in several ways, including individual provider meetings, provider town hall meetings, our Provider Relationship, Insight and Service Model (PRISM) provider service program, provider satisfaction survey results related to access, and provider grievances.

Provider Satisfaction

UnitedHealthcare conducts ongoing assessments of provider satisfaction as part of our continuous quality improvement efforts. Provider satisfaction surveys are designed to:

- Assess which services are important to our providers
- Determine provider satisfaction with our processes, including the care management and utilization management process
- Evaluate satisfaction with services and support provided by us such as authorizations process, claims payment, care management staff, provider advocates and coordination of care

Key activities related to the assessment and promotion of provider satisfaction includes:

- Annual provider satisfaction surveys
- Targeted improvement plan
- Regular visits to key medical health providers

The survey results are summarized and reviewed by the quality improvement committees to identify areas for improvement and develop action plans, as appropriate, to further improve provider satisfaction. The results are compared by health plan year over year and also in comparison to other contracted plans across the country.

Rural Access Coordination Team

The Rural Access Coordination Team (RACT) is a specialized, multi-disciplinary team focused on resolution of access to care challenges from lack of available providers or other circumstance unique to the area or the member. The team includes a care manager, provider relations representative and a community outreach representative that serves to document and expedite effective solutions for rural provider access. RACT serves as a resource for access concerns our rural providers identify.

Clinical Provider Advisory Committees

UnitedHealthcare has formed a CPAC to ensure we understand the provider's concerns and issues and provide an educational opportunity for providers and their staffs while meeting with our local Nebraska team. The CPAC meets quarterly and consists of providers from across the state. This committee will provide feedback on policies and procedures that will assist in addressing provider concerns regarding such areas as prior authorizations, credentialing, care management and claims processing. In addition, the

CPAC will serve as consultants to our network strategy, including how to improve the administrative experience of our network providers. In cases of noncompliance, if a provider fails to make meaningful improvements, we will refer the case to the Provider Advisory Committee for their review.

Outreach and Partnership with Provider Organizations

We will continue our collaborative approach with other agencies, as demonstrated by our outreach, just in the last year, to **more than 160 community and provider-based organizations and associations**. Some of these provider groups include the Nebraska Medical Association, Metro Omaha Medical Society, Nebraska Hospital Association, National Association of Behavioral Health Organizations, Lancaster County Medical Society, and the Nebraska Association of Home Community Agencies.

Delivering Provider Service

Providers Relations and Education

Our success is greatly influenced by the capability, commitment and capacity of our provider partners. We have a network of providers that have served the Medicaid population and who have proven themselves effective in improving the health and well-being of their patients. We recognize providing ongoing training and education to these professionals is crucial to maintaining their capabilities and positive relations.

Our provider advocates are assigned to providers in our current network. They are responsible for education and outreach to their assigned providers. These advocates assist providers in the field with claim issues, member complaints, compliance issues and training/education. They are the subject matter experts in their assigned area and conduct provider engagements visits on a regular basis, targeting high volume facilities and outpatient groups weekly or monthly. This local structure provides a single point of contact for all providers and a real opportunity for collaboration and innovative programming for members. By interacting on a personal level with providers, our provider advocates are able to better coordinate with them if concerns arise..

UnitedHealthcare acknowledges the importance of providing claims and billings support for providers during the transition from legacy Medicaid to Heritage Health. To ensure these providers receive the training and assistance they need, our provider advocates and provider claims educator will continue their work in the field with providers to educate, train, and provide ongoing support with claim/billing requirements. We also provide training to newly contracted providers, and recognizing when new providers may have a lack of experience working with managed care.

We also will provide education to all participating providers on the quality metrics that the state of Nebraska has identified relative to its membership, as well as any additional areas of quality performance improvement that we identify. This will include a written explanation of how the quality metrics are calculated. Our staff, both network and clinical, will continue to reinforce this education during meetings with network providers.

Field-based training is a key component of our continuous quality improvement efforts. We schedule routine trainings and educational forums to touch our highest volume providers and key facilities. The provider advocates hold at least monthly meetings with "top tier," high-volume providers to present regular updates and refresher trainings. Provider advocates and senior leaders hold Joint Operating Committee (JOC) meetings with key facilities to address operations, including training needs. Provider advocates schedule meetings as needed with primary care practices to ensure key policies and procedures are reviewed and access and availability information is gathered, as well as to discuss any other pertinent issues.

We coordinate the following to inform providers and office staff about contract and internal requirements including:

- Provider and staff training
- Resources available to answer provider and staff questions
- Provider portals
- Provider hotline
- Manuals
- Newsletters

We educate and train new providers within 30 days of their contract effective date through educational mailings, on-site provider visits and group training. Our provider relations team will assess each provider's training needs at the time of contracting and may conduct in-person training if needed. We provide upfront training to newly contracted providers and recognize when new providers may have a lack of experience when working with managed care.

Our provider trainings are scheduled at different times of the day, in multiple locations throughout the region and in locations that will generate local participation. In addition, we work with providers through the following methods to ensure they understand and are comfortable with all of the claims/billing processes:

- Face-to-face training
- Group (town hall) trainings
- Webinar trainings
- UnitedHealthcare tutorials
- Educational materials and instructions

Through provider complaints, staff feedback, trended claims data, associations and advisory councils, we identify common topics or opportunities for retraining as well as specific providers for focused retraining. We communicate to all providers on relevant training topics and update our training curriculum on an ongoing basis to better communicate information.

PRISM: Provider Relationship, Insight and Service Model (PRISM)

We also will use our recently implemented, enhanced PRISM to identify, track and rapidly resolve Nebraska provider problem areas. PRISM, with its single intake portal, offers a streamlined approach to issue resolution and also includes analytics and root cause analysis for proactive issue prevention and detection. PRISM:

- Integrates information from claims, enrollment, clinical episodes of care and utilization history
- Identifies gaps in care and compliance with clinical guidelines
- Provides clear escalation protocol for a rapid response to critical provider issues

Pharmacy Support and Education

Our regional and local dedicated pharmacy services team will ensure the pharmacy network meets access and service needs of all of our Nebraska members.

We agree to keep an up-to-date pharmacy provider directory on our website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies:

- Names, locations and telephone numbers
- Any non-English languages spoken
- Identification of hours of operation, including identification of providers that are open 24-hours per day
- Identification of pharmacies that provide vaccine services
- Identification of pharmacies that provide delivery services

We agree to educate network pharmacies and providers about how to access the formulary and Preferred Drug List (PDL) on our websites. We will provide provider education on claims processing and payment policies and procedures.

Improving Performance Together

Clinical Practice Consultants Program

The Clinical Practice Consultant (CPC) program is a targeted and comprehensive program dedicated to provider partnerships, practice level strategy, and education related to increasing HEDIS and state specific quality measures. This aligns with our plan goal to improve HEDIS compliance and state specific performance measures. The registered nurse CPCs work closely with the providers and practice managers to assess compliance with the measures and to recommend practice level process improvements to increase overall compliance rates and gap in care closures. They provide education regarding the quality improvement program process of engagement, review of practice and member level data, analysis of performance, and opportunities for supplemental data collection. The CPCs provide continuous feedback on key gap closure metrics to include Members in Need of Services (MINS) reports to assist with practice outreach efforts. The program represents our renewed and invigorated efforts to use the data analytic capabilities to effectively partner with providers to enhance member compliance and quality of care.

Clinical Tools for Providers and their Patients

Telehealth

When a needed specialist is not available within the required distance from the member's residence, we will leverage telemedicine and telepsychiatry technology to close specialty service delivery gaps as deemed appropriate by the specialty providers. Using telemedicine and telepsychiatry, the member's specialty providers can explore the use of a real-time audio-video connection to the appropriate specialist with the member and PCP at the presentation site and the consulting specialty provider located elsewhere. We are exploring collaborations with local organizations that have a long, rich history of delivering improved clinical services using telehealth technology for members in Nebraska, such as the Nebraska Statewide Telehealth Network, University of Nebraska Medical Center (UNMC), Indian Health Center, Richard Young Hospital, Bryan Health and Premier Psychiatry. An example of a potential collaboration is with UNMC's Diabetes Center to use telemedicine for follow-up care for members with diabetes who live in rural areas and often have to drive several hours to appointments. We are also working with several BH Regions to expand current telehealth capabilities by offering technology resources and support. Additionally, we cover telehealth services when required state and federal conditions are met.

Mobile Health Service

We are exploring a pilot to leverage mobile health services that is equipped with clinical resources to facilitate and provide health services to members in the home setting. Mobile health services can be used to coordinate visits with members after they are discharged from a hospital to lower readmission rates; set up a telehealth tool that will assist members with telepsychiatry, eliminating excessive travel for individuals with developmental and/or BH needs for mental health services, and provide assessment services for individuals that lack mobility or access to care. The assessment services would include lab work, medication checks, social barrier and safety assessments.

Tools to Ease Administrative Burdens

Provider Portal

Our provider portal will support our Nebraska Medicaid providers through many innovative features and tools and the portal is integrated with our key systems. Our interactive website enables providers to electronically determine member eligibility, submit claims, ascertain the status of claims, request claim adjustments, view claim trends and view summary data.

Our cloud-based website, *Link*, brings together multiple websites on the dashboard, incorporating new applications to improve efficiencies for our providers. Heritage Health providers will have a tab on *Link*, with icons for the following capabilities for ease of use:

- Eligibility & Benefits center
- Prior authorizations
- *unitedhealthcareonline.com*
- Optum provisioning
- Claims management
- CommunityCare
- *uhccommunityplan.com*

Our provider portal, *Link*, streamlines and simplifies the administrative experience for our providers, by providing a single platform to request services that require prior authorization (PA) for their members. Link supports access to our medical necessity definition, clinical criteria, clinical practice guidelines (CPGs), list of services requiring PA, user-friendly automated PA processes, and information on available peer-to-peer consultation as needed. Providers can also attach member records for our consideration and communicate in real-time to exchange information and documents with utilization management (UM) staff directly.

The provider website will contain an online version of the provider handbook, the provider directory, the PDL (both searchable and comprehensive listing), CPGs, quality and utilization requirements, and educational materials such as cultural competency information, newsletters, recent bulletins and other provider information. We also post notifications regarding changes in laws, regulations, bulletins, alerts, and newsletters and subcontract requirements..

Our provider portal allows providers to monitor their own performance and progress toward goals by viewing their individual profiles and comparing their performance to overall plan performance. Underperforming providers can easily identify the specific areas they should target for improvement. The portal also supports clinical practice by giving PCPs a list of members with upcoming and missed preventive visits as well as other missed care opportunities that are in line with clinical practice (for example, a diabetic missing an annual eye or foot exam). The Quick Reference Guide, electronic UnitedHealthcare Alerts, and blast faxes and material are also available on the provider portal.

Provider Handbook

Another key component of our network development plan is our *Provider Administrative Guide*. The *Provider Administrative Guide* is distributed in hard copy form and is posted to our provider portal for distribution to Nebraska providers and is continuously updated as changes in procedures or policy may occur. The *Provider Administrative Guide* includes information about the Nebraska program benefits and our policies and procedures, as well as information regarding payment terms and utilization review. The *Provider Administrative Guide* is furnished in hard copy to all newly contracted providers, at all town hall meetings, and upon request.

Clinical Tools

UnitedHealthcare will offer clinical tools and new training opportunities on BH and for caring for individuals with special health needs, through the following innovative education strategies:

- ***CommunityCare:*** Our care coordination platform, CommunityCare, supports timely information flow, communication pathways and team-based health care decision-making. Through CommunityCare we deploy and make available to our providers and care teams a suite of automated, evidence-based risk assessment and stratification tools. These tools enable us to identify members who have the greatest needs and align appropriate levels of care coordination over time in support of the MLTC's goals to improve system efficiencies.

- ***Impact Pro***: Impact Pro is another tool made available to providers, which compliments CommunityCare, and helps to identify individuals who may be at risk for future health care needs. This tool allows for the efficient allocation of health care resources to focus interventions, identify gaps in care and improve overall quality for the members we serve.
- ***Mental Health First Aid*:** We will provide Mental Health First Aid, an innovative approach to training that provides individuals with a basic understanding of the warning signs and what to do if they encounter someone who may have mental illness or an SUD, particularly someone who may be in crisis and in need of rapid assessment.
- ***Question, Persuade and Refer (QPR):*** We will provide QPR, an emergency mental health intervention that teaches providers to recognize and respond effectively to individuals who are exhibiting suicide warning signs and behaviors.
- ***Common Ground:*** We will share information on our Web-based resource that enhances provider-patient communications and supports BH self-management by enabling the member to create a recovery goal on which to focus his/her BH treatment and share with their PCP. This enables the provider to understand and assess the issues requiring treatment.
- ***Behavioral Health Tool Kit:*** It is a guide for providers to our BH clinical practice guidelines and evidence-based approaches, such as Screening, Brief Intervention & Referral to Treatment (SBIRT), and provides access to our BH advocates for help accessing care for members who screen positive for a BH condition.
- ***Seeking Safety:*** This program delivers information on coping-skill therapy to help children, youth and adults attain safety from trauma or substance abuse.
- ***I/DD Toolkit:*** Another resource available to clinicians is the I/DD Toolkit from the Vanderbilt Kennedy Center for Excellence. The focus of the toolkit is to address the disparities in primary care services for individuals with I/DD in comparison to the general population. It includes information regarding the unique medical and behavioral needs of an individual living with I/DD, as well as resources and supports for the individual, family and caregivers. The Toolkit is divided into four categories: General Issues, Physical Health Issues, Health Watch Tables and Behavioral and Mental Health Issues.
- ***Provider Cultural Competency Training:*** We are providing links to providers for abstracts of peer-reviewed journal articles relevant to patient health literacy and the promotion of a health-literate society. Additional cultural sensitivity and health literacy materials are available to physicians at *unitedhealthcareonline.com.* This training provides easy, accessible, user-friendly tools that can improve the cultural competency of physicians and other health care professionals.
- ***Healthify:*** Through our partnership with the FQHCs, we will share the *Healthify* tool to help them connect individuals to key services such as food pantries, housing assistance, job assistance, financial help and more. The tool is a database of culturally matched community-based organizations to help remove barriers to care.

Summary

We have demonstrated our capability to deliver a network to Nebraska members for close to 20 years to support their health needs and we have used this experience as the foundation for our Heritage Health network development plan. We will use this plan to continue to strengthen existing and new provider relationships through ongoing outreach, development of useful, provider-centric resources and local support.

KEY STAFF RÉSUMÉS

These documents have been marked confidential/proprietary and appear in the Proprietary binder per the instructions in RFP 5151 Z1, Section III. Terms and Conditions, NN. Proprietary Information.

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
1	**Nebraska Heritage Health Implementation**		**26%**	**Mon 6/22/15**	**Wed 5/31/17**	**509 days**	**Kathy Mallatt,Jennifer Brayton,Sean Jones**	**Implementation and Business Alignment (IBA)**
2	**Implementation Team Readiness Management**		**37%**	**Wed 10/21/15**	**Wed 3/1/17**	**357 days**	**Jennifer Brayton**	**IBA**
3	**Project Initiation**		**64%**	**Wed 10/21/15**	**Mon 3/14/16**	**104 days**	**Jennifer Brayton**	**IBA**
4	RFP Drop		100%	Wed 10/21/15	Wed 10/21/15	1 day	Jennifer Brayton	IBA
5	IBA creates PPM Optics Idea/ UCMGID submission		0%	Mon 1/4/16	Fri 1/15/16	10 days	Jennifer Brayton	IBA
6	Accountability matrix finalized		50%	Sun 11/1/15	Wed 12/16/15	34 days	Jennifer Brayton	IBA
7	Establish implementation meeting schedule		0%	Tue 2/2/16	Tue 2/2/16	1 day	Jennifer Brayton	State
8	Create IRAAD		50%	Tue 2/2/16	Tue 2/2/16	1 day	Jennifer Brayton	IBA
9	Resource Estimates Complete		90%	Sun 11/1/15	Mon 2/1/16	67 days	Jennifer Brayton	IBA
10	Hold member materials strategy meeting to ID all materials and owner		0%	Tue 3/1/16	Mon 3/14/16	10 days	Jennifer Brayton	IBA
11	**Benefit and Administrative Review (BAR): Contract Requirements**		**61%**	**Wed 10/21/15**	**Mon 2/1/16**	**74 days**	**Jennifer Brayton**	**IBA**
12	Route the RFP and associated documents to BAR for analysis		100%	Wed 10/21/15	Wed 10/21/15	1 day	Jennifer Brayton	IBA
13	Obtain requirements grid from BAR		100%	Fri 11/6/15	Mon 11/16/15	7 days	Jennifer Brayton	IBA
14	Assign owners for each requirement		100%	Mon 11/16/15	Mon 11/30/15	11 days	Morgan Perez	IBA
15	BAR Validation		90%	Mon 11/16/15	Mon 11/30/15	11 days	Morgan Perez	IBA
16	Solution for non-standard requirements		50%	Mon 11/30/15	Mon 2/1/16	46 days	Jennifer Brayton	IBA
17	BAR Requirement Sign off by Functional Leads		50%	Mon 11/16/15	Fri 1/15/16	45 days	Morgan Perez	IBA
18	**Compliance Readiness**		**50%**	**Mon 11/2/15**	**Fri 4/1/16**	**110 days**	**Timothy Langdon**	**Compliance**
19	Develop a process/infrastructure for the communication and/or submission of State deliverables		50%	Tue 2/2/16	Fri 3/18/16	34 days	Timothy Langdon	Compliance
20	Confirm Contractual Regulatory Reporting requirements and management plan		50%	Mon 11/2/15	Tue 3/1/16	87 days	Timothy Langdon	Compliance
21	Integrate/update scope of corporate program integrity within health plan		50%	Mon 11/2/15	Fri 4/1/16	110 days	Timothy Langdon	Compliance
22	**Capital Requests**		**10%**	**Mon 11/2/15**	**Sun 1/1/17**	**306 days**	**Jennifer Brayton**	**IBA**
23	Pro Forma Due Date		100%	Mon 11/2/15	Tue 12/15/15	32 days	Jennifer Brayton	IBA
24	Bridge Funding Approval		0%	Tue 12/15/15	Fri 1/1/16	14 days	Jennifer Brayton	IBA
25	Capital Request Completed (CSIC)		0%	Fri 1/1/16	Tue 3/1/16	43 days	Jennifer Brayton	IBA
26	Full Capital Approved (UCIC)		0%	Fri 1/1/16	Fri 4/1/16	66 days	Jennifer Brayton	IBA
27	Summary of Change Controls by Project		0%	Mon 5/2/16	Sun 1/1/17	176 days	Jennifer Brayton	IBA
28	**Stage Gate Reviews**		**0%**	**Mon 5/2/16**	**Wed 3/1/17**	**219 days**	**Jennifer Brayton**	**IBA**
29	Stage Gate 1 - BGE/BVD/Budget/IT/Requirement Assignment		0%	Mon 5/2/16	Mon 5/2/16	1 day	Jennifer Brayton	IBA
30	Stage Gate 2 - Network Readiness		0%	Fri 7/1/16	Fri 7/1/16	1 day	Jennifer Brayton	IBA
31	Stage Gate 3 - SSD/BAR Requirement Readiness		0%	Mon 8/1/16	Mon 8/1/16	1 day	Jennifer Brayton	IBA
32	Stage Gate 4 - Pre go-live Readiness (- 90/60 days)		0%	Mon 10/3/16	Mon 10/3/16	1 day	Jennifer Brayton	IBA
33	Stage Gate 5 - Go-live Readiness (- 30 days)		0%	Thu 12/1/16	Thu 12/1/16	1 day	Jennifer Brayton	IBA
34	Lessons Learned		0%	Wed 3/1/17	Wed 3/1/17	1 day	Jennifer Brayton	IBA
35	**Functional Readiness**		**26%**	**Mon 8/3/15**	**Wed 5/31/17**	**479 days**	**Multiple**	**Multiple**

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
36	**I. Member Services**		**5%**	**Mon 11/2/15**	**Sun 1/1/17**	**306 days**	**Sean Jones/Heather Johnson**	**Plan**
37	**Enrollment**		**19%**	**Mon 11/2/15**	**Sun 1/1/17**	**306 days**	**Jennifer Glanville**	**Enrollment**
38	Confirm membership number from finance		0%	Tue 3/15/16	Tue 3/15/16	1 day	Jennifer Glanville	Enrollment
39	Identify frequency of files as reported by the state		100%	Tue 12/1/15	Tue 12/1/15	1 day	Jennifer Glanville	Enrollment
40	Receive Companion Guide		100%	Fri 4/1/16	Fri 4/1/16	1 day	Jennifer Glanville	Enrollment
41	Confirm Pre-Go Live Timing of milestones		0%	Tue 3/1/16	Tue 6/7/16	71 days	Jennifer Glanville	Enrollment
42	Develop end to end Workflow process		0%	Fri 1/1/16	Fri 7/1/16	131 days	Jennifer Glanville	Enrollment
43	Completion/Updating of SOPs		80%	Fri 1/1/16	Fri 7/1/16	131 days	Jennifer Glanville	Enrollment
44	Confirm Training Timeframe		0%	Sun 5/1/16	Sun 5/1/16	1 day	Jennifer Glanville	Enrollment
45	Participate in PRD/SSD reviews and approvals		0%	Mon 2/1/16	Mon 5/2/16	66 days	Jennifer Glanville	Enrollment
46	Confirm PCP process & auto assignment rules		100%	Mon 11/2/15	Mon 11/2/15	1 day	Jennifer Glanville	Enrollment
47	Review nonstandard and new contract requirements		20%	Mon 11/2/15	Fri 1/1/16	45 days	Jennifer Glanville	Enrollment
48	Request Enrollment box in Macess		100%	Mon 11/2/15	Mon 11/2/15	1 day	Jennifer Glanville	Enrollment
49	Enrollment Staff Trained		0%	Mon 8/1/16	Fri 8/5/16	5 days	Jennifer Glanville	Enrollment
50	Confirm access requirements / granted to State systems		0%	Mon 11/2/15	Mon 11/2/15	1 day	Jennifer Glanville	Enrollment
51	Manual Workarounds finalized/approved (as needed)		0%	Mon 8/1/16	Thu 12/15/16	99 days	Jennifer Glanville	Enrollment
52	Test 834 File Received		0%	Thu 9/1/16	Thu 9/1/16	1 day	Jennifer Glanville	Enrollment
53	834 Tested		0%	Thu 9/1/16	Sat 10/1/16	23 days	Jennifer Glanville	Enrollment
54	Confirm provider load deadline		0%	Thu 9/1/16	Thu 9/1/16	1 day	Jennifer Glanville	Enrollment
55	Go-live confirmation of Membership number		0%	Thu 12/1/16	Thu 12/1/16	1 day	Jennifer Glanville	Enrollment
56	Receive copies/proofs of Member Materials (ID card/letter)		0%	Tue 11/1/16	Tue 11/1/16	1 day	Jennifer Glanville	Enrollment
57	Production Enrollment File Received		0%	Thu 12/1/16	Thu 12/29/16	21 days	Jennifer Glanville	Enrollment
58	Production Enrollment File Loaded		0%	Thu 12/29/16	Thu 12/29/16	1 day	Jennifer Glanville	Enrollment
59	Enrollment Go Live		0%	Sun 1/1/17	Sun 1/1/17	1 day	Jennifer Glanville	Enrollment
60	**Marketing**		**2%**	**Fri 1/22/16**	**Sun 1/1/17**	**247 days**	**Kim Manning**	**Marketing**
61	Determine Marketing General Guidelines/understand allowable and prohibited marketing activities		0%	Mon 11/2/15	Thu 3/3/16	89 days	Kim Manning	Marketing
62	**Engage Communication/PR (External) Team**		**0%**	**Tue 11/3/15**	**Fri 2/24/17**	**345 days**	**Alice Ferreira**	**Communications**
63	Communicate Member/Provider Experience and Onboarding Requirements with PR Team		0%	Tue 3/1/16	Thu 3/3/16	3 days	Alice Ferreira	Communications
64	Determine if a communication plan is needed		0%	Mon 3/7/16	Fri 3/11/16	5 days	Alice Ferreira	Communications
65	Conduct Lunch n Learn programs each month to educate clinical and nonclinical of CBOs, providers and advocates that serve the members		0%	Mon 1/5/15	Fri 3/3/17	566 days	Kim Manning	Marketing
66	Obtain State approval on ALL communications and materials		0%	Mon 2/8/16	Fri 2/24/17	276 days	Kim Manning	Marketing
67	Conduct town halls/listening sessions and host a MAC meeting to address needs of members		0%	Fri 3/4/16	Fri 2/24/17	257 days	Kim Manning	Marketing
68	Provide detailed description of Marketing Plan to State for approval as described in Section IV.G-Marketing materials		0%	Mon 4/4/16	Mon 5/16/16	31 days	Kim Manning	Marketing

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
69	Provide description of the expanded value added and member enhanced program the MCO will provide as described in Section IV.E-Covered Services and Benefits		0%	Mon 2/8/16	Mon 5/2/16	61 days	Kim Manning	Marketing
70	Submit Member handbook as described in Member Services to State for approval		0%	Wed 6/1/16	Mon 8/1/16	44 days	Kim Manning	Marketing
71	Submit Welcome Packet materials as described in Section IV.F - Member Services/Education for approval		0%	Wed 6/1/16	Mon 8/1/16	44 days	Kim Manning	Marketing
72	Submit Welcome Call script for member welcome calls as described in Section IV.F - Member Services/Education		0%	Wed 6/1/16	Mon 8/1/16	44 days	Kim Manning,Heather	Marketing
73	Obtain State approval on member education materials/communications		0%	Wed 6/1/16	Mon 8/1/16	44 days	Kim Manning	Marketing
74	P&P for all Marketing and Marketing Activities		66%	Mon 6/6/16	Fri 9/2/16	65 days	Kim Manning	Marketing
75	Conduct general outreach communication member		0%	Tue 9/6/16	Tue 2/28/17	127 days	Kim Manning	Marketing
76	Conduct general outreach communication provider		0%	Tue 9/6/16	Tue 2/28/17	127 days	Kim Manning	Marketing
77	**Member Materials**		**2%**	**Mon 6/22/15**	**Mon 12/26/16**	**396 days**	**Joyce McVey,Kim Manning**	**Member Materials**
78	**Operational Letters**		**0%**	**Thu 10/8/15**	**Thu 11/10/16**	**286 days**	**Soteris Karoly**	**Operational Letters**
79	**Provider Letters**		**0%**	**Fri 7/1/16**	**Thu 11/10/16**	**95 days**	**Soteris Karoly**	**Operational Letters**
80	Receive templates		0%	Fri 7/1/16	Mon 8/1/16	22 days	Soteris Karoly	Operational Letters
81	Build out templates		0%	Fri 8/5/16	Thu 8/11/16	5 days	Soteris Karoly	Operational Letters
82	Approvals Internal/HP/State		0%	Sat 8/13/16	Wed 10/5/16	39 days	Soteris Karoly	Operational Letters
83	Uploaded to Client Letter		0%	Fri 10/7/16	Thu 11/10/16	25 days	Soteris Karoly	Operational Letters
84	**Member Letters/Billing/Enrollment**		**0%**	**Fri 7/1/16**	**Thu 11/10/16**	**95 days**	**Soteris Karoly**	**Operational Letters**
85	Receive templates		0%	Fri 7/1/16	Tue 7/5/16	3 days	Soteris Karoly	Operational Letters
86	Build out templates		0%	Fri 8/5/16	Thu 8/11/16	5 days	Soteris Karoly	Operational Letters
87	Approvals Internal/HP/State		0%	Sat 8/13/16	Wed 10/5/16	39 days	Soteris Karoly	Operational Letters
88	Uploaded to Client Letter		0%	Fri 10/7/16	Thu 11/10/16	25 days	Soteris Karoly	Operational Letters
89	**G&A Letters**		**0%**	**Thu 10/8/15**	**Wed 10/5/16**	**260 days**	**Soteris Karoly**	**Operational Letters**
90	Receive templates		0%	Fri 7/1/16	Tue 7/5/16	3 days	Soteris Karoly	Operational Letters
91	Build out templates		0%	Mon 8/15/16	Fri 8/19/16	5 days	Soteris Karoly	Operational Letters
92	Approvals Internal/HP/State		0%	Sat 8/13/16	Wed 10/5/16	39 days	Soteris Karoly	Operational Letters
93	Uploaded to Client Letter		0%	Thu 10/8/15	Wed 11/11/15	25 days	Soteris Karoly	Operational Letters
94	**Pharmacy Letters**		**0%**	**Fri 7/1/16**	**Thu 11/10/16**	**95 days**	**Soteris Karoly**	**Operational Letters**
95	Receive templates		0%	Fri 7/1/16	Tue 7/5/16	3 days	Soteris Karoly	Operational Letters
96	Build out templates		0%	Fri 8/5/16	Thu 8/11/16	5 days	Soteris Karoly	Operational Letters
97	Approvals Internal/HP/State		0%	Wed 7/13/16	Mon 9/5/16	39 days	Soteris Karoly	Operational Letters
98	Uploaded to Client Letter		0%	Fri 10/7/16	Thu 11/10/16	25 days	Soteris Karoly	Operational Letters
99	**Member Newsletter**		**1%**	**Fri 1/1/16**	**Tue 9/6/16**	**178 days**	**Kim Manning**	**Marketing**
100	Determine Requirements		0%	Fri 1/1/16	Fri 4/29/16	86 days	Kim Manning	Marketing
101	Confirm Vendor		100%	Tue 3/1/16	Tue 3/1/16	1 day	Kim Manning	Marketing
102	Mail/fulfillment schedule		0%	Fri 7/1/16	Thu 9/1/16	45 days	Kim Manning	Marketing

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
103	Obtain State approval of initial member newsletters		0%	Wed 8/3/16	Tue 9/6/16	25 days	Kim Manning	Marketing
104	**ID Cards**		**3%**	**Fri 11/6/15**	**Fri 12/30/16**	**300 days**	**Delecia Jenkins,Kim Manning**	**Member Materials - ID Cards**
105	Determine ID Card Requirements		100%	Fri 4/1/16	Fri 4/1/16	1 day	Delecia Jenkins	Member Materials - ID Cards
106	Confirm vendor		100%	Fri 11/6/15	Fri 11/6/15	1 day	Delecia Jenkins	Member Materials - ID Cards
107	ID card mock up approval		0%	Fri 4/1/16	Wed 8/24/16	104 days	Delecia Jenkins	Member Materials - ID Cards
108	Submit DRG Documentation (new market/new business)		100%	Tue 3/1/16	Tue 3/1/16	1 day	Delecia Jenkins	Member Materials - ID Cards
109	Approval of DRG Documentation Received		45%	Tue 3/1/16	Tue 3/15/16	11 days	Delecia Jenkins	Member Materials - ID Cards
110	Submit ID card and inserts/pods to state for readiness review and approval		0%	Thu 9/1/16	Thu 9/1/16	1 day	Delecia Jenkins	Member Materials - ID Cards
111	State Approval		0%	Thu 9/1/16	Mon 10/3/16	23 days	Delecia Jenkins	Member Materials - ID Cards
112	Determine ID card run schedule		0%	Thu 9/1/16	Tue 11/1/16	44 days	Delecia Jenkins	Member Materials - ID Cards
113	ID card test with vendor		0%	Sat 10/1/16	Tue 11/1/16	23 days	Delecia Jenkins	Member Materials - ID Cards
114	ID card production ready with vendor		0%	Thu 12/15/16	Thu 12/15/16	1 day	Delecia Jenkins	Member Materials - ID Cards
115	Send ID card to Call Center teams		0%	Sat 10/1/16	Sat 10/1/16	1 day	Delecia Jenkins	Member Materials - ID Cards
116	ID card Mail/fulfillment schedule		0%	Thu 9/1/16	Tue 11/1/16	44 days	Delecia Jenkins	Member Materials - ID Cards
117	ID cards mailed		0%	Fri 12/23/16	Fri 12/23/16	1 day?	Delecia Jenkins	Member Materials - ID Cards
118	Date when ID card will be received by Member		0%	Wed 12/21/16	Tue 12/27/16	5 days	Delecia Jenkins	Member Materials - ID Cards
119	Notify Inbound Call Center of actual mail date		0%	Fri 12/16/16	Fri 12/30/16	11 days	Delecia Jenkins	Member Materials - ID Cards
120	ID Card error notification		0%	Thu 12/15/16	Fri 12/30/16	12 days	Delecia Jenkins	Enrollment
121	**Welcome Kit/Member Handbook**		**5%**	**Mon 6/22/15**	**Tue 3/7/17**	**448 days**	**Sue Richins,Kim Manning**	**Member Materials**
122	Identify vendor		100%	Fri 11/6/15	Fri 11/6/15	1 day	Sue Richins	Member Materials
123	Submit DRG Documentation (new market/new business)		100%	Tue 3/1/16	Tue 3/1/16	1 day	Sue Richins	Member Materials
124	Approval of DRG Documentation Received		100%	Tue 3/1/16	Tue 3/15/16	11 days	Sue Richins	Member Materials
125	Determine Member Handbook/Letter Requirements		0%	Fri 4/1/16	Fri 4/1/16	1 day	Joyce McVey	Member Materials
126	Engage member materials for Draft Member Handbook, welcome letter, ID card inserts		0%	Fri 4/1/16	Wed 8/24/16	104 days	HP and Mktg	HP and Mktg
127	Receipt of finalized benefits		0%	Fri 7/1/16	Fri 7/1/16		Sue Richins	Member Materials
128	Validate ALL phone numbers for Call Centers		0%	Wed 8/24/16	Wed 8/24/16	1 day	Sue Richins	Member Materials

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
129	HP/Functional leads sign off on materials		0%	Wed 8/31/16	Wed 8/31/16	1 day	Sue Richins	Member Materials
130	Submit handbook and all kit materials to state for readiness review and approval		0%	Thu 9/1/16	Thu 9/1/16	1 day	Sue Richins	Member Materials
131	Send English File to Translations Dept for alternate formats		0%	Sat 10/1/16	Tue 11/1/16	23 days	Sue Richins	Member Materials
132	Vendor to Program Language Translations		0%	Tue 11/1/16	Fri 11/4/16	4 days	Sue Richins	Member Materials
133	State approval of materials		0%	Thu 9/1/16	Wed 10/12/16	30 days	Sue Richins	Member Materials
134	Welcome/handbook/kit Materials sent to Print Vendor		0%	Tue 11/1/16	Tue 11/1/16	1 day	Sue Richins	Member Materials
135	Print vendor supplies proof and completes tesing		0%	Tue 11/1/16	Mon 11/14/16	10 days	Sue Richins	Member Materials
136	Determine mailing schedule		0%	Thu 9/1/16	Tue 11/1/16	44 days	Sue Richins	Member Materials
137	Communicate schedule and Materials to Call Center teams		0%	Thu 9/1/16	Tue 11/1/16	44 days	Sue Richins	Member Materials
138	Date when Handbook will be received by Member		0%	Fri 12/23/16	Fri 12/30/16	6 days	Sue Richins	Member Materials
139	**Member Call Center**		**0%**	**Tue 3/1/16**	**Sun 1/1/17**	**220 days**	**Reena Hopper**	**Member Call**
140	Determine strategy for integration of Behaviora & pharmacy I into call center		0%	**Tue 3/1/16**	**Sun 1/1/17**	220 days	Reena Hopper	Member Call
141	Confirm Location and Space		0%	Thu 3/31/16	Tue 4/26/16	19 days	Reena Hopper	Member Call
142	Prepare call forecasts and update site forecasts with impacts due to conversion/new hires		0%	Tue 3/1/16	Fri 3/25/16	19 days	Reena Hopper	Member Call
143	Define hours of operation		0%	Fri 5/27/16	Thu 7/7/16	30 days	Reena Hopper	Member Call
144	Confirm completion of SOPs and Workflows		0%	Wed 5/25/16	Fri 7/1/16	28 days	Reena Hopper	Member Call
145	Receive OneSource		0%	Wed 5/25/16	Fri 11/11/16	123 days	Reena Hopper	Member Call
146	Training Plan Developed		0%	Wed 6/1/16	Mon 10/17/16	99 days	Reena Hopper	Member Call
147	Update/develop training materials		0%	Fri 7/22/16	Fri 7/22/16	1 day	Reena Hopper	Member Call
148	Confirm completion of training		0%	Fri 10/7/16	Thu 11/10/16	25 days	Reena Hopper	Member Call
149	Confirm ID card/welcome kit mailing timeframe and volumes received		0%	Thu 12/15/16	Thu 12/15/16	1 day	Reena Hopper	Member Call
150	Update Macess with Member Materials		0%	Wed 6/1/16	Fri 7/22/16	38 days	Reena Hopper	Member Call
151	Verify HARC strategy		0%	Wed 6/1/16	Fri 7/22/16	38 days	Reena Hopper	Member Call
152	Confirm access requirements and that access is granted to State systems		0%	Wed 8/24/16	Tue 9/6/16	10 days	Reena Hopper	Member Call
153	Benefit summary received		0%	Wed 8/24/16	Tue 9/6/16	10 days	Reena Hopper	CCAM
154	IVR design workflow		0%	Wed 8/24/16	Tue 9/6/16	10 days	Reena Hopper	Member Call
155	Obtain and communicate TFNs		0%	Wed 5/25/16	Tue 6/21/16	20 days	Reena Hopper	Member Call
156	Review of Call Center Playbook		0%	Tue 3/1/16	Mon 3/28/16	20 days	Reena Hopper	Member Call
157	Obtain HP approval on IVR		0%	Fri 7/1/16	Wed 8/31/16	44 days	Reena Hopper	Member Call
158	Obtain State approval of IVR		0%	Thu 9/1/16	Wed 11/30/16	65 days	Reena Hopper	Member Call
159	New skills created		0%	Wed 7/6/16	Mon 10/31/16	84 days	Reena Hopper	Member Call
160	New IVR created		0%	Wed 7/6/16	Mon 10/31/16	84 days	Reena Hopper	Member Call
161	Update MIS		0%	Wed 7/6/16	Mon 10/31/16	84 days	Reena Hopper	Member Call
162	Update UES		0%	Wed 7/6/16	Mon 10/31/16	84 days	Reena Hopper	Member Call
163	Update mymetrics		0%	Wed 7/6/16	Mon 10/31/16	84 days	Reena Hopper	Member Call
164	Begin taking pre-enrollment Member calls		0%	Tue 11/1/16	Tue 11/1/16	1 day	Reena Hopper	Member Call

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
165	Begin Taking Member Calls		0%	Sun 1/1/17	Sun 1/1/17	1 day	Reena Hopper	Member Call
166	**HARC**		**21%**	**Mon 11/2/15**	**Sun 1/1/17**	**306 days**	**Darla Haagensen**	**HARC**
167	Define welcome call requirements		70%	Tue 3/1/16	Sun 1/1/17	220 days	Darla Haagensen	HARC
168	Identify Hiring needs		50%	Mon 11/2/15	Thu 12/17/15	34 days	Darla Haagensen	HARC
169	Recruiting		0%	Sun 5/1/16	Thu 7/21/16	60 days	Darla Haagensen	HARC
170	Determine hours welcome calls will be made		0%	Fri 7/1/16	Wed 8/17/16	34 days	Darla Haagensen	HARC
171	Verify Auto Dialer will not included members who have termed/re-enrolled within the past 120 days		0%	Fri 7/1/16	Wed 8/17/16	34 days	Darla Haagensen	HARC
172	HP review/approval of welcome call script		0%	Fri 7/1/16	Fri 9/16/16	56 days	Darla Haagensen	HARC
173	Confirming HP Reporting Requirements		0%	Fri 7/1/16	Fri 9/16/16	56 days	Darla Haagensen	HARC
174	Create and finalize postcard for members who were not reached		0%	Fri 7/1/16	Fri 9/16/16	56 days	Darla Haagensen	HARC
175	Otain HP/State approval on postcard if needed		0%	Thu 9/1/16	Thu 11/17/16	56 days	Darla Haagensen	HARC
176	PCP changes on initial welcome calls		0%	Fri 7/1/16	Tue 10/18/16	78 days	Darla Haagensen	HARC
177	Identify training needs		0%	Fri 7/1/16	Wed 8/17/16	34 days	Darla Haagensen	HARC
178	Develop Health Plan specific training		0%	Thu 8/18/16	Thu 9/15/16	21 days	Darla Haagensen	HARC
179	Develop culture training materials		0%	Thu 8/18/16	Thu 9/15/16	21 days	Darla Haagensen	HARC
180	Execute training		0%	Tue 11/1/16	Wed 11/30/16	22 days	Darla Haagensen	HARC
181	BI membership feed set up		0%	Tue 11/1/16	Tue 11/22/16	16 days	Darla Haagensen	HARC
182	HARC begins making Welcome Calls		0%	Thu 12/1/16	Sun 1/1/17	23 days	Darla Haagensen	HARC
183	**Member Education Plan**		**0%**	**Tue 3/1/16**	**Thu 9/1/16**	**133 days**	**Kim Manning**	**Health Plan/Marketing**
184	Develop and Submit Member Education Plan		0%	Tue 3/1/16	Thu 9/1/16	133 days	Kim Manning	Health Plan/Marketing
185	**Member Portal (Secure) MyUHC.com**		**2%**	**Mon 11/9/15**	**Sun 1/1/17**	**300.3 days**	**Jeanine Mendes,Kim**	**Member Portal (Secure)**
186	Determine Required Contract Changes/Updates		10%	Sun 11/1/15	Mon 2/1/16	67 days	Jeanine Mendes	Member Portal (Secure)
187	Create Content/Change Document		0%	Mon 2/1/16	Mon 10/3/16		Jeanine Mendes	Member Portal (Secure)
188	HP/State Review and approval		0%	Mon 8/29/16	Fri 12/2/16	70 days?	Jeanine Mendes	Member Portal (Secure)
189	Submit Materials to UHC Content team		0%	Thu 12/1/16	Thu 12/15/16		Jeanine Mendes	Member Portal (Secure)
190	Content Build/Update Complete		0%	Sun 1/1/17	Sun 1/1/17		Jeanine Mendes	Member Portal (Secure)
191	Member websites IT go-live		0%	Sun 1/1/17	Sun 1/1/17	0 days?	Jeanine Mendes	Member Portal (Secure)
192	**Member Portal (Unsecure) UHCCommunityPlan.com**		**1%**	**Tue 11/10/15**	**Sun 1/1/17**	**299.4 days**	**Jeanine Mendes,Kim**	**Member Portal (Unsecure)**
193	Determine Required Contract Changes/Updates (BAR)		10%	Mon 11/2/15	Mon 2/1/16	66 days	Jeanine Mendes	Member Portal (Unsecure)
194	Create Content/Change Document (Marketing Manager + HP via new copy deck)		0%	Mon 2/1/16	Mon 10/3/16		Jeanine Mendes	Member Portal (Unsecure)
195	Changes approved by HP		0%	Mon 2/1/16	Tue 11/1/16	197 days	Jeanine Mendes	Member Portal (Unsecure)
196	Changes approved by Compliance/State		0%	Mon 2/1/16	Tue 11/1/16		Jeanine Mendes	Member Portal (Unsecure)
197	Health Plan submit Numara Request for changes (updated documents only)		0%	Mon 10/3/16	Wed 11/30/16	43 days	Jeanine Mendes	Member Portal (Unsecure)

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
198	Update required content		0%	Tue 11/1/16	Thu 12/15/16	33 days	Jeanine Mendes	Member Portal (Unsecure)
199	Internal Testing		0%	Tue 11/1/16	Thu 12/15/16	33 days	Jeanine Mendes	Member Portal (Unsecure)
200	Unsecure Member website go-live		0%	Sun 1/1/17	Sun 1/1/17	1 day	Jeanine Mendes	Member Portal (Unsecure)
201	**II. Network Development and Management**		**24%**	**Mon 8/3/15**	**Sun 1/1/17**	**371 days**	**Jeremy Sand / Tekera Stanford**	
202	**Network - UHN (Medical/Surgical Network)**		**27%**	Mon 8/3/15	Thu 3/31/16	**174 days**	**Tekera Stanford**	**Network**
203	**Network Development Strategy Defined**		**95%**	Mon 8/3/15	Mon 8/31/15	**21 days**	**Tekera Stanford**	**Network**
204	Define and Solution Requirements		100%	Mon 8/3/15	Mon 8/31/15	21 days	Tekera Stanford	Network
205	Document Network Strategy By Provider Type		100%	Mon 8/3/15	Mon 8/31/15	21 days	Tekera Stanford	Network
206	Network Reporting Initiated		100%	Mon 8/3/15	Mon 8/31/15	21 days	Tekera Stanford	Network
207	Define Branding		100%	Mon 8/3/15	Mon 8/31/15	21 days	Tekera Stanford	Network
208	Define Licensing		100%	Wed 10/21/15	Thu 3/31/16	117 days	Tekera Stanford	Network
209	**GEOs Access Reports initiated (if applicable)**		**90%**	**Mon 8/3/15**	**Thu 3/31/16**	**174 days**	**Tekera Stanford**	**Network**
210	Engage NDAR for GEO Reporting		100%	Mon 8/3/15	Mon 8/3/15	1 day	Tekera Stanford	Network
211	Confirm 100% GEO Access		90%	Mon 8/3/15	Thu 3/31/16	174 days	Tekera Stanford	Network
212	**Network Development Plan**		**17%**	**Wed 10/21/15**	**Sun 1/1/17**	**314 days**	**Jeremy Sand/Tekera Stanford**	**Network**
213	Develop and submit a Network Development Plan		100%	Wed 10/21/15	Tue 12/22/15	45 days	Tekera Stanford	Network
214	From the date of contract award and then every two weeks until the contract effective date, the MCO shall provide updates about its network development activities.		0%	Tue 3/1/16	Sun 1/1/17	220 days	Tekera Stanford	Network
215	**Provider Manual/Admin Guide Readiness**		**25%**	**Tue 3/1/16**	**Sun 1/1/17**	**220 days**	**Tekera Stanford**	**Network**
216	Provider Manual reviewed/Approved		50%	Tue 3/1/16	Sun 1/1/17	220 days	Tekera Stanford	Network
217	Provider Manual/Admin Guide Posted to Portal/Accessible to State		0%	Tue 3/1/16	Sun 1/1/17	220 days	Tekera Stanford	Network
218	**Provider Directory Readiness**		**0%**	**Tue 3/1/16**	**Thu 12/15/16**	**208 days**	**Tekera Stanford**	**Network**
219	Provider Directory State Review and Approval		0%	Tue 3/1/16	Tue 11/1/16	176 days	Tekera Stanford	Network
220	Print/Mail Readiness		0%	Tue 3/1/16	Thu 12/15/16	208 days	Tekera Stanford	Network
221	Find-A-Doc Upload/Readiness		0%	Tue 3/1/16	Thu 12/15/16	208 days	Tekera Stanford	Network
222	Provider Directory Mail Date		0%	Tue 3/1/16	Thu 12/15/16	208 days	Tekera Stanford	Network
223	**Credentialing Readiness**		**83%**	Tue 3/1/16	Fri 4/29/16	**44 days**	**Tekera Stanford**	**Network**
224	Engage Credentialing Partners to comply with non-standard requirements		90%	Tue 3/1/16	Fri 4/29/16	44 days	Tekera Stanford	Network
225	All Providers Credentialed		75%	Tue 3/1/16	Fri 4/29/16	44 days	Tekera Stanford	Network
226	**Network Development by Provider Type**		**73%**	Wed 10/21/15	Wed 8/31/16	**226 days**	**Tekera Stanford**	**Network**
227	Medical/Surgical Network		90%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
228	FQHC and RHC's Network		75%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
229	Behavioral Health Network		50%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
230	Physical Health Network (Therapies and Chiro)		90%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
231	SNF Health Network		90%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
232	Vision Health Network		90%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
233	Pharmacy Health Network		50%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
234	Transplant Health Network		50%	Wed 10/21/15	Fri 12/30/16	313 days	Tekera Stanford	Network
235	**Communications and Training**		**3%**	Tue 3/1/16	Wed 8/31/16	**132 days**	**Tekera Stanford**	**Network**
236	Develop strategy plan for provider training		20%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
237	Complete Development of FAQs Training doc (Phy, Hospital, Anc) based on Business needs (Audience: Provider Relations - provider call units that support C&S)		0%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
238	Provider Communication Plan		0%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
239	Provider Training Plan		0%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
240	Recruitment Packets Reviewed/Approved		0%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
241	Provider Training Events		0%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
242	**Readiness Review**		**0%**	Tue 3/1/16	Wed 8/31/16	**132 days**	**Tekera Stanford**	**Network**
243	Coordinate readiness review deliverables		0%	TBD	TBD	132 days	Tekera Stanford	Network
244	HP audit of (20) selected Providers		0%	Tue 3/1/16	Wed 8/31/16	132 days	Tekera Stanford	Network
245	**Provider Load Readiness (PCDM)**		**10%**	Wed 10/21/15	Tue 2/28/17	**356 days**	**Tekera Stanford**	**Network**
246	**Define and Solution Requirements**		**28%**	Fri 4/1/16	Wed 11/30/16	**174 days**	**Tekera Stanford**	**Network**
247	Document Implementation Details		32%	Wed 10/21/15	Fri 4/29/16	138 days	Tekera Stanford	Network
248	Complete PCDM Staffing Assessment		25%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
249	**Network Configuration (PCRL)**		**63%**	Fri 4/1/16	Wed 11/30/16	**174 days**	**Tekera Stanford**	**Network**
250	Line of Business Codes Configured		100%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
251	Agreement IDs configured		90%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
252	Fee schedules configured		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
253	**Provider Loading (New Providers)**		**0%**	Fri 4/1/16	Wed 11/30/16	**174 days**	**Tekera Stanford**	**Network**
254	Track Mass Mailings		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
255	Contract/Paper Mailing(s) Complete		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
256	444 Y Line & Contract Master Set up		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
257	333 Y Line Build Complete (OneShot via NDB on CSP)		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
258	Data Requirements Documented		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
259	Early Remediation of Data		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
260	Network Implementation Dashboard Audit/Tracking/Review		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
261	Confirm Contract Loading Complete		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
262	PRD/SSD Call Engagement		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
263	Agreement ID Tracking		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
264	State Provider Outbound File Validated		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
265	Provider UAT/Testing Completed		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
266	Steady State Loading Tool and Process Flow Updates		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
267	Steady State Loading Guidelines and Socialization		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
268	Provider Go Live		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
269	Post Provider Go Live Clean Up		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
270	Y Line Remediation		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
271	Claims Go Live		0%	Fri 4/1/16	Wed 11/30/16	174 days	Tekera Stanford	Network
272	Post Claim Go-Live Support		0%	Sun 1/1/17	Tue 2/28/17	43 days	Tekera Stanford	Network
273	**Provider Relations**		**12%**	Tue 3/1/16	Tue 5/31/16	**66 days**	**Tekera Stanford**	**Network**
274	Develop training to all providers and their staff regarding the requirements of the contract		70%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
275	Establish provider advisory committee		0%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
276	Establish a behavioral health advisory committee to provide input to the provider advisory committee		0%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
277	ID top (10) Providers by type (hospital/physician)		0%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
278	Outreach to top (10) providers post go-live to reduce implementation Network ask		0%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
279	Convey Continuity of Care strategy		0%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
280	**Policies and Procedures**		**75%**	Tue 3/1/16	Tue 5/31/16	**66 days**	**Tekera Stanford**	**Network**
281	Develop and Submit Provider Network Policies and Procedures		75%	Tue 3/1/16	Tue 5/31/16	66 days	Tekera Stanford	Network
282	**Network Development Activities Reassessed**		**0%**	Wed 10/21/15	Wed 11/30/16	**291 days**	**Tekera Stanford**	**Network**
283	Complete Contracting for Network Coverage		0%	Wed 10/21/15	Mon 10/31/16	269 days	Tekera Stanford	Network
284	State Approval of Network Adequacy		0%	Tue 3/1/16	Wed 11/30/16	197 days	Tekera Stanford	Network
285	Contract Load (Emptoris) 100%		0%	Tue 3/1/16	Fri 9/30/16	154 days	Tekera Stanford	Network
286	Confirm EPS/OnePay and EDI In Place		0%	Wed 10/21/15	Mon 10/31/16	269 days	Tekera Stanford	Network
287	Network Adequacy 100%		0%	Wed 10/21/15	Mon 10/31/16	269 days	Tekera Stanford	Network
288	**Behavioral Health - Optum Behavioral**		**11%**	Wed 7/1/15	Mon 10/31/16	**349 days**	**Tekera Stanford**	Network
289	**Network Readiness**		**20%**	Wed 10/21/15	Wed 8/31/16	**226 days**	**Tekera Stanford**	Network
290	Optum Network contracting and credentialing readiness		90%	Wed 10/21/15	Thu 6/30/16	182 days	Tekera Stanford	Network
291	Provider communication plan		0%	Tue 3/1/16	Thu 6/30/16	88 days	Tekera Stanford	Network
292	Provider education plan		0%	Tue 3/1/16	Thu 6/30/16	88 days	Tekera Stanford	Network
293	Network configuration and system set-up		0%	Wed 10/21/15	Wed 8/31/16	226 days	Tekera Stanford	Network
294	BH Network Load Completion - Network Ready		0%	Wed 10/21/15	Wed 8/31/16	226 days	Tekera Stanford	Network
295	**Claims Readiness**		**0%**	Tue 3/1/16	Mon 10/31/16	**175 days**	**Tekera Stanford**	Network
296	System Config Complete		0%	Tue 3/1/16	Fri 9/30/16	154 days	Tekera Stanford	Network
297	Determine Continuity of Care strategy if applicable		0%	Tue 3/1/16	Fri 9/30/16	154 days	Tekera Stanford	Network
298	Recruit and hire as appropriate.		0%	Tue 3/1/16	Fri 9/30/16	154 days	Tekera Stanford	Network
299	Identify training requirements-develop training module and materials		0%	Tue 3/1/16	Fri 9/30/16	154 days	Tekera Stanford	Network
300	Confirm Mixed Claims Protocal		0%				Tekera Stanford	Network
301	Schedule & Conduct Staff Training on state-specific benefits		0%	Wed 7/1/15	Thu 7/16/15	12 days	Tekera Stanford	Network
302	Claim Go Live		0%	Wed 7/1/15	Wed 7/1/15	1 day?	Tekera Stanford	Network
303	**Vendor Management**		**23%**	**Wed 10/21/15**	**Tue 5/31/16**	**160 days**	**Tekera Stanford**	Network

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
304	**Vendor Management - National Medical**		**23%**	Wed 10/21/15	Tue 5/31/16	**160 days**	**Tekera Stanford**	Network
305	**Vision**		**13%**	Wed 10/21/15	Tue 5/31/16	**160 days**	**Tekera Stanford**	Network
306	Contract Initiation/Amendment		100%	Wed 10/21/15	Thu 10/22/15	2 days	Tekera Stanford	Network
307	Determine Benefits		100%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
308	EOB/NOA/Operational Letter Vendor		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
309	**Data Exchange Processes:**		**0%**	Wed 10/21/15	Tue 5/31/16	**160 days**	**Tekera Stanford**	Network
310	Vendor Checklist Completed and Distributed		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
311	Eligibility Test File		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
312	Eligibility Production File		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
313	Encounter File Readiness		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
314	Provider File Test		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
315	SLA Created/Approved		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
316	**Radiology/EviCore**		**50%**	Wed 10/21/15	Tue 5/31/16	**160 days**	**Tekera Stanford**	Network
317	Contract Initiation/Amendment		50%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
318	**Optum Behavioral**		**0%**	Wed 10/21/15	Tue 5/31/16	**160 days**	**Tekera Stanford**	Network
319	SLA Created/Approved		0%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
320	**Optum Care Solutions - PT/OT/ST**		**99%**	Wed 10/21/15	Tue 5/31/16	**160 days**	**Tekera Stanford**	Network
321	SLA Created/Approved		100%	Wed 10/21/15	Tue 5/31/16	160 days	Tekera Stanford	Network
322	**Provider Services/Call Center**		**38%**	**Tue 12/1/15**	**Thu 6/30/16**	**153 days**	**Sandy Faulkner**	**Provider Call**
323	Determine strategy for integration of Behavioral & Pharmacy		50%	Mon 11/2/15	Mon 5/9/16	136 days	Sandy Faulkner	Provider Call
324	Define performance/quality metrics		100%	Fri 1/1/16	Fri 1/1/16	0 days	Sandy Faulkner	Provider Call
325	Confirm Location and Space		100%	Mon 11/2/15	Thu 12/17/15	34 days	Sandy Faulkner	Provider Call
326	Staff hired		80%	Tue 3/1/16	Thu 6/30/16	88 days	Sandy Faulkner	Provider Call
327	Training plan developed		80%	Tue 3/1/16	Tue 5/31/16	66 days	Sandy Faulkner	Provider Call
328	Confirm completion of SOPs and Workflows		70%	Fri 1/1/16	Tue 5/3/16	88 days	Sandy Faulkner	Provider Call
329	Confirm completion of Health Plan specific training		70%	Fri 1/1/16	Fri 7/15/16	141 days	Sandy Faulkner	Provider Call
330	Review of Call Center Playbook		80%	Tue 3/1/16	Mon 3/28/16	20 days	Sandy Faulkner	Provider Call
331	Telephonic testing of IVR/Skill modifications		0%	Wed 7/6/16	Mon 10/31/16	84 days	Sandy Faulkner	Provider Call
332	Macess QueueTested		0%	Thu 9/15/16	Fri 12/30/16	77 days	Sandy Faulkner	Provider Call
333	Receipt of OneSource and Mem/Provider materials/Communications		0%	Wed 5/25/16	Fri 11/11/16	123 days	Sandy Faulkner	Provider Call
334	Reciept of Benefit Summary		0%	Wed 8/24/16	Tue 9/6/16	10 days	Sandy Faulkner	Provider Call
335	Training Completed		0%	Fri 10/7/16	Thu 11/10/16	25 days	Sandy Faulkner	Provider Call
336	Determine reporting requirements (metrics, timing and if must by split by product)		0%	Tue 3/1/16	Tue 8/30/16	131 days	Sandy Faulkner	Provider Call
337	Provider Services receives provider calls		0%	Thu 12/1/16	Sun 1/1/17	23 days?	Sandy Faulkner	Provider Call
338	**Provider Portal (Secure) unitedhealthcareonline.com**		**0%**	**Tue 12/1/15**	**Wed 3/1/17**	**328 days**	**Tammy Cronan Fears,Jeremy Sand**	**Provider Portal - Secure**
339	Review requirements & identify needed updates		0%	Tue 12/1/15	Fri 2/19/16	59 days	Tammy Cronan Fears	Provider Portal - Secure
340	Update portal to reflect state-specific requirements		0%	Mon 2/22/16	Fri 12/2/16	205 days?	Tammy Cronan Fears	Provider Portal - Secure

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
341	Confirm FAD Linked		0%	Sat 2/20/16	Mon 2/29/16	7 days	Tammy Cronan Fears	Provider Portal - Secure
342	Secure Provider Portal HP & State review/ approval		0%	Mon 12/5/16	Fri 12/30/16	20 days?	Tammy Cronan Fears	Provider Portal - Secure
343	Provider Portal (secure) go-live		0%	Thu 12/29/16	Sun 1/1/17	3 days?	Tammy Cronan Fears	Provider Portal - Secure
344	**Provider Portal (Non-Secure) uhccommunityplan.com**		**0%**	**Tue 3/1/16**	**Sun 1/1/17**	**220 days**	**Jeremy Sand/Kim Manning**	**HP Provider/Marketing**
345	Review requirements & identify needed updates		0%	Tue 3/1/16	Fri 4/29/16	44 days	Jeremy Sand/Kim Manning	HP Provider/Marketing
346	Submit change request form to inbox		0%	Fri 7/1/16	Sat 10/1/16	67 days	Jeremy Sand/Kim Manning	HP Provider/Marketing
347	Update portal to reflect state-specific requirements		0%	Mon 2/1/16	Tue 11/1/16	197 days?	Jeremy Sand/Kim Manning	HP Provider/Marketing
348	Enusure monthly provider newsletter posted		0%	Tue 11/1/16	Thu 12/15/16	33 days	Jeremy Sand/Kim Manning	HP Provider/Marketing
349	Confirm FAD functional readiness		0%	Tue 11/1/16	Thu 12/15/16	33 days	Jeremy Sand/Kim Manning	HP Provider/Marketing
350	Non-secure Provider Portal HP & State review/ approval		0%	Thu 9/1/16	Thu 12/1/16	66 days?	Jeremy Sand/Kim Manning	HP Provider/Marketing
351	Non-secure Provider Portal go-live		0%	Sun 1/1/17	Sun 1/1/17	1 day?	Jeremy Sand/Kim Manning	HP Provider/Marketing
352	**iii. Quality management, including credentialing**		**60%**	**Fri 10/23/15**	**Mon 8/15/16**	**212 days**	**Cynthia Margritz**	**Quality**
353	Confirm UHC's QAPI program complies with State and Federal requirements (including 42 CRF 438.204) and UM program requirements described in 42 CFR 456.		10%	Fri 10/23/15	Thu 3/31/16	115 days	Cynthia Margritz	Quality
354	Establish QAPIC (QAPI Committee)		10%	Fri 10/23/15	Thu 3/31/16	115 days	Cynthia Margritz	Quality
355	Confirm data collection measures, and state reporting metrics, are in alignment with requirements		90%	Fri 10/23/15	Thu 3/31/16	115 days	Cynthia Margritz	Quality
356	Confirm ability to accurately report on required Quality Performance Measures		90%	Fri 10/23/15	Thu 3/31/16	115 days	Cynthia Margritz	Quality
357	Develop Performance Improvement Projects		70%	Fri 1/1/16	Thu 3/31/16	65 days	Cynthia Margritz	Quality
358	Confirm readiness of Member Satisfaction Surveys		90%	Tue 3/1/16	Mon 8/15/16	120 days	Cynthia Margritz	Quality
359	Confirm readiness of Provider Satisfaction Surveys		80%	Tue 3/1/16	Mon 8/15/16	120 days	Cynthia Margritz	Quality
360	Ensure conformity with Member Advisory and Clinical Advisory Committee contractual requirements		10%	Fri 10/23/15	Thu 3/31/16	115 days	Cynthia Margritz	Quality
361	**Credentialing/Recredentialing (additional detail captured under network)**		**80%**	**Mon 11/2/15**	**Mon 8/1/16**	**196 days**	**Doug Glista**	**Credentialing**
362	Establish/implement/update written policies for the selection and retention of providers, consistent with State provider credentialing and re-credentialing requirements		80%	Mon 11/2/15	Mon 8/1/16	196 days	Doug Glista	Credentialing
363	**iv. Care Management**		**20%**	**Mon 11/2/15**	**Sun 1/1/17**	**306 days**	**Dr. Michael Horne/Barbara Palmer/Stephanie Hover**	**Clinical**
364	Identify Core Clinical Team & Define Areas of Responsibility		20%	Tue 3/1/16	Fri 4/1/16	24 days	Mary Bageard	Clinical
365	Identify Non-standard Requirements		0%	Tue 3/1/16	Fri 4/15/16	34 days	Mary Bageard	Clinical

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
366	**Schedule & Conduct Clinical Coordination Session (Clinical Build)**		**73%**	**Tue 3/1/16**	**Wed 5/4/16**	**47 days**	**Mary Bageard**	**Clinical**
367	Identify benefits / products		90%	Tue 3/1/16	Fri 4/1/16	24 days	Mary Bageard	Clinical
368	Define cl cinical model strategy (BH, ER Diversion, CC/CM, Share of Cost, etc.)		80%	Tue 3/1/16	Mon 5/2/16	45 days	Mary Bageard	Clinical
369	Transition of Care Process Identified, Documented, Assigned and Ready for Implementation		90%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
370	Care Coordination stratification algorithm tested		80%	Tue 3/1/16	Thu 12/1/16	198 days	Mary Bageard	Clinical
371	Final Prior Authorization List Loaded/Configured		50%	Fri 4/1/16	Tue 11/1/16	153 days	Mary Bageard	Clinical
372	**Staffing**		**70%**	**Fri 1/1/16**	**Thu 12/1/16**	**240 days**		
373	All Clinical Staff Hired		70%	Fri 1/1/16	Mon 10/31/16	217 days	Mary Bageard	Clinical
374	All Clinical Staff Trained		70%	Mon 8/1/16	Thu 12/1/16	89 days	Mary Bageard	Clinical
375	Review and update member Collateral Materials		25%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
376	Identify assessment tools		70%	Fri 1/1/16	Mon 6/6/16	112 days	Mary Bageard	Clinical
377	Telephonic Readiness		80%	Fri 1/1/16	Sat 12/31/16	262 days	Mary Bageard	Clinical
378	Reporting Requirements Completed and Ready for Implementation		50%	Fri 1/1/16	Tue 11/1/16	218 days	Mary Bageard	Clinical
379	All Contractual Requirements Implemented		0%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
380	CM Letters Developed and Approved		60%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
381	**Behavioral**		**0%**	**Fri 1/1/16**	**Sun 1/1/17**	**262 days**	**Mary Bageard**	**Clinical**
382	Confirm BH Services Scope		100%	Fri 1/1/16	Fri 1/1/16	1 day	Mary Bageard	Clinical
383	All Clinical Staff Hired		0%	Mon 8/1/16	Mon 10/31/16	66 days	Mary Bageard	Clinical
384	All Clinical Staff Trained		0%	Mon 8/1/16	Thu 12/1/16	89 days	Mary Bageard	Clinical
385	Review and update member Collateral Materials		0%	Tue 3/1/16	Mon 10/3/16	155 days	Mary Bageard	Clinical
386	Telephonic Readiness		0%	Fri 1/1/16	Thu 12/1/16	240 days	Mary Bageard	Clinical
387	Reporting Requirements Completed and Ready for Implementation		0%	Fri 1/1/16	Tue 11/1/16	218 days	Mary Bageard	Clinical
388	All Contractactual Requirements Implemented		0%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
389	**Pharmacy - OptumRx**		**5%**	**Fri 1/1/16**	**Sun 1/1/17**	**262 days**	**Jeanne Cavanaugh**	**Pharmacy**
390	Define development requirements		50%	Fri 1/1/16	Fri 4/1/16	66 days	Jeanne Cavanaugh	Pharmacy
391	Determine if standard C&S Formulary will be used or state formulary		0%	Fri 1/1/16	Fri 4/1/16	66 days	Jeanne Cavanaugh	Pharmacy
392	Determine if Standard C&S Clinical Guidelines will be used or state guidelines		0%	Fri 1/1/16	Fri 4/1/16	66 days	Jeanne Cavanaugh	Pharmacy
393	Pharmacy Network Readiness		90%	Fri 4/1/16	Sun 1/1/17	197 days	Jeanne Cavanaugh	Pharmacy
394	MTM Program		0%	Fri 4/1/16	Sun 1/1/17	197 days	Jeanne Cavanaugh	Pharmacy
395	DUR Program		0%	Fri 4/1/16	Sun 1/1/17	197 days	Jeanne Cavanaugh	Pharmacy
396	CAG creation & Distribution		0%	Fri 4/1/16	Fri 7/1/16	66 days	Jeanne Cavanaugh	Pharmacy
397	Rx Benefit configuration complete		0%	Sat 10/1/16	Thu 12/15/16	55 days	Jeanne Cavanaugh	Pharmacy
398	Draft & get Approved Rx Operational Letters Loaded to PAS		0%	Fri 7/1/16	Tue 11/1/16	88 days	Jeanne Cavanaugh	Pharmacy
399	Prior Authorization/Clinical Guidelines in Place		0%	Fri 4/1/16	Thu 12/15/16	185 days	Jeanne Cavanaugh	Pharmacy
400	Eligibility file testing		0%	Sat 10/1/16	Wed 11/30/16	44 days	Jeanne Cavanaugh	Pharmacy
401	Production Eligibility files to ORx		0%	Thu 12/1/16	Tue 12/20/16	14 days	Jeanne Cavanaugh	Pharmacy
402	Load historical pharmacy & PA data from the state (if available)		0%	Tue 12/20/16	Sat 12/31/16	10 days	Jeanne Cavanaugh	Pharmacy

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
403	Pharmacy lock-in: members locked into pharmacies are loaded and verified in system/Caid		0%	Tue 12/20/16	Sat 12/31/16	10 days	Jeanne Cavanaugh	Pharmacy
404	**WorkFlows/ P & Ps/ SOPs/ Job Aids/ DES Updated**		**0%**	**Fri 1/1/16**	**Sun 1/1/17**	**262 days**	**Mary Bageard**	**Clinical**
405	Develop/Update Health-Risk Screening/Assessment		0%	Fri 1/1/16	Mon 10/31/16	217 days	Mary Bageard	Clinical
406	Confirm inclusion of Behavioral Health Principles of Care in delivery model		0%	Fri 1/1/16	Mon 6/6/16	112 days	Mary Bageard	Clinical
407	Confirm Care Management Program includes meets criteria of the state's Basic CM Services		0%	Fri 1/1/16	Sun 5/1/16	87 days	Mary Bageard	Clinical
408	Create P&Ps for Coordination with Providers and other CM Programs		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
409	Create and implement Special Considerations for Pregnant Members		0%	Fri 1/1/16	Sun 1/1/17	262 days	Mary Bageard	Clinical
410	Establish Policies and Procedures for Coordination with HCBS Service Coordinators		100%	Fri 1/1/16	Fri 1/1/16	1 day	Mary Bageard	Clinical
411	Establish policies for Coordination with Tribal Organizations		100%	Fri 1/1/16	Fri 1/1/16	1 day	Mary Bageard	Clinical
412	Establish processes and procedures for Coordination with the Division of Children and Family Services		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
413	Establish processes and procedures for coordination with the Division of Developmental Disabilities		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
414	Establish processes and procedures for coordination with the Division of Behavioral Health and Nebraska's six local Behavioral Health Regions		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
415	Establish processes and procedures for coordination with the Community agencies – Aging and League of Human Dignity Waiver Offices		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
416	Establish processes and procedures for coordination with the Nebraska Department of Education Early Development Network		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
417	Establish processes and procedures for coordination with the Office of Probation		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
418	Continuity of Care Process Identified & Prepared (Including Staffing)		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
419	Documentation Verified within Collateral Materials		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
420	Review / approval of member letters		0%	Fri 1/1/16	Mon 10/3/16	197 days	Mary Bageard	Clinical
421	Reporting Requirements Completed and Ready for Implementation		0%	Fri 1/1/16	Tue 11/1/16	218 days	Mary Bageard	Clinical
422	All Contractactual Requirements Implemented		0%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
423	**Clinical Technology**		**22%**	**Mon 11/2/15**	**Thu 12/15/16**	**294 days**	**Mary Bageard**	**Clinical**
424	Define Clinical Technology and Solution Requirements		20%	Tue 3/1/16	Fri 4/15/16	34 days	Mary Bageard	Clinical
425	Clinical Platform Determined		100%	Mon 11/2/15	Tue 12/1/15	22 days	Mary Bageard	Clinical
426	Clinical Platform Configured		15%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
427	Work Queues Set up		15%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
428	Plan Codes Set Up		15%	Tue 3/1/16	Thu 9/1/16	133 days	Mary Bageard	Clinical
429	Group Structure Set up		15%	Tue 3/1/16	Thu 9/1/16	133 days	Mary Bageard	Clinical
430	Portal Configuration Complete		40%	Tue 3/1/16	Thu 12/15/16	208 days	Mary Bageard	Clinical
431	Clinical Assessments Configured and Complete		70%	Tue 3/1/16	Tue 11/1/16	176 days	Mary Bageard	Clinical
432	Sign Off of PRD		0%	Tue 3/1/16	Sun 5/1/16	45 days	Mary Bageard	Clinical

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
433	UAT Complete		0%	Tue 3/1/16	Thu 12/1/16	198 days	Mary Bageard	Clinical
434	Clinical Platform Built		0%	Tue 3/1/16	Tue 11/1/16	176 days	Mary Bageard	Clinical
435	**v. Utilization Management**		**66%**	**Tue 3/1/16**	**Sun 1/1/17**	**220 days**	**Mary Bageard**	Clinical
436	Develop UM Program description		90%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
437	Develop Practice Guidelines		90%	Tue 3/1/16	Wed 6/1/16	67 days	Mary Bageard	Clinical
438	Develop Service Authorization Requirements		90%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
439	Develop Pharmacy Service Authorization Requirements		80%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
440	Develop Concurrent Review Process		90%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
441	Develop Retrospective Utilization Review of Network Providers		90%	Tue 3/1/16	Sat 10/1/16	155 days	Mary Bageard	Clinical
442	Develop a medication therapy management (MTM) program		50%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
443	Develop Drug Utilization Review Program		80%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
444	Confirm Psychotropic Drug Oversight Readiness		0%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
445	Implement a Restricted Services Program		0%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
446	Establish a Utilization Management Committee		90%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
447	Establish a Clinical Advisory Committee		90%	Tue 3/1/16	Sun 1/1/17	220 days	Mary Bageard	Clinical
448	**vi. Transition and Care Coordination**		**49%**	**Wed 10/21/15**	**Sun 12/17/17**	**564 days?**	**Kathy Mallatt/Sean Jones/Adam Gillund**	**Health Plan/Implemenatino**
449	Create preliminary implementation plan		100%	Fri 10/23/15	Thu 12/3/15	30 days	Jennifer Brayton	IBA
450	Define Transition Period		0%	Tue 3/1/16	Tue 3/15/16	11 days	Jennifer Brayton	IBA
451	**Initiate collaboration with MLTC to review the contract, its proposal, and preliminary implementation plan**		**78%**	**Mon 11/2/15**	**Sun 1/1/17**	**306 days**	**Jennifer Brayton**	**IBA**
452	Defining project management and reporting standards		0%	Tue 3/1/16	Fri 4/1/16	24 days	Jennifer Brayton	IBA
453	Establishing communication protocols between the MCO, MLTC, and existing providers		0%	Tue 3/1/16	Fri 4/1/16	24 days	Jennifer Brayton	IBA
454	Defining expectations for the content and format of contract deliverables		0%	Tue 3/1/16	Mon 8/1/16	110 days	Jennifer Brayton	IBA
455	Resolving transition and implementation issues to MLTC's satisfaction		0%	Tue 3/1/16	Fri 12/30/16	219 days	Jennifer Brayton	IBA
456	Submit weekly implementation plan updates		0%	Tue 3/1/16	Sun 1/1/17	220 days	Jennifer Brayton	IBA
457	**Confirm the following key staff are in place:**		**100%**	**Mon 11/2/15**	**Fri 12/30/16**	**305 days**	**Ann Ribbens**	**Human Capital**
458	i. Chief Executive Officer.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
459	ii. Chief Operating Officer.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
460	iii. Medical Director/Chief Medical Officer.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
461	iv. Behavioral Health Clinical Director.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
462	v. Member Services Manager.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
463	vi. Provider Services Manager.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
464	vii. Information Management and Systems Director.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
465	viii. Quality Management Coordinator.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
466	ix. Case Management Administrator.		100%	Mon 11/2/15	Fri 12/30/16	305 days	Ann Ribbens	Human Capital
467	Develop Comprehensive Implementation Plan (post-award)		0%	Tue 3/1/16	Mon 3/14/16	10 days	Jennifer Brayton	Human Capital
468	Attest to network adequacy 90 days prior to Go-Live		0%	Tue 8/30/16	Sun 1/1/17	90 days	Jeremy Sand	Health Plan

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469	Network Development Plan updates - Updated upon contract award and bi-weekly until the contract effective date		50%	Tue 3/1/16	Sun 1/1/17	220 days	Jeremy Sand/Tekera Stanford	Health Plan/Network
470	**Personnel**		**25%**	**Tue 3/15/16**	**Tue 9/13/16**	**131 days**	**Kathy Mallatt/Ann Ribbens**	**Health Plan/Human Capital**
471	Key staff hired prior to readiness review		80%	Tue 3/15/16	Tue 9/13/16	131 days	Ann Ribbens/Sean Jones	Health Plan/Human Capital
472	Submit to MLTC the resumes of any key staff member (that was not submitted with the MCO's proposal)		0%	Tue 3/15/16	Mon 8/29/16	120 days	Timothy Langdon	Compliance
473	Submit updated organizational charts		0%	Tue 3/15/16	Mon 8/29/16	120 days	Timothy Langdon	Compliance
474	Ensure sufficient personnel working and operating in the State during the transition and implementation period in order to be fully compliant with the terms of the contract		0%	Tue 3/15/16	Fri 5/13/16	44 days	Ann Ribbens/Sean Jones	Health Plan/Human Capital
475	**Confirm ability to meet requirements regarding Transitioning of Managed Care Members and Operations**		**33%**	**Fri 1/1/16**	**Fri 12/30/16**	**261 days**	**Kathy Mallatt/Sean Jones/Adam Gillund**	**Health Plan/Implemenatino**
476	Collaborate with the current MCOs, the behavioral health MCO, the Pharmacy Benefits Manager, and providers to develop and implement care plans for members who require them during the transition and deliver all services contained in the plans		0%	Tue 3/1/16	Fri 12/30/16	219 days	Sean Jones	Health Plan Operations
477	Develop content to provide to each member affected by the transition including: service information, emergency telephone numbers, and instructions about how to obtain additional services		70%	Fri 1/1/16	Tue 8/30/16	173 days	Sean Jones/Kim Manning	Health Plan Operations
478	Develop P&P for the transition from the current MCO to the new MCO, pending grievances, appeals, and member/provider service issues to ensure their timely resolution		70%	Fri 1/1/16	Tue 8/30/16	173 days	Sean Jones/Heather Johnson	Health Plan Operations
479	Confirm a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings		0%	Fri 1/1/16	Tue 8/30/16	173 days	Sean Jones	Health Plan Operations
480	**Transitioning from the MLTC FFS Pharmacy Program to the UHC/OptumRx Pharmacy Program**		**0%**	**Wed 10/21/15**	**Tue 12/20/16**	**305 days**	**Jeanne Cavanaugh/Judy**	Pharmacy
481	Submit pharmacy transition plan		0%	Wed 10/21/15	Tue 12/15/15	40 days	Jeanne Cavanaugh/Judy Taylor	Pharmacy
482	Load current (state FFS or other MCO) / open prior authorization records		0%	Thu 9/1/16	Tue 12/20/16	79 days	Jeanne Cavanaugh/Judy	Pharmacy
483	**Readiness Review**		**0%**	**Tue 3/1/16**	**Sun 12/17/17**	**470 days?**	**Jennifer Brayton**	**IBA**
484	**Desk Review**		**0%**	**Tue 3/1/16**	**Sun 12/17/17**	**470 days?**	**Jennifer Brayton**	**IBA**
485	IBA/HP/Functional alignment on Roles		0%	Fri 7/1/16	Fri 7/1/16	1 day	Jennifer Brayton	IBA
486	**Define Readines Review Scope**		**0%**	Fri 7/1/16	Fri 7/1/16	**1 day?**	Jennifer Brayton	IBA
487	i. Network adequacy.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
488	ii. Staffing adequacy.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
489	iii. Subcontracts.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
490	iv. Provider services.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
491	v. Member services.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
492	vi. Quality management.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
493	vii. Care management.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
494	viii. Utilization management.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
495	ix. Financial management.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
496	x. Information processing and system testing.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
497	xi. Transition of behavioral health recipients.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
498	xii. Continuity of care.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
499	xiii. Grievance and appeal process.		0%	Tue 3/1/16	Mon 7/4/16	90 days	Jennifer Brayton	IBA
500	Identify readiness owners		0%	Fri 7/1/16	Thu 7/14/16	10 days	Jennifer Brayton	IBA
501	Schedule readiness meetings		0%	Fri 7/1/16	Thu 7/14/16	10 days	Jennifer Brayton	IBA
502	Compliance Approval of Readiness Documents		0%	Mon 8/15/16	Mon 8/15/16	1 day	Jennifer Brayton	IBA
503	**Submission of Readiness Documents**		**0%**	**Thu 9/1/16**	**Wed 3/1/17**	**131 days**	**Timothy Langdon**	**Compliance**
504	Member Handbook		0%	Thu 9/1/16	Thu 9/1/16	1 day	Timothy Langdon	Compliance
505	Marketing Plan		0%	Thu 9/1/16	Thu 9/1/16	1 day	Timothy Langdon	Compliance
506	Welcome Packet Contents		0%	Thu 9/1/16	Thu 9/1/16	1 day	Timothy Langdon	Compliance
507	Welcome Call Script		0%	Thu 9/1/16	Thu 9/1/16	1 day	Timothy Langdon	Compliance
508	Member Education Plan		0%	Thu 9/1/16	Thu 9/1/16	1 day	Timothy Langdon	Compliance
509	Enrollment Broker Policies and Procedures		0%	Thu 9/1/16	Thu 9/1/16	1 day	Timothy Langdon	Compliance
510	Provider Network List		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
511	Provider Network Sufficiency Attestation		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
512	Subcontracts		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
513	MCO Provider Website		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
514	Provider Training Handbook and Training Schedule		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
515	Provider Handbook		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
516	Pharmacy Claims Policies and Procedures		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
517	Pharmacy Pricing Rules and Algorithms		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
518	MAC Pricing Policies and Procedures		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
519	Care Management Program		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
520	Continuity of Care Policies and Procedures		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
521	HCBS Coordination Policies and Procedures		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
522	Pharmacy Coverage Policies and Procedures		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
523	Extemporaneously Compound Drugs Policies		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
524	Pharmacy Formulary		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
525	OTC Drug List		0%	Sat 10/1/16	Sat 10/1/16	1 day	Timothy Langdon	Compliance
526	QAPI Committee Description		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
527	QM Program Description and Goals		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
528	Remedial Action Policy and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
529	Corrective Action Triggers		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
530	Corrective Action Monitoring Policies and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
531	Provider Review Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
532	SHCN Care Quality Assessment		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
533	Clinical Advisory Committee Plan		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
534	Member Advisory Committee Plan		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
535	Tribal Members Coordination Policies and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
536	Coordination with Division of Family Services Policies and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
537	Health Risk Assessment Algorithms and Methodologies		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
538	PBM Independence Assurance Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
539	PBM Oversight Plan		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
540	Claims Dispute Process Policies and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
541	Physician Incentive Plan Contract Templates		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
542	Service Authorization Policies and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
543	Retrospective UR Functions Policies		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
544	Utilization Management Program Description		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
545	Drug Utilization Review Program Guidelines		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
546	Clinical Criteria for Drug Prior Authorization		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
547	Grievances and Appeals Policies and Procedures		0%	Tue 11/1/16	Tue 11/1/16	1 day	Timothy Langdon	Compliance
548	Amount, Duration, and Scope Policies		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
549	Lab Services Authorization Policies		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
550	Value-Added Services Descriptions		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
551	Provider Complaint System Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
552	Provider Directory Template		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
553	Human Resources and Staffing Plan		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
554	Key Staff List		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
555	Credentialing/Recredentialing Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
556	Provisional Credentialing for Behavioral Health		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
557	Network - Communication of Change Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
558	Network Compilance Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
559	Network Service Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
560	Network Insufficiency Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
561	Network Monitoring Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
562	Specialty Drug List		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
563	Compliance Plan		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
564	Fraud, Waste, Abuse and Erroneous Payments Policies		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
565	Advance Directives Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
566	Timely Access Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
567	Selection and Retention of Providers Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
568	Member Privacy Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
569	PCP Assignment Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
570	Second Opinions Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
571	Restricted Services Policies and Procedures		0%	Tue 11/15/16	Tue 11/15/16	1 day	Timothy Langdon	Compliance
572	Copies of Subcontractor Evaluations		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
573	TPL procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
574	Provider Preventable Conditions Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
575	Clinical Practice Guidelines		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
576	Emergency Medical and Post-Stabilization Services Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
577	Family Planning Services Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
578	Indian Health Protections Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
579	Direct Access to Women's Health Specialists Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
580	EPSDT Services Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
581	Staffing Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
582	Maintenance of Medical Records Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
583	Medical Record Confidentiality Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
584	Transportation Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
585	Dual Eligibles Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
586	Member Calls Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
587	Referrals Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
588	Brand Name Products Policies and Procedures		0%	Thu 12/1/16	Thu 12/1/16	1 day	Timothy Langdon	Compliance
589	PCMH Implementation Plan		0%	Wed 3/1/17	Wed 3/1/17	1 day	Timothy Langdon	Compliance
590	Value-Based Contracting Plan		0%	Sun 12/17/17	Sun 12/17/17	1 day	Timothy Langdon	Compliance
591	State review response to deficiencies		0%	Thu 9/1/16	Thu 3/30/17	151 days	**Jennifer Brayton**	IBA
592	**Onsite Review**		**0%**	**Fri 7/1/16**	**Sun 1/1/17**	**132 days**	**Jennifer Brayton**	**IBA**
593	**Onsite Kick-off**		**0%**	Fri 7/1/16	Fri 7/1/16	**1 day**	**Jennifer Brayton**	**IBA**
594	IBA/HP/Functional alignment on Roles		0%	Mon 8/1/16	Mon 8/1/16	1 day	Jennifer Brayton	IBA
595	Schedule onsite preperation meetings		0%	Mon 8/1/16	Mon 8/1/16	1 day	Jennifer Brayton	IBA
596	Onsite Logistics		0%	Mon 8/1/16	Mon 8/1/16	1 day	Jennifer Brayton	IBA
597	Complete onsite readiness review		0%	Tue 11/1/16	Tue 11/1/16	1 day	Jennifer Brayton	IBA
598	Follow-up Management		0%	Tue 11/1/16	Sun 1/1/17	45 days	Jennifer Brayton	IBA
599	**System Demo**		**0%**	**Mon 8/1/16**	**Tue 11/1/16**	**67 days**	**Jennifer Brayton**	**IBA**
600	IBA/HP/Functional alignment on Roles		0%	Mon 8/1/16	Mon 8/1/16	1 day	**Jennifer Brayton**	IBA
601	Test scenarios received		0%	Thu 9/1/16	Thu 9/1/16	1 day	Jennifer Brayton	IBA
602	Confirm functions/vendors to be tested		0%	Thu 9/1/16	Thu 9/1/16	1 day	Jennifer Brayton	IBA
603	Test Providers Loaded		0%	Fri 9/30/16	Fri 9/30/16	1 day	Jennifer Brayton	IBA
604	Test Members Loaded		0%	Fri 9/30/16	Fri 9/30/16	1 day	Jennifer Brayton	IBA
605	Test Environment Ready		0%	Fri 9/30/16	Fri 9/30/16	1 day	Jennifer Brayton	IBA
606	Test Config Complete		0%	Fri 9/30/16	Fri 9/30/16	1 day	Jennifer Brayton	IBA

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
607	Claims Team Prepared		0%	Fri 9/30/16	Fri 9/30/16	1 day	Jennifer Brayton	IBA
608	Vendor Teams Prepared		0%	Fri 9/30/16	Fri 9/30/16	1 day	Jennifer Brayton	IBA
609	Demonstration Presented		0%	Thu 9/1/16	Tue 11/1/16	44 days	Jennifer Brayton	IBA
610	Pre-Enrollment Validation		0%	Thu 12/1/16	Fri 12/30/16	22 days	Jennifer Brayton	IBA
611	Network Validation		0%	Thu 12/1/16	Fri 12/30/16	22 days	Jennifer Brayton	IBA
612	Follow-up Management		0%	Tue 11/1/16	Fri 12/30/16	44 days	Jennifer Brayton	IBA
613	**vii. Information Systems Management**		**22%**	**Wed 10/21/15**	**Wed 3/1/17**	**357 days**	**Cybele Kanin,Gabe Moreno, Amy Falk**	**IT and Configuration**
614	**System Configuration**		**18%**	**Fri 4/1/16**	**Fri 12/16/16**	**186 days**	**Travis Johnson**	**CCAM**
615	**Benefit Readiness (CCAM)**		**39%**	**Fri 4/1/16**	**Fri 9/30/16**	**131 days**	**Travis Johnson**	**CCAM**
616	**Benefit Matrix**		**34%**	**Fri 4/1/16**	**Wed 8/31/16**	**109 days**	Travis Johnson	**CCAM**
617	Benefit Matrix Kick-off		0%	Fri 4/1/16	Fri 4/1/16	1 day	Travis Johnson	CCAM
618	Benefit Matrix data / requirement gathering		80%	Fri 4/1/16	Wed 6/1/16	44 days	Travis Johnson	CCAM
619	Benefit Matrix HP Review and Approval		0%	Wed 6/15/16	Fri 7/15/16	23 days	Travis Johnson	CCAM
620	Submit and Review with Config Team		0%	Fri 7/15/16	Fri 7/15/16	1 day	Travis Johnson	CCAM
621	Revisit Assumptions to complete and share with Config Team		0%	Fri 7/15/16	Wed 8/31/16	34 days	Travis Johnson	CCAM
622	**Benefit Summary**		**57%**	**Mon 8/1/16**	**Fri 9/30/16**	**45 days**	**Travis Johnson**	**CCAM**
623	Benefit Summary Complete		80%	Mon 8/1/16	Wed 9/14/16	33 days	Travis Johnson	CCAM
624	Benefit Summary Meetings and Approval with HP & Call Centers		0%	Thu 9/15/16	Fri 9/30/16	12 days	Travis Johnson	CCAM
625	Benefit Summary to Config for Loading		0%	Fri 9/30/16	Fri 9/30/16	1 day	Travis Johnson	CCAM
626	**Benefit Configuration Dependencies**		**0%**	**Fri 7/1/16**	**Fri 7/1/16**	**1 day**	**Kurin Garro**	**Configuration**
627	Behavioral Health Limits Finalized and Approved		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
628	BH Prior Auth List Finalized and Approved		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
629	Mixed Services Protocol – Confirm Following the Standard		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
630	EPAL Finalized and Approved		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
631	Non-Covered Codes – Professional Finalized and Approved		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
632	Non-Covered Codes – Facility (if a non-covered code comes in on a facility claim, is it handled the same way as the professional)		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
633	POS 99 – Confirm Following the Standard		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
634	Adjunct Provider Policy – Confirm Following the Standard		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
635	Group Structure Received by Config Finalized and Approved		0%	Fri 7/1/16	Fri 7/1/16	1 day	Kurin Garro	Configuration
636	**Benefit Configuration Readiness (GFO)**		**15%**	**Wed 6/1/16**	**Wed 12/7/16**	**136 days**	**Kurin Garro**	**Configuration**
637	Group Structure Configured		80%	Wed 6/1/16	Thu 6/30/16	22 days	Kurin Garro	Configuration
638	Benefit Config Analysis		0%	Fri 7/15/16	Wed 8/17/16	24 days	Kurin Garro	Configuration
639	Benefit Configuration Complete and audited prior to testing turnover		0%	Fri 7/15/16	Wed 8/31/16	34 days	Kurin Garro	Configuration
640	Benefit Summary Configured (GFO)		0%	Sat 10/1/16	Fri 10/14/16	11 days	Kurin Garro	Configuration
641	Defect Remediation		0%	Thu 9/1/16	Thu 9/29/16	21 days	Kurin Garro	Configuration
642	Group Structure pushed to Production		0%	Fri 12/2/16	Wed 12/7/16	4 days	Kurin Garro	Configuration
643	Benefit Tables pushed to Production		0%	Fri 12/2/16	Wed 12/7/16	4 days	Kurin Garro	Configuration

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
644	**Configuration Testing (CQM)**		**0%**	**Mon 10/24/16**	**Fri 12/16/16**	**40 days**	**Theresa McNair**	**Testing**
645	Identify timelines, critical milestone dates, testing scope, and resources.		0%	Mon 5/2/16	Fri 7/1/16	45 days	Theresa McNair	Testing
646	Requirements completed and approved.		0%	Fri 7/15/16	Wed 8/17/16	24 days	Theresa McNair	Testing
647	Testing Requirements review with business partners		0%	Fri 7/1/16	Fri 7/1/16	1 day	Theresa McNair	Testing
648	Test plan, scope, scenario development		0%	Fri 7/15/16	Wed 8/31/16	34 days	Theresa McNair	Testing
649	Test plan/scenario review with and approval by Health Plan, business partner		0%	Thu 9/1/16	Thu 9/1/16	1 day	Theresa McNair	Testing
650	Test Environment Readiness		0%	Mon 8/15/16	Thu 9/1/16	14 days	Theresa McNair	Testing
651	Benefit configuration complete and audited prior to testing turnover		0%	Thu 9/1/16	Thu 9/1/16	1 day	Theresa McNair	Testing
652	Pricing configuration complete and audited prior to testing turnover		0%	Thu 9/1/16	Thu 9/1/16	1 day	Theresa McNair	Testing
653	Script Testing & Defect management		0%	Thu 9/1/16	Thu 9/29/16	21 days	Theresa McNair	Testing
654	Parallel testing and defect management		0%	Thu 9/1/16	Thu 9/29/16	21 days	Theresa McNair	Testing
655	Testing results review and sign off		0%	Mon 10/3/16	Mon 10/3/16	1 day	Theresa McNair	Testing
656	Testing close-out		0%	Mon 10/3/16	Mon 10/3/16	1 day	Theresa McNair	Testing
657	**Technology / IT / Testing**		**0%**	**Wed 10/21/15**	**Wed 3/1/17**	**357 days?**	**Cybele Kanin**	**IT**
658	**Initiate Phase**		**0%**	**Wed 10/21/15**	**Mon 5/16/16**	**148.9 days?**	**Julie Serverson**	**IT**
659	BVD & Program Initiation		0%	**Wed 10/21/15**	**Thu 1/21/16**	67 days	Julie Serverson	IT
660	Project Schedule		0%	**Wed 10/21/15**	**Mon 5/16/16**	148.9 days?	Julie Serverson	IT
661	Budgetary Guidance Estimate		0%	**Mon 1/18/16**	**Tue 3/1/16**	32 days?	Julie Serverson	IT
662	Project Release Commitment (Booking)		0%	**Wed 3/23/16**	**Tue 3/29/16**	5 days	Julie Serverson	IT
663	**Definition & Analysis Phase**		**0%**	**Mon 2/1/16**	**Thu 4/14/16**	**54 days**	**Julie Serverson**	**IT**
664	Requirement Gathering		0%	Tue 2/2/16	Mon 3/7/16	25 days	Julie Serverson	IT
665	Solutioning		0%	Fri 3/25/16	Thu 4/14/16	15 days	Julie Serverson	IT
666	**DESIGN & ENGINEERING Phase**		**0%**	**Thu 4/14/16**	**Tue 7/19/16**	**69 days**	**Julie Serverson**	**IT**
667	HLD - High Level Design		0%	Thu 4/14/16	Tue 7/19/16	69 days	Julie Serverson	IT
668	**DEVELOP & CONSTRUCT Phase**		**0%**	**Tue 8/30/16**	**Tue 8/30/16**	**1 day?**	**Julie Serverson**	**IT**
669	Code Turnover Date		0%	Tue 8/30/16	Tue 8/30/16	1 day?	Julie Serverson	IT
670	**INTEGRATE & UAT TEST Phase**		**0%**	**Wed 8/31/16**	**Wed 11/9/16**	**51 days**	**Julie Serverson**	**IT**
671	System Integration Test		0%	Wed 8/31/16	Mon 10/10/16	29 days	Julie Serverson	IT
672	UAT Testing		0%	Wed 11/9/16	Wed 11/9/16	1 day	Julie Serverson	IT
673	**CODE FREEZE**		0%	**Tue 11/1/16**	**Thu 11/10/16**	8 days	**Julie Serverson**	**IT**
674	**DEPLOY Phase**		0%	**Sat 11/12/16**	**Sat 11/12/16**	0 days	Julie Serverson	IT
675	**PRODUCTION GO LIVE**		**0%**	**Mon 11/14/16**	**Wed 3/1/17**	**79 days?**	**Julie Serverson**	**IT**
676	**Provider Go Live**		**0%**	**Mon 11/14/16**	**Thu 11/24/16**	**9 days?**	**Julie Serverson**	**IT**
677	**Production Verification**		**0%**	**Mon 11/14/16**	**Thu 11/24/16**	**9 days?**	**Julie Serverson**	**IT**
678	Network Production Ready		0%	Mon 11/14/16	Mon 11/14/16	1 day?	Julie Serverson	IT
679	Provider Directory		0%	Thu 11/24/16	Thu 11/24/16	1 day?	Julie Serverson	IT

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
680	**Enrollment Go Live (system processing)**		**0%**	**Tue 11/15/16**	**Mon 12/5/16**	**15 days**	**Julie Serverson**	**IT**
681	**Production Verification**		**0%**	**Tue 11/15/16**	**Mon 12/5/16**	**15 days**	**Julie Serverson**	**IT**
682	First Production 834/Supp Daily		0%	Tue 11/15/16	Thu 11/17/16	3 days	Julie Serverson	IT
683	First ID Card Extract		0%	Fri 11/18/16	Mon 11/21/16	2 days	Julie Serverson	IT
684	First New Member Kit Extract		0%	Tue 11/22/16	Wed 11/23/16	2 days	Julie Serverson	IT
685	First Downstream Elig File Extracts (as many as needed)		0%	Thu 11/24/16	Tue 11/29/16	4 days	Julie Serverson	IT
686	Vendor Verification (as many as needed)		0%	Wed 11/30/16	Mon 12/5/16	4 days	Julie Serverson	IT
687	First Production 834/Supp Weekly/Monthly		0%	Fri 11/18/16	Mon 11/28/16	7 days	Julie Serverson	IT
688	**Clinical Go live**		0%	**Wed 11/16/16**	**Wed 11/16/16**	1 day	Julie Serverson	IT
689	**Portal Go Live**		**0%**	**Sun 1/1/17**	**Mon 1/2/17**	**2 days**	**Julie Serverson**	**IT**
690	Production Verification		**0%**	**Sun 1/1/17**	**Mon 1/2/17**	**2 days**	Julie Serverson	IT
691	Provider Portal		0%	Sun 1/1/17	Mon 1/2/17	2 days	Julie Serverson	IT
692	Member Portal		0%	Sun 1/1/17	Mon 1/2/17	2 days	Julie Serverson	IT
693	**Claims Go live**		**0%**	**Sun 1/1/17**	**Wed 3/1/17**	**44 days**	**Julie Serverson**	**IT**
694	**Production Verification**		**0%**	**Sun 1/1/17**	**Wed 3/1/17**	**44 days**	**Julie Serverson**	**IT**
695	Claim Audit		0%	Sun 1/1/17	Wed 3/1/17	44 days	Julie Serverson	IT
696	Claim Release		0%	Mon 1/16/17	Mon 1/16/17	1 day	Julie Serverson	IT
697	**Finance Go Live**		**0%**	**Mon 1/9/17**	**Tue 1/10/17**	**2 days?**	**Julie Serverson**	**IT**
698	1st 820 File		0%	Mon 1/9/17	Mon 1/9/17	1 day?	Julie Serverson	IT
699	Process 820 file		0%	Mon 1/9/17	Tue 1/10/17	2 days?	Julie Serverson	IT
700	**Encounter Go Live**		**0%**	**Wed 2/1/17**	**Thu 2/2/17**	**2 days**	**Julie Serverson**	**IT**
701	Production Go Live		0%	**Wed 2/1/17**	**Thu 2/2/17**	2 days	Julie Serverson	IT
702	**POST DEPLOYMENT Phase**		**0%**	**Sun 1/1/17**	**Wed 3/1/17**	**44 days**	**Julie Serverson**	**IT**
703	Post Deployment Warranty Monitoring		0%	**Sun 1/1/17**	**Wed 3/1/17**	44 days	Julie Serverson	IT
704	**Documentation - State Submissions**		**62%**	**Mon 8/1/16**	**Sat 12/31/16**	**110 days**	**Julie Serverson**	**IT**
705	Provide to MLTC an annual systems refresh plan		0%	Tue 11/1/16	Sat 12/31/16	45 days	Julie Serverson	IT
706	Develop a Technology Contingency Plan		90%	Tue 11/1/16	Sat 12/31/16	45 days	Julie Serverson	IT
707	Develop required Policies and Procedures		75%	Mon 8/1/16	Sat 12/31/16	111 days	Julie Serverson	IT
708	**Business Intelligence**		**42%**	**Mon 5/23/16**	**Wed 3/1/17**	**204 days**	**Lalanna Yoder**	**BI**
709	Receive new CSP Group Structure		0%	Mon 5/23/16	Fri 8/12/16	60 days	Lalanna Yoder	BI
710	**Reporting**		**53%**	**Mon 5/23/16**	**Thu 3/16/17**	**215 days**	**Lalanna Yoder**	**BI**
711	Receive Finalized RFP and/or Contract Reporting List from State		85%	Wed 10/21/15	Tue 5/17/16	150 days	Lalanna Yoder	BI
712	Define BI Reporting Scope & assign Analyst		0%	Mon 7/25/16	Fri 9/23/16	45 days	Lalanna Yoder	BI
713	Go-Live Reports - BI Report development / coding complete and Numara ticket closed		0%	Sun 1/1/17	Sun 1/1/17	1 day	Lalanna Yoder	BI
714	Post Go-Live Reports - BI Report development / coding complete and Numara ticket closed		0%	Sun 1/1/17	Wed 3/1/17	44 days	Lalanna Yoder	BI
715	**SMART Data Warehouse Tasks**		**0%**	**Fri 12/30/16**	**Wed 3/29/17**	**65 days**	**Lalanna Yoder**	**BI**
716	Complete Unit Testing		0%	Thu 12/15/16	Fri 12/16/16	1 day	Lalanna Yoder	BI

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
717	Deploy into Production		0%	Tue 12/20/16	Mon 12/26/16	5 days	Lalanna Yoder	BI
718	**viii. Claims Management**		**26%**	**Thu 1/1/15**	**Wed 5/31/17**	**631 days**	**Patti Jocham**	
719	**Claims and Claims Rework**		**34%**	**Fri 1/8/16**	**Tue 1/31/17**	**279 days**	**Patti Jocham**	**Claims**
720	**Requirements and Configuration**		**64%**	**Fri 1/8/16**	**Wed 11/2/16**	**214 days**	Patti Jocham	Claims
721	All Requirements defined		80%	Fri 1/8/16	Thu 8/4/16	150 days	Patti Jocham	Claims
722	Performance Gurantees defined		100%	Fri 1/8/16	Thu 8/4/16	150 days	Patti Jocham	Claims
723	BH Integration strategy defined		80%	Tue 3/22/16	Sat 9/3/16	120 days	Patti Jocham	Claims
724	Need for Auth Waiver defined		80%	Tue 3/22/16	Sat 9/3/16	120 days	Patti Jocham	Claims
725	Continuity Of Care Strategy determine If Applicable		50%	Tue 3/22/16	Sat 9/3/16	120 days	Patti Jocham	Claims
726	All Requirements solutioned and cofigured		0%	Tue 5/31/16	Mon 10/3/16	90 days	Patti Jocham	Claims
727	All BAR Requirements solutioned and configured		0%	Thu 8/11/16	Wed 11/2/16	60 days	Patti Jocham	Claims
728	**Testing**		**0%**	**Tue 3/22/16**	**Sat 12/17/16**	**194 days**	Patti Jocham	Claims
729	Test Strategy Developed/Communicated to UAT Lead		0%	Tue 3/22/16	Sat 9/3/16	120 days	Patti Jocham	Claims
730	Test scenarios completed		0%	Thu 5/19/16	Wed 9/28/16	95 days	Patti Jocham	Claims
731	Test Scenarios Loaded		0%	Tue 5/31/16	Mon 10/3/16	90 days	Patti Jocham	Claims
732	Test Scenarios Executed and Passed w/o Defects		0%	Tue 11/29/16	Sat 12/17/16	15 days	Patti Jocham	Claims
733	**Onsite/Desktop Review Readiness**		**14%**	**Fri 1/8/16**	**Fri 1/8/16**	**1 day**	Patti Jocham	Claims
734	P&Ps Complete		65%	Wed 8/24/16	Thu 9/1/16	7 days	Patti Jocham	Claims
735	Readiness Presentation Slides Complete		0%	TBD	TBD	7 days	Patti Jocham	Claims
736	Claim Examples Defined and held		0%	TBD	TBD	2 days	Patti Jocham	Claims
737	Dry Run Completed		0%	TBD	TBD	2 days	Patti Jocham	Claims
738	Desktop and Site Review Questions Remediated		0%	TBD	TBD	14 days	Patti Jocham	Claims
739	**Claim Go Live Readiness**		**0%**	**Tue 3/22/16**	**Tue 1/31/17**	**227 days**	Patti Jocham	Claims
740	Confirm New Day Training Classes Scheduled		0%	Tue 3/22/16	Sat 9/3/16	120 days	Patti Jocham	Claims
741	Confirm Up-Training Classes Scheduled		0%	Tue 5/31/16	Mon 10/3/16	90 days	Patti Jocham	Claims
742	Post Go Live Strategy Developed		0%	Mon 10/24/16	Fri 12/2/16	30 days	Patti Jocham	Claims
743	Rework letters Updated		0%	Mon 10/24/16	Fri 12/2/16	30 days	Patti Jocham	Claims
744	Check write schedule and BRC Update Confirmed		0%	Tue 11/8/16	Sat 12/17/16	30 days	Patti Jocham	Claims
745	Confirm New Day Training Complete		0%	Thu 12/22/16	Tue 1/31/17	30 days	Patti Jocham	Claims
746	Confirm Up-Training Complete		0%	Wed 12/28/16	Mon 1/16/17	15 days	Patti Jocham	Claims
747	Onsite Claim support completed		0%	Fri 12/30/16	Wed 1/11/17	10 days	Patti Jocham	Claims
748	SOP Development Complete		0%	Thu 12/22/16	Tue 1/31/17	30 days	Patti Jocham	Claims
749	**Encounters - State Submission/Caid**		**32%**	Tue 8/30/16	**Tue 1/31/17**	**112 days?**	**Michael Policky**	**Encounters**
750	Identify changes from old contract/BAR verification		100%	Wed 10/21/15	Tue 12/1/15	30 days	Michael Policky	Compliance
751	Identify state-specific encounter requirements that are not in contract or companion guide		0%	Wed 10/21/15	Tue 12/1/15	30 days	Michael Policky	Encounters
752	Obtain finalized state companion guide		0%	Tue 5/3/16	Tue 5/3/16	1 day	Michael Policky	Encounters
753	Define state encounter testing and production timelines		0%	Mon 2/1/16	Fri 2/5/16	5 days	Michael Policky	NEMIS IT
754	Ensure data is available for testing – claims and provider		0%	Mon 9/12/16	Fri 9/16/16	5 days	Michael Policky	NEMIS IT

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
755	Encounter Post go-live readiness		0%	Mon 1/2/17	Tue 1/31/17	22 days	Michael Policky	NEMIS IT
756	**PRA**		**49%**	**Tue 12/1/15**	**Sun 1/1/17**	**285 days**	**Tammy Cronan Fears**	**PRA**
757	Review Contractual Requirements		100%	Tue 12/1/15	Fri 2/19/16	59 days	Tammy Cronan Fears	PRA
758	Template completed base on contract requirements		80%	Mon 2/22/16	Fri 3/11/16	15 days	Tammy Cronan Fears	PRA
759	HP Approval of template		0%	Mon 3/14/16	Mon 4/11/16	21 days	Tammy Cronan Fears	PRA
760	Template sent to PE & UAT Lead		0%	Mon 4/4/16	Fri 4/8/16	5 days	Tammy Cronan Fears	PRA
761	UAT Template Completed		0%	Mon 4/11/16	Fri 4/29/16	15 days	Tammy Cronan Fears	PRA
762	UAT Template sent to UAT Lead		0%	Mon 5/2/16	Fri 5/6/16	5 days	Tammy Cronan Fears	PRA
763	UAT Defect & Remediation		0%	Mon 12/5/16	Sun 1/1/17	21 days	Tammy Cronan Fears	PRA
764	Approved and moved to Production		0%	Tue 12/27/16	Sun 1/1/17	5 days	Tammy Cronan Fears	PRA
765	**Payment Integrity**		**19%**	**Tue 3/1/16**	**Tue 1/31/17**	**242 days**	**Timothy Langdon/Tiffany Hoover/Mark Gregg**	**Payment Integrity**
766	Develop required Program Integrity Policies and Procedures		80%	Tue 3/1/16	Fri 12/30/16	219 days	Timothy Langdon/Tiffany Hoover/Mark Gregg	Payment Integrity
767	**ARO/Subro/ICC/DMRO Readiness**		**13%**	**Fri 1/1/16**	**Sun 1/1/17**	**262 days**	**Tiffany Hoover/Mark Gregg/Kristina**	**Payment Integrity - ARO/Subrogation**
768	Identification of Key Data Elements		100%	Sat 7/2/16	Sat 9/3/16	47 days	Justin Orr	Payment Integrity - ARO/Subrogation
769	System updates completed for the Key Data Elements		0%	Sat 7/2/16	Mon 10/3/16	67 days	Justin Orr	Payment Integrity - ARO/Subrogation
770	New Business Processes or Changes to Existing Processes Identified		0%	Sat 7/2/16	Thu 10/13/16	75 days	Justin Orr	Payment Integrity - ARO/Subrogation
771	Reporting development identification		0%	Sat 9/3/16	Wed 11/2/16	44 days	Justin Orr	Payment Integrity - ARO/Subrogation
772	Reporting development completed		0%	Sat 9/3/16	Wed 11/2/16	44 days	Justin Orr	Payment Integrity - ARO/Subrogation
773	Implementation Execution		0%	Sun 1/1/17	Sun 1/1/17	1 day	Justin Orr	Payment Integrity - ARO/Subrogation
774	Post deployment Issue reporting		0%	Sun 1/1/17	Wed 2/1/17	24 days	Justin Orr	Payment Integrity - ARO/Subrogation
775	Business Validation		0%	Sun 1/1/17	Sat 4/1/17	67 days	Justin Orr	Payment Integrity - ARO/Subrogation
776	**Fraud/Waste/Abuse/Error Readiness**		**7%**	**Tue 3/1/16**	**Sat 3/4/17**	**265 days**	**Timothy Langdon/Tiffany Hoover/Mark Gregg/Kristina Gunderson**	**Payment Integrity - WAE**
777	Develop FWA and erroneous payments compliance plan		0%	Tue 3/1/16	Fri 12/30/16	219 days	Timothy Langdon/April Bauer	Payment Integrity - WAE
778	Identification of Key Data Elements		100%	Tue 8/23/16	Tue 11/1/16	51 days	April Bauer	Payment Integrity - WAE

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
779	System updates completed for the Key Data Elements		0%	Tue 8/23/16	Fri 12/2/16	74 days	April Bauer	Payment Integrity - WAE
780	New Business Processes or Changes to Existing Processes Identified & Completed		0%	Tue 8/23/16	Fri 12/2/16	74 days	April Bauer	Payment Integrity - WAE
781	Reporting development identification		0%	Tue 8/23/16	Fri 12/2/16	74 days	April Bauer	Payment Integrity - WAE
782	Reporting development completed		0%	Tue 8/23/16	Fri 12/2/16	74 days	April Bauer	Payment Integrity - WAE
783	Internal UAT test scenarios and scripts written		0%	Tue 11/15/16	Fri 12/16/16	24 days	April Bauer	Payment Integrity - WAE
784	Internal UAT Completed		0%	Tue 11/15/16	Fri 12/16/16	24 days	April Bauer	Payment Integrity - WAE
785	Implementation Execution		0%	Tue 11/15/16	Sun 1/1/17	35 days	April Bauer	Payment Integrity - WAE
786	Post deployment Issue reporting		0%	Sun 1/1/17	Fri 3/3/17	46 days	April Bauer	Payment Integrity - WAE
787	Business Validation		0%	Sun 1/1/17	Sat 3/4/17	47 days	April Bauer	Payment Integrity - WAE
788	**High Dollar Readiness**		**0%**	**Fri 10/28/16**	**Fri 2/10/17**	**77 days**	**Tiffany Hoover/Mark Gregg/Kristina**	**Payment Integrity - High Dollar**
789	System updates completed for the Key Data Elements		0%	Fri 10/28/16	Wed 11/2/16	4 days	Michael Perkins	Payment Integrity - High
790	Reporting development identification		0%	Sun 11/27/16	Fri 12/2/16	6 days	Michael Perkins	Payment Integrity - High
791	Post deployment Issue reporting		0%	Sun 1/1/17	Fri 2/10/17	31 days	Michael Perkins	Payment Integrity - High
792	Business Validation		0%	Sun 1/1/17	Tue 1/31/17	23 days	Michael Perkins	Payment Integrity - High
793	**COB Readiness**		**37%**	**Tue 8/23/16**	**Thu 3/2/17**	**139 days**	**Tiffany Hoover/Mark Gregg/Kristina**	**Payment Integrity - COB**
794	Identification of Key Data Elements		100%	Tue 8/23/16	Tue 11/22/16	66 days	Diane Reece	Payment Integrity - COB
795	New Business Processes or Changes to Existing Processess Identified		80%	Sun 10/2/16	Sat 12/17/16	57 days	Diane Reece	Payment Integrity - COB
796	New Business Processes or Changes to Existing Processess Completed		0%	Sun 10/2/16	Sat 12/17/16	57 days	Diane Reece	Payment Integrity - COB
797	Reporting development identification		0%	Tue 8/23/16	Sat 9/3/16	10 days	Diane Reece	Payment Integrity - COB
798	Reporting development completed		0%	Tue 8/23/16	Sat 9/3/16	10 days	Diane Reece	Payment Integrity - COB
799	Internal UAT test scenarios and scripts written		0%	Wed 11/2/16	Thu 11/17/16	12 days	Diane Reece	Payment Integrity - COB
800	Internal UAT Completed		0%	Sat 11/12/16	Tue 11/22/16	8 days	Diane Reece	Payment Integrity - COB
801	Implementation Execution		0%	Mon 12/19/16	Sat 12/31/16	10 days	Diane Reece	Payment Integrity - COB
802	Post deployment Issue reporting		0%	Sun 1/1/17	Thu 3/2/17	45 days	Diane Reece	Payment Integrity - COB
803	Business Validation		0%	Sun 1/1/17	Tue 1/31/17	23 days	Diane Reece	Payment Integrity - COB
804	**Payment Policy/ICES/CES/Webstrat Readiness**		**0%**	**Fri 7/1/16**	**Sun 1/1/17**	**132 days**	**Tiffany Hoover/Mark Gregg/Kristina**	**Payment Policy/ICES/CES/Webstr**
805	System updates completed for the Key Data Elements		0%	Thu 9/1/16	Tue 11/1/16	44 days	Katie Schallie & Peggy Gottschalk	Payment Integrity - Payment Policy
806	New Business Processes or Changes to Existing Processes Identified		0%	Thu 7/28/16	Thu 10/6/16	51 days	Katie Schallie & Peggy Gottschalk	Payment Integrity - Payment Policy
807	Implement new polices/policy changes		0%	Thu 7/28/16	Thu 10/6/16	51 days	Katie Schallie & Peggy Gottschalk	Payment Integrity - Payment Policy
808	Provider Notification if Needed		0%	Fri 7/1/16	Thu 12/15/16	120 days	Katie Schallie & Peggy Gottschalk	Payment Integrity - Payment Policy

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
809	New Business Processes or Changes to Existing Processes Completed		0%	Thu 7/28/16	Tue 11/1/16	69 days	Katie Schallie & Peggy Gottschalk	Payment Integrity - Payment Policy
810	Post deployment Issue reporting		0%	Thu 7/28/16	Sun 1/1/17	113 days	Katie Schallie & Peggy Gottschalk	
811	**SAM Editing Readiness**		**39%**	Sun 1/1/17	Thu 3/2/17	45 days	**Tiffany Hoover/Mark Gregg/Kristina**	**Payment Integrity - Payment Policy**
812	New Business Processes or Changes to Existing Processes Identified		80%	Sat 9/3/16	Fri 12/2/16	66 days	Darla Lake	Payment Integrity - SAM
813	Post deployment Issue reporting		0%	Sun 1/1/17	Thu 3/2/17	45 days	Darla Lake	Payment Integrity - Payment Policy
814	Business Validation		0%	Sun 1/1/17	Tue 1/31/17	23 days	Darla Lake	Payment Integrity - Payment Policy
815	**ix. Grievances and Appeals (including Provider Complaints)**		**22%**	**Sun 11/1/15**	**Sun 1/1/17**	**307 days**	**Patti Jocham**	
816	**Appeals & Grievances**		**18%**	**Sun 11/1/15**	**Sun 1/1/17**	**307 days**	**Randy Skadsberg**	**Appeals & Grievances**
817	Solution Requirements		0%	**Sun 11/1/15**	Wed 6/1/16	154 days	Randy Skadsberg	Appeals & Grievances
818	Workflow and Track changes are completed		0%	**Sun 11/1/15**	Wed 6/1/16	154 days	Randy Skadsberg	Appeals & Grievances
819	Update P&Ps and obtain approval		60%	**Sun 11/1/15**	Sat 10/1/16	242 days	Randy Skadsberg	Appeals & Grievances
820	SOP Completion		60%	**Sun 11/1/15**	Sat 10/1/16	242 days	Randy Skadsberg	Appeals & Grievances
821	Staffing in Place		75%	**Sun 11/1/15**	Thu 12/1/16	285 days	Randy Skadsberg	Appeals & Grievances
822	Obtain approved letter template from state and HP		0%	**Sun 11/1/15**	Tue 11/1/16	263 days	Randy Skadsberg	Appeals & Grievances
823	Client Letters in Production		0%	**Sun 11/1/15**	Thu 12/1/16	285 days	Randy Skadsberg	Appeals & Grievances
824	A&G ETS System Update		0%	**Sun 11/1/15**	Sat 10/1/16	242 days	Randy Skadsberg	Appeals & Grievances
825	A&G reporting capability developed		0%	**Sun 11/1/15**	Thu 12/1/16	285 days	Randy Skadsberg	Appeals & Grievances
826	Plan and Execute Training		0%	**Sun 11/1/15**	Thu 12/15/16	295 days	Randy Skadsberg	Appeals & Grievances
827	Post Implementation Monitoring (Scorecard)		0%	**Sun 11/1/15**	Mon 5/1/17	393 days	Randy Skadsberg	Appeals & Grievances
828	**Provider Complaint System (aligned to A&G)**		**71%**	**Tue 3/1/16**	**Tue 11/15/16**	**186 days**	**Sean Jones/Mark Britton/Randy Skadsberg**	**Provider Complaints/A&G**
829	Develop Provider Complaint System Policies and Procedures		75%	Wed 5/18/16	Tue 11/1/16	120 days	Sean Jones/Mark Britton/Randy Skadsberg	Provider Complaints/A&G
830	Ensure Provider Complaint System Readiness		75%	Wed 6/1/16	Tue 11/15/16	120 days	Sean Jones/Mark Britton/Randy Skadsberg	Provider Complaints/A&G
831	Identify key staff person specifically designated to receive and process provider complaints		0%	Tue 3/1/16	Mon 3/21/16	15 days	Sean Jones/Mark Britton/Randy	Provider Complaints/A&G
832	**x. Staffing and Real Estate**		**5%**	**Thu 8/13/15**	**Tue 1/3/17**	**365 days**	**Ann Ribbens/Kathy Mallatt**	**Human Capital**
833	**Human Capital**		**7%**	**Thu 8/13/15**	**Fri 12/30/16**	**362 days**	**Ann Ribbens**	**Human Capital**
834	Finalize Org Design		50%	Fri 8/21/15	Fri 11/20/15	66 days	Ann Ribbens	Human Capital
835	Assign Recruitment Project Manager		100%	Thu 8/13/15	Thu 8/13/15	1 day	Suzanne Oxley	Human Capital
836	Identify Key Staff & vacancies/required for key positions & staff		100%	Thu 10/22/15	Fri 11/20/15	22 days	Ann Ribbens	Human Capital

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
837	Governance Review and Approval of Key Roles		0%	Tue 3/15/16	Tue 3/15/16	1 day	Ann Ribbens	Human Capital
838	Finalize the Pre -Award Staffing Plan		0%	Fri 11/6/15	Mon 12/7/15	22 days	Jaydon Mitchell	Human Capital
839	Create Recruiting Strategy & Media Plans		0%	Tue 12/1/15	Fri 1/1/16	24 days	Jaydon Mitchell	Human Capital
840	Refresh the Post-Award Staffing Plan		0%	Tue 3/1/16	Fri 4/1/16	24 days	Jaydon Mitchell	Human Capital
841	Governance Approval of Post-Award Staffing Plan		0%	Fri 4/1/16	Fri 4/1/16	1 day	Ann Ribbens Suzanne Oxley	Human Capital
842	Post Requisitions		0%	Tue 12/15/15	Thu 9/1/16	188 days	Ann Ribbens Suzanne Oxley	Human Capital
843	**Staff hired**		**0%**	**Tue 3/15/16**	**Sat 12/31/16**	**209 days**	**Ann Ribbens**	**Human Capital**
844	Confirm All Requisitions Filled (For new FTEs required)		0%	Tue 3/15/16	Sat 12/31/16	210 days	Ann Ribbens	Human Capital
845	Assimilate Key Leadership Roles		0%	Tue 3/15/16	Sat 12/31/16	210 days	Ann Ribbens	Human Capital
846	**Real Estate**		**0%**	**Fri 1/1/16**	**Tue 1/3/17**	**264 days**	**Tami Kurtzweil**	**Real Estate**
847	RES/Business Alignment on New Requirement		50%	Fri 1/1/16	Fri 1/1/16	1 day	Tami Kurtzweil	Real Estate
848	RES Project Team (Internal) Alignment and Kick Off		0%	Sat 1/2/16	Tue 2/9/16	28 days	Tami Kurtzweil	Real Estate
849	Customer (External) Kick Off		0%	Sat 1/30/16	Thu 2/18/16	15 days	Tami Kurtzweil	Real Estate
850	Building Tours		0%	Sun 2/14/16	Fri 3/11/16	21 days	Tami Kurtzweil	Real Estate
851	Programming		0%	Sun 3/6/16	Wed 3/23/16	14 days	Tami Kurtzweil	Real Estate
852	Final Building Approved (following RFP and Financial Analysis Review)		0%	Sun 3/20/16	Fri 5/13/16	41 days	Tami Kurtzweil	Real Estate
853	Final Allocation Plan Approved		0%	Sat 4/30/16	Thu 6/2/16	25 days	Tami Kurtzweil	Real Estate
854	Capital Committee Approval		0%	Wed 5/25/16	Thu 7/21/16	42 days	Tami Kurtzweil	Real Estate
855	Lease Execution		0%	Wed 7/6/16	**Wed 8/3/16**	21 days	Tami Kurtzweil	Real Estate
856	Submit for Permit		0%	Wed 7/27/16	Tue 8/23/16	20 days	Tami Kurtzweil	Real Estate
857	Permit Approved		0%	Tue 8/16/16	Thu 9/22/16	28 days	Tami Kurtzweil	Real Estate
858	Move Sheet Completed by Business		0%	Tue 9/13/16	Tue 1/3/17	82 days	Tami Kurtzweil	Real Estate
859	Construction		0%	Sun 12/4/16	Mon 12/5/16	2 days	Tami Kurtzweil	Real Estate
860	Occupancy		0%	Tue 12/6/16	Sat 12/31/16	20 days	Tami Kurtzweil	Real Estate
861	**Go-Live Execution**		**0%**	**Tue 11/1/16**	**Tue 3/21/17**	**102 days**	**Jennifer Brayton**	
862	**Go-Live Prep**		**0%**	**Tue 11/1/16**	**Fri 12/30/16**	**44 days**	**Jennifer Brayton**	**IBA**
863	Assessment of Manual Workaround Form Completion & Sign off		0%	Tue 11/1/16	Fri 12/30/16	44 days	Jennifer Brayton	IBA
864	Confirm all state readiness & go-live meetings		0%	Thu 12/1/16	Sat 12/31/16	23 days	Jennifer Brayton	IBA
865	Schedule mock Member and Provider Call Center Calls		0%	Tue 11/1/16	Mon 11/7/16	5 days	Jennifer Brayton	IBA
866	Complete mock Member and Provider Call Center calls		0%	Tue 11/1/16	Thu 12/1/16	23 days	Jennifer Brayton	IBA
867	Create Daily Go-Live ScoreCard		0%	Tue 11/1/16	Tue 11/15/16	11 days	Jennifer Brayton	IBA
868	Confirm Daily Scorecard Owners		0%	Tue 11/1/16	Tue 11/1/16	1 day	Jennifer Brayton	IBA
869	Week of go-live Mailing Fulfillment Check		0%	Fri 12/23/16	Sun 1/1/17	7 days	Jennifer Brayton	IBA
870	Set up Claims War Room		0%	Thu 12/1/16	Thu 12/1/16	1 day	Jennifer Brayton	IBA
871	Request Claims report		0%	Thu 12/1/16	Thu 12/1/16	1 day	Jennifer Brayton	IBA
872	**Post Implementation Monitoring (Go-Live to 60 Days Post Go-Live)**		**0%**	**Sun 1/1/17**	**Wed 3/1/17**	**44 days**	**Jennifer Brayton**	**IBA**
873	Go Live Scorecard Metrics Tracking Begins		0%	Sun 1/1/17	Sun 1/1/17	1 day	Jennifer Brayton	IBA

ID	Task Name	Health Status	% Complet	Start	Finish	Duration	Resource Names	Functional Area
874	Attend all state go-live meetings (DH, DD, Rx Benefit configuration complete , Provider etc)		0%	Sun 1/1/17	Wed 3/1/17	44 days	Jennifer Brayton	IBA
875	Start Daily Go Live Monitoring Calls		0%	Mon 1/2/17	Wed 3/1/17	43 days	Jennifer Brayton	IBA
876	**Project Closure (Go-Live to 60 Days Post Go-Live)**		**0%**	**Sun 1/1/17**	**Tue 3/21/17**	**58 days**	**Jennifer Brayton**	**IBA**
877	Project Transition (Monitoring) to HP Complete		0%	Wed 2/15/17	Fri 3/10/17	18 days	Jennifer Brayton	IBA
878	Create Transition Plan		0%	Wed 2/15/17	Fri 2/24/17	8 days	Jennifer Brayton	IBA
879	Communicate Transition Plan		0%	Mon 2/27/17	Tue 3/7/17	7 days	Jennifer Brayton	IBA
880	IBA transition to health plan and functional areas		0%	Wed 2/15/17	Fri 3/10/17	18 days	Jennifer Brayton	IBA
881	Health Plan approves ownership/transition to Steady State (45 days post Go-Live)		0%	Wed 3/1/17	Wed 3/1/17	1 day	Jennifer Brayton	HP
882	Assume Transition of the HP Operations (60 Days post Go-Live)		0%	Wed 3/1/17	Wed 3/1/17	1 day	Jennifer Brayton	HP
883	Project Close		0%	Wed 3/1/17	Wed 3/1/17	1 day	Jennifer Brayton	IBA
884	60 Day Resource Look-Back		0%	Wed 3/1/17	Tue 3/21/17	15 days	Jennifer Brayton	IBA
885	Perform Lessons Learned Lookback and Survey		0%	Wed 3/1/17	Tue 3/21/17	15 days	Jennifer Brayton	IBA

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM TWELVE

Date: December 30, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151 Z1
to be opened January 5, 2016 at 2:00 p.m. Central Time

The State does not anticipate posting additional amendments and/or addendums.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Attachment 40 - Updated MLR and Risk Corridor Examples

Example 1. MCO pays money back to State under MLR and risk corridor

Earned Revenue for MLR/Risk Corridor		
Gross Capitation Payment	$	105.54
HIT	$	3.69
Hold-Back	$	1.53
Performance Penalty	$	0.25
Net Capitation Payment for MLR/Risk Corridor	$	100.06
MMs		1,000
Earned Revenue for MLR/Risk Corridor	**$**	**100,065**

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	3,000
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	80,500
Net Qualified Medical Expenses divided by Earned Revenue		80.4%
Minimum MLR %		85.0%
Percentage below MLR		4.6%
MLR Reconciliation Payment	**$**	**(4,555)**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
MLR Rebate	$	(4,555)
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	77,500
Total Activities that Improve Health Care Quality	$	3,000
Allowed Activities that Improve Health Care Quality	$	3,000
Total Incurred Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Allowed Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Administration (QI and non-QI)	$	10,000
Profit/(Loss)	$	8,010
Risk Corridor Profit/(Loss) Share	**$**	**(5,008)**

Example 2. State pays money back to MCO under risk corridor

Earned Revenue for MLR/Risk Corridor		
Gross Capitation Payment	$	105.54
HIT	$	3.69
Hold-Back	$	1.53
Performance Penalty	$	0.25
Net Capitation Payment for MLR/Risk Corridor	$	100.06
MMs		1,000
Earned Revenue for MLR/Risk Corridor	**$**	**100,065**

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	3,000
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	110,500
Net Qualified Medical Expenses divided by Earned Revenue		110.4%
Minimum MLR %		85.0%
Percentage below MLR		0.0%
MLR Reconciliation Payment	**$**	**-**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
MLR Rebate	$	-
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,500
Total Activities that Improve Health Care Quality	$	3,000
Allowed Activities that Improve Health Care Quality	$	3,000
Total Incurred Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Allowed Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Administration (QI and non-QI)	$	10,000
Profit/(Loss)	$	(17,435)
Risk Corridor Profit/(Loss) Share	**$**	**14,433**

Example 3. Administrative expenses exceed admin cap

Earned Revenue for MLR/Risk Corridor		
Gross Capitation Payment	$	105.54
HIT	$	3.69
Hold-Back	$	1.53
Performance Penalty	$	0.25
Net Capitation Payment for MLR/Risk Corridor	$	100.06
MMs		1,000
Earned Revenue for MLR/Risk Corridor	**$**	**100,065**

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	4,000
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	111,500
Net Qualified Medical Expenses divided by Earned Revenue		111.4%
Minimum MLR %		85.0%
Percentage below MLR		0.0%
MLR Reconciliation Payment	**$**	**-**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
MLR Rebate	$	-
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,500
Total Activities that Improve Health Care Quality	$	4,000
Allowed Activities that Improve Health Care Quality	$	3,002
Total Incurred Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	12,000
Total Allowed Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,005
Total Administration (QI and non-QI)	$	10,006
Profit/(Loss)	$	(17,442)
Risk Corridor Profit/(Loss) Share	**$**	**14,440**

Addendum 11 – Additional Revisions to RFP

Document	Section	Change From:	Change to:
RFP	IV.H.4.b	The member or provider may file an appeal within 90 calendar days from the date on the MCO's Notice of Action.	The member or provider may file an MCO-level appeal within a timeframe that is not less than 20 calendar days and not more than 90 calendar calendar days from the date on the MCO's Notice of Action.
RFP	IV.H.7.c	The member or the member's representative (if any) may request a state fair hearing within 90 calendar days from the date of the MCO Notice of Action.	The member or the member's representative (if any) may request a state fair hearing within a timeframe that is not less than 20 calendar days and not more than 90 calendar days from the date of the MCO's notice of resolution.
Addendum 6	Q. 112	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region.	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region. Currently, the 0.25% State Performance Penalty is loaded in to the rate as an at-risk incentive. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 7	Q. 227	The MLTC Quality Performance hold-back is not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back is factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute. The State Performance Penalty is included in the minimum MLR, risk corridor, and the Administrative Cap.	The MLTC Quality Performance hold-back and the State Performance Penalty (SPP) are not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back and SPP are factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute.
Addendum 7	Q. 230	In terms of the actuarial certification, only the MLTC Quality Performance hold-back is considered a withhold.	Yes, both the MLTC Quality Performance hold-back and State Performance Penalties will be considered withholds in the actuarial certification.

Addendum 7	Q. 249	See Attachment 21: "Non-Medical Load Assumptions". NML is based on the experience of current Managed Care Entities.	See Attachment 21: "Non-Medical Load Assumptions". NML is based on the experience of current Managed Care Entities. Currently, the 0.25% State Performance Penalty is loaded in to the rate as an at-risk incentive. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 7	Q. 254	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties is considered a component of non-medical load and is added in along with other administrative funding.	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties was originally considered a component of non-medical load and was added in along with other administrative funding. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 7	Q. 341	See response to Question #33.	Yes, both the MLTC Quality Performance Program and the State Performance Penalty are excluded from the revenue calculation of the risk corridor. Please see Attachment 40 for an example of the exclusion.

Addendum 9	Q. 67	This information will be posted to the procurement website no later than December 24, 2015.	The risk corridor calculation formula in Section IV.P.9.c is amended as follows: “Risk corridor profit/loss = qualifying revenue -MLR rebate -Net qualified medical expenses calculated for the risk corridor -Total allowed administration calculated for the administrative cap” This indicates that activities to improve health care quality may be considered a medical expense for the MLR calculation but will be considered an administrative expense for the risk corridor calculation. Activities to improve healthcare quality should be reported under the total allowed administration calculated for the administrative cap, under the risk corridor calculation. Please see Attachment 40.
Addendum 9	Q. 68	This information will be posted to the procurement website no later than December 24, 2015.	1. The UNMC portion of the revenue and expenses will be included in the MLR and Risk Corridor calculations. 2. The earned revenue used in the MLR and Risk Corridor calculations should exclude the QPP hold-back. As such, both the earned and unearned portions of the 1.5% hold-back are excluded from the calculations. 3. The earned and unearned portion of the 0.25% Performance Penalty are excluded from the risk corridor and MLR calculations. Please see Attachment 40.
Addendum 9	Q. 69	This information will be posted to the procurement website no later than December 24, 2015.	Please see Attachment 40.
Addendum 9	Q. 70	This information will be posted to the procurement website no later than December 24, 2015.	Please see Attachment 40.

Addendum 9	Q. 72	All items on this list will be considered in the rate certification in the Spring of 2016. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, the State's actuaries anticipate using additional runout from FFS data and current Managed Care entities. No changes to the base period are anticipated.	All items on this list are aspects of rate setting that will be revisited in the Spring. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, Optumas anticipates using additional runout from FFS data and current Managed Care entities. As part of receiving the updated data extracts the rate setting process will be revisited, but at this time it is not anticipated that a new base period will be used. Currently, the 0.25% State Performance Penalty is loaded in to the rate as an at-risk incentive. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 9	Q. 74	This information will be posted to the procurement site no later than December 24, 2015.	1) and 2): Hepatitis C expenditures occur in two aid categories in Rating Region 1 and two categories in Rating Region 2. In Rating Region 1, the AABD 21+ M&F cohort has a Hepatitis C PMPM of $18.55 and a non-Hepatitis C PMPM of $356.37. The Family 21+ M&F cohort has a Hepatitis C PMPM of $1.22 and a non-Hepatitis C PMPM of $76.12. In Rating Region 2 the AABD 21+ M&F cohort has a Hepatitis C PMPM of $25.14 and a non-Hepatitis C PMPM of $439.50, and the Non-Dual Waiver cohort has a Hepatitis C PMPM of $17.66 and a non-Hepatitis C PMPM of $360.20. 3) This information is not available.

Attachment 39
Revised Access Standards

Appointment Availability Access Standards

1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.

2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO.

3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation.

4. Family planning services must be available within seven calendar days.

5. Non-urgent, preventive care must be available within 4 weeks.

6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.

7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.

8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

Geographic Access Standards

1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties.

2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.

3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.

    a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences.

    b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences.

    c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.

4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.

5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census.

7. The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day. All reports must be submitted in an MLTC provided template or in a format approved by MLTC.

Monthly Deliverables	Description	Due Date
Claims Processing and Timely Payment of Claims	Summary data on claims payment activity and reasons for claims denials, per reporting requirements provided by MLTC. Include the disposition of every adjudicated and adjusted claim for each claim type.	15th day of the following calendar month
Provider Termination	All provider terminations by category and termination cause.	15th day of the following calendar month
Third Party Resource	All instances in which a TPR was identified for a member as described in Section IV.P - MCO Reimbursement.	15th day of the following calendar month
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	15th day of the following calendar month
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
New Referrals of Potential Fraud, Waste, Abuse and Erroneous Payments	Summary of new referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month

All Referrals of Fraud, Waste, Abuse, and Erroneous Payments Under Review by the MCO	Summary of all referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Overpayments Identified and Collected	Summary of overpayments as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Provider Who Have Left the MCO Network	Summary of provider network departures as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Miscellaneous Fraud Prevention Efforts	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Pharmacy Prior Authorizations	Prior authorizations summary, including clinical and technical prior authorizations, peer review, and peer to peer consultation statistics.	15th day of the following calendar month
Pharmacy Technical and Clinical Call Center	Performance summary for call center metrics, pharmacy services, prior authorization request turnaround time, and training issues.	15th day of the following calendar month
Pharmacy Claims Processing	Summary data and analysis on pharmacy claims processing including: generic analysis (will be detailed by MLTC), MAC priced medications, claims adjudication system availability and payment statistics, number of prescriptions dispensed by public retail pharmacies (mail order pharmacies and specialty pharmacies included but delineated), total members utilizing pharmacy claims system, and total membership.	15th day of the following calendar month
Psychotropic Medications for Youth	Summary of prior authorization and utilization relating to clinical edits.	15th day of the following calendar month
PDL Load	Data documenting that the PDL file was received and loaded weekly.	15th day of the following calendar month
Behavioral Health Residential Wait List	Summary data, by member, of the number of days before a member is accepted into a program and, by member, the number of days before the member is admitted to the program.	15th day of the following calendar month
Out of State Placement	Summary data of the number of members placed in out of state residential treatment.	15th day of the following calendar month
Eligible and Number Authorized	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	15th day of the following calendar month

Welcome Calls	Results of welcome calls to new members as described in Section IV.F - Members Services and Education.	15th day of the following calendar month
Hospice	Data summarizing hospice admissions.	15th day of the following calendar month
Medically Necessary State Wards in Residential Treatment	Data summarizing the number of state wards deemed "medically necessary" who are in residential treatment.	15th day of the following calendar month
Claims Adjudicated	Data summarizing claims adjudicated to finalization in the previous calendar month as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Member/Provider Call Center	Data summarizing MCO member/provider call center performance, including call abandonment rate and average speed to answer.	15th day of the following calendar month
Quarterly Deliverables	**Description**	**Due Date**
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter

Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Drug Utilization Management Retrospective Educational Intervention Project	Project update in a format approved by MLTC.	45 calendar days following the most recent quarter
Prospective DUR Statistics	DUR statistics to support preparation of MLTC's annual CMS DUR report.	45 calendar days following the most recent quarter
Pharmacy Financial Report	Summary data on committed pharmacy dollars, pharmacy total claims dollars, MCO supplemental rebate dollars, and MAC savings.	45 calendar days following the most recent quarter
Pharmacy Utilization Management	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	45 calendar days following the most recent quarter
PDL Compliance	Data documenting accuracy in dispensing medications in PDL categories.	45 calendar days following the most recent quarter
Care Management Report	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Enrollment and Disenrollment Report	Summary of disenrollments as described in Section IV.B - Eligibility and Enrollment.	45 calendar days following the most recent quarter

Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	45 calendar days following the most recent quarter
Provider Network Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Network Adequacy	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Network Cultural Competency Access	Summary data and metrics on cultural competency access as determined by MLTC.	45 calendar days following the most recent quarter
Provider Network PCP Access	Summary data and metrics on PCP access as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Credentialing	Data and metrics summarizing the number of providers credentialed by licensure type, their location, and the status of pending credentials.	45 calendar days following the most recent quarter
Quality Oversight Committee	Committee activity summary as described in Section IV.M - Quality Management.	45 calendar days following the most recent quarter
Service Verification Detail	Data detailing service verifications as described in Section IV.S - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Service Verification Summary	Service verification summary as described in Section X - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Utilization Management - Authorization	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter

Utilization Management - Claims	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Quality Performance	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Restraint and Seclusion	Data summarized, by behavioral health provider, on the number of incidents of restraint or seclusion by program type and location.	45 calendar days following the most recent quarter
Contracted Residential Beds	Summary data on the number of behavioral health-related residential beds available state-wide.	45 calendar days following the most recent quarter
Critical Incident Reporting	Summary data on the number of critical incident reports by behavioral health facility and location.	45 calendar days following the most recent quarter
Quarterly Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	45 calendar days following the most recent quarter
30 day Ambulatory/Inpatient Readmission Rates	Summary data on the number of individuals readmitted to the emergency room 30 or more days post the prior admission.	45 calendar days following the most recent quarter
7 and 30 Day Ambulatory Follow-up Following Residential Discharge	Summary data on the number of individuals presenting to the emergency room 30 days after discharge from Acute Psych or SUD.	45 calendar days following the most recent quarter
Admissions and Readmits to Psych Inpatient	Data summarizing the number of admissions and readmits to psych inpatient, including Psychiatric Residential Treatment Facilities and Therapeutic Group Homes.	45 calendar days following the most recent quarter
Value-Added Services	Summary of value added services as agreed upon by the MCO and MLTC.	45 calendar days following the most recent quarter

Indian Health Services	Data and metrics summarizing Indian Health Service delivery.	45 calendar days following the most recent quarter
Medication Therapy Management	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	45 calendar days following the most recent quarter
Subrogation	Data summarizing new and ongoing instances of subrogation.	45 calendar days following the most recent quarter
Top Ten Diagnoses by Service Category	Data summarizing the top ten diagnoses by service category.	45 calendar days following the most recent quarter
Semi-Annual Deliverables	**Description**	**Due Date**
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
Paid Claims Audit	Results of error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims as described in Section IV.O - Program Integrity.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Quality Management Program Description and Work Plan	Discussion of the MCO's quality goals, initiatives and work plan as described in Section IV.M – Quality Management.	30 calendar days following the 12th month of the contract year
Quality Management Program Evaluation	Data and analysis summarizing the results of the annual quality work plan as described in Section IV.M - Quality.	30 calendar days following the 12th month of the contract year
Member Satisfaction Survey	Data and analysis summarizing results of the annual member satisfaction survey.	30 calendar days following the 12th month of the contract year

Deficiency CAP Reports (All Provider Types)	Results and status of all corrective action plans by provider type.	30 calendar days following the 12th month of the contract year
Direct Medical Education/Indirect Medical Education Verification	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Due date to be provided prior to contract start
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	30 calendar days following the 12th month of the contract year
HEDIS Report	HEDIS results.	June 30
CHIPRA Quality Measures	CHIPRA performance measure results.	45 calendar days following the 12th month of the contract year
Adult Core Measures	Adult Core Measures results.	45 calendar days following the 12th month of the contract year
Provider Survey	Data and analysis summarizing results of the annual provider satisfaction survey. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	30 calendar days following the 12th month of the contract year
Facility Satisfaction Survey	Data and analysis summarizing results of the annual facility provider satisfaction survey.	30 calendar days following the 12th month of the contract year
Annual Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the contract year

Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Last day of the contract year
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	December 31
Department of Insurance Financial Report	Copy of annual audited financial statement submitted to the Nebraska Department of Insurance.	June 1
Network Development Plan	Details of the MCO's network, including GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	November 1
Utilization Management Program Review	Data and analysis summarizing the MCO's annual evaluation of its UM program.	30 calendar days following the 12th month of the contract year
Legislative Reports	**Description**	**Due Date**
LB 1063 - Children's Health and Treatment Act	Data and Geo Access reports related to youth Medicaid mental health authorization requests (all children ages 0-19) and Medicaid mental health authorization requests (all age groups reported by ages 0-18 years, 19-64 years, and 65+ years)	Quarterly reports submitted to Nebraska Legislature on January 1, April 1, July 1, and October 1 by MLTC.
LB 1160 Legislative Report	Number of state wards receiving behavioral health services as of September 1 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Upon DHHS request.

Attachment 37 - Delivery Costs by COA

	Rating Region 1			Rating Region 2		
Original COA	**Deliveries**	**Expenditures**	**Per Delivery**	**Deliveries**	**Expenditures**	**Per Delivery**
AABD 00-20 M&F	15	$ 112,062	$ 7,670	1	$ 5,986	$ 5,986
AABD 21+ M&F	106	$ 1,321,111	$ 12,423	21	$ 196,934	$ 9,433
AABD 21+ M&F-WWC	-	$ -	$ -	-	$ -	$ -
CHIP M&F	36	$ 264,095	$ 7,285	18	$ 112,076	$ 6,260
Family Under 1 M&F	-	$ -	$ -	-	$ -	$ -
Family 01-05 M&F	-	$ -	$ -	-	$ -	$ -
Family 06-20 F	1,072	$ 7,005,438	$ 6,535	399	$ 2,539,328	$ 6,364
Family 06-20 M	1	$ 6,064	$ 6,064	-	$ -	$ -
Family 21+ M&F	5,392	$ 35,796,353	$ 6,639	1,769	$ 11,676,614	$ 6,599
Foster Care M&F	26	$ 181,510	$ 6,901	3	$ 18,390	$ 6,130
Katie Beckett 00-18 M&F	-	$ -	$ -	-	$ -	$ -
Maternity	-	$ -	$ -	-	$ -	$ -
Claims/Encounters Total	6,649	$ 44,686,633	$ 6,721	2,211	$ 14,549,328	$ 6,580
Supplemental/Subcap Payments		$ 885,608			$ 217,203	
Total	6,649	$ 45,572,242	$ 6,854	2,211	$ 14,766,531	$ 6,678
Databook Total	6,649	$ 45,572,242	$ 6,854	2,211	$ 14,766,531	$ 6,678
Difference	-	$ -	$ -	-	$ -	$ -

Attachment 36 - COA Crosswalk

Rating Cohort	COA
AABD 00-20 M&F	AABD
AABD Under 1 M&F	AABD
AABD 01-20 M&F	AABD
AABD 21+ M&F	AABD
AABD 21+ M&F-WWC	AABD
CHIP Under 1 M&F	CHIP
CHIP 01-19 M&F	CHIP
CHIP M&F	CHIP
Family Under 1 M&F	Family
Family 01-05 M&F	Family
Family 06-20 F	Family
Family 06-20 M	Family
Family 21+ M&F	Family
Foster Care Under 1 M&F	Foster Care
Foster Care 01-19 M&F	Foster Care
Foster Care M&F-SA	Foster Care
Foster Care M&F	Foster Care
Maternity	Maternity
Katie Beckett 00-18 M&F	AABD

Rating Region 1

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 00-20 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.4%
AABD 00-20 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.9%
AABD 00-20 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	9.5%
AABD 00-20 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	3.7%
AABD 00-20 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	597.6%	-18.2%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.3%	0.2%
AABD 00-20 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 00-20 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.0%	0.0%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
AABD 00-20 M&F	Behavioral Health - OP	71.7%	0.0%	43.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	9.2%
AABD 00-20 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%
AABD 00-20 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%
AABD 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.8%
AABD 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	17.7%
AABD 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-2.1%
AABD 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	350.5%	-21.5%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.3%	-0.1%
AABD 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.2%
AABD 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.1%	-0.7%
AABD 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
AABD 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.5%
AABD 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
AABD 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 21+ M&F-WWC	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%
AABD 21+ M&F-WWC	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.7%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
AABD 21+ M&F-WWC	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.3%
AABD 21+ M&F-WWC	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
AABD 21+ M&F-WWC	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%
CHIP M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.0%
CHIP M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.4%
CHIP M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	10.7%
CHIP M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	-0.1%
CHIP M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	254.2%	-30.6%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-1.0%	0.6%
CHIP M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.4%	0.0%	0.0%	0.0%	0.0%
CHIP M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
CHIP M&F	Behavioral Health - OP	11.1%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	10.3%
CHIP M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	34.8%
CHIP M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.6%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family Under 1 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	1.5%
Family Under 1 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	10.3%
Family Under 1 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.7%
Family Under 1 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	316.7%	-42.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	-0.5%	0.3%
Family Under 1 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-4.2%	0.0%	0.0%	0.0%	0.0%
Family Under 1 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
Family Under 1 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.1%
Family 01-05 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	11.9%
Family 01-05 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	5.1%
Family 01-05 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	300.8%	-42.1%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.6%	0.4%
Family 01-05 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-3.0%	0.0%	0.0%	0.0%	0.0%
Family 01-05 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.7%
Family 01-05 M&F	Behavioral Health - OP	82.2%	0.0%	9.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.1%
Family 01-05 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 06-20 F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	3.1%
Family 06-20 F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.8%
Family 06-20 F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	11.8%
Family 06-20 F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	-1.5%
Family 06-20 F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	281.9%	-18.9%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-1.2%	0.6%
Family 06-20 F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.8%	0.0%	0.0%	0.0%	0.0%
Family 06-20 F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 F	Behavioral Health - OP	5.7%	0.0%	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	9.7%
Family 06-20 F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	34.0%
Family 06-20 F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Family 06-20 M	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.9%
Family 06-20 M	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	27.2%
Family 06-20 M	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	11.9%
Family 06-20 M	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.2%
Family 06-20 M	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	416.0%	-26.5%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.3%	0.2%
Family 06-20 M	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	0.0%	0.0%	0.0%	0.0%
Family 06-20 M	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 M	Behavioral Health - OP	4.8%	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	9.4%
Family 06-20 M	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	22.0%
Family 06-20 M	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%
Family 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	13.0%
Family 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.4%
Family 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	310.1%	-18.7%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.4%
Family 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-0.4%	-0.1%
Family 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.2%
Family 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.2%
Family 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.8%
Family 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.5%	0.0%	0.0%	0.0%	0.0%
Family 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
Family 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.7%
Family 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Family 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.8%
Foster Care M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.5%
Foster Care M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	6.7%
Foster Care M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	-1.0%
Foster Care M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	97.0%	-10.3%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	-0.1%	0.1%
Foster Care M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	0.0%	0.0%	0.0%	0.0%
Foster Care M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	Behavioral Health - OP	14.0%	0.0%	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Foster Care M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	22.7%
Foster Care M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Katie Beckett 00-18 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-2.4%
Katie Beckett 00-18 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.7%	0.0%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - OP	9373.3%	0.0%	59.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%
Katie Beckett 00-18 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Maternity	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	1.8%
Maternity	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.1%
Maternity	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	16.7%
Maternity	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.2%
Maternity	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	116.8%	12.4%	1.8%	0.0%	0.0%	0.0%
Maternity	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	-0.5%	0.4%
Maternity	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	-0.7%
Maternity	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Rating Region 2											
		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 00-20 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.2%
AABD 00-20 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.3%
AABD 00-20 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.0%
AABD 00-20 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.1%
AABD 00-20 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	15.4%	-8.5%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.4%	0.2%
AABD 00-20 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 00-20 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-0.6%	0.0%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
AABD 00-20 M&F	Behavioral Health - OP	46.4%	0.0%	34.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	9.1%
AABD 00-20 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
AABD 00-20 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
AABD 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.6%
AABD 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	3.8%
AABD 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.7%
AABD 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	65.6%	-13.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.2%	0.0%
AABD 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.2%	-0.7%
AABD 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
AABD 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.5%
AABD 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
AABD 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 21+ M&F-WWC	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	69.7%	-20.7%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.3%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
AABD 21+ M&F-WWC	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.5%
AABD 21+ M&F-WWC	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
AABD 21+ M&F-WWC	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
CHIP M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.3%
CHIP M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.1%
CHIP M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.2%
CHIP M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	-3.0%
CHIP M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	187.6%	-35.2%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.4%	0.2%
CHIP M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	0.0%	0.0%	0.0%	0.0%
CHIP M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
CHIP M&F	Behavioral Health - OP	9.1%	0.0%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	10.4%
CHIP M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.1%
CHIP M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family Under 1 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.3%
Family Under 1 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	1.4%
Family Under 1 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.2%
Family Under 1 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	189.8%	-48.8%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-4.1%	0.0%	0.0%	0.0%	0.0%
Family Under 1 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.1%
Family Under 1 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.5%
Family 01-05 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.5%
Family 01-05 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.8%
Family 01-05 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	243.1%	-31.2%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.2%	0.1%
Family 01-05 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
Family 01-05 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	Behavioral Health - OP	94.0%	0.0%	10.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
Family 01-05 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 06-20 F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.6%
Family 06-20 F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.5%
Family 06-20 F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.6%
Family 06-20 F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	3.6%
Family 06-20 F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	117.7%	43.9%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.6%	0.3%
Family 06-20 F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.5%	0.0%	0.0%	0.0%	0.0%
Family 06-20 F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 F	Behavioral Health - OP	4.2%	0.0%	6.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	9.6%
Family 06-20 F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	35.9%
Family 06-20 F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
Family 06-20 M	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.6%
Family 06-20 M	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.4%
Family 06-20 M	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	7.5%
Family 06-20 M	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	495.1%	-46.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.4%	0.2%
Family 06-20 M	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.0%	0.0%	0.0%	0.0%	0.0%
Family 06-20 M	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 M	Behavioral Health - OP	3.8%	0.0%	6.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	9.4%
Family 06-20 M	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.4%
Family 06-20 M	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.2%
Family 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	2.7%
Family 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.4%
Family 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	212.8%	-37.1%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.3%
Family 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-0.5%	0.2%
Family 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-0.3%	-0.9%
Family 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.6%	0.0%	0.0%	0.0%	0.0%
Family 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
Family 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Family 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.4%
Foster Care M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.2%
Foster Care M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	1.0%
Foster Care M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	5.0%
Foster Care M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	122.5%	-46.5%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-0.7%	0.0%	0.0%	0.0%	0.0%
Foster Care M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	Behavioral Health - OP	12.7%	0.0%	8.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Foster Care M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.9%
Foster Care M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Katie Beckett 00-18 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-2.4%
Katie Beckett 00-18 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%	0.0%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - OP	9373.3%	0.0%	59.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%
Katie Beckett 00-18 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Maternity	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.1%
Maternity	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	11.0%
Maternity	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.5%
Maternity	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	363.3%	-24.8%	1.8%	0.0%	0.0%	0.0%
Maternity	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	-0.1%
Maternity	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	-1.2%	0.9%
Maternity	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	-0.6%	-0.3%
Maternity	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Attachment 34 - Rate Adjustment Crosswalk

Attachment 20	Attachment 22
ASD Adjustment	ASD Adjustment
DD Adjustment	DD Adjustment
Service Delivery Adjustments	Service Delivery Adjustment
Immediate Enrollment	Immediate Enrollment
APR-DRG	Policy Changes
FQHC Rate Updates	Policy Changes
Prospective Behavioral Health Provider Increase	Policy Changes
PRTF Program Change	Policy Changes
MST/FFT Carve-In	Policy Changes
Behavioral Health Copay Adjustment	Policy Changes
Physical Health Copay Adjustment	Policy Changes
Benefit Limits	Policy Changes

Heritage Health:

Est Ave Monthly Medicaid Eligibles Remaining FFS *(based on SFY2015)*

County	County Code	Ave Monthly
Adams	01	**96**
Antelope	02	**18**
Arthur	03	**1**
Banner	04	**1**
Blaine	05	**1**
Boone	06	**15**
Box Butte	07	**37**
Boyd	08	**9**
Brown	09	**8**
Buffalo	10	**106**
Burt	11	**24**
Butler	12	**12**
Cass	13	**45**
Cedar	14	**21**
Chase	15	**8**
Cherry	16	**9**
Cheyenne	17	**29**
Clay	18	**18**
Colfax	19	**22**
Cuming	20	**23**
Custer	21	**28**
Dakota	22	**57**
Dawes	23	**20**
Dawson	24	**81**
Deuel	25	**7**
Dixon	26	**12**
Dodge	27	**139**
Douglas	28	**1,362**
Dundy	29	**7**
Fillmore	30	**12**
Franklin	31	**10**
Frontier	32	**3**
Furnas	33	**12**
Gage	34	**67**
Garden	35	**8**
Garfield	36	**8**
Gosper	37	**4**
Grant	38	**2**
Greeley	39	**3**
Hall	40	**154**
Hamilton	41	**17**
Harlan	42	**7**
Hitchcock	44	**12**
Holt	45	**28**
Hooker	46	**4**
Howard	47	**13**

County	County Code	Ave Monthly
Jefferson	48	**20**
Johnson	49	**8**
Kearney	50	**16**
Keith	51	**35**
Kimball	53	**14**
Knox	54	**21**
Lancaster	55	**561**
Lincoln	56	**116**
Logan	57	**2**
Loup	58	**2**
Madison	59	**131**
McPherson	60	**1**
Merrick	61	**26**
Morrill	62	**13**
Nance	63	**19**
Nemaha	64	**18**
Nuckolls	65	**16**
Otoe	66	**38**
Pawnee	67	**10**
Perkins	68	**4**
Phelps	69	**24**
Pierce	70	**13**
Platte	71	**61**
Polk	72	**14**
Red Willow	73	**28**
Richardson	74	**31**
Rock	75	**8**
Saline	76	**36**
Sarpy	77	**226**
Saunders	78	**54**
Scotts Bluff	79	**115**
Seward	80	**37**
Sheridan	81	**12**
Sherman	82	**10**
Sioux	83	**1**
Stanton	84	**10**
Thayer	85	**19**
Thomas	86	**6**
Thurston	87	**39**
Valley	88	**7**
Washington	89	**32**
Wayne	90	**17**
Webster	91	**18**
York	93	**38**
Out of State	00	**767**
	99	**85**

Total Ave Mo		**2,579**

Attachment 32, Nebraska Medicaid Eligible Providers removed due to confidential information

2,160 pages

Addendum 10 – Additional Revisions to RFP

Document	Section	Change From:	Change to:
RFP	IV.D.3.j	All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff.	All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff, customer service representatives staffing the toll-free call center, and certain care management staff.
RFP	IV.E.14.a.iii	The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR 438.114(a).	The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR 438.114(c)(1)(ii)(A).
RFP	IV.I.12.d	Add new section	The MCO is prohibited from explicitly or implicitly communicating to potential network providers that the provider may face a lower reimbursement rate or any other financial or operational sanction should that provider choose not to sign a letter of intent with the MCO prior to the deadline for Heritage Health Proposals included in Addendum 8.
RFP	IV.N.4.d.vii	Use a licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section IV.D Staffing Requirements of this RFP.	Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section IV.D Staffing Requirements of this RFP.
RFP	IV.N.10.a	Utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative. If appropriate, the MCO must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist.	Utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in Attachment 8. The MCO must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist.

RFP	IV.N.11.b	Restricted services are a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The restricted services mechanism cannot prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.	Restricted services are a mechanism for restricting Medicaid recipients to a specific hospital, primary care provider, prescribing provider, and/or a specific pharmacy provider in accordance with 471 NAC 2-004. The restricted services mechanism cannot prohibit the recipient from receiving services that meet the exceptions contained in 471 NAC 2-004.04.
RFP	IV.P.9.c	Risk corridor profit/loss = qualifying revenue - MLR rebate - Net qualified medical expenses calculated for the MLR - Total allowed administration calculated for the administrative cap.	Risk corridor profit/loss = qualifying revenue - MLR rebate - Net qualified medical expenses calculated for the risk corridor - Total allowed administration calculated for the administrative cap.
RFP	IV.Q.9.f	Add new section	If a MCO enters into a contract for the provision of services with a FQHC or RHC, the MCO shall provide payment that is not less than the level and amount of payment which the MCO would make for the services if the services were furnished by a provider which is not a FQHC or RHC.
RFP	Glossary of Terms	**Administrative expense rate:** The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that would have been incurred in the contract year in the absence of any related-party relationship.	**Administrative expense rate:** The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that were incurred in the contract year. These costs are subject to review to verify that the administrative services were actually provided and that the costs included for these services is reasonable. In the event the MCO paid any amounts for administrative services to a related party, only those administrative costs actually incurred by the related party in connection with the administration of this contract will be included in such costs.

RFP	Glossary of Terms	**Patient-centered medical home (PCMH):** The Center for Medical Home Improvement defines PCMH as a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.	**Patient-centered medical home (PCMH):** A health care delivery model in which a patient establishes an ongoing relationship with a primary care practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access and health outcomes in a cost effective manner.
RFP	Glossary of Terms	**Related-party administrative expense:** Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Such fees are not considered in the calculation of administrative expense under this contract.	**Related-party administrative expense:** Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related-party for administrative costs actually incurred by the related party in connection with the administration of the contract.
Addendum 6	Question 69	MLTC will provide this answer in the second round of questions for this RFP.	No, Nebraska State-licensure is not required for all prior authorization and concurrent review staff. The prior authorization and concurrent review functions must meet the requirements of IV.D.3.a and IV.D.3.B regarding additional required staff. Nebraska State licensure is required for peer-to-peer consultations on prior authorizations and for adolescent psychiatrist review of prior authorization requests for psychotropic medication use in youth. Please see the amended IV.N.4.d.vii in this addendum.

Addendum 7	Question 247	As nearly all Medicaid eligible individuals will be included in Heritage Health, the State does not currently have an exact figure by county for the number of individuals that will continue to receive core benefits and services through the fee-for-service program. This information will be posted to the procurement website as part of the second round of questions and answers.	Please see Attachment 33.
Addendum 7	Question 313	The State is reviewing this question further. This information will be posted to the procurement website as part of the second round of questions and answers.	Please see revised definitions for **Administrative expense rate** and **Related-party administrative expense** in this Addendum.
Addendum 7	Question 332	A list of Medicaid-eligible providers will be posted on the procurement website as soon as it is available. This information will be posted to the procurement website as part of the second round of questions and answers.	Please see Attachment 32.
Attachment 4		As amended by Addendum 3: Revisions to RFP: Core Competency 1: Facilitate ongoing patient relationship with a primary care provider in a physician-directed team.	Core Competency 1: Facilitate ongoing patient relationship with a primary care practice team.
Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: citalopram Recommended Max: 40mg/day	Generic Name: citalopram Recommended Max: 4-18 yrs – 40mg/day
Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: paroxetine hcl Recommended Max: children – not recommended; 12-18 years – 40mg IR, 50mg CR	Generic Name: paroxetine hcl Recommended Max: children – not recommended; 13-18 years – 40mg IR, 50mg CR
Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: fluoxetine hcl (all oral) Recommended Max: 60mg/day	Generic Name: fluoxetine hcl (all oral) Recommended Max: 4-18 yrs - 60mg/day

Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: sertraline hcl Recommended Max: 200mg/day	Generic Name: sertraline hcl Recommended Max: 4-18 yrs - 200mg/day

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM NINE
QUESTIONS and ANSWERS

Date: December 17, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151 Z1
to be opened January 5, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.			Considering that the Coalition for Community Pharmacy Action (CCPA)'s independent study of the cost to dispense based on 2013 data found the national cost of dispensing to be $10.55 and the cost of dispensing in Nebraska to be $10.62, what specific methodology was cited in "discussions with the state and research of other states" (per answers to various Question 37 and others in Round 1) to justify dispensing fees of $2.50 for chains and $4.45 for independents with less than six stores?	Please see response to Addendum 6, Question #37.
2.			What specific data-driven rationale and/or empirical research was cited in "discussions with the state and research of other states" (per answers to various Question 37 and others in Round 1) to justify differentiating dispensing fees for chain vs. independent pharmacies?	Please see response to Addendum 6, Question #37 for independent and non-independent pharmacy assumptions. For the purpose of capitation rate development for Heritage Health, the State's actuaries used the experience of another Midwestern state on its transition to a managed pharmacy benefit. This state experienced a significant drop in dispensing fees, below the fee used in the development of Heritage Health rates. This, along with discussion with Nebraska's pharmacy team served as the basis for adjusting non-independent pharmacy expenditures downward to account for lower dispensing fees.
3.			How will the Department ensure that pharmacies that do not fall under the category of an "independent pharmacy" will be paid dispensing fees	For nearly all other Heritage Health services, no rate floor exists. Reimbursement for pharmacy must consider both ingredient and dispensing fee components. Recognizing the unique nature of the pharmacy program MLTC has provided additional protections for pharmacy services, including

			that adequately cover their cost of dispensing?	requirements regarding timely updates to ingredient cost reimbursement and MAC transparency within the contract, as well as the minimum dispensing fee for smaller independent pharmacies. It is also important to note that network adequacy requirements exist to ensure that MCOs contract with a sufficient number of pharmacies based on their membership. MLTC will continue to evaluate these policies to ensure that recipients maintain adequate access to pharmacy services.
4.			Considering that when using cost as a determining factor for classifying specialty drugs, there is an increased risk that either some drugs will be inaccurately classified as specialty drugs, or others that are truly specialty drugs, will be inaccurately excluded, is the Department able to further revise the definition of the term "Specialty Drug" in the RFP?	The State does not intend to revise this term. Please see the Glossary of Terms for the definition of the term "Specialty Drug".
5.			Can you refer me to particular policymakers dedicated to the pharmacy-related provisions of the RFP?	Pharmacy-related provisions of the RFP were developed in conjunction with the MLTC Pharmacy Unit. Final decisions were made by MLTC leadership, including the Director and Deputy Directors. The MLTC organizational chart can be found at: http://dhhs.ne.gov/Org%20Charts/MLTC.pdf
6.	ATTACHEMENT 2 ACCESS STANDARDS		When looking at availability of Providers across both Regions we offer for your consideration as an indicator of access ONE PCP FTE per 10,000 population. This will ensure a more accurate picture as to the actual numbers of practicing and available Providers.	Access standards are set forth in Attachment 2.

7.	ATTACHEMENT 5 POLICIES, PROCEDURES AND PLANS		It is our understanding that "Letters of Intent" are not required as a part of the bidder's proposal. Is this true? If bidders make this request how should a provider respond?	A letter of intent from bidder(s) is not a requirement of the RFP. Please see Addendum 10.
8.	RFP SECTION Q PROJECT DESCRIPTION AND SCOPE	PAGE 149 PROVIDER REIMBURSEMENT	Will current Medicaid Rates be used to set the base rate for Provider Reimbursement? There is no mention or direction as to what will set the base rate for reimbursement. How will those base rates be determined if the Medicaid Rates are not used?	The MCO may negotiate rates with its network providers, except as otherwise provided for in the RFP. The following sections of the RFP provide specific provider reimbursement requirements: IV.E.16 Family Planning Services IV.Q.4 Indian Health Protections IV.Q.5 Psychiatric Residential Treatment Facilities IV.Q.8. Payment to Out-of-Network Providers IV.Q.9 Reimbursement to FQHCs and RHCs IV.Q.14 Emergency Medical and Post-Stabilization Services IV.Q.16 Pharmacy Reimbursement
9.	Attachment 6/Attachment 19	N/A	Please clarify if the state is requesting samples of all reports in Attachment 6? Or only the 3 listed in Attachment 19, Question 115?	Bidders are required to provide examples of the reports listed in Attachment 19, Question 115. Bidders are not required to provide samples of reports listed in Attachment 6 unless otherwise required in the RFP, Attachments or Addendums.
10.	3. Technical Approach (b)	198	Please clarify if additional attachments allowed (in response to Attachment 19 questions)?	Attachments that are not specifically requested may not be considered in the evaluation process.
11.	Attachment 6	Pg 10	Please clarify if the reference to Section IV.O is a scrivener error? IV.O is not Provider Network.	Attachment 6 is hereby amended and superseded by Attachment 38. Please see Attachment 38.
12.	Attachment 2		Will MLTC be providing access standards for hospitals (non- behavioral health)?	Attachment 2 is hereby amended and superseded by Attachment 39. Please see Attachment 39.

13.	Attachment 6	Pg 1	If MLTC will require bidders to submit templates of all reports outlined in Attachment 6, will the MLTC template or MLTC approved format be provided to bidders for RFP submital?	Please see the response to Question #9 above.
14.	Attachment 2	Pg 2	Will zip code classification be allowed to demonstrate pharmacy access?	Pharmacy access must be demonstrated in accordance with Attachments 2 and 3.
15.	IV.D.3.a Additional Required Staff	50	Does the following requirement: "Prior authorization staff must include a State-licensed registered nurse or physician's assistant." apply to Pharmacy Prior Authorizations?	Please see Addendum 10.
16.	IV.D.3.j Additional Required Staff	51	We are prepared to locate Member Services functions locally in Nebraska as required on p. 50-51 of the RFP. For clarification, are Member Services functions required to be located in Nebraska inclusive of Customer Service Representatives who staff our toll-free call center?	Customer service representatives staffing the toll-free call center are not required to be located in the State. Please see Addendum 10.
17.	IV.E.11.c Nebraska Medicaid Preferred Drug List	59	Can the State provide the MLTC guidelines for off-label drug use or point to URL?	Guidelines are in accordance with Social Security Act 1927.[42 U.S.C 1396r-8] (g). https://www.ssa.gov/OP_Home/ssact/title19/1927.htm
18.	IV.E.11.c.ii Nebraska Medicaid Preferred Drug List	59	Can the State provide a current copy of the national drug code (NDC) file delegating the preferred or non-preferred status of each NDC?	Current PDL listing by therapeutic drug class can be found at: https://nebraska.fhsc.com/downloads/PDL/NE_PDL.pdf

19.	IV.E.11.c.iii and c.v Nebraska Medicaid Preferred Drug List	59	On c.v. the timeframe appears to conflict with above 1 day requirement stated on c.iii: "The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes". Please provide further clarification.	The State will provide a biannual PDL file following review by the Pharmacy and Therapeutics Committee, as well as a weekly file with changes to the PDL. With respect to requirements for the weekly file, please see the response to Question #24-Addendum 6. Section IV.E.11.c.v refers to the biannual PDL file.
20.	IV.E.29 Excluded Services	67	Please clarify if state psychiatric hospitals fall under the definition of institutional care and whether services offered to Members in these institutions will be paid by MLTC on a FFS basis. In the event that a member enrolled in an MCO is admitted to a State psychiatric hospital, would the member be disenrolled from the MCO?	Services provided in State psychiatric hospitals are not excluded services per Section IV.E.29. A member would not be disenrolled as a result of an admission to a State psychiatric hospital. Per Section 1905(a) of the Social Security Act, federal financial participation is not available for Medicaid services provided to any individual under age 65 who is a patient in an institution for mental disease (IMD) unless the payment is for inpatient psychiatric services for individuals under age 21. Under this exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. Per Public Law 100-360, an IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in provided diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The IMD exclusion applies only to institutions with at least 17 beds.
21.	IV.F. 14.d. Member Education	82	Please provide further clarity on Member Education Activities in Provider Offices, and, particularly, how these activities differ from Provider Marketing guidelines outlined in Section G(6)(f). For example, does the restriction against conducting member education in provider offices	The State hereby amends the RFP to remove Section IV.F.14.d on page 82. Providers may display MCO-provided health education materials consistent with the guidelines included in IV.G.6.f.ii. Providers may display MCO marketing materials consistent with requirements in IV.G.6.f.iii.

			apply only to non-existing members of the MCO? In addition, is MCO staff allowed to provide leave-behind branded educational materials (i.e. brochures, flyers) for the provider staff to display in the provider office?	
22.	IV.J.5.e Provider Outreach, Education, and Training	107	Can the State provide clarification regarding its expectations of the provider advisory committee to "create network development and management strategies and procedures"?	The State anticipates that the provider advisory committee will provide MCOs with feedback on policies and procedures that will aid in addressing provider issues including but not limited to: service authorization, credentialing, care coordination, and claims adjudication. The MCO would consult with the provider advisory committee before making major decisions on policy changes regarding its network strategy whenever feasible, and would actively solicit feedback from the group on strategies to improve the administrative experience of network providers.
23.	IV.J.5.e Provider Outreach, Education, and Training	107	Can the behavioral health subcommittee be incorporated within the provider advisory committee (i.e. and not as a separate committee)?	The Behavioral Health Provider Advisory Committee may be considered a subcommittee of the Provider Advisory Committee so long as the Behavioral Health Provider Advisory Committee is comprised of behavioral health providers and providers knowledgeable about behavioral health related issues.
24.	IV.N.11.e.iv.a Restricted Services	132	RESTRICTED SERVICES (aka Pharmacy Lock-in): Assigning a care manager to review, document, and manage the clinical or organizational needs of a member enrolled in restricted services. What if a member does not agree to Care Management, is this mandatory on the member?	Any member identified for care management activities must be offered care management services. In the case of an individual declining care management, the MCO must document this in the member's record. The MCO must still assign a care manager. The State requires the MCO to provide its proposed policies and procedures for applicable care management activities and any plan for ongoing communication with members who refuse care management.
25.	IV.N.11.e.i Restricted Services	132	"The MCO must be able to implement in it's claims system a restricted services	The State will provide information available in its MMIS for restricted services for each individual enrolled with a

			status for a member and have the ability to communicate this status to MLTC and other MCOs". Please clarify the Party that is sharing lock-in information when a member joins a plan: (A) Is it MLTC sending info on a FFS member only joining the plan? OR (B) Is it MLTC sending both FFS and/or another MCO member joining the plan? If the answer is "A", then is there any requirement for a member who transfers to another MCO? How would this occur?	MCO, including the type of restriction (any combination of pharmacy, primary care provider or hospital). This includes both individuals who have been fee for service and individuals who have been enrolled with another MCO. Restricted services transfer information occurs at the same time as the enrollment transfer and is reported in the supplemental enrollment file.
26.	IV.O.6.f Program Integrity – The MCO and MFPAU	136	The RFP states that "The MCO must subrogate to MFPAU any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products." Is the intent of this clause to encompass any and all potential subrogation claims, including but not limited to, claims where the MCO may be a member of a class action?	Yes, that is the intent of this requirement. Section IV.0.6.f is hereby amended as follows: “The MCO must subrogate to DHHS any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products."
27.	IV.Q.16.a Pharmacy Reimbursement	153	Can the State provide a list of independent pharmacies from MLTC with corresponding	The State cannot provide a list at this time. The State will provide this information to the awarded MCOs.

			pharmacy NPI? (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider?	
28.	IV.Q.16.c Pharmacy Reimbursement	153	"The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge." Please confirm that these are examples only and that we can reimburse at Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) methodology.	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by the State. A MCO must maintain in each paid claim record which methodology was used to determine final payment amounts. The approved methodologies include: State maximum allowable cost, national average drug acquisition cost or the submitted usual and customary charge. The State will allow other standard national drug pricing.
29.	IV.Q.17.f.iii Maximum Allowable Cost Program	153	"If an update is warranted, the MCO must make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network." Does this requirement apply even if a pharmacy did not contest the MAC price?	If reimbursement rates are contested and as a result, are increased, this retroactive adjustment must be posted on the MCO's public website and available for all network pharmacies to reprocess claims retroactively.
30.	IV.S.4.h.ii Provider Identifier	166	"The MCO must deny prescriptions written by prescribers who are not enrolled with Nebraska Medicaid." What about members traveling out of state in emergency situations? What about Rx's written in hospital Emergency	Please see Provider Bulletin 12-36: http://dhhs.ne.gov/medicaid/Documents/pb1236.pdf The State will provide a weekly Medicaid-enrolled provider file.

			departments? Please describe how an MCO can regularly receive an up-to-date listing of Medicaid providers so that this requirement can be met.	
31.	IV.X.7.b Transitioning from the MLTC FFS Pharmacy Program to the MCO Pharmacy Program	189	"The MCO must load to its pharmacy claims processing system the current prior authorization records from MLTC or its designee prior to the contract start date." Can the State provide a sample file layout and data dictionary to ensure all of the necessary elements are included (i.e. authorization start and end dates)? Would the MCO obtain all FFS Pharmacy claims information for members transferring from FFS? If a member is in a FFS Lock-in Program and transfers to the Plan, will the MCO get this information in the data file? Is the MCO expected to continue the lock-in?	The State is not able to provide a sample file layout and data dictionary as the State does not have this information. The fields may be developed in the spring with MMIS and shared with MCOs during readiness review. The State will provide the needed data to meet this requirement. The State will provide historical pharmacy claims available in its information system for each individual enrolled with the MCO, including fee-for-service claims. The State will also provide information on restricted services for each individual enrolled with the MCO, including the type of restriction (any combination of: pharmacy, hospital, or primary care provider). MCOs are required to use this information to continue restricted services. The MCO's restricted services policies and program must be in compliance with requirements in Section IV.N.11 Restricted Services, including but not limited to implementing a restriction program consistent with the provisions of 471 NAC 2. Per Attachment 5, the MCO must submit its proposed policies and procedures for approval of restricted services 45 days prior to the contract start date. This proposal must also include a procedure that verifies enrollees in a restricted status are able to access services provided by only approved providers by the contract start date.
32.	Capitation Rate Development - General	Attachments 20 and 23	The capitation rate development in Attachment shows annualized gross medical per member per month trends by rate cohort. Attachment 23 shows annualized medical expense trends by category of service (COS) by category of aid (COA). Please show a cross-walk of how trends by COA	No, the same COS trends were not applied to all rate cohorts within a given COA. Trend assumptions by COS and detailed rating cohort will be provided in early 2016. Please see Attachment 36 for a crosswalk of the rating cohorts into the broad COAs.

			and COS may be reconciled to develop and cross-check the final projected medical expense. Were the same COS trends applied to all rate cohorts within any given COA?	
33.	Capitation Rate Development - General	Attachments 20 and 23	Please show the separate cost and utilization components of the medical expense trends for COA and COS.	As outlined in the “NE – Heritage Health Second Bidder’s Conference Presentation – Optumas”, utilization trend and unit cost will be provided to awarded MCOs when the final rates are developed in early 2016.
34.	Amendment 6 Question #79	P.27 in the Amendment	Please provide further clarification the Amendment six answer to question 79: "MCOs may negotiate supplemental rebates for medications outside of the State’s PDL. MCOs are prohibited from negotiating supplemental rebates for any medications listed in the State’s PDL."Do the restriction on negotiating Supplemental rebates for PDL Drugs apply only to "Preferred Drugs"? or to both Preferred and Non-Preferred PDL Drugs?	Covered outpatient drugs include drugs on the Nebraska Medicaid PDL (preferred and non-preferred) and drugs not on the PDL. The PDL consists of drugs within multiple therapeutic drug classes. The MCO may not negotiate supplemental rebates for preferred or non-preferred drugs within the PDL therapeutic drug classes covered by the Nebraska Medicaid PDL.
35.	Amendment 6 Question #37	P. 15 in the Amendment	Please provide further clarification to Amendment six, response to question 37, which specifies a $2.50 dispensing fee to "Non-independent" pharmacies. Is this a mandatory minimum dispensing fee or can we apply lower dispensing fee reimbursement to pharmacies that may already be	The $2.50 dispensing fee was assumed for non-independent pharmacies for capitation rate development. While there is not a mandatory minimum dispensing fee reimbursement to non-independent pharmacies, the MCO and its PBM must receive active agreement from the pharmacy for participation in the Medicaid network, even if they have an existing contract for non-Medicaid services. Please see Section IV.I.8.b in the RFP.

			contracted with the PBM?	
36.	Amendment 6 Question #210	P. 68 in the Amendment	Answer to Question 210 states: "RFP 5151 Z1 only applies to the MLTC Division." Please confirm that in the event the Legislature were to move responsibility for children in the juvenile justice system back to the Department that MCOs will be responsible only for the same Medicaid costs for these members as when they were under the jurisdiction of the Probation Office.	The MCO will be responsible for the services in the benefits package for Medicaid eligible clients enrolled in the health plan. This responsibility would not be impacted by potential administrative changes regarding the juvenile justice system.
37.	Attachment 19		Please provide the State's definition of an "affiliate", as that term is used in the RFP.	For the purpose of this RFP requirement, an affiliate is considered any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the MCO.
38.	Response to Q &A #301, Attachment 6, Reporting Requirements, and Section IV.T, Reporting and Deliverables.	178	When we originally read and interpreted the RFP Section IV.T and Attachment 6 around the audit requirements, we interpreted the combination of the sections that follow to mean that the annual financial audit conducted of the contracted insurer for purposes of the Nebraska Department of Insurance requirement, which does include obtaining management letters and any	See Attachment 38.

			applicable audit recommendations, would be acceptable for the audit requirement and timeline from the following example: For the contract year ended 12/31/2017, the submission of audited financial statement could be submitted on June 1, 2018, consistent with the audit timing filing with the Nebraska Department of Insurance. However, after reading the response to #301 we are questioning our prior conclusion and requesting further clarification. Upon reading the response to #301, which confirms the Nebraska Department of Insurance filing date (from p.10 of Attach 6) has been amended to read June 1, the response also states that "the deadline for the Audited Financial Statement is 30 calendar days following the 12th month of the contract year". We respectfully request clarification if this response is intentional, and if the Audited Financial Statement (from p.9 of Attach 6) is intended to be the same or different audit requirement? If 30 days after the 12th month of the contract year is intended to mean January 30, 2018 submission of an audited financial statement for	

			the contract year ended 12/31/2017, we respectfully request that be reconsidered as that is a very unusual and aggressive timeline that is unlikely feasible under normal business circumstances. Typically, the full 45 day reporting period is utilized (for example, the time period associated with the quarterly financial reporting required per p.7 of Attachment 6), and there is typically a longer period for preparation of annual financial statements, such as an additional 15 days for a total of 60 days. Then, when there is an audit requirement, there is additional time that is required to allow for the external auditing firm to conduct its fieldwork, testwork, quality control, and audit report issuance processes. For the statutory financial statement audit, this period is three months from the date the statement subject to audit has been prepared (e.g., 2017 contract year financials prepared by the entity by March 1 and then audited by the external audit firm during March-April, and finished in May to allow for the issuance of the audit report by June 1). We respectfully request clarification whether there is a	

			single audit requirement and if the deadline is submission of the audited statutory financial statement, management letter, and any audit recommendations by June 1. Our recommendation is for a single audit financial statement audit requirement that already exists for purposes of the Nebraska Department of Insurance.	
39.	Q	150	Under a value-based provider contract, will the State make allowances for provision of services for which no current encounterable procedure code exists? For example, if the provider/MCO identifies and addresses a member need that likely leads to better health outcomes, but that service is not a covered benefit, is there a mechanism such that the MCO is not "penalized" in the minimum MLR requirement?	A qualifying expense for purposes of the MLR calculation must fall under the categories listed in Attachment 15 – Medical Loss Ratio Requirements. Value-based contracting is an evolving concept and MLTC will review policy decisions based on future CMS guidance.
40.	Q	150	In a value-based provider contract, will the value of the contract be included in the MLR requirement, or the encountered services only?	Only encountered services will be included for purposes of the MLR calculation. Value-based contracting is an evolving concept and MLTC will review policy decisions based on future CMS guidance.
41.	5151Z1 Addendum Seven for Questions and Answers - 221-382	N/A	Please clarify if the vision data includes medical/surgical vision expenditures or merely routine exams, hardware, etc.?	Vision data includes medical/surgical vision expenditures in addition to routine eye exams, hardware, etc.
42.	5151Z1 Addendum	Q. 101	The answer to this question	The 0.25% State Performance Penalty is not a component

	Six for Questions and Answers - 1-220		refers to the answer to question 33, which does not address the State Performance Penalty. Please confirm that amounts both earned and unearned of the State Performance Penalty are factored into the Administrative Cap calculation, in a similar fashion to the QPP holdback.	of the 10% Administrative Cap calculation.
43.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q. 158	Please describe how the savings estimates for the Dual population were developed. What was the benchmark state(s) and what was the data source used to determine that level of savings on a Dual population (where the MCOs are not primary in managing members' care) in the first year of a new program.	Savings estimates for the Dual population are based on the prevalence of Behavioral Health services and anticipated changes in Physical Health experience when the two services are delivered under an integrated program. Duals frequently have a high need for Behavioral Health services, and the databooks provided in Attachment 10-C confirm this for the Heritage Health Dual population. When the care for these Dual enrollees is integrated under one delivery system, it is anticipated that better outcomes for Physical Health needs will occur, leading to a reduction in Physical Health utilization.
44.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 217 and Q. 265	In the answer to these questions, it is stated that all costs within the window are included in the delivery kick payment. However, there are no values included for behavioral health services or pharmacy. Please explain why this would be the case.	These costs are currently not included in the supplemental maternity payment, but are included in the standard rating cohort in which the member resides absent of a delivery event. Behavioral health and pharmacy costs will be included in the supplemental maternity payment in Heritage Health contracts.
45.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 221	The answer to this question states "The UNMC amount built into the capitation rates will remain the same throughout the <u>entire contract period</u>." Please clarify that this is a typo, and that this portion of the capitation rates will be recalculated each year	The answer to Addendum 7, Question # 221 is amended as follows: The application of risk scores will not begin until the second contract period, 1/1/18-12/31/18. The State and its contracted actuary will work together in determining the best risk adjustment methodology to use at that time. The Minimum MLR will be in effect beginning on the contract start date and will be calculated on an annual basis between

			as part of the rate development and certification process.	6-9 months after the end of the contract year. Although the MLR will be settled annually, as mentioned in Attachment 15 "the MCO must calculate the MLR and submit it to MLTC quarterly". The 85% Minimum MLR requirement will be calculate as an aggregate of Regions 1 and 2 and will be calculated across all categories of aid. The risk corridor will be in effect beginning on the contract start date and will be calculated at the end of each contract period between 6-9 months after the end of the contract year. The risk corridor calculation will be an aggregate of Regions 1 and 2 across all categories of aid. The administrative cap requirement is built into the capitation rates on a prospective basis. The contracted actuary ensured that the amount of non-medical load built into the rates meets the administrative cap requirement. **UNMC amounts are revisited each rate cycle, which is typically every 12 months.** The contracted actuary developed the UNMC Supplemental PMPM by COA, COS, and Rating Region. MLTC Quality Performance Program and Performance Penalities are effective Year 1 and calculated annually on a 6 – 9 month lag for program end total. Attachment 26:"MLR and Risk Corridor Examples" contains an illustrative example of this scenario. Please see Section IV.P.9.d-e.
46.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 221	Please clarify whether or not the revenue and medical expenses for each of the calculations in this question includes UNMC supplemental payments, and if not, why not, especially since MCOs are at risk for these amounts.	All calculations listed in the response to Addendum 7, Question #221 will be applicable to the UNMC portion of the rate development.
47.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 231 and 232	Please confirm that, as stated in the Second Pre-Proposal Conference, once the MCOs are selected, the quality metrics are finalized, Optumas will perform an analysis to ensure that paid rates, including the portion of all withholds that is expected to	This is confirmed.

			be reasonably achievable by MCOs, fall within the actuarially sound rate range.	
48.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 240	Regarding Critical Access Hospitals: a. Please split out cost settlement (i.e., amounts paid above Medicaid) in the base data. b. Please share the list of adjustments (e.g., trend) and the values that were applied to these settlement amounts when developing the rates in Attachment 11.	The base data contains $8.3 million dollars in Critical Access Hospital settlement payments made outside of the claim/encounter payment system for FY14 and $8.1 million for FY15. The Critical Access Hospital settlements are added into the base data. As such, all rate adjustments outlined in Attachment 22 are applicable to the Critical Access Hospital portion of the capitation rate.
49.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 243	Regarding FQHCs and RHCs: a. Please provide the 1/1/16 APM payment schedules. b. Please clarify that under the new APM methodology effective 1/1/16, the FQHCs and RHCs will no longer cost settle with the state since the APM will reflect full payment to these facilities.	The 1/1/16 APM payment schedules are not currently available for public release. The State does not cost settle with FQHCs and/or RHCs.
50.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 244	Please confirm whether or not historical encounter/FFS data for physical and behavioral health services (i.e., non-pharmacy) under the contract, will be provided to plans upon member assignment.	Please see response to Addendum 7, Question #244.
51.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 245	Please clarify whether or not claims broker services will be needed for all services paid though fee for service (even for those members in managed care) in addition to	The Claims Broker will potentially handle all FFS claims. This could include Long-term Services and Supports related claims as those services are not currently included in the Heritage Health program. However, this will be dependent on final timing of CBS implementation and other program decisions regarding LTSS.

			all populations receiving benefits through fee for service. (For example, will long term services and supports be included for those managed care members receiving those services through fee for service?)	
52.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 254	In the answer to this question, it is stated that "The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back" but our calculations (based on the data and assumptions provided by Optumas) do not show that the QPP hold-back of 1.5% has explicitly been added into the rates. Please clarify how the QPP hold-back of 1.5% of premium is added to the rates.	Rates are developed based on reported base data, not capitation payments. Since rates are developed using reported experience, there is no need to add in an additional 1.5%. When the rates are finalized, the State's actuaries will remove the withhold consistent with CMS guidance.
53.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 254	Please confirm the value to which the 1.5% is applied to calculate the amount to be deposited into the reinvestment accounts: does this amount include NML? UNMC Supplemental payments? Or is it just 1.5% of the Medical PMPM?	The 1.5% hold back referenced in Section IV.P.10 and required by Neb. Rev. Stat. §71-831 (Attachment 13) is 1.5% of the capitation payment.
54.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 257	The answer to this question refers to a different question that does not address the definitions of related parties. Please confirm that all references to related parties for each of the admin cap, risk corridor, and MLR calculation	The response to Addendum 7, Question #257 is hereby amended to read: "See response to Question #53." References to related parties in the RFP refer to the same definition of related parties contained in the Glossary of Terms.

			refer to the same definition of related parties.	
55.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 259	Please summarize the values of both adjustments made to the rates for copays: a. Reduction embedded in base data to reflect amounts actually collected by providers over the base years. b. Reduction made during rate development process to reflect additional amounts not collected, but representative of all copays (mandatory and voluntary) being collected.	The reduction embedded in the base data reflecting amounts collected by current MCOs is not available. The amount paid by the MCOs is used as the basis for rate development, so the collected copays are not itemized. The adjustment to account for uncollected copays is a 0.02% reduction to the rates for traditional Physical Health managed populations, a 0.03% reduction for the LTSS populations, and no change for the Dual population.
56.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 261	Please provide a detailed list of all of the adjustments made to the encounter data (e.g., CAH settlements, PCP shared risk agreements) that are added in to the base data to reconcile to MCO financial statements.	Please see Attachments 34 and 35 for a complete list of program changes necessary to get from base data shown in Attachment 10 to the final rates shown in Attachment 11.
57.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 265	Please clarify that deliveries with a qualifying procedure code which resulted in a stillbirth were not considered to be "qualifying delivery events" and please also confirm how the term stillbirth is defined, including weeks gestation.	The response to Addendum 7, Question #265 is hereby amended and superseded with the following: A qualifying delivery procedure code must be found on an encounter in order for the maternity experience to be captured in the rates. ~~Currently the State does not pay a supplemental payment for stillbirths, so those expenses are not in the supplemental payment and remain in the regular monthly capitation rate.~~ **The State pays a supplemental payment for live birth events and only those expenses are in the supplemental payment.** When a qualifying delivery event is found in the data, the contracted actuary captures all other expenses for that member in the five months prior to delivery date and the two months post-delivery. All of these expenses are re-categorized from the member's original aid category to the Maternity aid category.

				The maternity cell separately captures maternity-related services for all populations, dating back 5 months from the date of delivery (5 months prenatal) and going forward 2 months after the delivery (2 months post-partum). Prenatal costs for delivery occurring within the first five months of the base data period, and postpartum costs for deliveries occurring within two months of the end of the base data period could be understated in the base data. As a result, an adjustment has been made to reflect the missing prenatal and postpartum services for deliveries occurring on the left and right tails of the base data. The contracted actuary reviewed the average per-member-per-delivery costs for delivery events occurring between December 2013 and April 2015 (step one) and compared these costs with the per-member-per-delivery costs for deliveries occurring July-November 2013 and May-June 2012 (step two). The differential between the deliveries identified in step one and step two was used to adjust costs observed in step two. The overall impact of this is an upward adjustment to the Maternity cell of 1.8%. Maternity experience split by service type can be found in Attachment 10-A and Attachment 10-B by viewing the Maternity aid category. Please note that for this aid category member months are actually deliveries, as the denominator for the supplemental payment is a delivery event, not a covered month. Physician, facility, prenatal, postpartum, and delivery costs can not be independently itemized.
58.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 265	Please provide each of the following **by rate cell and region:** 1) A count of qualifying deliveries during the base period 2) The associated dollars removed from the rate cell due to these deliveries Also, to the extent that the total deliveries and dollars removed do not add up to the	Please see Attachment 37.

			total dollars and deliveries used for the maternity kick payment for each of the two regions, please provide a reconciliation to explain the discrepancy.	
59.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 270	The answer to this question refers to Attachment 22 and Attachment 20. Please provide 1) a crosswalk that shows how the descriptions in Attachment 22 (narrative) align to the adjustments in Attachment 20 or elsewhere. 2) a new attachment that breaks out each of these impacts as requested, including breaking out the impacts into their COS and COA specific components, ideally also breaking the impacts out between any values included within the base data and applied between Attachment 10 and Attachment 11, and also indicating whether the changes are unit cost changes or utilization changes.	Please see Attachments 34 and 35.
60.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 272	Please confirm that the rates have not been reduced for MCO-collected supplemental Rx rebates. These are typically reflected in MCOs' financial statements and if data was adjusted to match these statements, reductions	Rates have not been reduced by rebates. The existing managed care program does not include pharmacy and therefore comments surrounding reported rebates are irrelevant to this rate cycle.

			for rebates could be embedded in the base data.	
61.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 313	We know the state indicated that this question would be answered in the second round of questions, but just want to include this question here to ensure that it is not overlooked.	Please see Addendum 10.
62.	Addendum Three: Revisions to the RFP	1	Questions regarding the Auto-Assignment Algorithm 1) How long is the initial Heritage Health enrollment period? 2) After the initial Heritage Health enrollment period ends, will the auto assignment algorithm take into consideration the enrollee's previous MCO assignment? 3) What steps would be taken to ensure that MCOs who contracted with the state prior to the contract period do not get a disproportionate share of members, or a significantly different mix of members than entering plans?	The initial Heritage Health enrollment period will begin October 1, 2016 and end December 16, 2016. Medicaid-covered individuals who have not made a Heritage Health plan choice on December 16 or whose Medicaid eligibility determination is made between December 17 and 31 will be auto-assigned to a Heritage Health plan. The auto-assignment algorithm will not take into consideration previous MCO assignment except in cases where the member is automatically reenrolled in his or her previous MCO because he or she loses Medicaid eligibility for a period of 2 months or less per 42 CFR § 438.56(g) as referenced in IV.B.7.c.ii.b). Per IV.B.3.e, "After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction." Per IV.B.3.f.iii, "If a MCO's membership is comprised of 40% or more of total statewide enrollment at the end of any quarter, that plan will be removed from the auto-assignment round robin process for the following quarter but members can continue to pro-actively select that plan."
63.	Attachment 21	N/A	Please confirm that the values in this exhibit are shown as a percent of the rate exclusive of the UNMC supplemental payment	Non-medical load will apply to the UNMC portion of the rate when rates are finalized in early 2016.
64.	Attachment 21	N/A	Since the UNMC	Please see the response to Question #63 above.

			Supplemental payments represent increased reimbursement that the MCOs are responsible for and at risk for, why are these not included in the rate development (Att. 11) as a medical costs, so that NML is applied to the amounts as well? We believe the NML percentages should be of revenue inclusive of the UNMC supplemental payments.	
65.	Attachment 22	p. 3	A number of program changes, both historical and anticipated, are described in the narrative. This is very helpful, and we are requesting that additional columns be added in the tables to the right of these descriptions to indicate the impact on the rates, and where that impact can be found (populations, services, base data, policy change factors, etc.) with additional exhibits as appropriate to describe particularly complex adjustments.	Please see Attachment 35.
66.	Attachment 23	N/A	Thank you for providing this additional detail for trends by COA and COS. Please also extend the exhibit to show the trends used for each of the four LTC categories, the Katie Beckett members, and Duals.	Katie Beckett is considered AABD for trend setting purposes. LTC categories and Duals used the same assumptions as the AABD population.
67.	Attachment 26	Example 1	In each of the risk corridor and	This information will be posted to the procurement

			MLR calculations, the qualified medical expenses are shown in the same way, including the activities that improve healthcare quality. Based on the glossary (p. xiii) this amount is defined differently for each of the two calculations, such that activities that improve healthcare quality are not included in net qualified medical expense for the risk corridor.	website no later than December 24, 2015.
68.	Attachment 26	Example 1 and Example 2	Please revise the examples to show how each of the following components of revenue would be handled within these examples: 1) UNMC payments 2) Hold-back (earned and unearned) 3) State Performance Penalty (earned and unearned)	This information will be posted to the procurement website no later than December 24, 2015.
69.	Attachment 26	Example 1 Risk Corridor	Please provide additional detail regarding the $8,000 shown as "Total Allowed Administration." In particular, we would expect that no more than $7,000 of this number (7% of revenue) would be for activities not categorized directly to improve healthcare quality, which would leave $1,000 for activities that do improve healthcare quality. Additionally, we would expect this value to be shown in the line labeled "activities that	This information will be posted to the procurement website no later than December 24, 2015.

			improve healthcare quality"	
70.	Attachment 26	Example 1 Risk Corridor	Please provide another example where the amount spent on admin expenses is higher than the total allowed	This information will be posted to the procurement website no later than December 24, 2015.
71.	Attachments 10-11	N/A	Please provide a detailed crosswalk that defines the logic used to determine the categories of service used in this development, using CPT codes, place of service information, or any other information needed to determine the categories of service. Please also ensure that this detailed crosswalk includes logic for services that are excluded under the contract, in particular, long term services and supports.	As the detailed category of service logic is specific to the data elements reported in the encounter data for each of the current managed care entities, the State cannot provide this information as it is proprietary information.
72.	Attachments 10-11	N/A	Please confirm/edit/add to the following list of rate items expected to be reviewed in Spring 2016. a. HEP-C b. Retroactive Enrollment c. UNMC supplemental payments d. CAHs cost settlement amounts e. Provider rate changes (e.g., FQHC) f. Health Insurer Fee/Tax g. Program changes such as ASD, DD h. Foster care behavioral health experience i. Updated trends	All items on this list will be considered in the rate certification in the Spring of 2016. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, the State's actuaries anticipate using additional runout from FFS data and current Managed Care entities. No changes to the base period are anticipated.

73.	Attachments 10-11	N/A	What are the drivers in the pmpm increases seen in the behavioral health component of the ABD populations? Is it new benefits, acuity, member mix? In particular, we saw PMPMs for these services in the range of $70 between 2009 and 2011, and these services are now upwards of $100.	The historical ABD population for behavioral health managed care is spread across the AABD populations in Attachments 10-A and 10-B, the Dual population in Attachment 10-C, and the LTSS population in Attachment 10-D. The average behavioral health PMPM weighted on the membership of each of these populations is consistent with the $70 quoted in the question.
74.	Attachments 10-11	N/A	Please provide additional breakouts in the category of service lines in all of Attachment 10's to split out utilization and unit cost for each of the following: 1) Pharmacy Expenditures - Hepatitis C 2) Pharmacy Expenditures - Non-Hepatitis C 3) For each inpatient and outpatient category, please split into hospital type: Critical Access Hospital, out-of-state hospital, other	This information will be posted to the procurement site no later than December 24, 2015.
75.	Attachment 11	Lower Bound of Rates	Please confirm the following conveyed at the pre-proposal conference. The rates in Attachment 11 include all of the following items at the stated values: a) Non-QI admin at 7%, b) QPP at 1.5%, c) QI admin at 3%, d) Perf Guar at 0.25%, and e) profit, risk and contingencies at 2%	Slide 15 of the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)" itemizes the components of the non-medical load. Please see Attachment 21 for the breakout of the non-medical load components by cohort. The 1.5% QPP is a withhold from the rates, so it is not added in as a component of non-medical load. Rather, it is withheld from the non-medical load rates.

76.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q262	Please describe what adjustments have been built into the rates to account for Hep C treatment. Given the number and costly drugs recently available in addition to recent news from CMS about utilizing these benefits, we would like a better understanding of what is included in the rates.	Hepatitis C drug utilization in Nebraska has historically been low. However, the higher pharmacy trend is meant to reflect potential increase in both average unit cost and utilization related to breakthrough therapies.
77.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q262	Please provide the state's current policy re: when Hep C drugs are allowed to be used for member treatment. Also, please provide a description of how the policy will change in Nebraska.	Current clinical criteria may be found at https://nebraska.fhsc.com/Downloads/NEcriteria_Sovaldi-201409.pdf. A current prior authorization request form may be found at https://nebraska.fhsc.com/Downloads/NEfaxform_HepatitisC-201507.pdf. Clinical criteria and prior authorization forms are reviewed and updated annually and as determined by the State.
78.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q200	Please provide a count these special populations - by region, rate cell, etc.	This level of detail is not available.
79.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q200	How are MCOs expected to identify these people? Is pharmacy data expected to be adequate for the identification of these members?	Pharmacy data will be provided to bolster any additional mechanisms a MCO has to assess a member for SHCN. Furthermore, per IV.E.22.d and IV.E.22.e, PCPs must notify the MCO of members who meet SHCN criteria and members may also self-identify to either the enrollment broker or the MCO that they have SHCNs.
80.	Attachment 6	Attachment 6, p. 9	Attachment 6 of the contract states HEDIS results are due "45 calendar days following the 12th month of the contract year". NCQA requires HEDIS rates be submitted by June 15th following the measurement year. For	Please see Attachment 38.

			example HEDIS rates for measurement year 2017 would be submitted in June of 2018. Will the state consider changing the due date for HEDIS reporting to align with NCQA timeframes?	
81.	IV.L.4.e.viii Care Management	115	What is the state's definition of "group visits" in this requirement? For example, is this intent for this to be interdisciplinary care team meetings with representatives of the member's unique care team? Are these support groups, i.e. classes/resources in the community? Are these groups facilitated by a provider (e.g. a PCP) on condition self-management?	Group visits include members of the interdisciplinary care team and members of the specialty treatment team as well as members and their families and additional local social and community services supports as necessary.
82.	IV. Project Description and Scope of Work, E. Covered Services, 11. Pharmacy Section, C. Nebraska Medicaid Preferred Drug List	59	After review of the state's PDL, it is noted that the drugs listed on Attachment 8 do not appear to be included in the current PDL posted on the state's website. Does the state have a separate behavioral health preferred drug list that the MCO will be required to implement?	Drugs listed on Attachment 8 are not included in the current PDL posted on the State's website. Attachment 8, which contains required edits for the pharmacy claims system to promote safe prescribing practices for mental health drugs used in children, is unrelated to the PDL. The State does not have a separate preferred drug list for antidepressants, antipsychotics and anticonvulsants.
83.	Z. FFS Claims Management and Processing	191-195	The RFP makes reference to many of the responsibilities of the MCO is awarded the FFS Claims Management and Processing duties. We would like to confirm whether the State will continue to be responsible for managing enrollment processing and	The MCO awarded the FSS Claims Broker contract will only be responsible for the claims-related activities outlined in Section IV.Z. The State, or its designated agent, will continue to oversee program responsibilities including enrollment and member communication for Medicaid-eligible individuals excluded from Heritage Health.

			development of the 834 file to all the MCOs, development of ID cards (including replacement cards) for Fee for Service members, and mailing and development of all member materials and newsletters for Fee for Service members.	
84.	Z. FFS Claims Management and Processing	191-195	In order to meet the requirements for claims processing against duplicates, etc. will the MCO that is chosen to be the FFS Claims broker receive claims history, eligibility history, and prior authorization history for both medical and pharmacy claims. If so, how far back will the claims data go?	MLTC will work with the MCO awarded the Claims Broker contract to provide the MCO with sufficient data to allow the MCO to meet the requirements outlined in Section IV.Z. Per IV.Z.3, the implementation of the Claims Broker role is targeted for the second year of the contract to allow sufficient time for MLTC to coordinate on all aspects of the transition with the awarded MCO.
85.	Z. FFS Claims Management and Processing	191-195	Will the state close out any open grievances & appeals or provider claims disputes, open TPL recoveries, complete all claims prior to the date of service that the claims broker implementation date that are active (or have a date of service) prior to the effective date of the FFS claims management contract with the MCO?	All activities outlined in the question will be handled by MLTC for dates of services or claims paid on dates prior to the effective date of the FFS claims management contract. Per IV.Z.3, the implementation of the Claims Broker role is targeted for the second year of the contract to allow sufficient time for MLTC to coordinate on all aspects of the transition with the awarded MCO.
86.	Z. FFS Claims Management, Section 12 Provider Services	194	Will the State continue to enroll Providers and assign the State Medicaid number to all Nebraska providers? Will the state continue to process all Nebraska Medicaid	The State or its designated agent will continue to enroll providers and assign State Medicaid provider numbers to approved providers.

			Provider additions, demographic changes, etc., or will this be the responsibility of the MCO who is awarded the FFS claims management contract?	
87.	Z. FFS Claims Management	191-195	Will the MCO who is selected to serve as the claims broker be responsible for processing dental and non emergent transportation claims?	The MCO awarded the FSS Claims Broker contract will be responsible for processing dental and non-emergency transportation claims if those benefits remain in the FFS program. However, dental services are currently scheduled to be included in a capitated dental benefit manager procurement that is expected to go-live in mid-2017. MLTC continues to evaluate administration of non-emergent transportation benefits.
88.	Attachment 23	557	Please provide a breakout of the assumed trend by utilization and unit cost.	As outlined in the "NE - Heritage Health Second Bidder's Conference Presentation - Optumas", utilization trend and unit cost trend will be provided in early 2016.
89.	Attachment 21	Page 3	For the dual population, what level of managed care is currently being assumed for the members that are currently enrolled in Medicare? What is the basis for this assumption?	The level of Medicare Advantage penetration in the Heritage Health Dual population is not known. Savings estimates for the Dual population are based on the prevalence of Behavioral Health services and anticipated changes in Physical Health experience when the two services are delivered under an integrated program. Duals frequently have a high need for Behavioral Health services, and the databooks provided in Attachment 10-C confirm this for the Heritage Health Dual population. When the care for these Dual enrollees is integrated under one delivery system, it is anticipated that better outcomes for Physical Health needs will occur, leading to a reduction in Physical Health utilization.
90.	Attachment 20	Attachment 20	For pharmacy, how were high cost hepatitis C drugs considered in the base data? Additionally, what considerations were made with regard to these drugs in setting the pharmacy trend? How does FY 14 prescription drug costs compare to FY 15	Please see the response to Question #76 above. Pharmacy costs by year will be provided to awarded MCOs in early 2016.

			costs by region and rate cell?	
91.	Attachment 21	4	Can you provide a summary of the most up to date analysis on the impact of the AP to APR DRG change? When was this analysis completed? Has the recent increase in high dollar inpatient NICUs been factored into this analysis?	Please refer to Attachment 22 for a thorough description of the analysis of the change from AP to APR DRG. This analysis was conducted in the Fall of 2015. NICUs expenditures are included in the base data and were reviewed for the DRG conversion analysis. The AP to APR DRG conversion increased expenses for the maternity case rate.
92.	Addendum Eight - Revised Schedule of Events	Page 1 (Addendum 8)	Will the agency release a revised "Request for Proposal For Contractual Services Form" to reflect the new "Opening Date and Time"?	No, the State will not release a revised “Request for Proposal For Contractual Services Form”.
93.	Attachment 2	1	What are the network access standards for vision, hearing, durable medical equipment , laboratory serves, home health, skilled nursing facilities, hospice, ambulatory surgical center, respite, physical therpay, occuapationa therory, speech therapy, if any?	Please see Attachment 2 for all current network standards.
94.	Addendum 3, RFP § IV(E)(29)(h)	1	Addendum 3 adds the following sentence as new section IV.E.29.h: Non-emergency transportation (except as indicated in Section IV.E.8.a) - Does this mean that non-emergency transportation is excluded (carved out for the State to manage) and MCOs are not required to provide member transportation?	Non-emergency transportation is excluded (“carved out”), with the exception of non-emergency ambulance transportation, which is included (“carved in”).
95.	Attachment 6 -	7	We would like to request	Critical incidents for the purpose of Critical Incident

	Quarterly Deliverables		further clarification regarding the Critical Incident Reporting requirement referenced in Attachment 6, in particular: • How does Nebraska define "critical incident"? • In some states, critical incident reporting relates only to members in long-term care. Is this also the case in Nebraska? • Please confirm that MCOs are only required to collect critical incident reports from behavioral health facilities.	Reporting per Attachment 6 include the following when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit: • Suicide attempt • Suicide death • Non-suicide death • Unexpected death • Homicide • Homicide attempt • Allegation of abuse/neglect (physical) • Allegation of abuse (psychological) • Fire setting or property damage • Medication error resulting in requiring medical intervention • Adverse drug reaction • Unauthorized leave • Accidental injury with significant medical intervention • Emergency medical treatment resulting from injury, medication error, or adverse medication reaction • Use of restraints or seclusion requiring significant medical intervention • Unusual, unexpected illness or disease • Other serious occurrence, including sexual contact between peers or peers and staff which member is under treatment The RFP requires critical incident reporting related to behavioral health providers only.
96.	RFP § IV (B)(2)(d) and RFP § IV (B)(5)(c)	33 & 36	Please confirm how much time the MCO is required to allow members to choose a PCP. RFP § IV(B)(2)(d) indicates 15 days and RFP § IV(B)(5)(c) indicates 10 days.	Members have 15 days to elect a MCO and may elect PCP within this timeframe. After MCO assignment, members have an additional ten days to elect a PCP. The MCO may elect to auto-assign the member as early as the 11th day, but must auto assign the member to a PCP within one month of the enrollment date.
97.	RFP § IV (I)(14)(b)	100	This provision requires that all providers be credentialed	There is no required credentialing timeframe prior to the contract start date.

			within 30 calendar days upon receipt of a completed credentialing application. Please confirm that the 30-day credentialing timeframe applies only after the Contract goes live.	
98.	RFP § IV(M)(1)(b)	118	We understand MLTC's quality strategy has been submitted to CMS for approval. Can MLTC a draft of the submitted quality strategy for preliminary review?	The MLTC Quality Strategy is currently under revision to come into compliance with proposed managed care regulation changes.
99.	RFP § IV(O)(17)	141	Following up on Round 1 Q&A #156, please confirm that the MCO will not be required to consult with NMPI and MFPAU in connection with recouping overpayments due to TPL, retroactive reductions to state fee schedules, members that were retrospectively disenrolled by the state and similar situations.	Please see the response to Addendum 6, Question #156.
100.	RFP § IV(Q)(6)(b)	150	The State indicated in response to Question 103 of the first round of questions that the 30% and 50% of the provider network measure includes all providers in the network. Would this include ancillary services such as laboratories, pharmacies, DME, radiologists, therapy services, etc.?	Please see the response to Addendum 6, Question #102. All providers in the network including ancillary services will be considered in the denominator.
101.	RFP § V(A)(2)(h)	197	We wanted to follow up on Question 174 from the first	The budget refers to the contract value. Please provide original contract value projections and actual contract value.

			round of Q&A. The State indicated that the originally scheduled budget and actual budget mean the project budget and the actual budget. What type of information would this be in the case of a capitated contract? Payment is made on a pmpm basis; by its structure the rate is simply the rate. Would the amount received by the MCO annually be the responsive information?	
102.	RFP § IV(Q)(11)	152	Will the UNMC payments be a fixed dollar amount each month, or will they vary based on the actual plan utilization with UNMC?	The UNMC payment is a fixed dollar amount.
103.	RFP § IV(Q)(11)	152	Given that the state has now advised that the UNMC payments will not be a pass-through and will instead be part of the at-risk capitation payment, will the UNMC portion of the capitation rate be removed when developing the capitation rate risk adjustments in year 2? If the UNMC payment is a fixed dollar amount, it is not actuarially sound to risk adjust these.	Risk adjustment factors will be applied to the aggregate rate, inclusive of UNMC.
104.	RFP § IV(P)(10) and IV(P)(11)	146-147	Given that the state has now advised that the UNMC payments will not be a pass-through and will instead be part of the at-risk capitation payment, will the UNMC	Non-medical load, the QPP Withhold, and the State Performance Penalty will apply to the UNMC portion of the rate.

			portion of the capitation rate be removed when calculating the QPP Withhold and the State Performance Penalty amounts? If the UNMC payment is a fixed dollar amount that must be paid out, it is not actuarially sound to reduce the amounts by the withhold and penalty amounts.	
105.	RFP Section IV.Z	191	Regarding the Procurement of FFS Claims Management and Processing services, can the State share how it will evaluate which MCO will be awarded this business? EG: what would the award criteria be?	Please see the response to Addendum 7, Question # 278.
106.	RFP Section IV.S.10	169	Does the State have documentation that it could make available to bidders on the Encounter Submission process? For example: should we assume that the HIPAA 837 I&P Companion Guides on the Nebraska Medicaid website are not only for Provider submissions for FFS Medicaid - but are also for MCO's to submit encounter data? In addition, does the State have any information it could share on the format of ancillary encounter submission file formats (e.g. error files returned from the State, acknowledgement files, provider file submissions)?	The posted HIPAA 5010 837I and 837P Companion Guides apply for both FFS and Encounter submissions, and contain only requirements that clarify state-specific usage of the standard transaction documented in the respective ASC X12 TR3 Implementation Guides. Exceptions where requirements differ in the companion guides for FFS and Encounter are identified as “Chargeable” for FFS submissions and “Reporting” for Encounter submissions. The State returns HIPAA 837 file acknowledgements via HIPAA 5010 999/TA1 Transactions. Encounter submission results are also sent via HIPAA 5010 277Claim Acknowledgement Transaction. In addition, a month-to-date error summary and acceptance percentage report is sent in a proprietary format.

107.	Attachments 30 & 31, and Question & Answer #304 (11.19.15) RFP Section IV.B.12	Attachment 30 Attachment 31 Q/A Part 2, page 34 IV.B.12, page	The NE Medicaid 5010 Companion Guide for 834 transactions (published 3/12/13) is very short and only specifies sender and receiver IDs. Our question: although the monthly enrollment file as specified in Attachment 30 is not an 834 format, does MLTC's 834 eligibility file contain the same *data elements* as the monthly enrollment file as specified in Attachment 30?	The posted HIPAA 5010 834 Companion Guide contains only requirements that clarify state-specific usage of the standard transaction documented in the ASC X12 TR3 Implementation Guide. The Nebraska Medicaid Managed Care Client Eligibility Data Supplemental Enrollment File in Attachment 30 is a proprietary supplement to the HIPAA 5010 834 Benefit Enrollment and Maintenance Transaction which contains additional data that cannot be reported in the 834 transaction. There is limited data element duplication in the 834 and the supplemental files to enable the MCO to tie the data in the two files for each client.
108.	RFP Section IV.S.10.x RFP Section IV.P.13	IV.S.10.x: p.171 IV.P.13: p.148	Regarding this sentence: *Control totals will also be reviewed and verified. Additionally, the MCO must reconcile all encounter data submitted to the State to control totals and to the MCO's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 6 – Reporting Requirements*. We cannot find information in Attachment 6 that relates to MLR reports or reconciliation of encounter data to MLR reports. Does MLTC have additional information that is intended for inclusion in Attachment 6?	Quarterly and annual financial reporting requirements included in Attachment 6 reference Section IV.T – Reporting and Deliverables. IV.T.5 contains a list of required reports including IV.T.5.v – Medical loss ratio calculation.
109.	RFP Section IV.R.13.a	161	Regarding this sentence: *The MCO must have online retrieval and access to documents and files for six (6)*	MLTC will develop a policy in coordination with awarded MCOs in regards to the final disposition of claims with a once-in-a-lifetime indicator.

			years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged. Does the second sentence override the first sentence? Specifically: how long must the MCO maintain "once-in-a-life-time" claims online - greater than 10 years? Wouldn't MLTC be better served to require MCO's to turn over such claims data to MLTC after 10 years?	

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM EIGHT
REVISED SCHEDULE OF EVENTS

Date: November 20, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

NEW Opening Date: January 5, 2016 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
8	Last day to submit Second Round written questions	~~November 23, 2015~~ **November 30, 2015**
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~December 7, 2015~~ **December 18, 2015**
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	~~December 22, 2015~~ **January 5, 2016** 2:00 PM Central Time
11	Review for conformance of mandatory requirements	~~December 22, 2015~~ **January 5, 2016**
12	Evaluation period	~~January 6, 2016 –~~ ~~January 22, 2016~~ **January 12, 2016 –** **January 29, 2016**
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~January 29, 2016~~ **February 5, 2016**

	ACTIVITY	DATE/TIME
15	Contract finalization period	~~January 29, 2016 –~~ ~~February 29, 2016~~ **February 5, 2016 – March 15, 2016**
16	Contract award	~~March 1, 2016~~ **March 15, 2016**
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA MEDICAID MANAGED CARE

UNBORN FILE

OCTOBER 25, 2013

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DOCUMENT SUMMARY **1**

NEBRASKA MANAGED CARE UNBORN FILE DATA RECORD LAYOUT **2**

H RECORD - UNBORN HEADER RECORD 2
N, C, E RECORD - UNBORN DETAIL RECORD 3
T RECORD - UNBORN TRAILER RECORD 4

NOTES FOR HEALTH PLAN UNBORN HEADER DATA RECORD - "H" RECORD **6**

FIELD HHH NEBRASKA MANAGED CARE UNBORN HEADER RECORD 6
FIELD H01 HEADER ACTION TYPE 6
FIELD H02 HEADER DATE/TIME STAMP 6

NOTES FOR HEALTH PLAN UNBORN DETAIL DATA RECORD - "D" RECORD **7**

FIELD DDD NEBRASKA MANAGED CARE UNBORN DETAIL RECORD 7
FIELD D01 DETAIL ACTION TYPE 7
FIELD D02 UNBORN MEDICAID IDENTIFICATION NUMBER 7
FIELD D03 EXPECTED DATE OF BIRTH 7
FIELD D04 MOTHERS NAME 7
FIELD D05 HEAD OF THE HOUSEHOLD NAME 8
FIELD D06 HEAD OF HOUSEHOLD ADDRESS - LINE 1 8
FIELD D07 HEAD OF HOUSEHOLD ADDRESS - LINE 2 8
FIELD D08 HEAD OF HOUSEHOLD ADDRESS - LINE 3 8
FIELD D09 HEAD OF HOUSEHOLD CITY 8
FIELD D10 HEAD OF HOUSEHOLD STATE 8
FIELD D11 HEAD OF HOUSEHOLD ZIP CODE 8
FIELD D12 HEAD OF HOUSEHOLD ZIP 4 9
FIELD D13 XREF MEDICAID IDENTIFICATION NUMBER 9
FIELD D14 FETAL NUMBER 9

NOTES FOR HEALTH PLAN UNBORN TRAILER DATA RECORD - "T" RECORD **10**

FIELD TTT NEBRASKA MANAGED CARE UNBORN TRAILER RECORD 10
FIELD T01 TRAILER ACTION TYPE 10
FIELD T02 TRAILER DATE/TIME STAMP 10
FIELD T03 TOTAL DETAIL RECORD 10

DOCUMENT SUMMARY

This document describes the Nebraska Medicaid Managed Care Program record layout used by the State of Nebraska to send information regarding unborn clients to the health plans.

This file will be sent daily and monthly. It will include unborn clients that have either the mom or a sibling enrolled with the health plan.

The file characteristics are:

a. Record length = 500

b. The first record in the file must be a header record

c. The last record in the file must be a trailer record.

d. All date fields must be in **YYYY**MMDD format.

NEBRASKA MANAGED CARE UNBORN FILE DATA RECORD LAYOUT

H RECORD - Unborn Header Record

```
                                                                    Required/
COBOL Record Layout                                                 Optional    Field   Position

01  NMC-UNBORN-HDR.                                                                HHH     001-500
    03  NMC-HDR-ACTION-TYPE            PIC X     VALUE 'H'.          R         H01     001-001
    03  NMC-HDR-DATE-STAMP.                                          R         H02     002-015
        05  NMC-HDR-SYSTEM-DATE.
            10  NMC-HDR-SYSTEM-YEAR    PIC 9(04) VALUE 0.
            10  NMC-HDR-SYSTEM-MONTH   PIC 9(02) VALUE 0.
            10  NMC-HDR-SYSTEM-DAY     PIC 9(02) VALUE 0.
        05  NMC-HDR-SYSTEM-TIME.
            10  NMC-HDR-SYSTEM-HOUR    PIC 9(02) VALUE 0.
            10  NMC-HDR-SYSTEM-MINUTE  PIC 9(02) VALUE 0.
            10  NMC-HDR-SYSTEM-SECOND  PIC 9(02) VALUE 0.
    03  FILLER                         PIC X(485).                                 016-500
```

N, C, E RECORD - Unborn Detail Record

COBOL Record Layout		Required/ Optional	Field	*Position*
01 NMC-UNBORN-DET.			DDD	001-500
03 NMC-ACTION-TYPE	PIC X.	R	D01	001-001
03 NMC-UNBORN-DETAIL.				
05 NMC-UNBORN-MEDICAID-NBR.		R	D02	002-012
10 NMC-UNBORN-CASE-NBR	PIC 9(09) VALUE 0.			
10 NMC-UNBORN-CASE-ID	PIC 9(02) VALUE 0.			
05 NMC-EXPECTED-DATE-OF-BIRTH.		R	D03	013-020
10 NMC-EXPECTED-DOB-YEAR	PIC X(04).			
10 NMC-EXPECTED-DOB-MONTH	PIC X(02).			
10 NMC-EXPECTED-DOB-DAY	PIC X(02).			
05 NMC-MOM-NAME.		R	D04	021-066
10 NMC-MOM-FNAME	PIC X(20).			
10 NMC-MOM-MINIT	PIC X.			
10 NMC-MOM-LNAME	PIC X(25).			
05 NMC-HEAD-OF-HOUSE-NAME.		R	D05	067-096
10 NMC-HOH-FNAME	PIC X(10).			
10 NMC-HOH-MINIT	PIC X.			
10 NMC-HOH-LNAME	PIC X(19).			
05 NMC-HOH-MAILING-ADDRESS.				
10 NMC-MAILING-ADDRESS1	PIC X(50).	R	D06	097-146
10 NMC-MAILING-ADDRESS2	PIC X(50).	O	D07	147-196
10 NMC-MAILING-ADDRESS3	PIC X(50).	O	D08	197-246
10 NMC-MAILING-CITY	PIC X(25).	R	D09	247-271
10 NMC-MAILING-STATE	PIC X(02).	R	D10	272-273
10 NMC-MAILING-ZIP-CODE	PIC 9(05) VALUE 0.	R	D11	274-278
10 NMC-MAILING-ZIP-4	PIC 9(04) VALUE 0.	O	D12	279-282
05 NMC-XREF-MEDICAID-NBR.		R	D13	283-293
10 NMC-XREF-CASE-NBR	PIC 9(09) VALUE 0.			
10 NMC-XREF-CASE-ID	PIC 9(02) VALUE 0.			
05 NMC-FETAL-NBR	PIC 9(4) VALUE 0.	R	D14	294-297
05 FILLER	PIC X(203).			298-500

T RECORD - Unborn Trailer Record

COBOL Record Layout			Required/ Optional	Field	*Position*
01 NMC-UNBORN-TRL.				TTT	001-500
03 NMC-TRL-ACTION-TYPE	PIC X VALUE 'T'.		R	T01	001-001
03 NMC-TRL-DATE-STAMP.			R	T02	002-015
05 NMC-TRL-SYSTEM-DATE.					
10 NMC-TRL-SYSTEM-YEAR	PIC 9(04)	VALUE 0.			
10 NMC-TRL-SYSTEM-MONTH	PIC 9(02)	VALUE 0.			
10 NMC-TRL-SYSTEM-DAY	PIC 9(02)	VALUE 0.			
05 NMC-TRL-SYSTEM-TIME.					
10 NMC-TRL-SYSTEM-HOUR	PIC 9(02)	VALUE 0.			
10 NMC-TRL-SYSTEM-MINUTE	PIC 9(02)	VALUE 0.			
10 NMC-TRL-SYSTEM-SECOND	PIC 9(02)	VALUE 0.			
03 NMC-TOTAL-DETAIL-RECORDS	PIC 9(07)	VALUE 0.	R	T03	016-022
03 FILLER	PIC X(478).				023-500

NEBRASKA MEDICAID MANAGED CARE

UNBORN FILE DATA

Document B: Health Plan Unborn File Data Descriptive Notes

NOTES FOR HEALTH PLAN UNBORN HEADER DATA RECORD - "H" RECORD

Field HHH Nebraska Managed Care Unborn Header Record

Field Name: NMC-UNBORN-HDR
Purpose: This is the Unborn Header Data Record.
Valid Values: Follow.

Field H01 Header Action Type

Field Name: NMC-HDR-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'H'.

Field H02 Header Date/Time Stamp

Field Name: NMC-HDR-DATE-STAMP

NMC-HDR-SYSTEM-DATE	
NMC-HDR-SYSTEM-YEAR	PIC 9(04)
NMC-HDR-SYSTEM-MONTH	PIC 9(02)
NMC-HDR-SYSTEM-DAY	PIC 9(02)
NMC-HDR-SYSTEM-TIME	
NMC-HDR-SYSTEM-HOUR	PIC 9(02)
NMC-HDR-SYSTEM-MINUTE	PIC 9(02)
NMC-HDR-SYSTEM-SECOND	PIC 9(02)

Purpose: The header record will contain the system date and time documenting when the file was created.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24 hour HHMMSS format

NOTES FOR HEALTH PLAN UNBORN DETAIL DATA RECORD - "D" RECORD

Field DDD Nebraska Managed Care Unborn Detail Record

Field Name: NMC-UNBORN-DET
Purpose: This is the Unborn Detail Data Record.
Valid Values: Follow.

Field D01 Detail Action Type

Field Name: NMC- ACTION-TYPE PIC X.
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: N = New - First time unborn is being sent to plan
C = Continue - Unborn continues to be assigned to plan
E = End - Pregnancy has ended or unborn is no longer assigned to plan

Field D02 Unborn Medicaid Identification Number

Field Name: NMC-UNBORN-MEDICAID-NBR.
NMC-UNBORN-CASE-NBR PIC 9(09) VALUE 0.
NMC-UNBORN-CASE-ID PIC 9(02) VALUE 0.

Purpose: 11-digit Medicaid number assigned by Health and Human Services to a person who has applied and is eligible for public assistance benefits. This number consists of a Medicaid case number and a client identification number within that case.
REQUIRED: YES
Valid Values: 11-digit Medicaid number.

Field D03 Expected Date of Birth

Field Name: NMC-EXPECTED-DATE-OF-BIRTH.
NMC-EXPECTED-DOB-YEAR PIC X(04).
NMC-EXPECTED-DOB-MONTH PIC X(02).
NMC-EXPECTED-DOB-DAY PIC X(02).

Purpose: This field contains the unborn's expected date of birth.
REQUIRED: YES

Field D04 Mothers Name

Field Name: NMC-MOM-NAME.
NMC-MOM-FNAME PIC X(20).
NMC-MOM-MINIT PIC X.
NMC-MOM-LNAME PIC X(25).
Purpose: This field contains the name of the pregnant mother.
REQUIRED: YES

Field D05 Head of the Household Name

Field Name: NMC-HEAD-OF-HOUSE-NAME
- NMC-HOH-FNAME PIC X(10).
- NMC-HOH-MINIT PIC X.
- NMC-HOH-LNAME PIC X(19).

Purpose: This field contains the case head name associated with the mailing address.
REQUIRED: YES

Field D06 Head of Household Address - Line 1

Field Name: NMC-MAILING-ADDRESS1 PIC X(50)
Purpose: This field contains the first line of the address.
REQUIRED: YES

Field D07 Head of Household Address - Line 2

Field Name: NMC-MAILING-ADDRESS2 PIC X(50)
Purpose: This field contains the second line of the address.
REQUIRED: NO

Field D08 Head of Household Address - Line 3

Field Name: NMC-MAILING-ADDRESS3 PIC X(50)
Purpose: This field contains the third line of the address.
REQUIRED: NO

Field D09 Head of Household City

Field Name: NMC-MAILING-CITY PIC X(25)
Purpose: This field contains the city name.
REQUIRED: YES

Field D10 Head of Household State

Field Name: NMC-MAILING-STATE PIC X(02)
Purpose: This field contains a two-digit state code.
REQUIRED: YES

Field D11 Head of Household Zip Code

Field Name: NMC-MAILING-ZIP-CODE PIC 9(05).
Purpose: This field contains the five-digit postal zip code.
REQUIRED: YES

Field D12 Head of Household Zip 4

Field Name: NMC-MAILING-ZIP-4 PIC 9(04).
Purpose: This field contains the four-digit postal zip code.
REQUIRED: NO

Field D13 XREF Medicaid Identification Number

Field Name: NMC-XREF-MEDICAID-NBR.
NMC-XREF-CASE-NBR PIC 9(09) VALUE 0.
NMC-XREF-CASE-ID PIC 9(02) VALUE 0.

Purpose: Medicaid number of the mom or sibling used to assign the unborn to a plan.
REQUIRED: YES
Valid Values: 11-digit Medicaid number.

Field D14 Fetal Number

Field Name: NMC-FETAL-NBR PIC 9(4)
Purpose: This field contains the number of fetuses of the pregnant mother.
REQUIRED: YES

NOTES FOR HEALTH PLAN UNBORN TRAILER DATA RECORD - "T" RECORD

Field TTT Nebraska Managed Care Unborn Trailer Record

Field Name: NMC-UNBORN-TRL
Purpose: This is the Unborn Trailer Data Record.
Valid Values: Follow.

Field T01 Trailer Action Type

Field Name: NMC-TRL-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'T'.

Field T02 Trailer Date/Time Stamp

Field Name: NMC-TRL-DATE-STAMP

NMC-TRL-SYSTEM-DATE	
NMC-TRL-SYSTEM-YEAR	PIC 9(04)
NMC-TRL-SYSTEM-MONTH	PIC 9(02)
NMC-TRL-SYSTEM-DAY	PIC 9(02)
NMC-TRL-SYSTEM-TIME	
NMC-TRL-SYSTEM-HOUR	PIC 9(02)
NMC-TRL-SYSTEM-MINUTE	PIC 9(02)
NMC-TRL-SYSTEM-SECOND	PIC 9(02)

Purpose: The trailer record will contain the system date and time documenting when the file was created.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24-hour HHMMSS format.

Field T03 Total Detail Record

Field Name: NMC-TRL-TOTAL-DETAIL-RECORD PIC 9(07)
Purpose: This field contains an accumulated total count of the records in this batch. A batch is the group of records between the header and the trailer record.
REQUIRED: YES

NEBRASKA MEDICAID MANAGED CARE

CLIENT ELIGIBILITY DATA

SUPPLEMENTAL ENROLLMENT FILE REPORT

July 2015

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DOCUMENT SUMMARY 1

NEBRASKA MANAGED CARE CLIENT ELIGIBILITY DATA RECORD LAYOUT 2

H RECORD - CLIENT ELIGIBILITY HEADER RECORD 2
N, C, X, D RECORD - CLIENT ELIGIBILITY DETAIL RECORD 2
T RECORD - CLIENT ELIGIBILITY TRAILER RECORD 6

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY HEADER DATA RECORD - "H" RECORD 8

FIELD HHH NEBRASKA MANAGED CARE CLIENT ELIGIBILITY HEADER RECORD 8
FIELD H01 HEADER ACTION TYPE 8
FIELD H02 HEADER DATE/TIME STAMP 8

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY DETAIL DATA RECORD - "D" RECORD 9

FIELD DDD NEBRASKA MANAGED CARE CLIENT ELIGIBILITY DETAIL RECORD 9
FIELD D01 DETAIL ACTION TYPE 9
FIELD D02 CLIENT MEDICAID IDENTIFICATION NUMBER 9
FIELD D03 CLIENT SOCIAL SECURITY NUMBER 9
FIELD D04 CLIENT NAME 10
FIELD D05 MEDICAL PLAN NUMBER 10
FIELD D06 PROVIDER IDENTIFICATION NUMBER 10
FIELD D07 MEDICAL MEDICAID PROVIDER TERMINATED 10
FIELD D08 VENDOR PROVIDER NUMBER 10
FIELD D09 BEHAVIORAL HEALTH PLAN NUMBER 10
FIELD D10 CAP RATES 11
FIELD D11 DSS AGENCY CODE 11
FIELD D12 CLIENT LIVING ARRANGEMENT 11
FIELD D13 CLIENT NATIONALITY 13
FIELD D14 PREGNANCY RELATED SERVICES FEE INDICATOR 13
FIELD D15 NMC AUTOASSIGNMENT INDICATOR 13
FIELD D16 CLIENT CAP GENDER 13
FIELD D17 SPECIAL NEEDS CLIENT INDICATOR 13
FIELD D18 REASON FOR CLIENTS CASE CLOSING 13
FIELD D19 LOCK IN CODE 14
FIELD D20 LOCK IN PHARMACY NUMBER 14
FIELD D21 LOCK IN PRIMARY PRACTITIONER NUMBER 14
FIELD D22 LOCK IN LICENSE (PRESCRIBING PHYSICIAN NUMBER) 14
FIELD D23 LOCK IN HOSPITAL 14
FIELD D24 FETAL NUMBER 15
FIELD D25 MOTHERS NAME 15
FIELD D26 CARRIER NUMBER 15
FIELD D27 CARRIER NAME 15
FIELD D28 POLICY KEY 15
FIELD D29 SUBSCRIBER SOCIAL SECURITY NUMBER 15
FIELD D30 SUBSCRIBER NAME 15
FIELD D31 RELATION POLICY HOLDER 16
FIELD D32 COVERAGE CODE 16
FIELD D33 EFFECTIVE TPL STARTING DATE 17
FIELD D34 EFFECTIVE TPL ENDING DATE 17
FIELD D35 TPL TOTAL TIMES 17
FIELD D36 PREGNANCY INDICATOR 18
FIELD D37 EXPECTED DATE OF BIRTH 18
FIELD D38 TRANSFER REASON CODE 18
FIELD D39 PAE PROGRAM CODE 19
FIELD D40 RATE GROUP 20
FIELD D41 CLIENT COUNTY 20
FIELD D42 SPECIAL PROGRAM INDICATOR (SPI) CODES 21

FIELD D43 CO-PAY INDICATOR 22

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY TRAILER DATA RECORD - "T" RECORD 23

FIELD TTT NEBRASKA MANAGED CARE CLIENT ELIGIBILITY TRAILER RECORD 23
FIELD T01 TRAILER ACTION TYPE 23
FIELD T02 TRAILER DATE/TIME STAMP 23
FIELD T03 TOTAL DETAIL RECORDS 24
FIELD T04 TOTAL ENROLLED CLIENTS 24
FIELD T05 TOTAL DIS-ENROLLED CLIENTS 24
FIELD T06 TOTAL TRANSFERRED CLIENTS 24
FIELD T07 TOTAL CAPITATION AMOUNT 1 24
FIELD T08 TOTAL CAPITATION AMOUNT 2 24
FIELD T09 TOTAL CAPITATION AMOUNT 3 24
FIELD T10 TOTAL CAPITATION AMOUNT 4 25
FIELD T11 TOTAL CAPITATION AMOUNT 5 25
FIELD T12 TOTAL CAPITATION AMOUNT 6 25

DOCUMENT SUMMARY

This document describes the Nebraska Medicaid Managed Care Program record layout used by the State of Nebraska to send information regarding Medicaid Managed Care clients enrolled with the health connection vendor(s).

This file will be sent on a monthly basis. It will include all clients who are newly enrolled, clients who were enrolled last month and continue to be enrolled, clients who will transferred into the health plan, and clients who are no longer enrolled with the health plan.

The file characteristics are:

a. EBCDIC format

b. LRECL **=** 1500, RECFM = FB

c. The first record in the file must be a header record

d. The last record in the file must be a trailer record.

e. All date fields must be in YYYYMMDD format.

NEBRASKA MANAGED CARE CLIENT ELIGIBILITY DATA RECORD LAYOUT

H RECORD - Client Eligibility Header Record

(NMCMENRL)

--------- FIELD LEVEL/NAME ----------	-PICTURE-	FIELD -NUMBER	START	END	LENGTH
:E-:NMC-MEDICAID-ENROLL-DATA			1	1500	1500
2 :E-:NMC-MEDICAID-ENROLL-HDR	GROUP	1	1	1500	1500
3 :E-:NMC-HDR-ACTION-TYPE	X	2	1	1	1
3 :E-:NMC-HDR-DATE-STAMP	GROUP	3	2	15	14
5 :E-:NMC-HDR-SYSTEM-DATE	GROUP	4	2	9	8
7 :E-:NMC-HDR-SYSTEM-YEAR	9(4)	5	2	5	4
7 :E-:NMC-HDR-SYSTEM-MONTH	99	6	6	7	2
7 :E-:NMC-HDR-SYSTEM-DAY	99	7	8	9	2
5 :E-:NMC-HDR-SYSTEM-TIME	GROUP	8	10	15	6
7 :E-:NMC-HDR-SYSTEM-HOUR	99	9	10	11	2
7 :E-:NMC-HDR-SYSTEM-MINUTE	99	10	12	13	2
7 :E-:NMC-HDR-SYSTEM-SECOND	99	11	14	15	2
3 FILLER	X(1481)	12	16	1496	1481
3 :E-:NMC-HDR-TRANSMIT-PLAN-NBR	9(4)	13	1497	1500	4

N, C, X, D RECORD - Client Eligibility Detail Record

--------- FIELD LEVEL/NAME ----------	-PICTURE-	FIELD -NUMBER	START	END	LENGTH
2 :E-:NMC-MEDICAID-ENROLL-DET REDEFINES :E-:NMC-MEDICAID-ENROLL-HDR					
2 :E-:NMC-MEDICAID-ENROLL-DET	GROUP	14	1	1500	1500
3 :E-:NMC-ACTION-TYPE	X	15	1	1	1
3 :E-:NMC-ENROLLMENT-DETAIL	GROUP	16	2	1496	1495
5 :E-:NMC-CLIENT-MEDICAID-NBR	GROUP	17	2	12	11
7 :E-:NMC-MEDICAID-CASE-NBR	9(9)	18	2	10	9
7 :E-:NMC-CLIENT-CASE-ID	99	19	11	12	2
5 :E-:NMC-CLIENT-SSN	9(9)	20	13	21	9
5 :E-:NMC-CLIENT-NAME	GROUP	21	22	67	46
7 :E-:NMC-CLIENT-FNAME	X(20)	22	22	41	20
7 :E-:NMC-CLIENT-MIDINIT	X	23	42	42	1
7 :E-:NMC-CLIENT-LNAME	X(25)	24	43	67	25
5 :E-:NMC-MD-PLAN-NUMBER	9(4)	25	68	71	4
5 :E-:NMC-PROVIDER-NUMBER	GROUP	26	72	82	11
7 :E-:NMC-MD-MEDICAID-PROV-NBR	X(9)	27	72	80	9
7 :E-:NMC-MD-MEDICAID-PROV-SFX	99	28	81	82	2
5 :E-:NMC-MD-MEDICAID-PROV-TERM	X	29	83	83	1
5 :E-:NMC-VENDOR-PROV-NBR	X(15)	30	84	98	15
5 :E-:NMC-BH-PLAN-NUMBER	9(4)	31	99	102	4
5 :E-:NMC-CAP-RATES	GROUP	32	103	144	42
7 :E-:NMC-CAP-AMT1	9(5)V99	33	103	109	7
7 :E-:NMC-CAP-AMT2	9(5)V99	34	110	116	7
7 :E-:NMC-CAP-AMT3	9(5)V99	35	117	123	7
7 :E-:NMC-CAP-AMT4	9(5)V99	36	124	130	7
7 :E-:NMC-CAP-AMT5	9(5)V99	37	131	137	7

7 :E-:NMC-CAP-AMT6	9(5)V99	38	138	144	7
5 :E-:NMC-DSS-AGENCY-CODE	GROUP	39	145	149	5
7 :E-:NMC-DSS-DISTRICT	99	40	145	146	2
7 :E-:NMC-DSS-ADM-OFFICE	9	41	147	147	1
7 :E-:NMC-DSS-WORKER	99	42	148	149	2
5 :E-:NMC-CLIENT-LIVING-ARRANGE	99	43	150	151	2
5 :E-:NMC-CLIENT-NATIONALITY	X	44	152	152	1
5 :E-:NMC-IND	GROUP	45	153	156	4
7 :E-:NMC-PREG-RELATED-SERV-IND	X	46	153	153	1
7 :E-:NMC-AUTO-ASSIGN-IND	X	47	154	154	1
7 :E-:NMC-CAP-GENDER	X	48	155	155	1
7 :E-:NMC-SPECIAL-NEEDS-IND	X	49	156	156	1
5 :E-:NMC-REASON-CLOSE-CODE	XXX	50	157	159	3
5 :E-:NMC-LOCK-IN-CODE	X	51	160	160	1
5 :E-:NMC-LOCK-IN-PHARMACY	X(11)	52	161	171	11
5 :E-:NMC-LOCK-IN-PRIM-PRACT	X(11)	53	172	182	11
5 :E-:NMC-LOCK-IN-LICENSE	X(13)	54	183	195	13
5 :E-:NMC-LOCK-IN-OP-HOSP	X(11)	55	196	206	11
5 :E-:NMC-FETAL-NBR	9(4)	56	207	210	4
5 :E-:NMC-MOM-NAME	GROUP	57	211	256	46
7 :E-:NMC-MOM-FNAME	X(20)	58	211	230	20
7 :E-:NMC-MOM-MNAME	X	59	231	231	1
7 :E-:NMC-MOM-LNAME	X(25)	60	232	256	25
5 :E-:NMC-TPL-INFO(1) OCCURS 4 TIMES	GROUP	61	257	410	154
7 :E-:NMC-CARRIER-NBR(1)	GROUP	62	257	264	8
10 :E-:NMC-CARRIER-CODE(1)	X(5)	63	257	261	5
10 :E-:NMC-CARRIER-SEQ-NBR(1)	XXX	64	262	264	3
7 :E-:NMC-CARRIER-NAME(1)	X(30)	65	265	294	30
7 :E-:NMC-POLICY-KEY(1)	GROUP	66	295	334	40
10 :E-:NMC-POLICY-NBR(1)	X(20)	67	295	314	20
10 :E-:NMC-GROUP-NUMBER(1)	X(20)	68	315	334	20
7 :E-:NMC-SUBSCRIBER-SSN(1)	X(9)	69	335	343	9
7 :E-:NMC-SUBSCRIBER-NAME(1)	GROUP	70	344	389	46
10 :E-:NMC-SUBSCR-FIRST(1)	X(20)	71	344	363	20
10 :E-:NMC-SUBSCR-MIDINT(1)	X	72	364	364	1
10 :E-:NMC-SUBSCR-LAST(1)	X(25)	73	365	389	25
7 :E-:NMC-RELATN-POLHLDR(1)	XX	74	390	391	2
7 :E-:NMC-COVERAGE-CODE(1)	XXX	75	392	394	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(1)	GROUP	76	395	410	16
10 :E-:NMC-TPL-START-DATE(1)	GROUP	77	395	402	8
15 :E-:NMC-TPL-YEAR-START(1)	X(4)	78	395	398	4
15 :E-:NMC-TPL-MONTH-START(1)	XX	79	399	400	2
15 :E-:NMC-TPL-DAY-START(1)	XX	80	401	402	2
10 :E-:NMC-TPL-END-DATE(1)	GROUP	81	403	410	8
15 :E-:NMC-TPL-YEAR-END(1)	X(4)	82	403	406	4
15 :E-:NMC-TPL-MONTH-END(1)	XX	83	407	408	2
15 :E-:NMC-TPL-DAY-END(1)	XX	84	409	410	2
5 :E-:NMC-TPL-INFO(2)	GROUP	61	411	564	154

7 :E-:NMC-CARRIER-NBR(2)	GROUP	62	411	418	8
10 :E-:NMC-CARRIER-CODE(2)	X(5)	63	411	415	5
10 :E-:NMC-CARRIER-SEQ-NBR(2)	XXX	64	416	418	3
7 :E-:NMC-CARRIER-NAME(2)	X(30)	65	419	448	30
7 :E-:NMC-POLICY-KEY(2)	GROUP	66	449	488	40
10 :E-:NMC-POLICY-NBR(2)	X(20)	67	449	468	20
10 :E-:NMC-GROUP-NUMBER(2)	X(20)	68	469	488	20
7 :E-:NMC-SUBSCRIBER-SSN(2)	X(9)	69	489	497	9
7 :E-:NMC-SUBSCRIBER-NAME(2)	GROUP	70	498	543	46
10 :E-:NMC-SUBSCR-FIRST(2)	X(20)	71	498	517	20
10 :E-:NMC-SUBSCR-MIDINT(2)	X	72	518	518	1
10 :E-:NMC-SUBSCR-LAST(2)	X(25)	73	519	543	25
7 :E-:NMC-RELATN-POLHLDR(2)	XX	74	544	545	2
7 :E-:NMC-COVERAGE-CODE(2)	XXX	75	546	548	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(2)	GROUP	76	549	564	16
10 :E-:NMC-TPL-START-DATE(2)	GROUP	77	549	556	8
15 :E-:NMC-TPL-YEAR-START(2)	X(4)	78	549	552	4
15 :E-:NMC-TPL-MONTH-START(2)	XX	79	553	554	2
15 :E-:NMC-TPL-DAY-START(2)	XX	80	555	556	2
10 :E-:NMC-TPL-END-DATE(2)	GROUP	81	557	564	8
15 :E-:NMC-TPL-YEAR-END(2)	X(4)	82	557	560	4
15 :E-:NMC-TPL-MONTH-END(2)	XX	83	561	562	2
15 :E-:NMC-TPL-DAY-END(2)	XX	84	563	564	2
5 :E-:NMC-TPL-INFO(3)	GROUP	61	565	718	154
7 :E-:NMC-CARRIER-NBR(3)	GROUP	62	565	572	8
10 :E-:NMC-CARRIER-CODE(3)	X(5)	63	565	569	5
10 :E-:NMC-CARRIER-SEQ-NBR(3)	XXX	64	570	572	3
7 :E-:NMC-CARRIER-NAME(3)	X(30)	65	573	602	30
7 :E-:NMC-POLICY-KEY(3)	GROUP	66	603	642	40
10 :E-:NMC-POLICY-NBR(3)	X(20)	67	603	622	20
10 :E-:NMC-GROUP-NUMBER(3)	X(20)	68	623	642	20
7 :E-:NMC-SUBSCRIBER-SSN(3)	X(9)	69	643	651	9
7 :E-:NMC-SUBSCRIBER-NAME(3)	GROUP	70	652	697	46
10 :E-:NMC-SUBSCR-FIRST(3)	X(20)	71	652	671	20
10 :E-:NMC-SUBSCR-MIDINT(3)	X	72	672	672	1
10 :E-:NMC-SUBSCR-LAST(3)	X(25)	73	673	697	25
7 :E-:NMC-RELATN-POLHLDR(3)	XX	74	698	699	2
7 :E-:NMC-COVERAGE-CODE(3)	XXX	75	700	702	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(3)	GROUP	76	703	718	16
10 :E-:NMC-TPL-START-DATE(3)	GROUP	77	703	710	8
15 :E-:NMC-TPL-YEAR-START(3)	X(4)	78	703	706	4
15 :E-:NMC-TPL-MONTH-START(3)					

	XX	79	707	708	2
15 :E-:NMC-TPL-DAY-START(3)					
	XX	80	709	710	2
10 :E-:NMC-TPL-END-DATE(3)					
	GROUP	81	711	718	8
15 :E-:NMC-TPL-YEAR-END(3)					
	X(4)	82	711	714	4
15 :E-:NMC-TPL-MONTH-END(3)					
	XX	83	715	716	2
15 :E-:NMC-TPL-DAY-END(3)					
	XX	84	717	718	2
5 :E-:NMC-TPL-INFO(4)	GROUP	61	719	872	154
7 :E-:NMC-CARRIER-NBR(4)					
	GROUP	62	719	726	8
10 :E-:NMC-CARRIER-CODE(4)					
	X(5)	63	719	723	5
10 :E-:NMC-CARRIER-SEQ-NBR(4)					
	XXX	64	724	726	3
7 :E-:NMC-CARRIER-NAME(4)					
	X(30)	65	727	756	30
7 :E-:NMC-POLICY-KEY(4)	GROUP	66	757	796	40
10 :E-:NMC-POLICY-NBR(4)					
	X(20)	67	757	776	20
10 :E-:NMC-GROUP-NUMBER(4)					
	X(20)	68	777	796	20
7 :E-:NMC-SUBSCRIBER-SSN(4)					
	X(9)	69	797	805	9
7 :E-:NMC-SUBSCRIBER-NAME(4)					
	GROUP	70	806	851	46
10 :E-:NMC-SUBSCR-FIRST(4)					
	X(20)	71	806	825	20
10 :E-:NMC-SUBSCR-MIDINT(4)					
	X	72	826	826	1
10 :E-:NMC-SUBSCR-LAST(4)					
	X(25)	73	827	851	25
7 :E-:NMC-RELATN-POLHLDR(4)					
	XX	74	852	853	2
7 :E-:NMC-COVERAGE-CODE(4)					
	XXX	75	854	856	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(4)					
	GROUP	76	857	872	16
10 :E-:NMC-TPL-START-DATE(4)					
	GROUP	77	857	864	8
15 :E-:NMC-TPL-YEAR-START(4)					
	X(4)	78	857	860	4
15 :E-:NMC-TPL-MONTH-START(4)					
	XX	79	861	862	2
15 :E-:NMC-TPL-DAY-START(4)					
	XX	80	863	864	2
10 :E-:NMC-TPL-END-DATE(4)					
	GROUP	81	865	872	8
15 :E-:NMC-TPL-YEAR-END(4)					
	X(4)	82	865	868	4
15 :E-:NMC-TPL-MONTH-END(4)					
	XX	83	869	870	2
15 :E-:NMC-TPL-DAY-END(4)					
	XX	84	871	872	2
5 :E-:NMC-TPL-TOTAL-TIMES	99	85	873	874	2
5 :E-:NMC-PREGNANCY-IND	X	86	875	875	1
5 :E-:NMC-EXPECTED-DATE-OF-BIRTH					
	GROUP	87	876	883	8
7 :E-:NMC-EXPECTED-DOB-YEAR					
	X(4)	88	876	879	4
7 :E-:NMC-EXPECTED-DOB-MONTH					
	XX	89	880	881	2
7 :E-:NMC-EXPECTED-DOB-DAY					
	XX	90	882	883	2
5 :E-:NMC-TRANSFER-REASON-CODE					
	XXX	91	884	886	3
5 :E-:NMC-PAE-PROGRAM-CODE					
	9(4)	92	887	890	4
5 :E-:NMC-RATE-GROUP	X(4)	93	891	894	4
5 :E-:NMC-CLIENT-COUNTY	99	94	895	896	2
5 :E-:NMC-SPI-CODE	X(01)	95	897	897	1
5 :E-:NMC-COPAY-IND	X(01)	96	898	898	1
5 FILLER	X(598)	97	899	1496	598
3 :E-:NMC-TRANSMIT-PLAN-NBR	9(4)	98	1497	1500	4

T RECORD - Client Eligibility Trailer Record

FIELD LEVEL/NAME	PICTURE	NUMBER	START	END	LENGTH
2 :E-:NMC-MEDICAID-ENROLL-TRL REDEFINES :E-:NMC-MEDICAID-ENROLL-HDR					
2 :E-:NMC-MEDICAID-ENROLL-TRL	GROUP	97	1	1500	1500
3 :E-:NMC-TRL-ACTION-TYPE	X	98	1	1	1
3 :E-:NMC-TRL-DATE-STAMP	GROUP	99	2	15	14
5 :E-:NMC-TRL-SYSTEM-DATE	GROUP	100	2	9	8
7 :E-:NMC-TRL-SYSTEM-YEAR	9(4)	101	2	5	4
7 :E-:NMC-TRL-SYSTEM-MONTH	99	102	6	7	2
7 :E-:NMC-TRL-SYSTEM-DAY	99	103	8	9	2
5 :E-:NMC-TRL-SYSTEM-TIME	GROUP	104	10	15	6
7 :E-:NMC-TRL-SYSTEM-HOUR	99	105	10	11	2
7 :E-:NMC-TRL-SYSTEM-MINUTE	99	106	12	13	2
7 :E-:NMC-TRL-SYSTEM-SECOND	99	107	14	15	2
3 :E-:NMC-TOTAL-DETAIL-RECORDS	9(7)	108	16	22	7
3 :E-:NMC-TOTAL-ENROLLED-CLIENT	9(7)	109	23	29	7
3 :E-:NMC-TOTAL-DIS-ENROLL-CLIENT	9(7)	110	30	36	7
3 :E-:NMC-TOTAL-TRANSFER-CLIENT	9(7)	111	37	43	7
3 :E-:NMC-TOTAL-CAP-AMTS-1	9(9)V99	112	44	54	11
3 :E-:NMC-TOTAL-CAP-AMTS-2	9(9)V99	113	55	65	11
3 :E-:NMC-TOTAL-CAP-AMTS-3	9(9)V99	114	66	76	11
3 :E-:NMC-TOTAL-CAP-AMTS-4	9(9)V99	115	77	87	11
3 :E-:NMC-TOTAL-CAP-AMTS-5	9(9)V99	116	88	98	11
3 :E-:NMC-TOTAL-CAP-AMTS-6	9(9)V99	117	99	109	11
3 :E-:FILLER	X(1387)	118	110	1496	1387
3 :E-:NMC-TRL-TRANSMIT-PLAN-NBR	9(4)	119	1497	1500	4

NEBRASKA MEDICAID MANAGED CARE

CLIENT ELIGIBILITY DATA

Document B: Health Plan Client Eligibility File Data Descriptive Notes

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY HEADER DATA RECORD - "H" RECORD

Field HHH Nebraska Managed Care Client Eligibility Header Record

Field Name: NMC-MEDICAID-ENROLL-HDR
Purpose: This is the Client Eligibility Header Data Record.
Valid Values: Follow.

Field H01 Header Action Type

Field Name: NMC-HDR-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'H'.

Field H02 Header Date/Time Stamp

Field Name: NMC-HDR-DATE-STAMP

NMC-HDR-SYSTEM-DATE	
NMC-HDR-SYSTEM-YEAR	PIC 9(04)
NMC-HDR-SYSTEM-MONTH	PIC 9(02)
NMC-HDR-SYSTEM-DAY	PIC 9(02)
NMC-HDR-SYSTEM-TIME	
NMC-HDR-SYSTEM-HOUR	PIC 9(02)
NMC-HDR-SYSTEM-MINUTE	PIC 9(02)
NMC-HDR-SYSTEM-SECOND	PIC 9(02)

Purpose: Each header record will contain the system date and time documenting when the file was created.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24 hour HHMMSS format

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY DETAIL DATA RECORD - "D" RECORD

Field DDD Nebraska Managed Care Client Eligibility Detail Record

Field Name: NMC-MEDICAID-ENROLL-DET
Purpose: This is the Client Eligibility Detail Data Record.
Valid Values: Follow.

Field D01 Detail Action Type

Field Name: NMC- ACTION-TYPE PIC X.
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: X = Client Transfer occurred (same plan)
N = Client is newly eligible/enrolled for managed care
C = Client continues to be enrolled in managed care
D = Disenrolled Client

Field D02 Client Medicaid Identification Number

Field Name: NMC-CLIENT-MEDICAID-NBR.
NMC-MEDICAID-CASE-NBR PIC 9(09) VALUE 0.
NMC-CLIENT-CASE-ID PIC 9(02) VALUE 0.

Purpose: 11 digit Medicaid number assigned by the Health and Human Services to a person who has applied and is eligible for public assistance benefits. This number consists of a Medicaid case number and a client identification number within that case.
REQUIRED: YES
Valid Values: 11 digit Medicaid number.

Field D03 Client Social Security Number

Field Name: NMC-CLIENT-SSN PIC 9(09)
Purpose: This field contains the client's social security number.
REQUIRED: YES
Valid Values: Social security number of client, if a SSN is unknown or does not exist at the time of application, a temporary number which is the Arp number from NFOCUS, with the first digit replace by a '9'. The temporary number will be changed when a valid SSN is received from the SSA.

Field D04 Client Name

Field Name: NMC-CLIENT-NAME.

NMC-CLIENT-FNAME	PIC X(20).
NMC-CLIENT-MIDINIT	PIC X.
NMC-CLIENT-LNAME	PIC X(25).

Purpose: This field contains the client's first name, middle initial, and last name.
REQUIRED: YES

Field D05 Medical Plan Number

Field Name: NMC-MD-PLAN-NUMBER PIC 9(04)
Purpose: This field identifies the Med/Surg plan sending the provider file.
REQUIRED: YES
Valid Values: 2000 = UnitedHealthCare Community Plan
3000 = Aetna Better Health of Nebraska
4000 = Arbor Health Plan

Field D06 Provider Identification Number

Field Name: NMC-PROVIDER-NUMBER

NMC-MD-MEDICAID-PROV-NBR	PIC X(09).
NMC-MD-MEDICAID-PROV SFX	PIC 9(02)

Purpose: This field contains the 11 digit State of Nebraska Medicaid Number that identifies the provider at the location indicated in the record.
REQUIRED: YES
Valid Values: 11 digit Nebraska Medicaid Provider number assigned by Health and Human Services.
NMC-MD-MEDICAID-PROV-NBR must be numeric and greater than 0.
NMC-MD-MEDICAID-PROV-SFX must be 00, or a value greater than 0.

Field D07 Medical Medicaid Provider Terminated

Field Name: NMC-MD-MEDICAID-PROV-TERM PIC X
Purpose: This field contains an indicator of whether or not the provider is terminated with the medical health plan.
REQUIRED: NO
Valid Values: 'Y' or 'N'

Field D08 Vendor Provider Number

Field Name: NMC-VENDOR-PROV-NBR PIC X(15)
Purpose: This field contains the provider vendor identification number, as assigned by the medical health plan.
REQUIRED: NO
Valid Values: Any value other than spaces.

Field D09 Behavioral Health Plan Number

Field Name: NMC-BH-PLAN-NUMBER PIC 9(04)
Purpose: This field contains the BH plan number of the behavioral health plan that the client is enrolled with.
REQUIRED: NO
6000 = Magellan Behavioral Health

Field D10 Cap Rates

Field Name: NMC-CAP-RATES.

NMC-CAP-AMT1	PIC 9(05)V99	Prospective Cap Payment
NMC-CAP-AMT2	PIC 9(05)V99	Current Month Cap Payment
NMC-CAP-AMT3	PIC 9(05)V99	Not Used
NMC-CAP-AMT4	PIC 9(05)V99	Not Used
NMC-CAP-AMT5	PIC 9(05)V99	Not Used
NMC-CAP-AMT6	PIC 9(05)V99	Reinsurance Amount

Purpose: This field contains the amounts used for Capitation payments and calculations.
NMC-CAP-AMT1 contains the Medical / Surgical or behavioral health prospective cap payment.
NMC-CAP-AMT2 contains the cap payment for the clients who were immediately enrolled in current month.

NMC-CAP-AMT3, AMT4, AMT5 are not used.
NMC-CAP-AMT6 *contains the Reinsurance Amount, for reference only*.

REQUIRED: NO

Field D11 DSS Agency Code

Field Name: NMC-DSS-AGENCY-CODE.

NMC-DSS-DISTRICT	PIC 9(02).
NMC-DSS-ADM-OFFICE	PIC 9.
NMC-DSS-WORKER	PIC 9(02).

Purpose: This field contains the HHS office/worker that manages the client's case. Currently the district and administrative office values are used to distinguish medical vs. nonmedical Managed Care coverage areas.

REQUIRED: NO

Valid Values: First three digits a valid DSS agency code, last two a valid DSS worker code.

Field D12 Client Living Arrangement

Field Name: NMC-CLIENT-LIVING-ARRANGE PIC 9(02)

Purpose: This field contains a numeric code describing the client's living arrangements.

REQUIRED: NO

Valid Values:

- 01 - Apartment or House, Single Family House, House Arrest Community Service, Halfway House, House Arrest Work Release, Adoptive Home, Adult Day Home
- 03 - Homeless Shelter for Profit or Non Profit, Room Only, (Dorms, Sororities, Fraternities - Meals Not Provided, Hospital - Acute Hospital Care, Room Only - No Meals Provided, Job Corps, Military, Hospital
- 05 - Public Housing (not responsible for paying heating bills), (Dorms, Sororities, Fraternities - Meals Provided), Battered Women and Children Shelter - Non Profit, Temporary Lodging
- 06 - Public Housing, Pub Hsing - Multi-Fam Hse Not Responsible for Heating & Cooling Bills, Pub Hsing - Multi-Fam Hse Not Responsible for Heating Bills, Pub Hsing - Multi-Fam Hse Not Responsible for Cooling Bills, Multi-Family Dwelling, Adult Day Center, Adult Day Health Center
- 07 - Pub Hsing - Single Fam Hse Responsible for Heating Bills & Cooling Bills, Pub Hsing - Single Fam Hse Responsible for Heating Bills, Pub Hsing - Single Fam Hse Responsible for Cooling Bills, Child Care Center
- 09 - Board and Room, Chemical Dependency Treatment and Rehabilitation Center
- 10 - Licensed Mental Health Center, Licensed Domiciliary Facility, Assisted Living - Waiver
- 12 - Veterans Hospital/Veterans Nursing, Nursing Home/Long Term Care, Nursing Home
- 13 - Institution - Psychiatric Care – IMD, Psych Residential Treatment Facility

14 - Child Caring Agency, Child Caring Agency, Child Placing Agency, Emergency Shelter Center, Family Child Care Home I, Family Child Care Home II
17 - Licensed/Approved Foster Home, Emergency Shelter Foster Home, Foster Home, Foster Home - Agency Based, Foster Home - Child Specific, Foster Home - Relative
18 - Licensed Residential Care Facility, Assisted Living
19 - Licensed Center for Developmentally Disabled
20 - Certified Adult Family Home, Adult Family Home
30 - Group Home For Profit, Group Home - Institution Non-Profit Meals Provided, Boarder - Board And Rooms - Meals Provided, Incarceration, Residential Care, Preschool
32 - Boardinghouse - Commercial - Non-Profit, Boardinghouse - Commercial - For Profit, licensed Drug Treatment Center, Boarding Home
35 - Licensed/Approved Group Home For Children, Disabled Group Home - Non Profit - Meals Provided, Group Home, Group Home for Adults
36 - Institution for Mental Diseases (IMD)
37 - Correctional Facility

Field D13 Client Nationality

Field Name: NMC-CLIENT-NATIONALITY PIC X
Purpose: NOT USED
REQUIRED: NO

Field D14 Pregnancy related services Fee Indicator

Field Name: NMC-PREG-RELATED-SERV-IND PIC X.

Purpose: This field contains an indicator, stating that pregnancy-related services Capitation fee payment was made on behalf of an unborn or newborn child.
REQUIRED: NO

Valid Values: For NMC-PREG-RELATED-SERV-IND
Y - Capitation payment made for pregnancy-related services.
N - No Capitation payment made for pregnancy-related services.

Field D15 NMC Autoassignment Indicator

Field Name: NMC-AUTO-ASSIGN-IND PIC X.
Purpose: This field contains a code indicating if the client was autoassigned to the plan and provider.
REQUIRED: NO

Valid Values: Y - Yes, client was autoassigned.
N - No, client was not autoassigned.

Field D16 Client Cap Gender

Field Name: NMC-CAP-GENDER PIC X
Purpose: This field contains the gender used to determine the cap payment.
REQUIRED: NO
Valid Values: F - Female
M - Male
U - Unborn

Field D17 Special Needs Client Indicator

Field Name: NMC-SPECIAL-NEEDS-IND PIC X
Purpose: This field contains a code to define the special needs of a Client.
REQUIRED: NO
Valid Values: A – Children eighteen years of age and younger receiving SSI benefits
B – Children eighteen years of age and younger in Foster Care
C – Children eighteen years of age and younger receiving Title V services
D – Combined codes of A and B
E – Combined codes of A and C
F – Combined codes of B and C
G – Combined codes of A, B and C

Field D18 Reason for Clients Case Closing

Field Name: NMC-REASON-CLOSE-CODE PIC X(03).
Purpose: This field contains the code indicating why the client's case was closed.

REQUIRED: NO
Valid Values:
200 - Waiver of Enrollment
201 - Not Eligible for Medicaid Benefits
202 - Medicaid Status - Suspended or Closed
203 - Medicare
204 - Share of Cost
205 - Admitted to Long Term Care Facility
206 - Excluded group
207 - Excluded group
210 - Unknown County
211 - Admit to IMD or Correctional Facility
212 - Admit to PACE

Field D19 Lock In Code

Field Name: NMC-LOCK-IN-CODE PIC X
Purpose: This field contains the lock in code for what a client is locked in to.
REQUIRED: NO
Valid Values:
0 = No Lock-in
1 = One Pharmacy
2 = One Primary Practitioner and One Pharmacy
3 = One Primary Practitioner, One Pharmacy and One Hospital
4 = One Prescribing Physician and One Pharmacy
9 = Emergency Medical Services (Provider Number is given a value of 90000049999, and Licensed Doctor number is given a value of 2801 LOCK)

Field D20 Lock In Pharmacy Number

Field Name: NMC-LOCK-IN-PHARMACY PIC X(11)
Purpose: This field contains the 11 digit State of Nebraska Medicaid provider number assigned to a pharmacy.
REQUIRED: NO

Field D21 Lock In Primary Practitioner Number

Field Name: NMC-LOCK-IN-PRIM-PRACT PIC X(11)
Purpose: This field contains the 11 digit State of Nebraska Medicaid provider number assigned to a primary practitioner.
REQUIRED: NO

Field D22 Lock In License (Prescribing Physician Number)

Field Name: NMC-LOCK-IN-LICENSE PIC X(13)
Purpose: This field contains the 13 digit State of Nebraska Medicaid license number assigned to a prescribing physician.
REQUIRED: NO

Field D23 Lock In Hospital

Field Name: NMC-LOCK-IN-OP-HOSP PIC X(11)
Purpose: This field contains the 11 digit State of Nebraska Medicaid provider number assigned to a hospital.
REQUIRED: NO

Field D24 Fetal Number

Field Name: NMC-FETAL-NBR PIC 9(4)
Purpose: This field contains the number of fetuses of the pregnant mother.
REQUIRED: NO

Field D25 Mothers Name

Field Name: NMC-MOM-NAME.
NMC-MOM-FNAME PIC X(20).
NMC-MOM-MNAME PIC X.
NMC-MOM-LNAME PIC X(25).
Purpose: This field contains the name of the pregnant mother if client is an unborn or newborn.
REQUIRED: NO

TPL Information - the first four Current TPL's are sent

Field D26 Carrier Number

Field Name: NMC-CARRIER-NBR
NMC-CARRIER-CODE PIC X(05).
NMC-CARRIER-SEQ-NBR PIC X(03).
Purpose: These fields contain the code and the sequence number assigned to a commercial insurance company or third party administrative office that handles the processing and payment of health and casualty insurance claims.
REQUIRED: NO

Field D27 Carrier Name

Field Name: NMC-CARRIER-NAME PIC X(30).
Purpose: This field contains the name of the commercial insurance company or third party administrative office that handles the processing and payment of health and casualty insurance claims.
REQUIRED: NO

Field D28 Policy Key

Field Name: NMC-POLICY-KEY.
NMC-POLICY-NBR PIC X(20).
NMC-GROUP-NUMBER PIC X(20).
Purpose: These fields contain the policy key, which is the policy, number (the number assigned to clients policy) and the group number (the number given to the group plan that specifies the medical benefits provided through the health insurance plan).
REQUIRED: NO

Field D29 Subscriber Social Security Number

Field Name: NMC-SUBSCRIBER-SSN PIC X(09).
Purpose: This field contains the social security number of the owner of a commercial health insurance policy.
REQUIRED: NO

Field D30 Subscriber Name

Field Name: NMC-SUBSCRIBER-NAME.

	NMC-SUBSCR-FIRST	PIC X(20).
	NMC-SUBSCR-MIDINT	PIC X.
	NMC-SUBSCR-LAST	PIC X(25).

Purpose: These fields contain the name of the owner of a commercial health insurance policy.
REQUIRED: NO

Field D31 Relation Policy Holder

Field Name: NMC-RELATN-POLHLDR PIC X(02)
Purpose: This field contains a code that indicates the relation of the TPL.
REQUIRED: NO

10 - Self
11 - Spouse - policyholder living in the home eligible under another case number
12 - Spouse - policyholder living in home NOT eligible for Medicaid
13 - Spouse - policyholder NOT living in home - not legally separated or divorced
14 - Ex-spouse - policyholder NOT living in home - legally separated or divorced
15 - Friend - policy holder living in the home; may be common law arrangement or other like relationship
20 - Child - (natural or adoptive or step) - policyholder in home but not eligible for Medicaid
21 - Child - (natural or adoptive or step) - policyholder in home and eligible for Medicaid
22 - Child - (step) - policyholder NOT in the home
23 - Child - (natural or adoptive) - policyholder NOT in home (IVD referral)
30 - Foster Child - no legal obligation
31 - Grandchild - natural parent living in the home
32 - Grandchild - natural parent NOT living in the home
50 - Potential adoptive child - adoptive parents financially responsible
51 - Other - legally liable

Field D32 Coverage Code

Field Name: NMC-COVERAGE-CODE PIC X(03)
Purpose: This field contains the code that describes the coverage the client has.
REQUIRED: NO
Valid Values:

101 - MAJOR MEDICAL PLAN WITHOUT DENTAL; INCLUDES RX
120 - HMO PLAN WITHOUT DENTAL; INCLUDES RX
130 - MEDICARE SUPPLEMENT PLAN; EXCLUDES RX
140 - INPATIENT HOSPITAL AND RELATED SERVICES
149 - INPATIENT AND OUTPATIENT HOSPITAL AND RELATED SERVICES
150 - NURSING FACILITY CONFINEMENT PLAN
160 - PPO PLAN WITHOUT DENTAL; INCLUDES RX

Note: coverage is pending as policy has newly been identified and verification has not been received yet from the insurer to completely determine benefits.

201 - STANDARD MAJOR MEDICAL PLAN WITHOUT DENTAL; INCLUDES RX
202 - STANDARD MAJOR MEDICAL PLAN WITH DENTAL; EXCLUDES RX
203 - STANDARD MAJOR MEDICAL PLAN WITH DENTAL; INCLUDES RX
204 -STANDARD MAJOR MEDICAL PLAN WITHOUT DENTAL; EXCLUDES RX
208 -HEALTH INSURANCE FOR PAY & CHASE
301 -PPO OR HMO PLAN WITHOUT DENTAL; INCLUDES RX
302 -PPO OR HMO PLAN WITHOUT DENTAL; EXCLUDES RX
303 -PPO OR HMO PLAN WITH DENTAL; INCLUDES RX
304 -PPO OR HMO PLAN WITH DENTAL; EXCLUDES RX
375 -MEDICARE MANAGE CARE; EXCLUDES RX
401 -MEDICARE SUPPLEMENT TO PART A ONLY; EXCLUDES RX
402 -MEDICARE SUPPLEMENT TO PART B ONLY; EXCLUDES RX
403 - MEDICARE SUPPLEMENT TO PART A & B; EXCLUDES RX

404 -MEDICARE SUPPLEMENT WITH MAJOR MEDICAL; INCLUDES RX
405 -MEDICARE SUPPLEMENT TO PART A & B; EXCLUDES RX & PART B DEDUCTIBL
406 -MEDICARE SUPPLEMENT WITH MAJOR MEDICAL; INCLUDES NURSING HOME & R
407 -MEDICARE CARVE OUT PLAN; INCLUDES RX
500 -CHAMPUS/TRICARE OR CHAMPVA; INCLUDES RX
501 -IN AND OUTPATIENT HOSPITAL, INCLUDING ANCILLARY SERVICES
502 -IN AND OUTPATIENT HOSPITAL, PLUS ANCILLARY CHARGES; DUE TO ACCIDENT
531 -INPATIENT HOSPITAL, INCLUDING ANCILLARY CHARGES
532 -INPATIENT HOSPITAL AND ANCILLARY SERVICES RELATED TO AN ACCIDENT
533 -HOSPITAL INDEMNITY PLAN
534 -HOSPITAL INDEMNITY PLAN RELATED TO AN ACCIDENT
550 -DENTAL BENEFITS COVERAGE
551 - VISION BENEFITS COVERAGE
552 -PRESCRIPTION DRUG COVERAGE
553 -CHAMPUS/TRICARE OR CHAMPVA SUPPLEMENT POLICY
554 -VISION AND DENTAL BENEFITS COVERAGE
558 -PRESCRIPTION DRUG COVERAGE FOR PAY & CHASE
560 -CANCER BENEFITS POLICY
561 -SPECIFIED SERVICE POLICY
562 -DRUG CANCER BENEFITS POLICY
578 -NURSING HOME CONFINEMENT POLICY
600 -LIMITED BENEFITS POLICY

Note: Pay & Chase cases would include uncooperative non-custodial parent problem cases and/or insurance carriers not recognizing Medicaid regulations (requiring Legal Division assistance)that have been identified by TPL staff (all of these claims will edit in MCP165 to set Bypass Code - 'Z').

Field D33 Effective TPL Starting Date

Field Name: NMC-TPL-START-DATE.
NMC-TPL-YEAR-START PIC X(04).
NMC-TPL-MONTH-START PIC X(02).
NMC-TPL-DAY-START PIC X(02).
Purpose: These fields contain the starting date of clients TPL.
REQUIRED: NO

Field D34 Effective TPL Ending Date

Field Name: NMC-TPL-END-DATE.
NMC-TPL-YEAR-END PIC X(04).
NMC-TPL-MONTH-END PIC X(02).
NMC-TPL-DAY-END PIC X(02).
Purpose: These fields contain the ending date of clients TPL.
REQUIRED: NO

Field D35 TPL Total Times

Field Name: NMC-TPL-TOTAL-TIMES PIC 9(02)
Purpose: Indicates how many TPL policies the client has.
REQUIRED: NO

Field D36 Pregnancy Indicator

Field Name: NMC-PREGNANCY-IND PIC X.
Purpose: This field contains a code indicating if the client is known to be pregnant.
REQUIRED: NO

Valid Values: Y - Yes, client is pregnant.
N - No, we have no record of client being pregnant.

Field D37 Expected Date of Birth

Field Name: EXPECTED-DATE-OF-BIRTH.

EXPECTED-DOB-YEAR	PIC X(04).
EXPECTED-DOB-MONTH	PIC X(02).
EXPECTED-DOB-DAY	PIC X(02).

Purpose: This field contains the date the expected date of birth for an unborn child.
REQUIRED: NO

Field D38 Transfer Reason Code

Field Name: NMC-TRANSFER-REASON-CODE PIC X
Purpose: This field contains the code indicating why the client transferred.
REQUIRED: NO
Valid Values: 400 - AUTO ASSIGN-DIFFERENT PCP
401 - AUTO ASSIGN-DIFFERENT PLAN
402 - AUTO ASSIGN-EXISTING RELATIONSHIP W/ANOTHER PCP
404 - ACCESS-PCP WITH HISTORY NOT IN PLAN NETWORK
405 - ACCESS-SPECIALIST(S) WITH HX NOT IN PLAN NETWORK
406 - AUTO REENROLLMENT DURING OPEN ENROLL MONTH
407 - MOVE OUT OF MCO'S SERVICE AREA
410 - ACCESS-DISTANCE
412 - ACCESS-POOR PHYSICAL ACCESSIBLILTY FOR HANDICAPPED
413 - ACCESS-LANGUAGE BARRIER
414 - ACCESS-TOO LONG WAIT FOR APPOINTMENT
415 - ACCESS-DIFFICULT CONTACTING PCP
416 - ACCESS-LACK OF ACCESS TO COVERED SERVICES
420 - QUALITY-PROBLEM WITH EMERGENCY CARE
421 - DON'T LIKE PCP
422 - DON'T LIKE REFERRAL
424 - QUALITY - RECEIVED POOR CARE
425 - QUALITY - LONG WAITING ROOM LINE
426 - ACCESS - PCP REFUSED REFERRAL
427 - QUALITY - BETTER TREATED BY ANOTHER PCP
440 - ACCESS-INADEQUATE NETWORK
441 - QUALITY-SERVICE UNSATISFACTORY
450 - PCP REQUEST-CLIENT NON COMPLIANT
451 - PCP NO LONGER IN MC
452 - PCP REQUEST-ABUSE OF MC SERVICES
453 - REQUESTS DIFFERENT PCP LOCATION
454 - PCP NO LONGER IN PLAN
455 - PCP NO LONGER AT ADDRESS
456 - REQUESTED PCP NOW AVAILABLE
457 - PROVIDER ID CHANGE
458 - REQUESTED PCP NOT AVAILABLE/DIFFERENT PCP SELECTED
459 - PCP NOW HAS AVAILABLE SLOTS
460 - PCP HAS A SUSPENSION DATE/DIFFERENT PCP SELECTED
461 - ACCESS - PCP REFUSED TO SEE CLIENT

462 - INCORRECT LOCK-IN PCP
470 - CHOICE BASED ON PCP SPECIALITY
471 - PCP UNKNOWN TO CLIENT
472 - ACCESS-NEED BETTER ACCESS TO SPECIALIST
473 - WANT SAME PLAN FOR ENTIRE FAMILY
474 - ACCESS - WANT SAME PCP FOR ENTIRE FAMILY
480 - INTERIM PCP
485 - PLAN NO LONGER IN MC, NEW PLAN
488 - ACCESS-MORAL OR RELIGIOUS OBJECTION TO SERVICES
489 - RELATED SERVICES UNAVAILABLE
494 - PLAN REQUEST FOR TRANSFER APPROVED
498 - OTHER-PCP
499 - OTHER-PLAN

Field D39 PAE Program Code

Field Name: NMC-PAE-PROGRAM-CODE PIC X(04)
Purpose: This field contains the code for the public assistance in which the client is currently eligible to receive medical benefits
REQUIRED: YES
Valid Values:

PROGRAM CODE	*DESCRIPTION*
2001	ABD - ELDERY
2002	ABD - BLIND
2003	ABD - DISABLED
4004	AFDC-04
4005	AFDC-05
4090	Pregnant Women or 599 CHIP
6010	FC-HHS WARD
6020	FC-SUB GUARDIAN
6030	FC-HHS WARD
6031	FC-CRRCTNS WARD
6032	FC-HHS WARD
6033	FC-CRRCTNS WARD
6034	NON-HHS WARD
6040	NON-HHS WARD
6041	CORRECTIONS WARD
6042	NON-HHS WARD
6045	Presumptive Eligibility
6050	Ribicoff Medical Assistance
6051	FORMER HHS WARD
6055	MAC
6056	School Age Medical Assistance
6057	SCHOOL AGE MAC
6060	Subsidized Adoption Medicaid
6065	SCHOOL AGE MAC
6086	Subsidized Guardianship Title IV-E
6087	Subsidized Guardianship Non-IV-E
7800	PRESUMPT-HOSP
7810	NON-MAGI FFC
7820	MAGI INFANT
7830	MAGI PW
7840	MAGI CHILD 1-5
7850	MAGI CHILD 6-18
7860	MAGI CHIP

7870	MAGI PC-ABSENCE
7880	MAGI PC-DEATH
7890	MAGI PC-INCAP
7910	MAGI PC-UNEMP
7920	MAGI SCHIP
7930	MAGI FW
7940	MAGI IMD

Field D40 Rate Group

Field Name: NMC-RATE-GROUP PIC X(04)
Purpose: This field contains the code for the rate group for the client.
REQUIRED: YES
Valid Values: PHYSICAL HEALTH

AABD - Assistance to the Aged, Blind, Disabled, program grouping
FAM - Family program grouping
WARD - State foster care program grouping
CHIP - Kids Connection program grouping (same as KIDS)
KB - Katie Beckett

BEHAVIORAL HEALTH

BHAG - Behavioral health Aged program grouping
BHBD - Behavioral health Blind and Disabled program grouping
FAM - Family program grouping
WARD - State foster care program grouping
CHIP - Kids Connection program grouping (same as KIDS)
KB - Katie Beckett

Field D41 Client County

Field Name: NMC-CLIENT-COUNTY PIC 9(02)
Purpose: This field contains the numeric code identifying the Nebraska county in which the client resides.
REQUIRED: NO
Valid Values: COUNTY OF RESIDENCE

01 Adams	33 Furnas	65 Nuckolls
02 Antelope	34 Gage	66 Otoe
03 Arthur	35 Garden	67 Pawnee
04 Banner	36 Garfield	68 Perkins
05 Blaine	37 Gosper	69 Phelps
06 Boone	38 Grant	70 Pierce
07 Box Butte	39 Greely	71 Platte
08 Boyd	40 Hall	72 Polk
09 Brown	41 Hamilton	73 Red Willow
10 Buffalo	42 Harlan	74 Richardson
11 Burt	43 Hayes	75 Rock
12 Butler	44 Hitchcock	76 Saline
13 Cass	45 Holt	77 Sarpy
14 Cedar	46 Hooker	78 Saunders
15 Chase	47 Howard	79 Scotts Bluff
16 Cherry	48 Jefferson	80 Seward
17 Cheyenne	49 Johnson	81 Sheridan
18 Clay	50 Kearney	82 Sherman
19 Colfax	51 Keith	83 Sioux
20 Cuming	52 Keya Paha	84 Stanton
21 Custer	53 Kimball	85 Thayer
22 Dakota	54 Knox	86 Thomas

23 Dawes	55 Lancaster	87 Thurston
24 Dawson	56 Lincoln	88 Valley
25 Deuel	57 Logan	89 Washington
26 Dixon	58 Loup	90 Wayne
27 Dodge	59 Madison	91 Webster
28 Douglas	60 McPherson	92 Wheeler
29 Dundy	61 Merrick	93 York
30 Fillmore	62 Morrill	99 Out-of-State
31 Franklin	63 Nance	
32 Frontier	64 Nemaha	

Field D42 Special Program Indicator (SPI) codes

Field Name: NMC-SPI-CODE PIC X(01)
Purpose: This field contains the Special Program Indicator (SPI) codes.
REQUIRED: YES
Valid Values:

SPI Code	Description
A	Waiver Child DD (Prior to Jan 2003, included adult waiver)
B	MR Case Management Recipients
C	AABD Aged and Disabled Waiver Recipients
D	Waiver Children with Autism
E	AABD MA Only Recipients Using The 100% OMB Poverty Level
F	AABD Disabled Child Waiver Of Deeming Parental Income and Resources ('Katie Beckett' Cases)
G	Refugee Resettlement Clients
H	Aliens w/ Limited Medical Coverage
I	Early Intervention
K	CHIP
L	Breast / Cervical Cancer
M	Inmate of Public Institution
N	Not Currently Defined in N-FOCUS (EF Non-Employable)
O	Waiver Adult DD Comprehensive
P	Waiver Adult DD Residential
Q	Waiver Adult DD Day
R	Waiver Adult DD CSP
S	State (Permanent Legal Residents/UNDOC Immigrant Pregnant Women)
T	ADC/MA 12 Months Of Transitional Medical Assistance
U	Not Currently Defined in N-FOCUS (Previous Description: Indiv Exempt From Copayments. This code is only used for a Pregnant Woman Who Is Not Listed Under The Same Case Number As The Unborn)
V	Waiver TBI and Money Follows The Person
W	Waiver Traumatic Brain Injury (Effective Date: Oct. 2000)
X	Waiver A&D and Money Follows The Person
Y	Waiver Child DD and Money Follows The Person

Z	Waiver Adult DD Comprehensive and Money Follows The Person
1	MSP/QMB Medicare Crossover Only
BLANK	Recipient Is Not In A Medicaid Waiver Category

Field D43 Co-Pay Indicator

Field Name:	NMC-COPAY-IND	PIC X(01)
Purpose:	This field contains the Copay Indicator	
REQUIRED:	YES	
Valid Values:	0-INDIVIDUAL NOT SUBJECT TO COPAY	
	1-INDIVIDUAL SUBJECT TO COPAY	

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY TRAILER DATA RECORD - "T" RECORD

Field TTT Nebraska Managed Care Client Eligibility Trailer Record

Field Name: NMC-MEDICAID-ENROLL-TRL
Purpose: This is the Client Eligibility Trailer Data Record.
Valid Values: Follow.

Field T01 Trailer Action Type

Field Name: NMC-TRL-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'T'.

Field T02 Trailer Date/Time Stamp

Field Name: NMC-TRL-DATE-STAMP
NMC-TRL-SYSTEM-DATE
NMC-TRL-SYSTEM-YEAR PIC 9(04)
NMC-TRL-SYSTEM-MONTH PIC 9(02)

```
                    NMC-TRL-SYSTEM-DAY          PIC 9(02)
               NMC-TRL-SYSTEM-TIME
                    NMC-TRL-SYSTEM-HOUR         PIC 9(02)
                    NMC-TRL-SYSTEM-MINUTE       PIC 9(02)
                    NMC-TRL-SYSTEM-SECOND       PIC 9(02)
```

Purpose: This field identifies the date and time that the plan sent the provider file.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24 hour HHMMSS format.

Field T03 Total Detail Records

Field Name: NMC-TRL-TOTAL-DETAIL-RECS PIC 9(07)
Purpose: This field contains an accumulated total count of the records in this batch. A batch is the group of records between the header and the trailer record.
REQUIRED: YES

Field T04 Total Enrolled Clients

Field Name: NMC-TOTAL-ENROLLED-CLIENT PIC 9(07)
Purpose: This field contains an accumulated total count of the clients that were enrolled.
REQUIRED: YES

Field T05 Total Dis-Enrolled Clients

Field Name: NMC-TOTAL-DIS-ENROLL-CLIENT PIC 9(07)
Purpose: This field contains an accumulated total count of the clients that were dis-enrolled.
REQUIRED: YES

Field T06 Total Transferred Clients

Field Name: NMC-TOTAL-TRANSFER-CLIENT PIC 9(07)
Purpose: This field contains an accumulated total count of the clients that were transferred.
REQUIRED: YES

Field T07 Total Capitation Amount 1

Field Name: NMC-TOTAL-CAPS-AMTS-1 PIC 9(07)
Purpose: This field contains an accumulated total count of fees or medical surgical or behavioral health prospective Capitation payments.
REQUIRED: YES

Field T08 Total Capitation Amount 2

Field Name: NMC-TOTAL-CAPS-AMTS-2 PIC 9(07)
Purpose: The field contains the total count of capitation payments for the clients who were immediately enrolled in current month.
REQUIRED: YES

Field T09 Total Capitation Amount 3

Field Name: NMC-TOTAL-CAPS-AMTS-3 PIC 9(07)
Purpose: NOT USED
REQUIRED: YES

Field T10 Total Capitation Amount 4

Field Name: NMC-TOTAL-CAPS-AMTS-4 PIC 9(07)
Purpose: NOT USED
REQUIRED: YES

Field T11 Total Capitation Amount 5

Field Name: NMC-TOTAL-CAPS-AMTS-5 PIC 9(07)
Purpose: NOT USED
REQUIRED: YES

Field T12 Total Capitation Amount 6

Field Name: NMC-TOTAL-CAPS-AMTS-6 PIC 9(07)
Purpose: This field contains an accumulated total count of reinsurance amounts.
REQUIRED: YES

Attachment 29 - Unit Definition for Category of Service

COS	Units
DME/Supplies	Claim Count
Emergency Room	Claim Count
Emergency Transportation	Claim Count
EPSDT	Claim Count
Family Planning	Claim Count
FQHC/RHC	Claim Count
Home Health	Days
Hospice	Days
Inpatient Hospital	Days
Lab and Radiology	Reported Units
Non-Emergency Transportation - Ambulance	Claim Count
Other Care	Claim Count
Other Professional	Claim Count
Outpatient Hospital	Claim Count
PCP	Claim Count
Specialist	Claim Count
Vision	Claim Count
Rx	Claim Count
Behavioral Health - IP	Days
Behavioral Health - OP	Reported Units
Behavioral Health - Residential	Reported Units
Behavioral Health - Other	Reported Units

Department of Health & Human Services
DHHS
NEBRASKA

RURAL HEALTH CLINIC RATES EFFECTIVE 07/01/2015

RHC FY2015 RATES			
Provider Name	**Provider #**	**Type**	
Edgar Satellite Clinic - PRHC	10025431100	23	$ 156.08
Blue Hill Clinic - PRHC	10025431300	23	$ 148.62
Avera Medical Group Verdigre - RHC	10025951100	23	$ 100.27
Avera Medical Group - Crofton PRHC	10026249100	23	$ 100.27
Avera Medical Group - Pierce PRHC	10026249200	23	$ 100.27
Avera Medical Group - Niobrara PRHC	10026249500	23	$ 100.27
Avera Medical Group - Hartington PRHC	10026249600	23	$ 100.27
Avera Medical Group - Laflan PRHC	10026323700	23	$ 100.27
Friend Medical Center - RHC	10025086100	20	$ 86.50
Lone Tree Medical Associates, PC - IRHC	10025126000	20	$ 90.62
Fillmore County Medical Center, PC - RHC	10025197500	20	$ 81.69
Saline Medical Specialities - IRHC	10025219200	20	$ 126.68
Bonesteel Medical Clinic - IRHC	10025312600	20	$ 105.52
Akron Mercy Medical Clinic - IRHC	10025463500	20	$ 86.26
Brady Rural Health Clinic - IRHC	10025533300	20	$ 91.49
Country Clinic, PC - IRHC	10025570200	20	$ 92.21
Country Clinics - Cedar Rapids - IRHC	10025570700	20	$ 92.21
Greater Sandhills Family Healthcare - IRHC	10025616100	20	$ 92.18
Greater Sandhills Family Healthcare - IRHC	10025616200	20	$ 92.18
Greater Sandhills Family Healthcare - IRHC	10025622300	20	$ 92.18
Regional West Physicians Clinic - IRHC - Morrill	10025713200	20	$ 120.35
Witter, Jo A. - IRHC	10025734500	20	$ 122.01
Ponca Mercy Medical Clinic - IRHC	10025783700	20	$ 102.99
Valentine Medical Clinic - RHC	10025859100	20	$ 139.18
Park Street Medical Clinic - IRHC	10025947900	20	$ 112.60
Family Medicine Clinic - IRHC	42095537920	20	$ 82.37
Medical Clinic - IRHC - Hamburg	42099401717	20	$ 83.72
Medical Clinic - IRHC - Sidney	42099401718	20	$ 83.72
Medical Clinic - IRHC - Tabor	42099401719	20	$ 83.72
Beemer Mercy Medical Clinic - IRHC	42128384930	20	$ 81.69
Pender Mercy Medical Clinic - IRHC	42128384931	20	$ 81.69
Bancroft Mercy Medical Clinic - IRHC	42128384932	20	$ 81.69
Emerson Mercy Medical Clinic - IRHC	42128384933	20	$ 81.69
Avera Medical Group - IRHC	46022474319	20	$ 99.00
Fairbury Clinic, PC - IRHC	47057349021	20	$ 77.36
Main Street Medical Clinic - IRHC	47064911100	20	$ 91.49
Burwell Family Practice - IRHC	47083890820	20	$ 146.17
	Statewide Average/Interim Rates		$ 100.20

In-State FQHC

PROVIDER #	TY	SP	ST	CN	PROVIDER NAME	Per Diem	MEI increase	New Per Diem	
100250243-00	17	70	28	55	PEOPLE'S HEALTH CENTER-FQHC	14023	1.008	$ 141.35	
100250761-00	17	70	28	71	GOOD NEIGHBOR COMM HLTH CTR - FQHC	12576	1.008	$ 126.77	
100255827-00	17	70	28	13	CASS FAMILY MEDICINE - FQHC	15001	1.008	$ 151.21	
100257047-00	17	70	28	59	MIDTOWN HEALTH CTR FQHC	12347	1.008	$ 124.46	
100257169-00	17	70	28	59	MIDTOWN HEALTH CENTER FQHC	12347	1.008	$ 124.46	
100258773-00	17	70	28	28	BENSON COMMUNITY HLTH CTR-FQHC-SB	15311	1.008	$ 154.33	
100259026-00	17	70	28	28	INDIAN HILLS ELEMENTARY-FQHC-SB	15001	1.008	$ 151.21	
100259028-00	17	70	28	28	SPRING LAKE ELEMENTARY-FQHC-SB	15001	1.008	$ 151.21	
100259030-00	17	70	28	28	LIBERTY ELEMENTARY-FQHC SB	15001	1.008	$ 151.21	
100262308-00	17	70	28	28	NORTHWEST HIGH SCHOOL - FQHC SB	15311	1.008	$ 154.33	
100262309-00	17	70	28	28	BELEVEDERE PUBLIC ELEMENTARY-FQHCSB	15311	1.008	$ 154.33	
100262310-00	17	70	28	28	KING SCIENCE & TECH MAGNET - FQHCSB	15311	1.008	$ 154.33	
100262311-00	17	70	28	28	KELLOM PUBLIC ELEMENTARY - FQHC SB	15311	1.008	$ 154.33	
100262747-00	17	70	28	28	CHARLES DREW HLTH CTR-CROWN FQHC	15311	1.008	$ 154.33	
100262749-00	17	70	28	28	CHARLES DREW HLTH CTR-EVANS FQHC	15311	1.008	$ 154.33	
100262761-00	17	70	28	28	CHARLES DREW HLTH CTR-JACKSON FQHC	15311	1.008	$ 154.33	
100262763-00	17	70	28	28	CHARLES DREW HLTH CTR-FLORENCE FQHC	15311	1.008	$ 154.33	
100262857-00	17	70	28	28	ONEWORLD COMM HLTH-LEAVENWORTH FQHC	15001	1.008	$ 151.21	
100262867-00	17	70	28	28	ONEWORLD COMM HLTH CTRS-NORTH FQHC	15001	1.008	$ 151.21	
100262868-00	17	70	28	28	ONEWORLD COMM HEALTH - SOUTH FQHC	15001	1.008	$ 151.21	
100262994-00	17	70	28	28	ONEWORLD COMM HLTH CTR - 120TH FQHC	15001	1.008	$ 151.21	
100263985-00	17	70	28	28	ONEWORLD COMM HEALTH CENTERS,INC	15001	1.008	$ 151.21	
100264170-00	17	70	28	28	ONEWORLD COMM HLTH CENTERS,INC FQHC	15001	1.008	$ 151.21	
470493594-10	17	70	28	79	COMM ACTION PARTNERSHP WEST NE-FQHC	13613	1.008	$ 137.22	
470548990-17	17	70	28	28	ONE WORLD COMMUNITY HEALTH CTR FQHC	15001	1.008	$ 151.21	
470666715-17	17	70	28	28	CHARLES DREW HLTH CTR FQHC	15311	1.008	$ 154.33	
470697260-17	17	70	28	55	NE URBAN INDIAN MEDICAL CTR FQHC	13474	1.008	$ 135.82	
								$ 148.03	Statewide Average as of 2-12-2015
								$ 148.03	

Out of State FQHC

PROVIDER #	TY	SP	ST	CN	PROVIDER NAME	Per Diem	MEI increase	New Per Diem
100250646-00	17	70	43	0	BENNETT COUNTY COMMUNITY HLTH FQHC	14002	1.008	$ 141.14
100256538-00	17	70	43	0	COMMUNITY HEALTH CLINIC - FQHC	14493	1.008	$ 146.09
100261217-00	17	70	43	0	SPRINGFIELD FAMILY CLINIC - FQHC	14271	1.008	$ 143.85
100263708-00	17	70	17	0	HEALTH PARTNERSHIP CLINIC-FQHC	16228	1.008	$ 163.58
421374894-10	17	70	16	0	SIOUXLAND COMMUNITY HLTH CTR FQHC	16420	1.008	$ 165.51
421466508-17	17	70	16	0	ALL CARE HEALTH CENTER-FQHC	16667	1.008	$ 168.00

PROVIDER #	TY	SP	ST	CN	PROVIDER NAME	Per Diem	MEI increase	New Per Diem	
100264329-00	17	70	17	0	HEALTH PARTNERSHIP CLINIC-FQHC			$ 148.03	This new FQHC should receive the Statewide Average for its initial year.

Attachment 26 - MLR and Risk Corridor Examples

Example 1. MCO pays money back to State under MLR and risk corridor

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	77,550
Net Qualified Medical Expenses divided by Earned Revenue		77.6%
Minimum MLR %		85.0%
Percentage below MLR		7.5%
MLR Reconciliation Payment	**$**	**(7,450)**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
MLR Rebate	$	(7,450)
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	77,550
Total Allowed Administration (Excluding HIT)	$	8,000
Profit/(Loss)	$	7,000
Risk Corridor Profit/(Loss) Share	**$**	**(4,000)**

Example 2. State pays money back to MCO under risk corridor

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,550
Net Qualified Medical Expenses divided by Earned Revenue		107.6%
Minimum MLR %		85.0%
Percentage below MLR		0.0%
MLR Reconciliation Payment	**$**	**-**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
MLR Rebate	$	-
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,550
Total Allowed Administration (Excluding HIT)	$	8,000
Profit/(Loss)	$	(15,550)
Risk Corridor Profit/(Loss) Share	**$**	**12,550**

Attachment 25 - IBNR Assumptions by Source

	Physical Health Encounters				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	0.96	0.96	0.95	0.96	0.95
Emergency Room	0.95	0.96	0.95	0.96	0.97
Emergency Transportation	0.98	0.99	0.99	0.98	0.99
EPSDT	0.95	0.95	0.95	0.95	0.96
Family Planning	0.98	0.98	0.97	0.98	0.98
FQHC/RHC	0.95	0.96	0.96	0.97	0.97
Home Health	0.95	0.90	0.93	0.84	0.94
Hospice	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital	0.95	0.96	0.94	0.97	0.92
Lab and Radiology	0.93	0.94	0.93	0.96	0.96
Non-Emergency Transportation - Ambulance	0.99	0.99	0.99	0.99	0.99
Other Care	0.96	0.95	0.96	0.98	0.98
Other Professional	0.98	0.98	0.98	0.98	0.98
Outpatient Hospital	0.95	0.96	0.95	0.95	0.97
PCP	0.95	0.96	0.96	0.96	0.97
Specialist	0.97	0.97	0.97	0.97	0.98
Vision	0.97	0.98	0.97	0.97	0.98
Rx	N/A	N/A	N/A	N/A	N/A
Behavioral Health - IP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - OP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Residential	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Other	N/A	N/A	N/A	N/A	N/A

	Behavioral Health Encounters				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	N/A	N/A	N/A	N/A	N/A
Emergency Room	N/A	N/A	N/A	N/A	N/A
Emergency Transportation	N/A	N/A	N/A	N/A	N/A
EPSDT	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
FQHC/RHC	N/A	N/A	N/A	N/A	N/A
Home Health	N/A	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital	N/A	N/A	N/A	N/A	N/A
Lab and Radiology	N/A	N/A	N/A	N/A	N/A
Non-Emergency Transportation - Ambulance	N/A	N/A	N/A	N/A	N/A
Other Care	N/A	N/A	N/A	N/A	N/A
Other Professional	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital	N/A	N/A	N/A	N/A	N/A
PCP	N/A	N/A	N/A	N/A	N/A
Specialist	N/A	N/A	N/A	N/A	N/A
Vision	N/A	N/A	N/A	N/A	N/A
Rx	N/A	N/A	N/A	N/A	N/A
Behavioral Health - IP	0.93	0.93	0.89	0.96	N/A
Behavioral Health - OP	0.96	0.97	0.96	0.96	N/A
Behavioral Health - Residential	0.96	0.96	0.91	0.96	N/A
Behavioral Health - Other	0.94	0.98	0.95	0.97	N/A

Attachment 25 - IBNR Assumptions by Source

	FFS Data				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	0.99	N/A	N/A	0.99	1.00
Emergency Room	1.00	N/A	1.00	1.00	1.00
Emergency Transportation	1.00	N/A	N/A	1.00	1.00
EPSDT	1.00	N/A	N/A	1.00	N/A
Family Planning	1.00	N/A	N/A	1.00	1.00
FQHC/RHC	0.98	N/A	N/A	0.98	1.00
Home Health	1.00	N/A	0.99	1.00	N/A
Hospice	1.00	N/A	1.00	1.00	N/A
Inpatient Hospital	1.00	N/A	N/A	0.99	0.99
Lab and Radiology	1.00	N/A	1.00	1.00	1.00
Non-Emergency Transportation - Ambulance	0.99	N/A	N/A	1.00	N/A
Other Care	0.99	N/A	1.00	0.99	0.98
Other Professional	1.00	N/A	N/A	1.00	1.00
Outpatient Hospital	1.00	N/A	1.00	1.00	1.00
PCP	0.96	N/A	1.00	0.97	0.91
Specialist	1.00	N/A	N/A	1.00	1.00
Vision	0.96	N/A	N/A	0.98	1.00
Rx	1.00	1.00	1.00	1.00	N/A
Behavioral Health - IP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - OP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Residential	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Other	N/A	N/A	N/A	N/A	N/A

	Total				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	0.96	0.96	0.95	0.98	0.95
Emergency Room	0.95	0.96	0.95	0.97	0.97
Emergency Transportation	0.98	0.99	0.99	0.99	0.99
EPSDT	0.95	0.95	0.95	0.96	0.96
Family Planning	0.98	0.98	0.97	0.99	0.98
FQHC/RHC	0.96	0.96	0.96	0.98	0.97
Home Health	0.95	0.90	0.93	0.97	0.94
Hospice	1.00	N/A	1.00	1.00	N/A
Inpatient Hospital	0.95	0.96	0.94	0.98	0.92
Lab and Radiology	0.93	0.94	0.93	0.98	0.96
Non-Emergency Transportation - Ambulance	0.99	0.99	0.99	1.00	0.99
Other Care	0.96	0.95	0.96	0.98	0.98
Other Professional	0.98	0.98	0.98	0.98	0.98
Outpatient Hospital	0.95	0.96	0.95	0.96	0.97
PCP	0.95	0.96	0.96	0.96	0.97
Specialist	0.97	0.97	0.97	0.98	0.98
Vision	0.97	0.98	0.97	0.97	0.98
Rx	1.00	1.00	1.00	1.00	N/A
Behavioral Health - IP	0.93	0.93	0.89	0.96	N/A
Behavioral Health - OP	0.96	0.97	0.96	0.96	N/A
Behavioral Health - Residential	0.96	0.96	0.91	0.96	N/A
Behavioral Health - Other	0.94	0.98	0.95	0.97	N/A

Attachment 24 - NEMT - Ambulance Rates

	Rating Region 1			Rating Region 2		
COA	MMs	Addtl. Dollars	Addtl. PMPM	MMs	Addtl. Dollars	Addtl. PMPM
AABD 00-20 M&F	35,303	$ 13,616	$ 0.39	9,807	$ 192	$ 0.02
AABD 21+ M&F	106,576	$ 92,040	$ 0.86	27,407	$ 8,361	$ 0.31
AABD 21+ M&F-WWC	1,109	$ -	$ -	451	$ 115	$ 0.26
CHIP M&F	317,346	$ 9,644	$ 0.03	107,941	$ 3,771	$ 0.03
Family Under 1 M&F	106,184	$ 7,190	$ 0.07	32,855	$ 3,242	$ 0.10
Family 01-05 M&F	332,138	$ 6,643	$ 0.02	94,254	$ 4,549	$ 0.05
Family 06-20 F	284,805	$ 12,346	$ 0.04	82,972	$ 4,734	$ 0.06
Family 06-20 M	272,407	$ 9,490	$ 0.03	79,831	$ 2,996	$ 0.04
Family 21+ M&F	224,680	$ 24,670	$ 0.11	63,516	$ 7,359	$ 0.12
Foster Care M&F	82,203	$ 7,483	$ 0.09	22,223	$ 709	$ 0.03
Katie Beckett 00-18 M&F	412	$ -	$ -	412	$ -	$ -
Maternity	6,649	$ 11,567	$ 1.74	2,211	$ 10,274	$ 4.65

Attachment 23 - COS and COA Trends

	Rating Region 1 - Lower Bound				
	Annual PMPM Trend Rate				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	1.0%	1.7%	1.6%	1.3%	3.4%
Emergency Room	2.6%	2.7%	3.2%	2.3%	2.4%
Emergency Transportation	1.2%	1.7%	1.6%	1.3%	2.4%
EPSDT	1.4%	3.2%	1.4%	3.3%	2.4%
Family Planning	1.2%	1.7%	1.8%	1.3%	2.4%
FQHC/RHC	0.2%	1.7%	1.2%	2.3%	2.4%
Home Health	1.4%	1.7%	4.1%	1.3%	2.4%
Hospice	1.2%	0.0%	1.3%	1.3%	0.0%
Inpatient Hospital	1.1%	1.7%	3.9%	0.8%	3.4%
Lab and Radiology	1.2%	1.7%	2.2%	1.3%	1.9%
Non-Emergency Transportation - Ambulance	1.2%	1.7%	1.7%	1.3%	1.9%
Other Care	1.0%	1.7%	2.5%	2.3%	1.9%
Other Professional	2.6%	3.7%	2.8%	2.8%	4.0%
Outpatient Hospital	2.4%	1.7%	3.5%	1.8%	2.9%
PCP	1.6%	2.2%	1.5%	1.8%	2.9%
Specialist	1.1%	1.7%	3.1%	2.8%	2.4%
Vision	1.2%	1.7%	2.2%	1.8%	2.4%
Rx	7.0%	6.2%	6.5%	4.1%	N/A
Behavioral Health - IP	1.0%	0.5%	0.5%	-0.6%	N/A
Behavioral Health - OP	1.0%	1.0%	1.0%	0.9%	N/A
Behavioral Health - Residential	1.0%	1.4%	0.5%	0.0%	N/A
Behavioral Health - Other	0.3%	0.9%	0.8%	-0.1%	N/A

	Rating Region 2 - Lower Bound				
	Annual PMPM Trend Rate				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	1.1%	1.5%	2.1%	0.9%	3.6%
Emergency Room	3.2%	3.5%	3.6%	1.9%	2.6%
Emergency Transportation	1.3%	1.5%	1.5%	0.9%	2.6%
EPSDT	1.5%	1.5%	1.4%	2.4%	2.6%
Family Planning	2.3%	1.5%	1.7%	0.9%	2.6%
FQHC/RHC	0.3%	2.5%	1.8%	0.4%	3.1%
Home Health	2.1%	2.5%	1.5%	0.9%	2.0%
Hospice	1.3%	0.0%	1.6%	0.0%	0.0%
Inpatient Hospital	1.6%	1.5%	4.3%	0.4%	3.6%
Lab and Radiology	2.7%	2.5%	3.2%	0.9%	2.0%
Non-Emergency Transportation - Ambulance	1.3%	1.5%	1.6%	0.9%	2.0%
Other Care	1.1%	3.0%	1.8%	1.9%	2.0%
Other Professional	1.1%	3.5%	2.8%	1.4%	2.0%
Outpatient Hospital	2.9%	2.0%	3.6%	1.4%	3.1%
PCP	1.1%	3.0%	1.9%	3.4%	3.1%
Specialist	1.2%	2.0%	3.1%	2.4%	2.6%
Vision	1.2%	1.5%	2.0%	1.4%	2.6%
Rx	7.4%	6.1%	6.6%	4.8%	N/A
Behavioral Health - IP	1.0%	0.5%	0.5%	-0.6%	N/A
Behavioral Health - OP	1.1%	1.0%	1.0%	0.9%	N/A
Behavioral Health - Residential	1.0%	1.4%	0.4%	0.0%	N/A
Behavioral Health - Other	0.3%	0.9%	0.7%	-0.1%	N/A

Heritage Health Rate Development Narrative

Background

The base data and adjustments used for the populations currently enrolled in Physical Health or Behavioral Health managed care were derived using the assumptions in the latest (January 2016 – June 2016) Physical Health and Behavioral Health rate development. For populations not currently enrolled in managed care FFS data was used, and rating adjustments from a comparable population were applied to create the projected rates. Optumas will update the base data and re-evaluate all assumptions when updating the Heritage Health rates in the spring.

Rating Regions

Optumas analyzed the cost differences (inclusive of the new populations and services) across counties and used the results of this analysis as the basis of the rating region recommendation for the Heritage Health program. After discussing the results of the regional analysis with the State, Optumas proposed Rating Region 1 (RR1) and Rating Region 2 (RR2) as outlined on page 142 of the RFP.

Covered Populations/Services

The populations and services that are included in the draft Heritage Health rates are illustrated in the "Heritage Health Pre-Proposal Conference" presentation.

Base Data

For the Physical Health acute care services, Optumas used SFY14 and SFY15 claims data from the existing Physical Health program, paid through September 30th, 2015.

For the Behavioral Health services, Optumas used claims data from the existing Behavioral Health program incurred from September 1st 2013 (the program's inception) through June 30th 2015. The Behavioral Health data for the Foster Care population was unique; Optumas only used SFY15 incurral dates. When analyzing the FY14 and FY15 Foster Care data, FY14 was substantially different than FY15 and Optumas determined that FY15 was the most reasonable basis for predicting future Foster Care expenses. The current managed care entity described the change in Foster Care experience as variance in utilization for PRTF due to a decrease in requests for PRTF. After further discussions, it was determined that the utilization levels inherent in the FY2015 data was more indicative of future utilization patterns. The Behavioral Health data was paid through June 30th 2015.

For the populations and services that are being carved into Managed Care, such as the Pharmacy benefit or the acute care services for the LTSS population, Optumas used SFY14 and SFY15 FFS data, paid through September 30th, 2015.

Figure 1. Data Sources

Populations	Services	Data Source
Populations currently enrolled in Physical Health Managed Care	Physical Health and Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entities

Populations	Services	Data Source
LTSS Population	Physical Health Services	SFY14 and SFY15 FFS data
LTSS Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Non-LTSS Dual Population	Physical Health Services	SFY14 and SFY15 FFS data
Non-LTSS Dual Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Subsidized Adoption Population	Physical Health Services	SFY14 and SFY15 FFS data
Subsidized Adoption Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Women with Cancer Population	Physical Health Services	SFY14 and SFY15 FFS data
Women with Cancer Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Hospice Population	Physical Health Services	SFY14 and SFY15 FFS data
Hospice Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
All Populations	Rx and Transplant Services	SFY14 and SFY15 FFS data

IBNR

Optumas analyzed the claim payment lag by category of service through the incurred but not reported (IBNR) analysis. IBNR factors were developed and applied to the base data by category of service and data source. Completion patterns and assumptions for encounter data sets were discussed with current managed care entities to ensure reasonableness. IBNR factors can be found in the accompanying Excel document, titled “IBNR Assumptions by Source”.

Program Changes

The State has implemented several program and policy changes that impacted the service costs that were not reflected in the base data. Optumas considered any prospective program change adjustments necessary to project the base to the contract period. Optumas and the State worked in partnership to determine the impact, shown within Figure 2 below, of the program changes on the projected capitation rate ranges:

Figure 2. Program Changes

Adjustment	Overview
ASD Adjustment	Beginning October 2015, the State is requiring the coverage of applied behavior analysis (ABA) and Behavioral Modification services for children with an Autism Spectrum Disorder (ASD) diagnoses. The State provided Optumas with the prevalence of ASD, which equated to 0.6% of Medicaid children having an ASD diagnosis. Optumas used this prevalence information, coupled with research and discussions with our internal clinician, to arrive at an estimated PMPM impact by cohort. The final Heritage Health rates will incorporate emerging program experience for this adjustment.
DD Adjustment	Beginning October 2015, the State is requiring coverage of ABA and Behavioral Modification services for children with a Developmental Disability (including Intellectual Disability) (DD). The State provided Optumas with the prevalence of DD, which equated to 0.7% of Medicaid children having a Development Disability. Optumas used this prevalence information and discussions with our internal clinician, to arrive at an estimated PMPM impact by cohort. The final Heritage Health rates will incorporate emerging program experience for this adjustment.
Service Delivery Adjustments	NEMT Ambulance – This adjustment represents the addition of NEMT Ambulance services to the Managed Care program. Rx Dispensing Fee Change – This adjustment represents a change in the dispensing fee for non-independent pharmacies, from $4.45 to $2.50. Dual Integrated Care Savings - Individuals dually eligible for Medicaid and Medicare were previously not enrolled in physical health managed care. The non-nursing home level of need duals represent a significant opportunity for care savings. Inpatient utilization was reduced by 10%, Outpatient utilization was reduced by 15%, and Emergency Room utilization rates were reduced by 25%. The aggregate impact of these changes to the healthy dual population is a reduction of 5.4%.
Immediate Enrollment	Beginning February 1, 2014, the State has implemented immediate enrollment in Medicaid managed care for newly eligible members. Enrollment is now effective back to the first day of the month that a health plan is chosen. Previously enrollment was effective the first day of the month following health plan selection. The impact of this program change was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that

Adjustment	Overview
	period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the Physical Health managed care program after the policy was implemented. This adjustment is somewhat mitigated because it is inherent in 17 of the 24 months of base data.
APR-DRG	On July 1, 2014 the State of Nebraska moved from using the AP DRG payment methodology to the APR DRG payment methodology for inpatient hospital claims. This change impacts all hospitals that are reimbursed on a DRG basis; this excludes hospitals reimbursed on a per diem basis such as Critical Access Hospitals (CAHs) and rehab facilities. The impact of this change was calculated by first re-pricing all impacted inpatient hospital claims in the SFY14 base data, at the AP DRG version 27 weights and SFY14 hospital rates specific to each hospital. This was done to ensure that the comparison between the AP DRG and APR DRG reimbursement would not be influenced by any contracting or payment differences between the MCO reimbursement and the State AP DRG fee schedule. Optumas then assigned an APR DRG and severity level to all inpatient hospital claims included in the analysis based on version 31 of the grouper. This was done by utilizing software from 3M who developed the APR DRG grouper. These claims were then re-priced using the APR DRG version 31 weights and SFY15 hospital rates. The final impact was calculated by comparing the percentage change from the SFY14 AP DRG re-priced amount to the SFY15 APR DRG re-priced amount for each category of aid and MCO. The transition to the APR DRG payment methodology was intended to be budget neutral at a global level, however it should be recognized that this may break down between health plans and especially between rate cells. The overall results do show that the impact is close to budget neutral in aggregate but does show increases and decreases by rate cell.
FQHC Rate Updates	Optumas calculated and applied an adjustment to account for FQHC APM rate changes. Optumas adjusted the FQHC rates inherent in the encounter data to be commensurate with the FQHC APM rates effective 1/1/16.
Prospective Behavioral Health Provider Increase	Beginning July 2014 and July 2015, the State has implemented a 2.25% provider increase. Optumas applied the 2.25% increase to all Behavioral Health services, with the exception of FQHC and RHC providers. The September-June 2014 data received three and a half 2.25% increases, while the July-June 2015 data received two and a half 2.25% increase.

Adjustment	Overview
PRTF Program Change	Optumas calculated and applied an adjustment to account for cost settlements made outside of the MMIS system to two Psychiatric Residential Treatment Facilities. Optumas adjusted the PRTF rates inherent in the encounter data to be commensurate with these cost settlements.
MST/FFT Carve-In	Effective July of 2016 Multisystematic Therapy (MST) and Functional Family Therapy (FFT) will be covered benefits. Optumas added the anticipated expense for these services into the Heritage Health rates. The expense was projected using provider information, case rates, and anticipated provider caseloads. Optumas developed these assumptions with the help of our internal clinician.
Behavioral Health Copay Adjustment	Beginning January 2014, the State implemented a $2.00 copay for certain services. Since this change was implemented within the base data period, Optumas only needed to adjust September-December 2013 to reflect the copay policy change. The January 2014 – June 2015 base data already reflected the copay implementation, so no adjustment for this time period was necessary.
Physical Health Copay Adjustment	The State currently imposes copays on several Medicaid populations. While MCOs are not required to charge copays, the State reimburses the MCOs as if they did impose copays. The impact of this program change was calculated by adjusting reimbursement as necessary to reflect full collection of copays.
Benefit Limits	The State currently imposes limits on chiropractic visits, rehab visits, hearing aids, and eyeglasses for Medicaid FFS. The impact of this program change was calculated by removing any utilization and corresponding cost from the SFY14-15 base data for any of the services listed above that exceeded the FFS utilization limit.

Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major category of service (COS) (e.g., inpatient, outpatient, etc.) and category of aid (e.g. AABD, Family, etc.). Trend values can be found in the accompanying Excel file, titled “COS and COA Trends”.

Physical Health and Pharmacy trends were applied for a total of 36 months from the midpoint of the July 2013 – June 2015 base (6/30/2014) to the midpoint of the contract period (7/2/2017).

With the exception of Foster Care, Behavioral Health trends were applied for a total of 35 months from the midpoint of the September 2013 – June 2015 base (7/31/2014) to the midpoint of the contract period (7/2/2017). Foster Care trends were applied for a total of 30 months from the midpoint of the July 2014 – June 2015 base (12/30/2014) to the midpoint of the contract period (7/2/2017).

Non-Medical Loading

The non-medical load measures the dollars associated with components such as administration, profit, and quality improvement (QI) and are expressed as a percentage of the capitation rate. Optumas utilized reported administrative and profit levels in the financials submitted by the current managed care entities to develop the non-medical load. Experience in other states and similar programs on both a PMPM and percentage basis were also reviewed to ensure reasonableness.

Nebraska State Statue 78-831 requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health services entered into by the Department on or after July 1, 2012, shall:

> (1) Provide a definition and cap on administrative spending that (a) shall not exceed 7% unless the implementing department includes detailed requirements for tracking administrative spending to ensure (i) that administrative expenditures do not include additional profit and (ii) that any administrative spending is necessary to improve the health status of the population to be served and (b) shall not under any circumstances exceed 10%.

The detailed non-medical loading assumption by each subcategory is included in slide 15 of the rate presentation.

UNMC Supplemental Payment

The University of Nebraska Medical Center (UNMC) providers are reimbursed at commercial fee levels. Since the MCOs contract at levels more commensurate with Medicaid reimbursement, a supplemental payment is required to be paid to UNMC by each MCO to make these providers whole. The State includes this supplemental payment as part of the capitation rates, which is then paid by the MCOs to UNMC.

Optumas received a list of UNMC provider IDs from the State as well as the MCOs. These lists were used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently un-managed populations and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC.

Attachment 21 - Non-Medical Load Assumption

	Rating Region 1			
	Lower Bound			
COA	**Admin/QI**	**Perf. Guarantee**	**Profit/Risk/Contingency**	**Total NML**
AABD 00-20 M&F	9.49%	0.25%	2.00%	11.74%
AABD 21+ M&F	9.57%	0.25%	2.00%	11.82%
AABD 21+ M&F-WWC	9.41%	0.25%	2.00%	11.66%
CHIP M&F	12.25%	0.25%	2.00%	14.50%
Family Under 1 M&F	8.50%	0.25%	2.00%	10.75%
Family 01-05 M&F	12.11%	0.25%	2.00%	14.36%
Family 06-20 F	12.33%	0.25%	2.00%	14.58%
Family 06-20 M	12.34%	0.25%	2.00%	14.59%
Family 21+ M&F	12.18%	0.25%	2.00%	14.43%
Foster Care M&F	9.01%	0.25%	2.00%	11.26%
Katie Beckett 00-18 M&F	0.65%	0.25%	2.00%	2.90%
Maternity	0.65%	0.25%	2.00%	2.90%

	Rating Region 2			
	Lower Bound			
COA	**Admin/QI**	**Perf. Guarantee**	**Profit/Risk/Contingency**	**Total NML**
AABD 00-20 M&F	9.46%	0.25%	2.00%	11.71%
AABD 21+ M&F	9.51%	0.25%	2.00%	11.76%
AABD 21+ M&F-WWC	9.38%	0.25%	2.00%	11.63%
CHIP M&F	12.22%	0.25%	2.00%	14.47%
Family Under 1 M&F	8.50%	0.25%	2.00%	10.75%
Family 01-05 M&F	12.09%	0.25%	2.00%	14.34%
Family 06-20 F	12.31%	0.25%	2.00%	14.56%
Family 06-20 M	12.35%	0.25%	2.00%	14.60%
Family 21+ M&F	12.18%	0.25%	2.00%	14.43%
Foster Care M&F	8.89%	0.25%	2.00%	11.14%
Katie Beckett 00-18 M&F	0.65%	0.25%	2.00%	2.90%
Maternity	0.65%	0.25%	2.00%	2.90%

Attachment 20 - COA-level Rate Development

	Rating Region 1													
	Base PMPM	Policy Changes	Adj. PMPM	ASD Adjustment	Adj. PMPM	DD Adjustment	Adj. PMPM	Immediate Enrollm	Adj. PMPM	Service Delivery A	Adj. PMPM	Annual PMPM Trend	Effective Trend Days	Final Medical Rate
AABD 00-20 M&F	$ 884.24	1.3%	$ 895.78	2.8%	$ 920.85	2.8%	$ 946.72	0.2%	$ 948.25	-0.2%	$ 946.24	1.0%	1,094	$ 976.29
AABD 21+ M&F	$ 1,262.51	0.5%	$ 1,268.58	0.0%	$ 1,268.58	0.0%	$ 1,268.58	0.2%	$ 1,270.85	-0.4%	$ 1,266.26	3.6%	1,094	$ 1,406.62
AABD 21+ M&F-WWC	$ 2,075.13	0.1%	$ 2,077.51	0.0%	$ 2,077.51	0.0%	$ 2,077.51	0.0%	$ 2,077.51	-0.2%	$ 2,072.48	2.0%	1,097	$ 2,201.95
CHIP M&F	$ 136.26	1.7%	$ 138.56	1.1%	$ 140.02	0.9%	$ 141.35	0.3%	$ 141.81	-0.4%	$ 141.23	3.2%	1,093	$ 155.04
Family Under 1 M&F	$ 405.53	0.7%	$ 408.24	0.0%	$ 408.24	0.0%	$ 408.24	2.7%	$ 419.14	-0.2%	$ 418.49	3.3%	1,097	$ 460.76
Family 01-05 M&F	$ 115.03	1.4%	$ 116.63	2.9%	$ 119.99	0.6%	$ 120.72	0.5%	$ 121.31	-0.4%	$ 120.78	2.3%	1,095	$ 129.13
Family 06-20 F	$ 131.16	2.1%	$ 133.92	0.7%	$ 134.87	1.1%	$ 136.38	0.3%	$ 136.84	-0.5%	$ 136.21	3.3%	1,092	$ 149.92
Family 06-20 M	$ 140.09	2.2%	$ 143.17	0.7%	$ 144.17	1.1%	$ 145.72	0.2%	$ 146.08	-0.4%	$ 145.45	3.7%	1,092	$ 161.93
Family 21+ M&F	$ 334.76	0.8%	$ 337.40	0.0%	$ 337.40	0.0%	$ 337.40	0.1%	$ 337.82	-0.6%	$ 335.78	3.9%	1,095	$ 377.16
Foster Care M&F	$ 396.57	2.7%	$ 407.08	3.0%	$ 419.23	2.1%	$ 427.84	0.1%	$ 428.46	-0.4%	$ 426.96	2.0%	1,037	$ 452.29
Katie Beckett 00-18 M&F	$ 11,797.62	-0.1%	$ 11,780.66	0.4%	$ 11,822.88	0.2%	$ 11,848.08	0.2%	$ 11,871.98	0.0%	$ 11,867.85	2.2%	1,097	$ 12,654.24
Maternity	$ 6,854.49	0.3%	$ 6,872.60	0.0%	$ 6,872.60	0.0%	$ 6,872.60	1.8%	$ 6,996.59	0.0%	$ 6,998.17	3.2%	1,098	$ 7,687.83
Dual Instituational	$ 208.41	0.9%	$ 210.26	0.0%	$ 210.26	0.0%	$ 210.28	0.3%	$ 210.87	0.0%	$ 210.87	3.0%	1,092	$ 230.31
Non-Dual Institutional	$ 2,606.23	-0.6%	$ 2,590.57	0.0%	$ 2,590.76	0.3%	$ 2,598.94	0.2%	$ 2,604.62	1.1%	$ 2,632.33	3.0%	1,093	$ 2,876.09
Dual HCBS	$ 249.48	0.9%	$ 251.65	0.0%	$ 251.65	0.1%	$ 251.93	0.3%	$ 252.63	0.0%	$ 252.63	2.4%	1,091	$ 271.09
Non-Dual HCBS	$ 1,280.79	0.1%	$ 1,282.24	0.1%	$ 1,283.11	3.1%	$ 1,323.01	0.2%	$ 1,325.28	-0.3%	$ 1,321.19	3.5%	1,092	$ 1,465.82
Dual	$ 271.91	2.4%	$ 278.32	0.0%	$ 278.32	0.0%	$ 278.32	0.2%	$ 278.93	-4.9%	$ 265.12	2.2%	1,085	$ 282.66

	Rating Region 2													
	Base PMPM	Policy Changes	Adj. PMPM	Immediate Enrollment	Adj. PMPM	Service Delivery Adjustment	Adj. PMPM	ASD Adjustment	Adj. PMPM	DD Adjustment	Adj. PMPM	Annual PMPM Trend	Effective Trend Months	Final Medical Rate
AABD 00-20 M&F	$ 1,005.20	0.6%	$ 1,011.22	0.2%	$ 1,012.75	-0.2%	$ 1,010.73	1.8%	$ 1,028.69	1.9%	$ 1,048.39	2.3%	1,095	$ 1,123.17
AABD 21+ M&F	$ 1,390.26	0.4%	$ 1,396.47	0.2%	$ 1,398.94	-0.3%	$ 1,395.22	0.0%	$ 1,395.22	0.0%	$ 1,395.22	4.1%	1,095	$ 1,571.78
AABD 21+ M&F-WWC	$ 2,357.86	0.0%	$ 2,357.99	0.0%	$ 2,357.99	-0.2%	$ 2,353.63	0.0%	$ 2,353.63	0.0%	$ 2,353.63	2.5%	1,097	$ 2,532.75
CHIP M&F	$ 135.71	0.9%	$ 136.98	0.4%	$ 137.47	-0.3%	$ 137.06	0.8%	$ 138.17	0.8%	$ 139.28	3.3%	1,094	$ 153.32
Family Under 1 M&F	$ 364.07	0.1%	$ 364.61	2.7%	$ 374.38	-0.1%	$ 373.89	0.0%	$ 373.89	0.0%	$ 373.89	3.4%	1,097	$ 413.76
Family 01-05 M&F	$ 122.05	0.5%	$ 122.67	0.5%	$ 123.29	-0.3%	$ 122.86	2.2%	$ 125.54	0.5%	$ 126.14	2.8%	1,096	$ 137.24
Family 06-20 F	$ 139.67	1.8%	$ 142.19	0.4%	$ 142.71	-0.3%	$ 142.23	0.5%	$ 142.96	0.9%	$ 144.21	3.3%	1,093	$ 158.84
Family 06-20 M	$ 143.31	2.5%	$ 146.92	0.3%	$ 147.31	-0.3%	$ 146.83	0.5%	$ 147.62	0.9%	$ 148.91	3.4%	1,092	$ 164.67
Family 21+ M&F	$ 404.79	0.6%	$ 407.33	0.1%	$ 407.84	-0.4%	$ 406.38	0.0%	$ 406.38	0.0%	$ 406.38	4.3%	1,095	$ 461.18
Foster Care M&F	$ 361.97	2.3%	$ 370.15	0.1%	$ 370.67	-0.3%	$ 369.70	2.4%	$ 378.46	1.7%	$ 384.98	2.7%	1,050	$ 415.70
Katie Beckett 00-18 M&F	$ 11,797.62	-0.1%	$ 11,780.66	0.2%	$ 11,804.42	0.0%	$ 11,800.31	0.4%	$ 11,842.60	0.2%	$ 11,867.85	2.2%	1,098	$ 12,654.24
Maternity	$ 6,678.14	0.3%	$ 6,694.97	1.8%	$ 6,818.26	0.1%	$ 6,822.50	0.0%	$ 6,822.50	0.0%	$ 6,822.50	3.2%	1,098	$ 7,504.02
Dual Instituational	$ 175.60	0.6%	$ 176.59	0.3%	$ 177.09	0.0%	$ 177.09	0.0%	$ 177.09	0.0%	$ 177.12	3.3%	1,092	$ 195.31
Non-Dual Institutional	$ 1,744.00	0.0%	$ 1,743.37	0.2%	$ 1,746.56	-0.1%	$ 1,745.47	0.0%	$ 1,745.49	0.8%	$ 1,758.74	3.9%	1,093	$ 1,974.47
Dual HCBS	$ 225.60	0.7%	$ 227.08	0.3%	$ 227.72	0.0%	$ 227.72	0.0%	$ 227.72	0.0%	$ 227.79	2.8%	1,092	$ 247.43
Non-Dual HCBS	$ 1,173.85	0.3%	$ 1,177.31	0.2%	$ 1,179.54	-0.2%	$ 1,177.36	0.0%	$ 1,177.72	2.5%	$ 1,207.31	3.6%	1,092	$ 1,340.45
Dual	$ 233.52	1.8%	$ 237.72	0.2%	$ 238.28	-6.9%	$ 221.81	0.0%	$ 221.81	0.0%	$ 221.81	2.6%	1,087	$ 239.11

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM SEVEN
QUESTIONS and ANSWERS

Date: November 19, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

The following are the responses to Questions 221 – 382 for the first round of questions.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
221.	IV. P.8-13 MCO Reimbursement	145	"Please provide a few detailed numerical examples to demonstrate the timing and order of calculation of the following adjustments/ limitations to capitation revenue, and how they are applied and interact with each other. In parentheses, we have shown our understanding of some of the specifics of these calculations: 1) Risk Adjustment (begins 7/1/2017, calculated annually? for each rating period? calculated by category of aid and region, for selected categories of aid) 2) Minimum MLR (begins on contract start date?, calculated annually on a six to nine month lag, for program in total) 3) Risk Corridor (begins on contract start date?, calculated annually on a nine month lag, for program in total) 4) MLTC Quality Performance Program (effective contract	The application of risk scores will not begin until the second contract period, 1/1/18-12/31/18. The State and its contracted actuary will work together in determining the best risk adjustment methodology to use at that time. The Minimum MLR will be in effect beginning on the contract start date and will be calculated on an annual basis between 6-9 months after the end of the contract year. Although the MLR will be settled annually, as mentioned in Attachment 15 “the MCO must calculate the MLR and submit it to MLTC quarterly”. The 85% Minimum MLR requirement will be calculate as an aggregate of Regions 1 and 2 and will be calculated across all categories of aid. The risk corridor will be in effect beginning on the contract start date and will be calculated at the end of each contract period between 6-9 months after the end of the contract year. The risk corridor calculation will be an aggregate of Regions 1 and 2 across all categories of aid. The administrative cap requirement is built into the capitation rates on a prospective basis. The contracted actuary ensured that the amount of non-medical load built into the rates meets the administrative cap requirement. The UNMC amount built into the capitation rates will remain the same throughout the entire contract period. The contracted actuary developed the UNMC Supplemental PMPM by COA, COS, and Rating Region. MLTC Quality Performance Program and Performance Penalities are effective Year 1 and calculated annually on a 6 – 9 month lag for program end total. Attachment 26:“MLR and Risk Corridor Examples” contains an illustrative example of this scenario. Please see Section IV.P.9.d-e.

			start date, calculated annually on a six month lag, for program in total) 5) State Performance Penalties (effective in contract year one, with metrics provided before year two, calculated annually 6) Administrative Cap (begins on contract start date?, calculated annually on a nine month lag, for program in total) 7) UNMC Supplemental Payments (begins on contract start date? calculated into the capitation rate on a quarterly basis, separate payments by category of aid and region) In particular, please ensure that these examples illuminate the answers to the questions in parentheses and demonstrate all of the calculations that would result in each of the following situations: 1) MCOs rebate to the state under the MLR, 2) MCOs deposit into the reinvestment accounts under	

			the risk corridor and the MLTC quality program 3) MCOs receive money back from the state under the risk corridor"	
222.	Attachment 15	Attachment 15 and page xiii	Attachment 15, Medical Loss Ratio Requirements, defines Net Qualified Medical Expense (the numerator in the MLR calculation) as follows: the sum of: a. Claims incurred b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense c. Medical incentive bonuses d. Reinsurance premiums less reinsurance recoveries e. Activities that improve health care quality, per 45 CFR 158.150 f. Less related-party medical margin Whereas, page xiii defines Medical Loss Ratio as: The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for	Confirmed. Item 4 under the MLR Calculation section of Attachment 15 defines “allowable QI expenses”.

			members and allowable QI expenses under this contract. For purposes of the MLR calculation, are "allowable QI expenses"" those as defined in the definition of Net Qualified Medical Expense in Attachment 15?"	
223.	Attachment 15	All	Please provide numerical examples of how related party medical margin is to be included in the calculation of Net Qualified Medical Expenses.	If a related party subcontractor was paid premiums of $100 by the MCO and had expenses of $75, an amount of $25 would be deducted from the Net Qualified Medical Expense calculation.
224.	Attachment 15	All	Please provide numerical examples of how affiliate/related party underwriting losses/gains on reinsurance are to be included in the calculation of Net Qualified Medical Expenses, which is defined in Attachment 15 as follows: the sum of: a. Claims incurred b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense c. Medical incentive bonuses d. Reinsurance premiums less reinsurance recoveries	Yes, these examples are correct.

			e. Activities that improve health care quality, per 45 CFR 158.150 f. Less related-party medical margin For example, if a related party reinsurer was paid reinsurance premiums of $100 by the MCO and had incurred reinsurance underwriting losses of $120 paid to the MCO, would losses of $20 be included as a subtraction in item d. in the calculation above, then added back for positive $20 in item f., since under this scenario the related party reinsurer had an underwriting loss of $20? Conversely, if a related party reinsurer was paid reinsurance premiums of $100 by the MCO and had incurred reinsurance underwriting losses of $75 paid to the MCO, presumably an amount of $25 would be added in item d. of the calculation and an amount of $25 would be deducted in item f. of the calculation. Is this correct?"	

225.	Glossary of Terms	xiv	Within the definition of Non-Quality Improvement Administrative Expenses (definition from glossary pasted below), as it relates to item 1., Direct Administration, please comment as to whether the use of the term ""medical management"" is for costs that do not meet the definition of activities that improve health care quality per 45 CFR 158.150. Said differently, please confirm that costs that meet the definition of improving health care quality per 45 CFR 158.150 are not included in the definition of ""direct administration"" as used in defining Non-Quality Improvement Administrative Expenses. Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses	Costs that meet the definition of improving health care quality per 45 CFR 158.150 are not included in the definition of “direct administration”.

			include: 1. Direct administration: customer service, enrollment, medical management, claims administration, etc. 2. Indirect administration: accounting, actuarial, legal, human resources, etc. 3. Net cost of reinsurance: reinsurance premium less projected reinsurance recoveries. Net cost of related party reinsurance is excluded."	
226.	IV.P.12 and Attachment 15	147 & Attachment 15	Is the definition of "quality improvement" administrative costs that are allowed to be included up to 3% in the determination of the MCO's administrative cap the same definition as "activities that improve health care quality per 45 CFR 158.150" as those are included in the numerator in the calculation of the MLR? We recognize there is the 3% limit for the Administrative Cap and there is not a specified limit for purposes of the MLR; in this question we are inquiring as to the consistency of the definition (not extent) of the	See response to Question # 178.

			quality improvement costs.	
227.	IV. P.8-13 MCO Reimbursement	145	"Please provide an explanation as to why there is different treatment of the MLTC Quality Performance hold-back within each of the following calculations: 1) Minimum MLR (earned holdback not factored into the calculation) 2) Risk Corridor (earned holdback not factored into the calculation) 3) Administrative Cap (earned and forfeited holdback is factored into the calculation) For example, by ""is factored in"" do you mean that these amounts are added back in to the calculation for the Administrative Cap? Similarly, is forfeited holdback factored into the calculation of Minimum MLR and Risk Corridor? Also, please explain how the State Performance Penalties are factored into each of the above calculations."	The MLTC Quality Performance hold-back is not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back is factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute. The State Performance Penalty is included in the minimum MLR, risk corridor, and the Administrative Cap.

228.	IV P.9. Risk Corridor	146	The numerator (profit or loss) in the calculation of the risk corridor is defined, but the denominator is not. Please include a description of the revenue to be included in the denominator of this calculation.	See response to Question #33.
229.	IV P.9. Risk Corridor	146	Please provide a definition of the term "Total allowed administration calculated for the administrative cap" as used in the definition of the risk corridor: does this reflect the full allowance for administration, or the portion of that allowance used by a specific MCO?	“Total allowed administration” as used in the calculation of the risk corridor reflects the portion of allowance used by a specific MCO.
230.	IV. P 10 and 11 MLTC Quality Performance Program and State Performance Penalties	146	In terms of the actuarial certification, are both the MLTC Quality Performance hold-back and State performance penalties considered withholds?	In terms of the actuarial certification, only the MLTC Quality Performance hold-back is considered a withhold.
231.	IV. P 10 and 11 MLTC Quality Performance Program and State Performance Penalties	146	What percentage of the MLTC Quality Performance hold-back does Optumas assume will be earned back (as part of the actuarial certification)?	The contracted actuary has not conducted this analysis for the Heritage Health program.
232.	IV. P 10 and 11 MLTC Quality Performance Program and State	146	What percentage of the State Performance Penalty does Optumas assumed will be	The contracted actuary has not conducted this analysis for the Heritage Health program.

	Performance Penalties		earned (as part of the actuarial certification) - especially given the metrics are not yet available?	
233.	IV. P 11 State Performance Penalties	147	In this section it is stated that this program is effective beginning on the contract start date. However, performance metrics will be provided to MCOs prior to year two of the contract. Can this information be provided earlier in order to allow MCOs to manage to and report on performance relative to these metrics during the first contract year?	As Heritage Health is a new program, the State will use operational and quality reporting required in the first year of the program, including but not limited to measurements found in Attachments 7 and 14, to establish minimum performance metrics for year two of the contract that will be subject to the minimum performance metric penalty required in Neb. Rev. Stat. §71-831.
234.	IV. Q. 3. Provider Reimbursement	149	What assumptions were built into the rates to account for the requirement to pay enhanced payments in accordance with section 1202 of the Affordable Care Act?	The current managed care entities reimburse providers consistent with the requirements of section 1202 of the Affordable Care Act. The rates are built using encounter data from current managed care entities, so the enhanced payment levels commensurate with section 1202 are fully inherent in the base data.
235.	IV. Q. 8. c. Payments to Out-of-Network Providers	149	Please provide additional information regarding out of network providers that can be paid at 90% of the Medicaid rate - are there any provider types excluded from this provision?	IHS provider types are excluded from this requirement set for in the RFP.
236.	IV. Q. Provider Reimbursement	149	Are there any other special reimbursement requirements beyond what is documented	The MCO may negotiate rates with its network providers, except as otherwise provided for in the RFP.

			in this section? For example, are MCOs allowed to contract with providers at values below the Medicaid Fee Schedule?	
237.	IV. Q. Provider Reimbursement	149	What assumptions were built into the rates regarding provider reimbursement requirements and experience under managed care and/or fee for service?	The Heritage Health capitation rates are based on the reimbursement levels underlying the managed care encounter data for services currently provided via managed care and FFS reimbursement levels for services currently provided via FFS.
238.	IV. Q. Provider Reimbursement	149	Where any specific assumptions built into the initial rates to account for the requirement that MCOs enter into value-based purchasing agreements with providers?	No assumptions were built into the initial rates to account for value-based purchasing agreements.
239.	IV. Q. Provider Reimbursement	149	What assumptions were built into the rates to take into account access to care requirements?	No assumptions were built into the rates to take into account access to care requirements. The base data consists of FFS data and data from the current managed care entities. All of these organizations are able to meet access to care requirements, so the data was considered sufficient to account for access requirements.
240.	IV. Q. 10. Critical Access Hospital Contracting and Reimbursement	152	"Please clarify each of the following with regard to Critical Access Hospitals: 1) What assumptions are built into the rates? 2) What protections exist if MCOs experience utilization at these facilities different than that assumed in the rates?	Rates are built using the payments made by current managed care entities to critical access hospitals. This includes both claim payments and supplemental payments made outside of the claims system. Currently no protections exist. Currently, the State does not allow for a settlement process and this is currently under review.

			3) Will the State consider a settlement process with MCOs to ensure that there is no variation in payment between MCOs based on differing utilization of Critical Access Hospitals?"	
241.	IV. Q. 11. University of Nebraska Medical Center (UNMC) Physician/Practitioner Payments	152	"Please clarify each of the following with regard to the UNMC supplemental payments: a) please describe the process of developing the amount to be paid to each provider eligible for these supplemental payments b) please describe the assumptions for the development of the amount built into the rates on a quarterly basis to account for these payments"	To develop the UNMC rate the contracted actuary receives a list of UNMC Provider IDs from the State as well as the current managed care entities. These lists are used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently unmanaged populations, and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC. The UNMC PMPM amount is provided in Attachment 11. Additionally, UNMC services are concentrated in professional service categories. Lab and Radiology, PCP, EPSDT, Specialist, and Other Practitioner represent 96% of the UNMC utilization. UNMC services are concentrated in Rating Region1; Rating Region 2 has about half as many services provided by UNMC. Statewide, UNMC utilization represents about 3.5% of Lab and Radiology services, about 0.5% of PCP and Other Practitioner utilization, and less than 0.5% of the other service categories.
242.	IV. Q. 11. University of Nebraska Medical Center (UNMC) Physician/Practitioner	152	Since the UNMC amounts built into the rates are estimates, there is the potential for the actual payout	The process outlined in the RFP is the methodology currently approved by CMS so there is not an intention to implement a reconciliation process.

	Payments		to be more or less, which puts the MCOs at risk. If this is intended to be a true pass though (i.e., every dollar received is paid out to providers or paid back to the State)?, there needs to be a reconciliation process so there are not winners and losers. Does DHHS intend to implement a reconciliation process?	
243.	IV. Q. 9. Reimbursement to FQHCs and RHCs	152	"Please provide the following for FQHCs and RHCs: a) a listing of FQHCs and RHCs and the current encounter rates by region b) What payment methodology is embedded in the base data (e.g. encounter rates vs. rates per service)? c) what adjustments were made to the base data to include these provider types in the final rates(e.g., payment methodology changes)? d) please clarify that MCOs pay FHQC and RHC providers similar to other PCPs, clinics, etc."	See Attachments 27 and 28: "FQHC-2015-Rates and "Rural Health Clinic Rates Effective 07012015" respectively. The base data prior to adjustment contains reimbursement at each FQHC's PPS rate. FQHCs receive the PPS rate for each patient encounter. These rates are traditionally been updated annually; however, effective January 2016, the State is moving to a re-based APM payment. To account for the impact the reimbursement change will have on the Heritage Health capitation rates, the contracted actuary identified all FQHC utilization in the base data and priced it at the new APM rate. The pricing was done separately for the FY14 and FY15 base data sets, and the resulting impact was blended together consistent with the overall rate development. MCOs are expected to pay FQHC and RHC providers at the designated per visit rate.
244.	IV. T. 4. Encounter	177	Will historical data be	Historical pharmacy data will be provided to MCOs upon member assignment.

	Data		provided to MCOs upon member assignment, to assist with care management and other operational requirements?	
245.	IV.Z. Claims Broker Services	192	"A description of the annual calculation of the per claim administrative fee is described in this section. Please provide: a) additional detail regarding the timing of the payment of this fee. b) an estimate or an actual value for the initial amount of this fee upon program implementation. c) Please provide an estimate of the volume of claims that would be expected to be processed by the claims broker MCO."	This information will be provided to the awarded contractor during the implementation timeframe outlined in Section IV.Z.3.
246.	V. Proposal Instructions	196	This section states that "Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order" however no additional information is provided regarding a cost proposal. Please provide any additional information regarding any cost proposal	No additional cost proposal information is required.

			information that bidders should provide.	
247.	Attachment 1	All	Please provide a breakout of the members shown in this exhibit into those that would be expected to be covered by the contract, and those who would remain covered under fee for service.	As nearly all Medicaid eligible individuals will be included in Heritage Health, the State does not currently have an exact figure by county for the number of individuals that will continue to receive core benefits and services through the fee-for-service program. This information will be posted to the procurement website as part of the second round of questions and answers.
248.	Attachment 11	All	Please break out the Non-Medical Load (NML) shown in the Optumas Pre-Bidders Conference presentation into the relevant components for each category of aid and each region.	See Response to Question #112.
249.	Attachment 11	All	Please describe the process used to arrive at the varying NML components by category of aid and region, considering both the PMPM values and the percentages.	See Attachment 21: “Non-Medical Load Assumptions”. NML is based on the experience of current Managed Care Entities.
250.	Attachment 11	All	Please confirm that the values shown in this exhibit represent the lower bound of the actuarially sound rate range.	Confirmed.
251.	Attachment 11	All	It was stated that these rates are the lower bound of the range. Has DHHS historically paid the low end of the rate range? If no, at what point in the range have the MCO	MLTC has historically paid the physical health managed care rates at the mid-point range. The behavioral health rates have been variable.

			capitation rates been set?	
252.	Attachment 11	All	Please provide the high and low end range of each assumption and adjustments used to create the high and low end rates.	The rates that have been discussed during the bidder's conference reference the lower bound, thus all assumptions that were shown in the power point reflect the lower bound assumption values. The ranges around the assumptions will not be shared.
253.	Attachment 11	All	It was stated that these rates are the lower bound of the range. When the rates are updated for retroactive eligibility and other changes, is it DHHS' intention to pay at the low end of the range?	While it has not been historical practice for MLTC to pay at the lowest end of the rate range, a final decision will be made in the context of the Department's budget.
254.	Attachment 11	All	"Are the rates shown in this exhibit net or gross of each of the following: a) MLTC hold-back (1.5%) b) State Performance Penalties (0.25%)"	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties is considered a component of non-medical load and is added in along with other administrative funding.
255.	Attachment 13	All	Based on the wording of this Statute, it appears that these requirements apply to "at-risk managed care service delivery for behavioral health services." Please confirm that this statue applies to the anticipated contract, which covers service delivery for behavioral health and physical health services.	Confirmed.

256.	Attachment 13	All	Each of sections IV.P.10, 11, 12, 14, and attachment 15 which is referenced by section IV.P.13 make a reference to this attachment, but section IV.P.9 does not. Please confirm that section IV.P.9 was written in accordance with paragraph (2) of this attachment, and that this is the only section of the scope of work written to conform to the requirements in this paragraph.	Section IV.P.9 is written in accordance with paragraph two (2) of Attachment 15.
257.	Attachment 13, 15 and IV.P.9 - 14	All	"The concept of revenue for the MCO and related parties is addressed multiple times in multiple calculations. The language is similar but not always consistent in each of these sections. Please define what is meant by this language, providing any instances in which the definition would be different between calculations. For example, the definition of Risk Corridor Calculation on page xvi states that the calculation ignores any forfeited hold-back, and the definition of Qualifying	See response to Question #33.

			Revenue (for the risk corridor calculation) per page xv states that any earned hold-back is not factored into the calculation. If a MCO had $150 of holdback and it was determined the MCO earned $100 of the holdback through the QPP, how much of the $150 holdback is included in the calculation/definition of Qualifying Revenue for the risk corridor? "	
258.	Attachment 15	All	"Please define the term ""Risk Bearing Partners."" In particular, a) please clarify whether providers with whom an MCO has a value-based contract as described in section IV.Q.6 (p. 150) would be included in this definition b) please clarify whether providers with whom an MCO has a contract including an physician incentive plan as described in section IV.Q.6 (p. 150) would be included in this definition"	Providers with whom an MCO has a value-based contract or providers with whom an MCO has a contract including a physician incentive plan as described in Section IV.Q.6 would be included in this definition.
259.	Attachments 10-11	All	Please provide a detailed development of the copayment assumption built into the rates, including the	Allowed copayment amounts are specified at 471 NAC 3-008. Copayments are collected at the discretion of the MCO, but the capitation rates are developed in accordance with 42 CFR 447.56(d). This adjustment is a 0.02% reduction in the total PMPM in each Rating Region.

			actual amounts collected historically by MCOs and by the state under fee for service during the base period, and any adjustments made to arrive at the expected amounts to be collected by MCOs under the contract	
260.	Attachments 10-11	All	At the bidders' conference, it was stated that only FY2015 experience was used to develop the Foster Care rates because PRTF experience in FY2014 was much higher than FY2015. Please explain the reason for the decrease. Was there a policy change?	The current managed care entity described the variance in utilization for PRTF as a decrease in requests for PRTF. It was assumed that the utilization levels inherent in the FY2015 data was more indicative of future utilization patterns.
261.	Attachments 10-11	All	"Regarding the base data: a) Please discuss any issues or concerns related to data collection. b) Does the data book capture all expenses that will be the MCOs' responsibility, even those paid outside of the claims system? c) Please confirm that encounter data represents actual reimbursements by MCOs and were not repriced to 100% of a fee schedule? d) Please provide average	There are no concerns about data collection. Data sources are comprised of FFS data and MCO encounters. Current MCOs are involved in validating the encounter data. The results of this validation confirm that encounter data is not underreported. All payments are captured. Supplemental payments such as CAH settlements and PCP shared risk agreements are added in to the base data. Encounter data represents actual reimbursements by MCOs were not re-priced to 100% of a fee schedule. The level of detail requested in part d of the question is not available.

			payment rates (reflected in the data book) relative to the fee schedule by region, category of aid, and category of service."	
262.	Attachments 10-11	All	"Can the databook be further split by: a) to separate populations and services under managed care versus fee for service during the base period? b) separate out all base data and assumptions for pharmacy by generic, specialty and brand c) by hospital type (e.g., critical access hospital, out-of-state, etc.)? d) drug utilization and unit cost for HEP-C treatments, e) ASD-related benefits."	No populations were under FFS for their Behavioral Health services. Physical Health services were provided under FFS for the following populations: AABD 21+ M&F-WWC; LTSS (Institutional) – Dual; LTSS (Institutional) - Non-Dual; LTSS (Home and Community Based) – Dual; LTSS (Home and Community Based) - Non-Dual; Dual. Pharmacy services were provided via FFS for all populations. This level of detail is contained in the base data books that are attachments to the RFP. This level of detail is not available for part b of the question. The impact of ASD related benefits is itemized in the Pre-Proposal presentation provided by the contracted actuary. Please submit further detail for c and d during the second round of questions.
263.	Attachments 10-11	All	Please provide the IBNP assumptions by region, category of aid, category of service and data type (FFS versus managed care).	See the Attachment 25: "IBNR Assumptions by Source". IBNR factors are shown on a statewide basis because payment patterns do not materially differ between rating regions.
264.	Attachments 10-11	All	Please provide a detailed development of the dispensing fee assumption built into the rates, including	Non-independent pharmacies were assumed to have a $2.50 dispensing fee and independent pharmacies were assumed to have a $4.45 dispensing fee. The independent pharmacy dispensing fee is the State FFS dispensing fee set for independent pharmacies. The $2.50 non-independent pharmacy dispensing fee

			the dispensing fee amounts reflected (classified into independents and non-independents as appropriate) in the base period, and any adjustments made to arrive at the dispensing fee amounts expected under the contract.	is based on discussions with the state and research of other states.
265.	Attachments 10-11	All	"Please provide a narrative describing how the underlying cost data and delivery counts are collected and adjusted in the development of the supplemental delivery payment and the capitation rate for all related categories of aid in order to account for each of the following: 1) limitations on payment (i.e. due to stillbirth or missing inpatient claims) 2) adjustments for maternity time periods that do not fall completely within the base period extended, to ensure that all costs associated with the deliveries shown on that exhibit were included, regardless of when the care was delivered. For example, please confirm that a delivery that occurred a month after the beginning of the experience period or a month	A qualifying delivery procedure code must be found on an encounter in order for the maternity experience to be captured in the rates. Currently the State does not pay a supplemental payment for stillbirths, so those expenses are not in the supplemental payment and remain in the regular monthly capitation rate. When a qualifying delivery event is found in the data, the contracted actuary captures all other expenses for that member in the five months prior to delivery date and the two months post-delivery. All of these expenses are re-categorized from the member's original aid category to the Maternity aid category. The maternity cell separately captures maternity-related services for all populations, dating back 5 months from the date of delivery (5 months prenatal) and going forward 2 months after the delivery (2 months post-partum). Prenatal costs for delivery occurring within the first five months of the base data period, and postpartum costs for deliveries occurring within two months of the end of the base data period could be understated in the base data. As a result, an adjustment has been made to reflect the missing prenatal and postpartum services for deliveries occurring on the left and right tails of the base data. The contracted actuary reviewed the average per-member-per-delivery costs for delivery events occurring between December 2013 and April 2015 (step one) and compared these costs with the per-member-per-delivery costs for deliveries occurring July-November 2013 and May-June 2012 (step two). The differential between the deliveries identified in step one and step two was used to adjust costs observed in step two. The overall impact of this is an upward adjustment to the

			before the end of the experience period would have been removed from both the counts and the claims. Additionally, please provide a breakout of the base data for the maternity supplemental payment using categories of service that reflect the specifics of this payment. In particular, it would be helpful to have the costs split into physician, facility, prenatal, postpartum, and delivery costs, for example."	Maternity cell of 1.8%. Maternity experience split by service type can be found in Attachment 10-A and Attachment 10-B by viewing the Maternity aid category. Please note that for this aid category member months are actually deliveries, as the denominator for the supplemental payment is a delivery event, not a covered month. Physician, facility, prenatal, postpartum, and delivery costs can not be independently itemized.
266.	Attachments 10-11	All	Please confirm that the values shown in the MM's column of the maternity exhibit are actually meant to represent deliveries	Confirmed.
267.	Attachments 10-11	All	Please describe how third party liability/ coordination of benefits are reflected in the data and rates.	Capitation rates are net of any third party payments or member share of cost.
268.	Attachments 10-11	All	Please describe the eligibility conditions for the Katie Beckett 00-18 M&F rate cell.	Medicaid eligibility for children whose parental income in disregarded due to the determination that the child meets hospital level of care. This includes families with a child or children under 18 years old who have one or more of the following: • A ventilator to breathe • A tracheostomy • Need for complex nursing services to be provided at home • Use excessive amounts of medical supplies, equipment,

				and/or therapies
269.	Attachments 10-11	All	All of the values are identical in each of 10-A and 10-B for the Katie Beckett 00-18 M&F Rate cell. Please confirm that this is a statewide rate cell and the counts represent a statewide count.	Confirmed.
270.	Attachments 10-11	All	"Summary detail was provided during the Pre-Proposal conference regarding at least 7 policy changes. However, these changes were grouped into 5 impacts, for which only summary information was shown. Please provide each of the following, with detail down to the level of region, fee for service versus managed care, category of service, unit cost and utilization impact, fiscal year, and any other breakout necessary to understand the change: a) a narrative describing each of the policy changes, including the effective date and the development of the impact of each item, describing each of the data, assumptions and methods used to calculate the impact.	Please see Attachment 22: "Heritage Health Rate Development Narrative". This question appears to be applicable to the Immediate Enrollment adjustment and the Behavioral Health copay adjustment. Immediate enrollment was effective February 2014, so they are inherent in 17 months of the base data and absent from seven months. Beginning January 2014, the State implemented a $2.00 copay for certain Behavioral Health services. The January 2014-June 2015 base data already reflected the copay implementation, so only the September-December 2013 Behavioral Health encounters were adjusted to reflect the copay policy change. The only adjustments included to get the data on a comparable basis as show in the attachments were IBNR, Subcapitation Payments, and Supplemental Payments. IBNR is detailed in Attachment 25: “IBNR Assumptions by Source”. Across both FY14 and FY15 Supplemental Payments are worth $11.2 million on a statewide basis and Subcapitation Expenses are worth $13.8 million on a statewide basis. Subcapitation represents predominantly Vision subcapitated agreements, while Supplemental Payments represents non-claims payments, such as CAH settlements. The value of all adjustments applied to get from Attachments 10-A--10-D is in the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas).” Additionally, see Attachment 20: “COA-level Rate Development”, to see the application of rate adjustment values.

			b) the impact of the policy change further broken out (beyond the breakouts listed above) into 1) how much of the impact of the policy change is already reflected in the base data 2) how much of the impact of the policy change was included as an adjustment to the base data in order to get all of the base data on a comparable basis, as shown in attachments 10-A - 10-D 3) how much of the impact of the policy change was included as an adjustment after the summary of the base data shown in attachments 10-A - 10-D was complete, and before final rates were developed as shown in attachment 11"	
271.	Attachments 10-11	All	"The trends used to develop these rates were shown in the Pre-Proposal Conference Rate Presentation by COA and separately by COS. a) Please confirm that the trend rates shown are per year trends, and, if so, please	Trend rates shown are annual trend rates. Trends are developed and applied by category of service and category of aid. This allows for each detailed trend rate to be compounded for the necessary amount of time depending on the data source. "COS and COA Trends" contains the trends by category of service and major category of aid.

			describe the process of calculating a single trend rate for a category of aid for which different components of the total PMPM are trended for different time periods. b) Please provide these assumptions at the level of detail used in the rate development (i.e., break these trends out by both of these dimensions at one time)."	
272.	Attachments 10-11	All	Please clarify any adjustments made to the pharmacy costs shown in the data book and rates. Specifically, have the expenses been reduced for both federal and supplemental rebates?	The pharmacy amounts in the data book and rates have not been reduced for rebates.
273.	Attachments 10-11	All	Please provide the values of the pharmacy rebates separated by federal and supplemental and by fiscal year, region, and rate cell.	Pharmacy rebates are not included in the capitation rate development. Therefore, this level of detail is not available.
274.	Attachments 10-11	All	Please confirm that there is no premium or provider taxes.	The contracted actuary did not build in premium or provider taxes into the capitation rates.
275.	Attachments 10-11	All	Please provide membership projections by rate cell for CY17 and any later time periods available.	This level of detail is not available.

276.	Attachments 10-11	All	Please provide the definition of units for each category of service shown in the data book.	See Attachment 29: "Unit Definitions for Category of Service".
277.	Attachments 10-11	All	Please clarify whether or not GME expenditures are reflected in the base data or rates. If so, please provide these values separately.	GME expenditures are not included in the base data or the rates.
278.	RFP Section IV.Z	191	Regarding the Procurement of FFS Claims Management and Processing services, can the State share how it will evaluate which MCO will be awarded this business and what the award criteria will be?	See the Evaluation Criteria by clicking on the link below: http://das.nebraska.gov/materiel/purchasing/5151/5151.html
279.	RFP Section IV.S.10	169	Does the State have documentation that it could make available to bidders on the Encounter Submission process? For example: should we assume that the HIPAA 837 I&P Companion Guides on the Nebraska Medicaid website are not only for Provider submissions for FFS Medicaid - but are also for MCO's to submit encounter data? In addition, does the State have any information it could share on the format of ancillary	The 837 I&P Companion Guides on the Nebraska Medicaid website are for both- Provider submissions of claims and for MCO submissions of encounters. The MCO receives the 999 File Acknowledgement, and 277 Claims Acknowledgement Transactions. A Month-To-Date Summary Report is also sent to the MCOs.

			encounter submission file formats (e.g. error files returned from the State, acknowledgement files, provider file submissions)?	
280.	Attachment 7	1	There is an asterisk on page 1 of Attachment 7 next to Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC); however there is no explanation of the asterisk. Can the state provide clarification?	The State is hereby amending to remove the astrick on page 1 of Attachment 7.
281.	Attachment 7	2	There is an asterisk on page 2 of Attachment 7 next to Child and Adolescent Major Depressive Disorder, Suicide Risk Assessment (SRA); however there is no explanation of the asterisk. Can the state provide clarification?	The State is hereby amending to remove the astrick on page 2 of Attachment 7.
282.	Attachment 14	n/a	Is the calculation for Claims Processing Timeliness and Pharmacy Claims Processing Timeliness business days or calendar days?	See section IV.S.3.
283.	Summary of bidder's corporate experience	197	The RFP language states that the State will use no more than 3 narrative project descriptions submitted by the bidder during its evaluation of	See the response to Question #44.

			the proposal. For entities that have more than 3 project descriptions to provide, would the State prefer that bidders provide only 3 or all applicable experience?	
284.	Attachment 19	17	Question 97, regarding value-based purchasing, asks bidders to provide evidence of effective use in Nebraska or other markets. Medicaid membership tends to be more medically-complex than Commercial membership. To allow for a more accurate comparison, for evaluation purposes, would the State consider that evidence be limited to only Medicaid experience? Alternatively, would the State consider weighing Medicaid experience differently than commercial?	A bidder should include in its response to Question # 97 a description of the MCO's approach to implementing a value-based purchasing model with Medicaid membership. In its presentation of evidence of effective use in Nebraska or other markets, a bidder should identify whether the applicable membership was Medicaid or commercial.
285.	RFP Section F. Member Services and Education, part 4, Item d	70	The SOW says “The MCO must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the MCO’s website, the materials that the members can find on the website and how to obtain	See response to Question #144.

			written materials if the member does not have access to the website." On page 80, Item b.1 it says "The MCO must send a welcome packet to new members within ten business days of receiving the new member file." Please clarify the difference between new member materials and the welcome packet?	
286.	II. Procurement Procedures, H.	4	Does the State want extra copies in addition to the one (1) original?	No, the State is only requesting one (1) original of the entire proposal response.
287.	II. Procurement Procedures, H.	4	Is there a specification for font size and style?	See response to Question #56.
288.	II. Procurement Procedures, H.	4	What are the margin and spacing requirements for the final proposal?	There are no such requirements.
289.	II. Procurement Procedures, O.	6	The RFP indicates only top scoring bidders may receive reference checks. Will the bidder be required to supply reference contact information? If so, where should bidder include this information within RFP the response?	The Bidder may provide references within the proposal response. References may be in a separate identified tab within the proposal response.
290.	III. Terms and Conditions, F. 3. a & c	10	Section a. states MCOs must file all contracts of reinsurance or a summary of the plan of self-insurance,	If the MCO chooses to self-insure, the maintenance of reinsurance agreements will not apply.

			however section c. states the MCO must maintain reinsurance agreements throughout the contract period including any extension(s) or renewal(s). If the MCO chooses to self-insure, how do the requirements of 3. c. apply to a self-insured MCO?	
291.	IV. Project Description and Scope of Work, D. 3. j.	51	With respect to "additional staffing requirements," are all prior authorization, concurrent review, and member services staff required to physically work in Nebraska? Which specific care management staff are required to work in Nebraska?	Per Section IV.D.3.j. all additional required staff in Section IV.D.3 must be located in the State with the exception of claims and encounter processing staff and certain care management staff.
292.	F. Member Services and Education, 11.	77-79	Is there currently a Nebraska requirement for all providers to utilize a consistent electronic medical records (EMR) program to aid MCOs in easily obtaining records?	There is no requirement for providers to utilize a consistent electronic medical record program. A provider may select a vendor, if the provider opts to install an electronic medical record in their practice.
293.	F. Member Services and Education, 13. c. iii.	81	What defines an "attempt to contact the member"? Do mailings count in this requirement for 3 attempts?	Attempts may include written correspondence sent via the US Postal Service or documented telephone calls.
294.	F. Member Services and Education, 13. c. iii.	81	The second part of iii. states that if the member has lost or never received a welcome	This is acceptable.

			packet that the MCO must resend it. If the welcome packet was returned to the MCO due to an invalid address and the member is unable to reach, is it acceptable not to resend the packet to the invalid address as long as the member is added to the monthly unable to reach report sent to MLTC?	
295.	M. Quality Management, 1. c.	118	How is "sufficient number of qualified personnel" defined? Is there an expected ratio?	The Bidder should propose the number of qualified personnel to comply with all QM requirements in a timely manner.
296.	M. Quality Management, 4. a.	120	How many child (adult guardians) and adult Medicaid members are required to be in attendance at QAPIC meetings? Is it a specific ratio or percentage of total membership?	The Bidder should propose the number of family members/guardians of children or youth who are Medicaid members and adult Medicaid members to participate in the QAPIC.
297.	IV. Project Description and Scope of Work, P. 5.	144	Is there a separate billing process for Supplemental Delivery payments or is submission of the encounter data evidence of the delivery to generate payment?	See response to Question #99.
298.	IV. Project Description and Scope of Work, P. 7. b. iii	145	Please clarify the reimbursement of the HIPF to the MCO and timing of payments. Will the MCO receive a lump sum	An estimate of HIPF liability will be built prospectively into the capitation rate. After the final tax bill is paid the following year the State will calculate a settlement payment based on the difference between what was paid during CY2017 in the capitation rates and the actual HIPF amount.

			adjustment for reimbursement of HIPF payment?	
299.	IV. Project Description and Scope of Work, P.12. c.	148	If the MCO contracts with a TPA for administrative services at a percentage of revenue, what documentation is the MCO required to provide under section c.?	The MCO must provide documentation to enable the State to support any expenses provided on the quarterly financial report.
300.	IV. Project Description and Scope of Work, Q. 6. b.	150	Please provide details on how the percentage of the value based purchasing agreements will be calculated. Will all provider types be included in this calculation (i.e. practitioner, ancillary, hospital)?	See response to Question #103.
301.	Attachment 6: Reporting Requirements	9-10	The reporting requirements for the Audited Financial Statement and the Department of Insurance Financial Report is 30 calendar days following the 12th month of the contract year • The quarterly filings are not due until 45 calendar days following the end of a quarter • The filing checklist on the Nebraska Department of Insurance website	The deadline for the Audited Financial Statement is 30 calendar days following the 12th month of the contract year. The due date for the Department of Insurance Financial Report in Attachment 6 is hereby amended to read as follows: "June 1".

			shows due dates of 6/1 for audited financial statements, and 3 /1 for annual statement	
302.	Attachment 19: Proposal Statements and Questions, Question 106.	19	"Prioritized business functions for resumption of operations and responsible key personnel" We generally do not share the specific priority of functions nor key personnel at a named person level, rather, we speak to the process for prioritizing functions and reviewing key personnel lists. Would this be acceptable or does it need to be more specific?	This would be acceptable.
303.	Evaluation Criteria	N/A	Can the department please provide a more comprehensive scoring breakdown, specifically relating to scoring for staffing (i.e., will the MCO be evaluated on how many positions are filled at time of RFP submission, or will MCO be evaluated on proposed staffing plan meeting the RFP requirements?	In order to protect the integrity of the evaluation process, the factors that will be scored within the evaluation criteria will not be provided. See the Evaluation Criteria by clicking on the link below: http://das.nebraska.gov/materiel/purchasing/5151/5151.html
304.	RFP, Section IV.B.1.	RFP page 33	Could MLTC provide the file layout/format or data	The 834 transaction is sent to the MCOs to provide eligibility data along with proprietary supplemental and unborn files. Please see Attachment 30: "Supplemental Enrollment File" and

			dictionary of the Eligibility Data being supplied?	Attachment 31: "Unborn File".
305.	RFP, Section IV.I.17.vi.	RFP page 103 and RFP Attachment 5, page 7	Could MLTC elaborate on the specific provisional credentialing requirements for behavioral health providers?	Regulations applicable to licensure of mental health practitioners are available at 172 NAC 94. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-094.pdf
306.	RFP Attachment 2, Access Standards, Geographic Access Standards, #4	RFP Attachment 2, page 2	Could MLTC clarify how the access standard will be measured? For example, will it be measured by the number of miles from the member's personal residence (no greater than X miles) or by the number of hours of travel time by car (no greater than X number of hours)?	Access standards are measured by the number of miles from the member's personal residence as set forth in Attachment 2.
307.	RFP Attachment 4	RFP Attachment 4	At what frequency will MCOs assess medical home providers for continued participation?	See Section IV.I.7.e.
308.	RFP Attachment 19, #45	RFP Attachment 19, page 8	Will MCOs be permitted to query the enrollment data to confirm the provider identification number in order to ensure that providers are enrolled in Medicaid and have a valid identification number?	MMIS will provide the MCOs a file (interface) with current provider information.
309.			It has come to my attention that the most recent Medicaid contractual information is not up to date with the law in	See response to Question #2.

			Nebraska. The antiquated language “”Primary care provider (PCP) A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (Dos) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology” would prohibit me from continuing to provide care for Medicaid patients in Nebraska as I no longer have a collaborating or supervising physician. This verbiage needs to change immediately to reflect the changed law in Nebraska.	

310.	Glossary of Terms	RFP page xv	"We request two points of clarification relating to the definitions of “Qualifying revenue (for the risk corridor calculation)” and “Qualifying revenue (for the administrative cap calculation)”. (1) Both definitions indicate that qualifying revenue is “[t]he aggregate of revenue earned by an MCO and related parties, including parent and subsidiary companies and risk bearing partners under this contract.” Please confirm that no amounts would be double-counted as revenue based on these definitions. For example, amounts received by MCO as premium and then paid to a related party in order to reimburse that related party for administrative costs would be counted as qualifying revenue only once. (2) Both definitions indicate that qualifying revenue ignores “federal and state	Points one and two are confirmed.

			premium taxes and non-operating income." Please confirm that this includes amounts paid to MCOs to reimburse them for the Health Insurance Providers Fee (see § IV(P)(7) on page 145)."	
311.	Glossary of Terms	RFP page xvi	Please confirm that in the definition of "Risk corridor calculation", the reference to "a contract" should be "this contract". Could the RFP be revised to reflect this?	The definition of "Risk corridor calculation" is hereby amended to read as follows: **Risk corridor calculation:** The computation of a MCO's profit or loss by MLTC's actuary, as a percentage of the aggregate of qualifying revenue for the MCO and related parties, including parent and subsidiary companies and risk-bearing parties under this contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.
312.	Glossary of Terms	RFP page xvii	"We have two clarification requests related to the definition of "Subcontractor": (1) Please confirm that the reference in the first sentence of the definition to "a contract" should be "this contract". (2) Please confirm that a provider (such as a hospital) that credentials its own staff would not be considered a subcontractor based on such credentialing activities.	1.) See response to Question #311. 2.) Confirmed.

			Could the RFP be revised to reflect these clarifications?"	
313.	Glossary of Terms	RFP pages ix and xvi	"We are concerned that the definitions of “administrative expense rate” and “related-party administrative expense” could be interpreted to mean that actual administrative costs incurred by the MCO and paid to a related party would not be included in the calculation of the MCO’s administrative expense. Could the State revise the RFP clarify that administrative expenses actually incurred will be counted toward administrative expense even when paid to a related party? For example, these definitions could be revised: “Administrative expense rate: The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that were incurred in the contract year. In the event the MCO paid any amounts for administrative services to a related party, only those administrative costs actually incurred by the related party	The State is reviewing this question further. This information will be posted to the procurement website as part of the second round of questions and answers.

			in connection with the administration of this contract will be included in such costs." "Related-party administrative expense: Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related party for administrative costs actually incurred by the related party in connection with the administration of this contract." "	
314.	Glossary of Terms	xvii	The definition of specialty drug is somewhat restrictive. Can the MCO use its own list of specialty drugs to be dispensed through specialty pharmacies or can ONLY drugs that meet this definition be dispensed through specialty pharmacies?	See response to Question #75.
315.	RFP § II(H)	4	Are there any font or font size requirements applicable to	See the response to Question #56.

			the proposal responses?	
316.	RFP § III(F)(4)	10	"The RFP requires that the MCO maintain Errors and Omissions ("E&O") coverage at $10,000,000 per occurrence and Cyber Liability coverage at $10,000,000 each occurrence. Neither Managed Care E&O coverage nor Cyber Liability coverage is commercially available on an occurrence basis. In connection with another recent RFP, we surveyed 15 insurance carriers and E&O policies are only written on a claims-made basis. The markets stated it could not be changed. Please confirm the State will accept claims made policies for E&O coverage and Cyber Liability coverage. If necessary the MCO could agree to purchase tail coverage if the coverage is moved to a new carrier."	Yes, the State will accept the Cyber and E&O coverages on a claims made basis. The E&O coverage and Cyber Liability coverage is not commercially available on an occurrence basis therefore the claims made basis is acceptable.
317.	RFP § III(GG)	20	This section provides that "State will render payment to Contractor when the terms and conditions of the contract	Capitation rates will be paid prospectively.

			and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State." Medicaid MCOs are typically paid for services in advance of (or at the beginning of) the month for which the payment is made. Advance payment also seems to be contemplated by RFP § IV(P) generally. Please confirm that MCOs will be paid prospectively.	
318.	RFP § III(II)	21	Please confirm that the provisions of RFP § IV(P)(7), which relate to the reimbursement by the State of the Health Insurance Providers Fee, take precedence over the language of this section.	Confirmed.
319.	RFP § III(NN)	23	Could the State provide more details regarding the submission process related to proprietary information? The instructions state that 1 original proposal should be submitted and proprietary information should be included in a separate package. Does that mean that the original should be a redacted version with the	Either way is acceptable as long as the proprietary information is labeled and in a separate sealed envelope.

			proprietary information removed (and the redacted information provided in a separate envelope)? Or would the State rather receive one complete copy of the proposal and one redacted copy suitable for public posting?	
320.	RFP § IV(A)(1)	30-31	RFP numbering in this section jumps from 1 to 9….was anything omitted as a result?	The jump from IV.A.1 to IV.A.9 was inadvertent. No information was omitted.
321.	RFP § IV(B)(1)(c)	33	The RFP states that Medicaid and CHIP eligibility will be conducted annually. Continuous eligibility in CHIP is limited to six months by statute. Will the annual review amount to continuous eligibility or will reviews continue on a rolling basis if and when DHHS is alerted to a change in family circumstances that could affect eligibility?	Review will be annual unless MLTC is alerted of a change that may affect eligibility.
322.	RFP § IV(B)(3)(f)(iii)	34	This provision provides than an MCO will be removed from the auto assignment algorithm if it has 40% or more of statewide enrollment. In the event the State only awards two contracts, what threshold would be used?	In the event only two contracts are awarded, this provision will be revised to reflect 65% or more statewide enrollment.

323.	RFP § IV(C)(10)(a) and (b)	41-42	Will the State require the MCO to open an Insolvency Bank Account? If yes, how much is the minimum Insolvency amount required by the State? When is it required to be opened and funded?	This will not be required.
324.	RFP § IV(C)(10)(a) and (b)	41-42	Aside from the Insolvency Bank account (if any is required), will the State also require the MCO to open a separate Statutory Deposit Bank Account? If yes, how much is the required statutory deposit amount? When is it required to be opened and funded?	This will not be required.
325.	RFP § IV(C)(14)and RFP § IV(K)(2)	43 and 110	The first section referenced specifies "The MCO must submit all proposed subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 120 calendar days prior to their planned implementation." whereas the 2nd section referenced specifies "2. The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a	The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 90 calendar days prior to their planned implementation.

			minimum of 90 calendar days prior to their planned implementation." Can MLTC confirm if the submission must be made at least 90 or 120 days?	
326.	RFP § IV(D)(3)(j)	51	Please clarify the requirement that "[a]ll additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff." We have found that having a mix of in-State and out-of-State personnel is the best way to serve members. For example, we plan to have member services and provider services personnel based in Nebraska to provide in-person services to members and providers. However, we also maintain member and provider call centers elsewhere that also would be available to assist Nebraska members and providers. Likewise, we would have in-State at least one Nebraska-licensed registered nurse or physician's assistant on our prior authorization staff, as	See response to Question #291.

			required, and we would support the prior authorization function through centralized services elsewhere. Please confirm this type of structure is consistent with this requirement.	
327.	RFP § IV(E)(1)(d)	52	"We note that the requirement that services be rendered by providers enrolled as MLTC providers does not apply to emergency services pursuant to § IV(Q)(15) on page 153. Please confirm that this requirement would also not apply to the following services: • Urgent care services performed out of state; • Specialty services unavailable within the MCO's network (for example, a member is referred to a specialty center out of state); and • Value-added services."	Confirmed.
328.	RFP Glossary of terms and § IV(E)(11)(b) - (d)	58-60	Please provide additional clarification regarding the difference between the Contractor's formulary and the preferred drug list ("PDL"). We understand that	See response to Question #75.

			MCOs are required to follow Nebraska's PDL. However, the RFP contemplates a separate MCO formulary (see, in particular, § IV(E)(11)(b)(iv)(a)) which must be approved by MLTC. Does this mean that the MCO can cover more drugs than are on the Nebraska PDL? What types of differences between MCO formularies and the Nebraska PDL does MLTC anticipate?	
329.	RFP § IV(E)(11)(b)(ix)	59	This section states that MCOs are permitted to require prior authorizations under certain circumstances so long as the prescriber and the pharmacy are notified within 1 business day of approval or denial. Please confirm that MCOs are not required to contact the pharmacy with respect to retrospective DUR determinations.	The MCO is not required to contact the pharmacy if an auto-drug look back was performed and payment was denied due to lack of drug-utilization history.
330.	RFP §§ IV(H)(3)(a)(ii) and IV(N)(4)(b)	88 and 127	Section IV(H)(3)(a)(ii) states that "any decision to deny a service authorization request . . . must be made by a health professional who has appropriate clinical expertise in treating the member's	Regardless of reasoning for service authorization denials and limitations, all decisions must be made by a health professional who has appropriate clinical expertise in treating the member's condition or disease.

			condition or disease." Section IV(N)(4)(b) contains similar language. Please confirm that this requirement does not prevent non-clinical MCO personnel from issuing denials and limitations based on administrative criteria not related to medical necessity (for example, request is for an excluded product, request is outside terms of coverage, etc.)	
331.	RFP § IV(I)(4)(e)	96	"Please confirm the following with respect to the requirement that MCO's network include providers currently serving Medicaid members: • The requirement applies only to the MCO's initial network as of the contract start date; • MCO is not required to contract with any provider that does not pass credentialing; and • MCO is not required to contract with any provider that refuses to accept MCO's standard provider agreement applicable to such provider's type and/or specialty."	IV.I.4.e applies only to the MCO's initial network as of the contract start date. A MCO is not required to contract with providers who do not meet credentialing standards that have been approved by MLTC per Section IV.I.14. A MCO is not required to contract with any provider that refuses to accept the MCO's applicable provider agreement; however, all provider agreements must be in accordance with requirements in the RFP.

332.	RFP § IV(I)(4)(j)	96	When does MLTC anticipate making available to MCOs the list of Medicaid eligible providers?	A list of Medicaid-eligible providers will be posted on the procurement website as soon as it is available. This information will be posted to the procurement website as part of the second round of questions and answers.
333.	RFP § IV(I)(8)(e)	99	"This section provides that "[t]he MCO must not incorporate branding of any pharmacy onto member ID cards. However, § IV(F)(9)(h) expressly requires MCO to include on the ID card "[t]he name or identifying trademark of the MCO and the prescription benefit manager." However, in some cases an MCo's PBM might be affiliated with a national pharmacy chain. Given the potential conflict above, please confirm that: • An MCO may elect to include the PBM routing information (BIN/PCN/RxGroup) without including the PBM logo on the card; and/or • The prohibition in § IV(I)(8)(e) will not prohibit MCO from including its PBM	Retail pharmacy branding may not appear on a member ID card. The MCO's contracted PBM branding may appear on a member ID card, but not if it reflects affiliation with a retail pharmacy chain.

			information on the member ID card as contemplated by § IV(F)(9)(h) even if that logo includes pharmacy branding."	
334.	RFP § IV(L)(6)(h)	116	This provision requires that the MCO develop engagement tools to improve engagement with pregnant members and help identify high-risk pregnancies. This type of activity seems to be member education, not member marketing. See, e.g., the definition of "Marketing" in the Glossary of Terms and RFP § IV(G)(1)(b), which states that "[m]arketing is different than member education. Member education is defined as communication with a MCO member for the purpose of retaining the member as a member and improving his/her health status." Why would the activities contemplated in § IV(L)(6)(h) be included in the Marketing Plan? Shouldn't the MCO's plans for pregnant member engagement contemplated in § IV(L)(6)(h) be submitted separate from the Marketing Plan?	Bidders should not address IV.L.6.h in the Marketing Plan. Bidders should address IV.L.6.h in Attachment 19 - Question #35.
335.	RFP § IV(L)(6)(i)	117	Should this provision be	IV.L.6.i is hereby amended to IV.L.6.h.iii.

			numbered § IV(L)(6)(h)(iii)? If not, please clarify this requirement.	
336.	RFP § IV(O)(1)(j)	133	Please confirm that the minimum number of investigators is 1 per 100,000 members or less (as stated in § IV(D)(3)(i)) rather than 1 per 50,000 members or less as stated in this section.	See response to Question #95.
337.	RFP § IV(P)(7)	145	"Please clarify the timing on the HIPF payments in 7.b.iii. using the 2018 HIPF payment as an example. Is either of the following examples correct? Example 1 • An estimated HIPF amount will be included in the capitation rates paid during CY2017. • MCOs will pay the 2018 HIPF based on 2017 revenue in September 2018. • After the MCOs receive their final invoices in September 2018, MLTC will calculate a settlement payment for the difference between what was paid in CY2017 as an estimate and the final HIPF	See response to Question #298.

			amount plus gross up amount for taxes. - OR - Example 2 • MCOs will pay the 2018 HIPF based on 2017 revenue in September 2018. • The State will recalculate the capitation rates payable to the MCO for the balance of CY2018 to include an estimated amount to reimburse the MCO for the 2018 HIPF fee plus an amount for the tax gross-up • After December 31, 2018, MLTC will calculate a settlement payment for the difference between the additional HIPF-related amount paid in capitation rates for the last few months of 2018 and the actual HIPF amount plus gross up amount for taxes."	
338.	RFP § IV(P)(10)	146	Why is the 1.5% MLTC Quality Performance Program amount not explicitly built into the premium capitation rates?	The 1.5% MLTC Quality Performance Program is considered a withhold and is not additional money added to the administrative load component of the rate development.

339.	RFP § IV(P)(10)	146	This section references Attachment 13 - Neb. Rev. Stat. 71-831. Neb. Rev. Stat. 71-831 reads that the requirements outlined in Attachment 13 apply to "at-risk managed care service delivery for behavioral health services". Does this mean that the 1.5% applies only to the behavioral health portion of the premium capitation rate?	The 1.5% MLTC Quality Performance Program applies to the aggregate premium capitation rate.
340.	RFP § IV(P)(10) and (11)	146 and 147	Please explain the interaction between the MLTC Quality Performance Program and the State Performance Penalties. Is the State Performance Penalties a subset of the MLTC Quality Performance Program?	State performance penalties are not a subset of the MLTC Quality Performance Program. Quality Performance Program measures (applicable to the Quality Performance Program) are identified separately from minimum performance metrics (applicable to the State performance penalties).
341.	RFP § IV(P)(10) and (11)	146 and 147	Are the MLTC Quality Performance Program and the State Performance Penalties amounts of 1.5% and 0.25% respectively excluded from revenue in the calculation of the 3% profit risk corridor?	See response to Question #33.
342.	RFP § IV(P)(11)(d)	147	Please confirm that the modifications contemplated by this provision would only occur prior to the year in	Confirmed.

			which the performance metrics would be effective and that no modifications would be made during any year in which the modified metrics would be effective.	
343.	RFP § IV(Q)(3)	149	The enhanced payment under § 1202 of the Affordable Care Act applied to provider payments in 2013 and 2014. Would the State consider deleting this provision to avoid confusion?	The State has elected to continue enhanced payments for primary care services beyond the federal mandate.
344.	RFP § IV(Q)(6)	150	For the purpose of calculating the percentage of providers on a value-based purchasing contract, how does MLTC define provider? Will there be any effort to weight the VBP requirement by membership to ensure that a large enough percentage of members are being seen by providers in a VBP contract?	Provider is defined in the glossary of the RFP. The VBP requirement does not consider weighting by membership.
345.	RFP § IV(Q)(10)	152	Can MCOs and CAHs agree to other settlement terms, such as building any settlement due to or from a CAH into rates going forward?	Any alternative arrangement agreed upon by the MCO and CAH must be in compliance with 471 NAC 10-010.03F.
346.	RFP § IV(Q)(11)	152	With regard to the UNMC supplemental payments, please clarify the final	Amounts built into the capitation rates will not change every quarter as a result of the UNMC supplemental payment.

			sentence: "These payments are calculated into the capitation rate on a quarterly basis." Does this mean the amounts built into the capitation rates will change every quarter?	
347.	RFP § IV(Q)(11)	152	How will MCOs be required to pay the UNMC provider pass-through? Will the MCOs pay each month the per rate cell pass-through amount in the rate multiplied by the members in each rate cell?	471 NAC 18-006.02, Supplemental Payment, describes how supplemental payment amounts are determined. The MCO will make supplemental payments to UNMC related to this contract provision on a quarterly schedule.
348.	RFP § IV(Q)(16) and Optumas Presentation at Bidder's Conference	153	What percent of pharmacies are independent pharmacies and what percent of pharmacy costs are incurred at independent pharmacies?	See response to Question #37.
349.	RFP § IV(Q)(16) and Optumas Presentation at Bidder's Conference	153	What dispensing fee was assumed in the rate development for non-independent pharmacies?	Non-independent pharmacies were assumed to have a $2.50 dispensing fee.
350.	RFP § IV(Q)(16)(a)	153	With respect to pharmacy reimbursement, the RFP states the Dispensing Fee must be consistent with the current Medicaid FFS rate for independents. Are we correct to interpret that the MCOs can manage the national network ingredient cost for all	The current Medicaid FFS rate for independent pharmacies must be provided for the duration of the contract. MCOs may manage and negotiate the network ingredient costs but must provide the dispensing fee in addition to this reimbursement for independent pharmacies, unless an alternative reimbursement arrangement is otherwise agreed to by the pharmacy.

			pharmacy providers (e.g. AWP discount, MAC), as long as the dispensing fee requirement to mirror FFS dispensing fees is in place for independents for 6 month as required?	
351.	RFP § IV(Q)(16)(a)	153	The MCO's dispensing fee reimbursement must be, at a minimum, the current Medicaid FFS rate for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider. Does this mean that if a pharmacy has accepted alternate rates to participate in a national network we can use that network and those rates? What is the current FFS dispensing fee?	A MCO may not require a pharmacy to agree to rates already established in a separate contract. The MCO must obtain a new agreement, or addendum to existing agreement, from a participating Nebraska Medicaid Pharmacy Provider prior to the start of services under this RFP even if that pharmacy has an existing relationship with that MCO (IV.I.8.b.). The current dispensing fee is $4.45, but is subject to change
352.	RFP § IV(Q)(16)(a)	153	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, with methodologies limited to state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

			allowable cost, national average drug acquisition cost, or the submitted usual and customary charge. Are these examples of particular pricing methodologies, or intended to be the only types allowed? Will AWP discount networks be allowed?	
353.	RFP § IV(Q)(17)(c)	153	There is a requirement that the MAC must be available and searchable on the MCO website. There is also a requirement to post the provider manual. Can these requirements be satisfied through the PBMs secure provider portal as MAC/network management is a delegated function of the PBM?	This is acceptable.
354.	RFP § IV(S)(17)	176	"Does Nebraska Medicaid always pick up the patient responsibility"" or are there situations in which Medicaid would not pay the patient responsibility such as Medicare payment exceeds Medicaid amount? If Medicare pays less than the Medicaid amount and the patient responsibility amount	Applicable regulations are available at 471 NAC 3-004.04-05. Medicaid pays the deductible and coinsurance for Medicare-covered services. The amount received from Medicare for Medicare-covered services and other TPR and/or Medicaid for deductible and/or coinsurance shall not exceed Medicare allowable amount. Medicaid payment is the lower of the provider's usual and customary charge or the Medicaid allowable less all third party payment. When a claim is submitted to Medicaid with a payment from a third party resource, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the Medicaid allowable amount. The provider may only

			is less than the difference between the primary payment and Medicaid allowed amount, it the patient responsibility amount paid? Are there any situations in which the secondary payment would exceed the patient responsibility e.g. always paying up to the FQHC encounter/PPS rate?" "	bill the client for a Medicaid non-covered service, or Medicaid copayment fees, where applicable, or if the client has received payment from the TPR.
355.	RFP § IV(T)(2)	177	"We have two questions associated with this provision: (1) Is there a particular form or format MLTC wishes MCOs to use when submitting the disclosures under 42 CFR 455.100 – 455.106? In particular, we note that § IV(T)(1)(b) states that the "State will not review a deliverable unless the format and content has been approved in advance." (2) Please confirm that this disclosure may be submitted confidentially and will not be posted publicly. The	Disclosures may be submitted confidentially and will not be posted publicly. Section IV.T.2 is hereby amended as follows: "Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.106). The MCO must disclose to MLTC this information at contract award, annually thereafter for each contract year, and within 30 calendar days of any change in the MCO's management, ownership or control."

			disclosures required by 42 CFR 455.100 – 455.106 include Social Security Numbers and dates of birth."	
356.	RFP § V(A)(2)(b)	196	"We have two requests for clarification regarding this section: (1) This requirement states that bidders must provide three years of financial statements. Please confirm that, where the bidder is a newly-formed subsidiary of a publicly traded company, three years of financial statements for the publicly-traded parent company will fulfill this requirement. (2) If publicly held, the bidder is required to provide a letter from ""the fiscally responsible representative of the bidder's financial or banking organization"". Please confirm that a bank reference from a bank officer would satisfy this requirement."	"(1) A newly-formed subsidiary of a publicly traded company that has fewer than three years of independently audited financial statements available should provide such statements it does have available and three years such statements for the parent company. (2) The purpose of this requirement is for the State to obtain contact information for the fiscally responsible representative of the bidder's financial or banking organization, not a receive a "letter". Please comply with Section V.A.2.b as written.
357.	RFP § V	196-198	"Please provide additional details regarding the order in which proposal elements	The sections should be included as separate identified tabs within the bidder's proposal response. There is no such requirement for the order of sections.

			should be provided. RFP § II(N) and RFP § V indicate that the following elements should be in the order indicated: • Request for Proposal Form • Section III (Terms and Conditions) • Corporate Overview • Technical Approach (responses to Proposal Statements and Questions in Attachment 19) However, we note that none of RFP § II(N), RFP § V nor Attachment 19 give instructions for the submission of the following documents, each of which is required to be submitted with the proposal: • Form A (Bidder Contact Sheet) (RFP § § II(H), page 4, and III(X), page 16) • Certification of authorization to transact business in the State of Nebraska (RFP § II(P), page 6) • Certificate of insurance coverage (RFP § III(F)(5),	

			page 10) • Proposed deviations from the RFP, if any (RFP § III(R), page 14) • U.S. Citizenship Attestation Form (for individuals and sole proprietorships) (RFP § III(AAA), page 27) • Ownership and control disclosure (RFP § IV(T)(2), page 177) "	
358.	RFP § V(A)(3)	198	Can the MCOs provide supplemental attachments to support the technical approach above and beyond those outlined as required in Attachment 5 and Attachment 19?	See the response to Question #172.
359.	Attachment 15	1	"We request two points of clarification relating to the definition of “Qualifying revenue for the MLR calculation”. (1) Paragraph 3 indicates that qualifying revenue is “[t]he aggregate of revenue earned by an MCO and related parties, including parent and subsidiary companies and risk bearing partners under	See response to Question #310.

			this contract." Please confirm that no amounts would be double-counted as revenue based on this definition. For example, amounts received by MCO as premium and then paid to a related party in order to reimburse that related party for administrative costs would be counted as qualifying revenue only once. (2) Paragraph 3 indicates that qualifying revenue ignores "federal and state premium taxes and non-operating income." Please confirm that this includes amounts paid to MCOs to reimburse them for the Health Insurance Providers Fee (see § IV(P)(7) on page 145)."	
360.	Attachment 15	1	For the purposes of calculating the MLR as described in Attachment 15, is the amount of payback of any profit in excess of 3% added to the numerator in the calculation? That is, does the definition of net qualified medical expense include dollars paid back to the state for profits exceeding 3%?	The MLR reconciliation will be calculated first, and any recoupments/paybacks will be factored into the 3% risk corridor calculation.

			Likewise, if the MCO receives a payment from the state because losses were greater than 3%, is that amount excluded from the numerator in the calculation?	
361.	Attachment 19	5	Question 31 Member Services Are the examples of information that will be available on the website and on portals for members included in the page count?	See response to Question #124.
362.	Attachment 19	5	Question 35 Member Services. The question asks us to "Attach examples" of member education material used with Medicaid or CHIP populations. Are these attachments included in the 10 page count?	See response to Question #125
363.	Attachment 19	5	Question 36, Please confirm that the 3 page limit to this response does not include the required flowcharts.	See response to Question #126.
364.	Attachment 19	8	Question 47, Provider Services: Are the requested sample provider outreach methods included in the 4 page count?	Example provider outreach methods will not be counted in the page limit. See response to Question # 119.
365.	Attachment 19	11	Question 59, This question requires that the bidder submit its proposed template for the health risk	See response to Question #127.

			assessment. Please confirm that this template would not be included in the page limits for this question.	
366.	B Eligibility for Enrollment (4)(a)(i) 7 Disenrollment , C (i)(a) 12 Audit Requirement (18) Moral or Religious Objections Glossary	p. 34 p. 37 p. 42 ix to xviii	If the MC) is not to discriminate on the basis of "religious beliefs" enrollment and provider claims should not be denied for "moral or religious beliefs", or "moral or religious objections" or "moral or religious grounds" or similar formulations and noting "moral" does not appear in the glossary, should not all such language be eliminated from the RFP?	IV.B.4.a.i fulfills federal regulatory requirement 42 CFR 438.6(d) regarding prohibitions against enrollment discrimination. IV.C.i.a fulfills federal regulatory requirement 42 CFR 438.56(d)(2) regarding member disenrollment. IV.C.18 fulfills federal regulatory requirements 1932(b)(3)(B)(i) and 42 CFR 438.102(a)(2) regarding MCO responsibility when it has a moral or religious objection to providing a covered benefit or service.
367.	7 Disenrollment, C (i) (e)	p. 37	If the member may initiate disenrollment for cause under (e) "other reasons including but not limited to poor quality of care or lack of access to providers experienced in dealing with the member's health care needs", should this not these particular requests become, with sanctions a data point analyzed quarterly or otherwise tracked because quality of care and access to experienced providers are the core purpose of this RFP and subsequent contract.	Cause for disenrollment is a federal requirement addressed in CFR 438.56, Disenrollment: Requirements and limitations. MLTC will monitor contracts and apply Liquidated Damages and Intermediate Sanction when contract requirements are not met.

368.	Terms and Conditions S Slip law copy LB605 Sec. 108(2)(a) 4. (c)(ii)	p. 14 p. 48-49 p. 35	Is it not true that LB605 Section 108 (2)(a) "Medical assistance under the medical assistance program shall be suspended rather than cancelled or terminated for a person who is an inmate of a public institution"…. and incarceration is not a cause for disenrollment.	See Addendum 3 – Revisions to the RFP.
369.	Terms and Conditions S 4. (c)(i)(ii)	p. 14 p. 35	Should not "involuntary commitment" be removed as a cause for disenrollment when persons whose disenrollment has not been suspended and who are not in a public institution?	See Addendum 3 – Revisions to the RFP.
370.	Heritage Health Heritage Health	Slide 14, item 3 Slide 19, item 4	If the MCO is to adhere to these program goals and principles of care would not it follow that the 10 components of Recovery below, (commentary included for context), be included as an amendment? NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY (contd)	Section IV.L.3. addresses the requirements the MCOs must follow for recovery-based care which include the nationally recognized ten components of recovery.

			BACKGROUND Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the “single most important goal” for the mental health service delivery system. To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and	

			reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings. Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. “THE 10 FUNDAMENTAL COMPONENTS OF RECOVERY • Self-Direction: Consumers lead, control, exercise choice over, and determine their own	

			path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals. • Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health. • Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that	

			will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life. • Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and	

			society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports. • Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery. • Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive,	

			trust-based relationships. • Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community. • Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives. • Responsibility: Consumers have a personal responsibility	

			for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness. • Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make,	

			ultimately becoming a stronger and healthier Nation." The National Consensus Statement on Mental Health Recovery was funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.	
371.			Definition of Primary-care provider (PCP): ....Advanced practice nurses (APNs)...may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology. Comments: --Earlier this year, LB 107 removed all statutory requirements for physician supervision of nurse practitioners (NPs) in	See response to Question #2.

			Nebraska. As written, it would seem that the preceding definition is no longer consistent with changes in the law that became effective September 1, 2015. --There is no statutory definition for Advanced Practice Nurses in Nebraska. Nurse practitioners are one of four groups of Advanced Practice Registered Nurses (APRNs) which also include Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists (CNSs). --In this definition, it appears that it is intended that both NPs and CNMs qualify as PCPs. Nurse midwives have different statutory requirements for physician oversight of practice. It may be appropriately stated that practice for NPs and CNMs as PCPs must be consistent with requirements for state licensure and statutory provisions within each profession's Practice Act. --Nurse practitioners must be	

			certified in specialty practice to obtain licensure. Those individuals practicing in primary care may be certified in adult, family, pediatric or women's health specialties.	
372.			Primary care services: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them. Comments: --As written, this definition excludes health care and laboratory services provided by advanced practice nursing providers, i.e., NPs and CNMs who qualify as primary care providers (PCPs) in the preceding section.	See response to Question #2.
373.			Provider requirements for a PCMH. Comments:	See response to Question #2.

			--As written, is it the intention to exclude NPs? This seems an oversight, considering 1. The removal of requirements for physician supervision that occurred with LB 107; 2. Nurse practitioners provide a significant portion of primary care services to rural and underserved populations in the state; and, 3. There is evidence to support NPs as PCMH providers, as well as health care providers with outcomes that meet or exceed those of physicians for equivalent services.	
374.	II. Procurement Procedures, H. Submission of Proposals	2	Please provide instructions on how to include any attachments we'd like to add to support our responses to questions in Attachment 19.	Attachments should be included within the applicable section or as separate identified tab(s) within the bidder's proposal response.
375.	IV. Project Description and Scope of Work O. Program Integrity 13. Monthly Reporting to MLTC iii	139	There appears to be a portion of this requirement missing for iii. Please confirm if this is to remain blank.	MLTC confirms that the requirement for iii. is to remain blank.
376.			Should not Medicaid Rehabilitation Option (MRO) be used liberally for individuals with functional and	The State is not mandating the use of a specific set of criteria for use of the Medicaid Rehabilitation Option.

			neurocognitive deficits, generally diagnosed with severe mental illness (SMI) or severe and persistent mental illness (SPMI), who need rehabilitative assistance with such daily living tasks as household management, communication, finances, transportation and comprehension/planning who need rehabilitation services, (e.g. skills training) and other rehabilitation services through MCO?	
377.	B 4 (c) (a)(i)	p. 34	Why should “disability” not be included in the definition of “MCO must not discriminate”…, as ‘disability” is the norm in non-discrimination clauses and should be included as a matter of equity and with reference to the federal law, Americans with Disabilities Act, ADA?	IV.B.4.a.i fulfills federal regulatory requirement 42 CFR 438.6(d) regarding prohibitions against enrollment discrimination. The prohibition against discrimination on the basis of health history, health status, and need for health care services is inclusive of members with disabilities.
378.	B 4 (c) (a)(i) B 2 (c)	p. 34 p. 33	Will all materials, e.g. member guidebook, plan matrix, provider directory and any program or other materials be made available in alternative formats and publicized in a way that members who need	Yes. The State will address this via the contracted enrollment broker. This is outside the scope of this RFP. However, the enrollment broker services RFP will be bid out at a later date.

			alternative formats know these materials are available and accessible to them?	
379.	Glossary	p. ix	If “advance directives” are used, are they part of an education and publicity program so that individuals are aware of them, create them correctly and include specific behavioral health and medical issues and are individualized for personal needs, such as a pet needing to be fed, flowers watered, etc., recognize that this is a legal document to be stored in a safe place, are assisted in notifying and leaving a copy with all their providers, and are offered whatever assistance the individual needs to have the Advance Directive honored in its entirety, is this available within the scope of this process?	Please see Section IV.F.12 of the RFP.
380.			Will there be an “Ask a Nurse” by whatever name but retaining the function, be created and available cost-free, and publicized to the members within the scope of this process?	See Section IV.F.2 Member Services Call Center.

381.			LB107 was passed and made into law in 2015, eliminating the need for Nurse Practitioners to be supervised by a Physician, yet the definition of Primary Care Provider (PCP) in the RFP references that old system: "Primary care provider (PCP) : A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology." Additionally, on the	See response to Question #2.

			requirements for the Primary Care Mental Health (PCMH) practice – am I reading it correctly that in order for a practice to qualify, that it must include a physician? Again, NPs in Nebraska can now practice without physician supervision as per LB 107 and are providing significant portions of primary care services particularly in the rural areas of our state. There is substantial research supporting NPs as PCMH providers. I am hopeful this is an oversight in the proposed RFP and that NPs are included in the PCMH definitions.	
382			I wanted to know if Non-Emergency Transportation (NEMT) was going to be included in this procurement, or if it was going to be procured separately.	Please see response to Question #82.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM SIX
QUESTIONS and ANSWERS

Date: November 18, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Due to the high volume of the questions, the state is providing the rsponses to questions 1 – 220 at this time. The State will provide responses for the remaining questions at a later date.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.			Our organization is most certainly equipped to do the full-risk physical health managed care program, but we would partner for behavioral and pharmacy. Would this arrangement be acceptable to you?	While the RFP does not prohibit sub-contracting, it does require that MCOs deliver an integrated approach to service delivery and care management.
2.			We have been reviewing the RFP for Medicaid, and it would be very helpful if we could have clarification on the definition of PCMH and also on which provider types can be primary care providers. With the passage of LB 107, NPs no longer have collaborative or supervisory agreements with physicians. So under this definition, NPs would not qualify. NPs offer a great opportunity for patient centered medical homes and also to be defined as a covered primary care provider under Medicaid, which increases the access for this vulnerable population. "Primary care provider (PCP)A medical professional chosen by or assigned to the	See Addendum 3 – Revisions to the RFP.

			member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN).Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology"	
3.			LB 107 was passed into law the last legislative session whereby Nurse Practitioners (NPs) in Nebraska no longer need physician supervision. The law became effective September 1st of this year. If you could explain the inclusion of NP supervision in the RFP (see below) it would be appreciated. It appears that LB 107 would render this	See response to Question #2.

			definition inconsistent with NP practice law: "Primary care provider (PCP) A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology" Additionally, on the requirements for the PCMH practice – am I reading it correctly that in order for a practice to qualify, that it must include a physician? Again, NPs in Nebraska can now practice without physician	

			supervision as per LB 107 and are providing significant portions of primary care services particularly in the rural areas of our state. There is research supporting NPs as PCMH providers. I am hopeful this is an oversight in the proposed RFP and that NPs are included in the PCMH definitions.	
4.	Section II(H), Submission of Proposals; Section III(NN) Proprietary Information	p. 4; p. 23	Please confirm that the State will await the outcome of any objections, legal challenges, or litigation in connection with a FOIA request to obtain proprietary, confidential, or trade secret information submitted in accordance with the instructions in this section before releasing it.	The State will not contact the bidder before responding to a FOIA request. The State will withhold the appropriately identified copywritten materials and proprietary information as identified by the bidder.
5.	Section II(H), Submission of Proposals; Section III(NN), Proprietary Information	p. 4; p. 23	Please confirm that proprietary or confidential information submitted in accordance with the instructions in Section III of the RFP will not be posted for public viewing even if the State disagrees with a bidder's assertion that the information is protected as confidential, proprietary, or a trade secret.	Appropriately identified copywritten materials and proprietary information will not be posted for public viewing. See the response to Question #4. Per Section III, NN Proprietary Information, “Bidders may not mark their entire Request for Proposal as proprietary.”
6.	Section II(H), Submission of	p. 4; p. 23	Please confirm that "non" should be inserted before the	The following language is hereby amended as follows: IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02,

	Proposals; Section III(NN), Proprietary Information		word "confidential" so that this statement should read as follows: "The language above should read "All non-proprietary or non-confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING."	all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or non-confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING.
7.	Section III(E), Ownership of Information and Data	8-9	Some Contractors may have license agreements with other companies for the use of certain proprietary computer software programs. Please confirm that the State of Nebraska will not require Contractor or any subcontractor to violate any aspect of license agreements or other contracts they may have with other companies for the use of certain proprietary computer software programs or make any modification to the proprietary software included in such license agreements or other contracts.	This section requires the Contractor to either own the license or obtain a license to utilize the software or other copywritten material the Contractor intends to use to perform under the contract. Any costs associated with license(s) will be the responsibility of the Contractor.
8.	Section III(E), Ownership of Information and Data	pp. 8-9	Please confirm that the State of Nebraska will not publish, duplicate, use, or disclose a Contractor's confidential, proprietary, or trade secret information without giving the	Subject to State law and the posting of contracts, it is the responsibility of the bidder to properly identify proprietary information as defined by the Nebraska State Statutes. See the response to Question #5.

			Contractor advance notice of its intention to do so and awaiting the outcome of any objection, legal challenge, or litigation that may occur as a result of the Contractor defending its position regarding the confidential and proprietary nature of the information to any appropriate State agency, Court of competent jurisdiction, or in any other appropriate venue.	
9.	Section III(E), Ownership of Information and Data	8-9	Please confirm that the intention of the State is not to have the unlimited right to publish, duplicate, use, and disclose Contractor's intellectual property, confidential, and proprietary information, including, but not limited to, inventions, patents, copyrights, trademarks, trade secrets, trade names, operating systems, policies, proprietary aspects of computer systems, proprietary computer software programs, proprietary software computer system design documents or other system documentation, and coding.	See response to Question #8.

10.	Section III(CC), Administration-Contract Termination; Section III(NN), Proprietary Information	19	Please confirm that the deliverables and/or data and documentation contained in the proposal that shall become the property of the State under either of these provisions do not include intellectual property, confidential, or proprietary information used or to be used in connection with work performed on this Contract, including, but not limited to, inventions, patents, copyrights, trademarks, trade secrets, trade names, operating systems, policies, proprietary aspects of computer systems, proprietary computer software programs, proprietary software computer system design documents or other system documentation, and coding and that upon completion or termination of the Contract, Contractor will be able to retain such information for use in connection with work on other current and future Medicaid contracts nationwide.	If a deliverable is created for the State as required by the contract, then the State owns the deliverable.
11.	III.EE.1 Performance Bond	19	Is the $50,000,000 performance for each region or statewide?	The performance bond is statewide per awarded Contractor.

12.	Section III(NN), Proprietary Information	23	If a particular page of a bidder's proposal or exhibit thereto contains proprietary information, but the page in its entirety is not proprietary, should the bidder redact the proprietary information and submit the remainder of the page with its proposal and then include an unredacted copy in a sealed envelope? If this is not the proper procedure, please explain what process bidders should use when submitting proprietary information included on a page that also contains non-proprietary information.	The bidder may submit the redacted version within the technical response and submit the proprietary information in a separate sealed envelope in accordance with Section III. NN Proprietary Information. See the response to Question #5.
13.	Section III(EEE), License/Service or Other Agreements Section V(A)(2)(j), Sub-Contractors Attachment 5	28-29; 198; Attachment 5, p. 2	Since Section V(A)(2)(j) does not require the bidder to submit subcontractor agreements with the subcontractor information to be submitted with the bid and since Attachment 5 states that subcontracts are to be submitted for review and approval 90 days prior to the contract start date, please confirm our understanding that the "service or other such agreements" that must be submitted with the bid under Section III(EEE) if bidders	Yes, Section III (EEE) does not include bidder agreements with subcontractors.

			wish the State to consider them do not include agreements with subcontractors for the performance of a service or function related to the fulfillment of an MCO's obligations under the contract and that therefore subcontract agreements are not subject to any of the requirements in Section III(EEE).	
14.	Section III(EEE), License/Service or Other Agreements; Section IV(I)(12)(b), Provider Outreach and Application Processing;	28-29; 100	Since Section IV(I)12)(b) addresses what must be submitted with the bid with respect to provider templates, please confirm that the "Service or other such agreements" that must be submitted with the bid if bidders want the State to consider them do not include provider agreements and that therefore provider agreements are not subject to the requirements of this provision.	Provider agreements are not subject to the provision set forth in Section III(EEE).
15.	Section III(EEE), License/Service or Other Agreements	7; 28-29	Please confirm that the State will not view the submission of all "license/service or other agreements" as proposed alterations to the Terms and Conditions but only those that actually conflict with or alter	Any terms and conditions, user agreement, or other document or clauses offered or purport to be included as a part of this RFP shall be subordinate to the original RFP. The Bidder shall specify which clauses the Bidder proposes to incorporate into the contract; documents will not be incorporated in their entirety unless the Bidder states the document is proposed in its entirety. For Bidder proposed clauses to be binding, the State

			the State's Terms and Conditions.	must acknowledge and accept the clause in writing.
16.	Section III(EEE), License/Service or Other Agreements	28-29	Since a reading of contract provisions is subjective and open to interpretation and since the State may view a provision in a license/service or other agreement as conflicting with or altering the State's Terms and Conditions, when the bidder did not intend to alter those terms at all, please confirm that if a bidder submits a "license/service or other agreement" with its bid that the State interprets as conflicting with or altering the State's Terms and Conditions, the State will notify the bidder and provide it with an opportunity to cure the alleged conflict or alteration before determining that the license/service or other agreement is a proposed alteration of the Terms and Conditions that may be cause for a rejection of the bidder's proposal.	Subject to the response in Question #15, the State will compare the terms offered by the bidder to the terms of the State.
17.	Section III(EEE), License/Service or Other Agreements	28-29	Please list examples of the types of "license/service or other such agreements" that must be submitted with the bid under this provision.	Examples may include a service level agreement, user agreements, license agreements and bidders supplemental conditions to the State's Terms and Conditions.

18.	IV.A.1.c Description of Current Program	30	Will these 40,000 individuals that are currently in BH managed care but not PH managed care be enrolled with an MCO starting on 1/1/17? What is the cost by category of service on a PMPM basis for this population in FY 14 and FY 15?	Yes, the individuals currently in BH managed care but not currently in PH managed care will be enrolled in an MCO on 1/1/17. These individuals are categorized in the LTSS (Institutional) – Dual, LTSS (Institutional) - Non-Dual, LTSS (Home and Community Based) – Dual, LTSS (Home and Community Based) - Non-Dual, and Dual aid categories. The FY14/FY15 combined expenditures by services category have been provided for these populations as Attachments 10-C and 10-D.
19.	IV.A.10.h Included Populations	32	How far back will retroactive enrollment be allowed? How will DHHS ensure that MCOs that receive a disproportionately higher percentage of these retroactive members are compensated appropriately?	Retroactive enrollment will be no earlier than the contract start date. The MCO will receive a capitation payment for each month of retroactive enrollment.
20.	IV.A.10.h Included Populations	32	Can DHHS add an indicator on the eligibility file that will designate whether a member is a regular enrollee, an immediate enrollee, or a retrospective enrollee? How were these three cohorts taken into account in rate development?	If the EBS or MMIS has access to this information, it can be added to the file. Current rates do not account for retroactive enrollment. Immediate enrollment is inherent in 17 months of the base data. The remaining 7 months are adjusted to account for immediate enrollment. The adjustment value was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the managed care program after the policy was implemented. Regular enrollees are fully inherent in the base data.
21.	IV.B.4.d. Eligibility and Enrollment (d)	35	Will all newborns be assigned to the same MCO for multiple births?	The Heritage Health Enrollment Broker will facilitate the assignment of multiple births to the same MCO for continuity of care.
22.	D.3. a. and b, 3. Additional Required	50	Are the MCOs permitted to use independently licensed	Yes.

	Staff		behavioral health practitioners to perform prior authorization and concurrent review?	
23.	IV.E.8.b. Rehabilitation services - iv.i)	57	Please provide the definition for Assertive community treatment (ACT) and Alt ACT.	See http://dhhs.ne.gov/medicaid/documents/act.pdf
24.	IV.E.11. Pharmacy Services - c. Nebraska Medicaid Preferred List	59	Can the timeframe be adjusted to 3 business days, by allowing the extension it would provide for adequate testing and quality processes.	Upon initial receipt of the file, an extension of three business days would be acceptable, but thereafter, the file must be uploaded in one business day.
25.	IV.F.13. Communication with New Members, b.ii.	80	Will the MLTC enrollment file list the "responsible party" for each new member? If not, can you explain what methods should be used to determine who is the "responsible party"	Yes, this information will be provided via the enrollment files.
26.	I. PROVIDER NETWORK REQUIREMENTS, 14. Provider Credentialing and Re-Credentialing	100	Currently the TAT for NE Medicaid is that of 45 days from the date of the receipt of a completed application thru Committee review/decision. For the expansion RFP for physical health, behavioral health and pharmacy, the state has a 30 calendar day TAT. Is the state willing to approve a 45 day TAT from receipt of a completed application to match what is currently in place for the NE Medicaid medical providers?	The 30 day TAT requirement will remain as written in the RFP.

27.	IV.L.4. Basic CM Services, e, viii	115	Does the state expect the MCOs to facilitate the development of group visits or help members participate in the existing group visits?	MCOs must facilitate the development of group visits for members assigned to high risk care management.
28.	IV.L.6.b Special Considerations for Pregnant Members	116	What is considered adequate? Is there a specific ratio the MCOs must adhere to?	There are no specific ratios that are required by the MCOs. Attachment 2 includes provider network access standards.
29.	IV.N.5. Service Authorization for Pharmacy Services	128	Please clarify what is meant in 5.a.iii by "Process Supporting Tables"	"Process supporting tables" references any proprietary table(s), resource table(s) or any other reference guide(s) used in the evaluation of the call center team for determining approval, denial or dose recommendations of medications.
30.	IV.P.2.i Capitation Rate Determination Process, i	143	What is the net rate increase comparing the current managed care rates to the RFP rates on an apples to apples benefit basis -- ignore pharmacy, behavioral health, and LTSS rate cells? What is the trend that was applied? How does this trend compare to the actual managed care trend experience from FY 2014 to FY 2015?	Growth rates for the current managed care rates in physical health from FY2014 to FY2015 are influenced by policy decisions such as immediate enrollment. This is expected to be a one-time impact, as such the assumed growth rates as indicated in the RFP and will commensurate with historical growth rates seen in the program.
31.	IV.P.4. Transplant Services	144	Will there be separate compensation for transplants? Case rate?	Costs associated with transplants are carved into the base data and are included in the capitation rates shown in Attachment 11. There will not be a separate case rates paid for transplants.
32.	IV.P.8.a Risk Adjustment	145	What risk adjustment methodology will be used after the first contract year? We recommend a methodology that is widely used and includes pharmacy	MLTC will work with the Actuaries and the MCOs in determining the best risk adjustment tool for the Heritage Health program.

			encounters such as CDPS + Rx.	
33.	IV.P.9.c Risk Corridor	146	Can you please define the qualifying revenue? Will the qualifying revenue exclude the 1.5% QPP hold back?	See Page xv of the RFP for the definition of qualifying revenue (for the risk corridor calculation). Since the 1.5% QPP hold back is not considered earned income, it will not be included in the risk corridor calculations.
34.	IV.P.11.c. State Performance Penalties	147	Please confirm that the provisions to appeal liquidated damages assessments identified in Section 2.i. on page 184 apply to this provision.	The provisions in Section IV.V.2.i would apply to the liquidated damages listed in Section IV.P.11.c.
35.	6. Value-Based Contracting, c.	150	Please define "risk- sharing".	Risk is defined as the chance or possibility of gain or loss associated with caring for a given population. A MCO awarded under this RFP will be at risk for whatever volume of care is provided to its members. A risk-sharing agreement with a network provider is one in which the MCO transfers some portion of risk to a network provider, such as payment of a fixed rate for which the network provider is to provide or arrange care for an assigned group of members.
36.	IV.Q.15 Payment for Emergency Services	153	Please clarify the definition of a "medical emergency."	The definition of "medical emergency" is synonymous with the definition of "Emergency medical condition", which can be found in the Glossary of Terms on page xi.
37.	IV.Q.16.a Pharmacy Reimbursement	153	What is the average dispensing fee for non-independent pharmacies? What is the percentage of non-independent pharmacies assumed in the rate development? What is the basis for the dispensing fee reduction estimate in the rate	Non-independent pharmacies were assumed to have a $2.50 dispensing fee and independent pharmacies were assumed to have a $4.45 dispensing fee. The independent pharmacy dispensing fee is the State FFS dispensing fee set for independent pharmacies. The $2.50 non-independent pharmacy dispensing fee is based on discussions with the state and research of other states. In Rating Region 1, 85% of prescriptions were filled by non-independent pharmacies. In Rating Region 2, 58% of prescriptions were filled by non-

			development?	independent pharmacies.
38.	IV.Z.1 Claims Broker Services	192	What is the current administrative cost paid on a per claims basis by DHHS? How will the per claim administrative fee paid to the CBS be determined?	Due to the current MMIS system, the State does not have current administrative costs paid on a per claim basis. Please see RFP Section IV.Z.1 for determination of the administrative fee paid to the CBS.
39.	V(A)(2)(e), Relationships with the State	197	Please confirm that for purposes of this question "any dealings with the State" is limited to contracts entered into with the State or other projects or initiatives the bidder, its organization, or any predecessor or party named in the bidder's proposal has worked on with the State in the last five years, and does not include day-to-day contact with State personnel related to existing contract requirements, obligations, or administration.	Section V.A.2.e pertains to contracts entered into between the State and the bidder.
40.	V(A)(2)(g), Contract Performance	197	Please confirm that contracts terminated for default must be reported for bidders and any proposed Sub-Contractor, but information regarding contracts terminated for convenience, non-performance, non-allocation of funds or any other reason, is required of the bidder only,	Per Section V.A.2.g, the bidder must provide if they or any proposed sub-contractor has had a contract terminated for default during the past five (5) years as detailed in this section. The bidder must provide if they have had a contract terminated for convenience, non-performance, non-allocation of funds, or any reason.

			since in the ordinary course of business contracts terminate for reasons other than default every day and requiring this information of each subcontractor could result in inundating the State with volumes of information.	
41.	V(A)(2)(g), Contract Performance	197	To avoid inundating the State with information for lines of business unrelated to the current RFP, please confirm that the State is seeking information regarding terminations of contracts for services related to Medicaid/CHIP programs only.	Per Section V, A, 2, g, “It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder’s position on the matter.”
42.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Is this question seeking two separate items: (1) a summary matrix; and (2) narrative project descriptions; or, is this question seeking one item (e.g., a summary matrix of bidder's experience in a tabular format to include the information requested in subparts (a)-(e) above)?	The summary matrix should consist of the items listed in subparts a – e.
43.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Please confirm that the "summary matrix" sought in this question should be in tabular form and include the information enumerated in subsections (a)-(e).	The summary matrix may be in a tabular form.
44.	V(A(2)(h), Summary of	197	Please confirm that the	The bidder may submit more than three (3) projects, but the State

	Bidder's Corporate Experience		"summary matrix" sought in this question, which bidder is interpreting as a tabular summary of its experience to include the items listed in subsections (a)-(e), can include more than three projects.	will use no more than three (3) narrative project descriptions. The bidders are discouraged from submitting more than three (3) project descriptions.
45.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	For what time period or "look back period" should bidders report the information requested in this section?	The State does not identify a time period.
46.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Please confirm that bidders are permitted to provide more than three (3) narrative project descriptions of other projects and experience from which the State will then choose no more than three (3) on which to evaluate the proposal.	See the response to Question #44.
47.	V(A)(2)(h)(i)(e), V(A)(2)(h)(ii), and V(A)(2)(h)(iii) Summary of Bidder's Corporate Experience	198	Please confirm that the reference to "Sub-Contractors" and "Sub-Contractor(s) experience" refers only to bidders' experience as a subcontractor, as opposed to a primary contractor, on similar projects and that bidders are not required to provide summary matrices and/or narrative project descriptions regarding previous similar projects for	Corporate Experience is the bidder's role as the prime Contractor and/or as the role of the Sub-Contractor.

			each of their proposed subcontractors.	
48.	Attachment 11 – Rates	Attachment 11	In the effort to maintain transparency, can DHHS share the capitation rate calculation sheet that was used to trend the base data and adjust it to the rates in Attachment 11?	See Attachment 20: "COA-level Rate Development" for the step-by-step development of the rates at a COA level.
49.	Attachment 12 - Historical Transplant Cost Distribution Data	Attachment 12	Please provide the transplant data separated by year. Has there been an increase in transplants in recent years versus earlier years? How has this been accounted for? By placing the transplant costs in the capitation rates, how will DHHS avoid underpricing the transplant costs for an MCO that receives a disproportionate share of overall transplants? We recommend a transplant kick payment instead of an adjustment to all members' capitation rates to more equitable compensate MCOs for their incurred costs. We also recommend transplant kicks that vary by type of transplant -- heart, bone marrow, lung, intestine, kidney, or pancreas/kidney.	Transplant costs by year are: $5.4 million in FY10, $4.5 million in FY11, $7.1 million in FY12, $7.6 million in FY13, and $6.0 million in FY14. MLTC does not intend to use a transplant kick payment. Bidders may purchase reinsurance or take other appropriate steps to mitigate the risk of fluctuation in the costs of transplants.
50.	Attachment 19, Proposal Statement	Attachment 19, p.1	Please confirm that the information sought from	The information sought is that related to Medicaid or CHIP contracts.

	and Questions, No. 2		bidders' parent company, affiliates, and subsidiaries in response to Question 2 includes only regulatory actions, monetary or non-monetary sanctions, letters of deficiency, and corrective actions related to Medicaid/CHIP contracts.	
51.	Attachment 19, Proposal Statements and Questions, No. 3	Attachment 19, p.1	Please confirm that the information sought from bidders' parent company, affiliates, and subsidiaries in response to Question 3 includes only investigations related to Medicaid/CHIP business.	See response to Question # 50.
52.			As a business owner this who would like to be able to accept Medicare and Medicaid patients someday, the language of this is limiting and very concerning to me. "Primary care provider (PCP)A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family	See response to Question #2.

			practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN).Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology" I am a Family Practice Nurse Practitioner. I own my own practice and provide care to over 300 patients. As Nebraska law allows, I do not have a supervising physician. I would like to be able to accept both Medicare and Medicaid insurance someday, but as of yet, they are not in agreement with Nebraska law. Thank you for taking this matter into your immediate consideration.	
53.	Glossary - Related-party	xv	The examples provided for "related-party" include "subcontractors to the MCO	Related-party: The parent company of a MCO or an entity partially or wholly owned by the MCO or the MCO's parent company that receives any revenue from the MCO for Medicaid

			performing services under this contract." Please clarify that this would apply only to subcontractors owned, either wholly or partially, by the MCO or its parent company and not to third party subcontractors.	contracted services. Examples of related parties include a clinic wholly or partly owned by a MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract. Yes, it relates to subcontractors wholly or partially owned by the MCO or its parent company. This does not include independent third party subcontractors.
54.	Request for Proposal for Contractual Services Form; IV.H-Submission of Proposals; IV.NN-Proprietary Information	i, 4, 23	"All non-proprietary or confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING." Should this read, "All non-proprietary or NON-confidential information…?"	See response to Question #6.
55.	II.H Submission of Proposals	4	Please verify that the Bidder must submit only one copy of the original proposal and that an electronic copy of the response is not required.	The bidder must submit one original of the entire proposal response. An electronic copy is not required.
56.	II.H Submission of Proposals	4	Is there a font style and font size that the Bidders must adhere to when responding to this RFP?	There are no such requirements.
57.	II.H Submission of Proposals	4	Is there a specific section in the Binder where the Bidder should attach the additional forms - Form A, Contractual Services Form, and the Confidentiality Sheet - or should they be included in a separate tab(s)?	The Contractual Services Form, Form A, and the Confidentiality Sheet should be included as a separate identified tab within the bidder's proposal response.
58.	III Terms and Conditions	7	"… a bidder may indicate any exceptions to the Terms and	No, a statement recommending terms and conditions that

			Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. Would "a statement recommending terms and conditions the bidder would find acceptable "constitute a "rejection in whole or in part"?	bidder would find acceptable does not constitute a rejection. The bidder should provide alternative(s) for the State's consideration.
59.	III.J Contractor Personnel	12	"Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State." Please clarify whether this applies to any personnel changes (individual staff, staffing levels due to changes in membership, etc.) or if it can be limited to changes of substance (key personnel, general staffing ratios, etc.).	Per Section III, J Contractor Personnel, "Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications."
60.	III.II Taxes	21	"The State is not required to pay taxes of any kind and assumes no such liability as a	No. The Health Insurer Tax will be incorporated in future rate setting cycles.

			result of this solicitation." Does this provision extend to the Health Insurer Tax enacted through the Affordable Care Act?	
61.	IV. A.1.g.ii Description of Current Program	31	Would pharmacy services have a different start date than physical health services? Please confirm the expected start date for pharmacy services.	The anticipated start date for pharmacy services is January 1, 2017. The State reserves the right to adjust the start date of pharmacy services at its discretion.
62.	IV.4A.1.g.iii Description of Current Program	31	Are Aged, Blind, and Disabled persons, whether dually eligible for Medicaid and Medicare, in a home and community-based services waiver program, or living in an institution, included in managed care only for physical health services and not for behavioral health services or pharmacy services?	All populations included in Heritage Health will have the Heritage Health benefits package, including physical health, behavioral health, and pharmacy services. The ABD population (including those who are dually-eligible, those receiving HCBS services, and those living in ICF/DDs) is included in Heritage Health.
63.	IV.4A.1.g.iii Description of Current Program	31	This population will be included "for managed care physical health services"; will the MCO be responsible only for physical health services and not facility, behavioral health, NEMT or other services?	Section IV.A.1.g.iii is hereby amended as follows: "Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for integrated physical health, behavioral health, and pharmacy services."
64.	B.4.d.iii Eligibility and Enrollment - MCO	35, 144	Are there any time limits that would apply to enrollment and/or capitation payment	See response to Question #19.

	Enrollment Procedures IV.P.3.b MCO Reimbursement - Capitation Rates and Payment		retroactivity regarding both the enrollment transaction as well as the ensuing capitation payment?	
65.	B.5.g Eligibility and Enrollment - PCP Assignment	36	Please clarify whether it may be possible for a provider to participate with Medicare and not Nebraska Medicaid?	All providers must be Nebraska Medicaid enrolled to participate in or be reimbursed by the MCO.
66.	B.5.g Eligibility and Enrollment - PCP Assignment	36	If a dual eligible member is obtaining services from a non-par PCP, will the plan be required to continue paying for those services at the Medicaid fee schedule?	See Section IV.S.15.a.x. and Section IV.S.17 for requirements related to dual eligible members.
67.	B.6.b Eligibility and Enrollment - MCO Changes	36	Does this mean that, regardless of a member's anniversary date, their open enrollment period would always be in December?	For the duration of the contract, the annual enrollment period will take place in December for all Heritage Health members.
68.	IV.D.3.a & IV.D.3.b Staffing Requirements - Additional Required Staff	50	Are the requirements under section 3a and 3b referring to medical and pharmacy staff or just medical?	Sections 3a and 3b are referring to medical staff.
69.	IV.D.3.a & D.3.bStaffing Requirements - Additional Required Staff	50	Is Nebraska state licensure required for all Prior Authorization staff and concurrent review registered nurses, including Pharmacy?	MLTC will provide this answer in the second round of questions for this RFP.
70.	IV.4E.8.a.xix Covered Services and Benefits - Core Benefits and Services	55	What are the definitions of "skilled services", "rehabilitative services", and "transitional nursing facility services" which must be	These services are defined as those meeting requirements outlined in 42 CFR 409 Subpart D, Requirements for Coverage of Post-hospital SNF Care.

			provided as a minimum benefit package?	
71.	IV.4E.8.a.,IV.4E.28, Iv.4E.29.b & 4E.29.b Covered Services and Benefits - Core Benefits and Services, Medical Transportation Services, and Excluded Services	54-55 66-67	Custodial nursing facility services are listed as excluded services. What core benefits and services are MCOs to provide to members who are residents of nursing homes but are receiving custodial services? For example, are MCOs required to provide emergency and non-emergency ambulance services to such members?	A MCO is to provide all core benefits and services with the exception of those included in the nursing facility per diem. Services included in the nursing facility per diem can be found at 471 NAC 12-009.05 http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-12.pdf
72.	IV.4E.8.a, IV.4E.29.e Covered Services and Benefits - Core Benefits and Services and Excluded Services	54-55 66-67	Home and community based services are not included as a part of the core benefits or services. What core benefits and services are MCOs to provide to persons receiving home and community based services?	A MCO is to provide all core benefits and services to persons receiving home and community-based services.
73.	IV.E.11.b.ii Covered Services and Benefits - Pharmacy Services	58	Does this include any changes post 1/1/17? Does this include post P & T formulary changes? Please confirm what is considered a "change".	Any modifications of drug coverage must be submitted for review and approval at minimum 30 days prior to implementation. Notice may be less than 30 days during the first month of implementation.
74.	E.11.b.iv.c Covered Services and Benefits - Pharmacy Services	58	Please confirm that the posting of the MAC list would occur behind a secure channel for providers.	The State confirms that the MCO MAC list is not required to be posted publicly, but the MCO must maintain a website and post current and accurate information, including the MAC pricing, to be available to the State and provider network.

75.	E.11.b.i Covered Services and Benefits - Pharmacy Services	58	The language in this section states that all formulary policies and procedures must be submitted to MLTC for approval, but the RFP states that the MCO must follow the State's PDL. Please clarify as to when this scenario would occur.	See Glossary of Terms for the definitions of PDL and Formulary. The State's PDL is not an all-inclusive list of therapeutic categories. The MCO must cover the medications listed on the State's PDL, but will also need to maintain a formulary that covers medications not listed in the PDL. Refer to the following link for additional information: http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx
76.	E.11b.iv.a Covered Services and Benefits - Pharmacy Services	58	Please confirm that the MCO formulary would need to be posted on the website, since the MCO is required to follow the State's PDL?	The MCO will be required to post and maintain the most current and accurate MCO formulary on their website. The State PDL must also be posted.
77.	E.11.b.vi Covered Services and Benefits - Pharmacy Services	59	Given that newly available medications may not be available in First Data Bank, they cannot be coded or processed yet at the point of sale, so the MCO may not always be able to fulfill the 10 day requirement. Please clarify any exceptions to this requirement.	The MCO has 10 days to implement coverage after a new drug has been loaded on a National Drug Reference File.
78.	E.11.c.iii Covered Services and Benefits - Pharmacy Services	59	Please provide additional information on the volume of changes expected.	PDL files will be shared with MCOs on a weekly basis. Large-scale PDL possible changes occur biannually in conjunction with P&T meetings.
79.	E.11.c. vi Covered Services and Benefits - Pharmacy Services	59	Please clarify if this provision would prohibit the MCO from negotiating supplemental rebates, in addition to the Medicaid rebates that pharmaceutical companies	MCOs may negotiate supplemental rebates for medications outside of the State's PDL. MCOs are prohibited from negotiating supplemental rebates for any medications listed in the State's PDL.

			are required to provide.	
80.	IV.E.19.a Covered Services and Benefits - Limitations on Abortions	64	Confirm that MLTC Medical Director must also review all approvals for elective abortions prior to determination notification to the requesting provider. If so, (a) how does the plan send, (b) what is required to be sent to the MLTC Med Director and (c) what is the expected turnaround time from the MLTC Med Director? Also, who will provide reviews if the MLTC Med Director is out of the office?	The State is currently establishing this process and will be provided to the awarded contractors.
81.	IV.E.21 Covered Services and Benefits – Transplants	65	Is the MCO required to follow Medicare policies for transplants (i.e. - the RFP states that if Medicare does NOT have a policy the MLTC Medical Director will determine).	The MCO must cover transplants (including donor services) that are medically necessary and defined as non-experimental by Medicare. Per Section IV, E.21, "As required by 471 NAC 18-004.40, the MCO must cover transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental."
82.	IV.E.28.a Covered Services and Benefits - Medical Transportation Services	66	The section states that NEMT is only covered for medical transportation by an ambulance; however, the other NEMT are not listed under Excluded Services IV.E.29, page 66/67. Please clarify.	See Addendum 3-Revisions to the RFP.
83.	IV.E.29	66-67	Eligible populations include	The MCO is responsible to provide all services in the core

	Covered Services and Benefits - Transplants		“Medicaid beneficiaries who participate in a HCBS Waiver program"; however, all HCBS waiver services are excluded from MCO responsibility. Which party will be financially responsible for any HCBS services for waiver-eligible individuals that are assigned to a “wait-list?”	benefits package and any value-added services as approved by the State for its members. This responsibility is not affected by the member’s waiver status.
84.	IV.F.2.b.v, IV.F.2.xi. Member Services and Education - Member Services Call Center	69	Please confirm that the lines on Section IV.F.2.b.v and IV.F.2.xi were left intentionally blank.	The lines were unintentionally left blank. No requirements are missing or intended for these numbers.
85.	IV.H.7.a. and IV.H.7.c Member Services and Education - Access to State Fair Hearings	92	Please clarify if the member is required to exhaust the plan’s internal appeal process prior to submitting a request for a State Fair Hearing?	The member is required to exhaust the plan's internal appeal process prior to submitting a request for a State Fair Hearing.
86.	IV.I.4.i Provider Network Requirements - Establishing the Network	96	"The MCO must strive to improve the ability of its behavioral health provider network to meet all the health needs of members through strengthened collaboration with PCPs, service providers, inpatient hospital providers, and consumer/peer providers.” Will the State allow providers to bill for same-day services for physical health and behavioral health visits when co-located in the same provider office?	Yes.

87.	IV.I.4.i Provider Network Requirements - Establishing the Network	96	Please further clarify what will constitute "collaboration with the DHHS Division of Behavioral Health and State behavioral health regions"	Collaboration will include, but is not limited to, a commitment by the health plan to participate in meetings or on committees that identify barriers and solutions that supports the level of care needed by Medicaid clients and other clients served by the Division of Behavioral Health.
88.	IV.I.13 Provider Network Requirements - Provider Enrollment in Medicaid	100	Please clarify whether a provider who has applied for MLTC enrollment but is not yet enrolled AND is credentialed by the MCO may see patients, or whether the MCO must wait until MLTC enrollment is complete.	MLTC enrollment must be complete in order for a provider to see patients. The MCO has the option to authorize services out of network until the MCO credentialing is complete.
89.	IV.J.3.a.ix Provider Services - Provider Handbook	104	Are the "medical record standards" to be included in the Provider Manual those that are reflected in the RFP (i.e. - applicable to MCOs) or are there separate regulatory requirements for physicians?	The medical records standards are to be included in the Provider Manual and must include all standards set forth in the RFP and all applicable regulatory requirements.
90.	IV.M.11 Quality Management - Member Advisory Committee	124	Please clarify who would be considered a member's representative, for purposes of fulfilling the requirements of the Member Advisory Committee.	See Page xvi in the Glossary of Terms for the definition of Representative.
91.	IV.M.12 Quality Management - Clinical Advisory Committee	124-125	Does the State intend for plan members to participate on this committee as well? There is a reference to "members" but it's unclear whether it is intended to mean members of the	Plan members will not participate in this committee. This reference to member refers to members of the committee.

			committee or members of the plan.	
92.	IV.N.2.f Utilization Management - UM Program Description	126	Please clarify the statement regarding involvement of "actively practicing", board certified physicians in the program to "supervise" ALL review decisions and review denials for medical appropriateness. Is it the intent of MLTC that this section is referencing the physicians that should participate in the Clinical Advisory Committee/UM Committee or actual practicing providers that are reviewing UM decisions?	Active practicing providers must supervise all UM review decisions and review denials for medical appropriateness.
93.	IV.N.11.b Utilization Management - Restricted Services	131	Please confirm the type of restriction program: pharmacy, provider, or both?	See NAC 471 NAC 2-004 for categories of pharmacy and provider restriction. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-02.pdf
94.	IV.O.1.h Program Integrity - General Requirements	133	The RFP states that "The MCO, as well as its subcontractors and providers, whether contracted or non-contracted, must comply with all Federal requirements (42 CFR 455) about disclosure reporting." Please clarify the MCO's responsibility with respect to non-contracted providers.	The MCO's responsibility is the same for both contracted and non-contracted providers.

95.	IV.O.1.j Program Integrity - General Requirements	133	The staffing ratio required under the Program Integrity section is one (1) investigator for every 50,000 or fewer members; however the Staffing Requirements section (IV.D.3.i,p.51) states a ratio of one investigator for every 100,000 members or less. Please clarify which requirement the MCO should abide by.	The MCO is required to comply with the ratio requirement of one (1) investigator for every 50,000 or fewer members as stated in Section IV.O.1.j. Section IV.D.3.i is hereby amended as follows "The MCO must have a minimum of one investigator for every 50,000 members or less."
96.	IV.O.3.a.ii. Program Integrity - Prohibited Affiliations	134-135	The cited section identifies those parties with whom an MCO may not knowingly have a relationship. The listed parties include the following: "An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of: a) A director, officer, or partner of the MCO. b) A person with beneficial ownership of 5% or more of MCO equity. c) A person or entity with an employment, consulting, or other arrangement with the MCO under its contract with the State. " Please confirm that a company, such as a parent or affiliate company, would not	A parent or affiliate company is not considered a person with respect to this requirement.

			be considered a “person” with respect to this requirement.	
97.	IV.O.15.b Program Integrity - Investigative Collaboration	140	Please clarify whether the ten year timeframe for investigation is limited only to that timeframe in which the MCO had a relationship with the applicable member or provider.	The ten year timeframe applies to the MCO and a parent or affiliate company's relationships with a provider.
98.	IV.P.2.e MCO Reimbursement - Capitation Rate Determination Process	142	Categories of eligibility include those individuals receiving LTSS, both institutional and home and community-based services. Please clarify those covered services for these categories of eligibility that the MCO will be responsible for.	The services covered for these individuals are outlined on page 54 of the RFP, Section IV.E.8. This includes physical health services, behavioral health services, and pharmacy services, and excludes NEMT non-ambulance, dental services, and long term services and supports.
99.	IV.P.5.g., IV.P.5.i MCO Reimbursement	144	"The supplemental payment for deliveries is intended to reimburse the MCO for five (5) months of prenatal care, the delivery, and two (2) months of post-partum care.” “The MCO must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.”	Yes, the supplemental payment will be issued to the MCO in which the mother is enrolled at time of delivery if maternity care (prenatal and/or post-partum care) is rendered by another MCO. The supplemental payment is initiated by the MCO sending maternity care information in the Maternity Care Payment file. In the absence of a hospital inpatient stay the MCO may submit other inpatient or outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.

			Will the supplemental payment be issued to the MCO in which the mother is enrolled at time of delivery if maternity care (prenatal and/or post-partum care) is rendered by another MCO? Does the encounter data for maternity care and the delivery need to be submitted by the same MCO in order to trigger the supplemental delivery payment?	
100.	IV.P.12.a MCO Reimbursement - Administrative Cap	148	"Per Neb. Rev. Stat. §71-831, 68-908, and 71-801 (2012), the MCO's administrative spending must not exceed 7%, except up to an additional 3% is allowed, if the additional amount is for the purpose of quality improvement and approved by MLTC." Please describe the MLTC approval process to determine whether certain administrative spending would qualify for "the purpose of quality improvement." Will there be a mechanism for this approval prior to submission of the RFP response? Additionally, the statutes cited above appear to refer to behavioral health services	Attachment 5 is hereby amended to include a Quality Administrative Expenses proposal for review and approval of quality activities for consideration in the 3% admin cap. The proposal is due 120 days prior to contract start date. The provision related to the Administrative Cap applies to all administrative expenditure.

			only. Does this provision related to the Administrative Cap apply to all administrative expenditures or just those specifically related to behavioral health services?	
101.	IV.P.12.e MCO Reimbursement - Administrative Cap	148	"Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation." Does this include both the holdback associated with the MLTC Quality Performance Program (1.5% of the aggregate of all income and revenue) as well as the State Performance Penalties (0.25% of the aggregate of all income and revenue)?	See response to Question #33.
102.	IV.Q.6.b Provider Reimbursement - Value Based Contracting	150	Please confirm that the 30% and 50% of the provider network measures that relate to Value-Based Contracting, refer to the number of contracts or providers and not the number of members.	30% and 50% of the provider network refers to the number of providers.
103.	IV.Q.6.b Provider Reimbursement - Value Based Contracting	150	Does this include all provider types? How is the denominator determined? Is it practitioners only or does it also include facilities?	The denominator includes all providers within the MCO's network.
104.	IV.Q.10 Provider Reimbursement -	152	Medicare cost reports are not prepared until well after the CAH's fiscal year end. Is the	MCOs are to use the cost report provided by DHHS Financial Services for cost settlement activities with CAHs.

	Critical Access Hospital Contracting and Reimbursement		MCO to use a mechanism other than the Medicare cost report? If the Medicare cost report is to be used, is the MCO to use the “as-filed” cost report, or the cost report that was audited and settled by CMS?	
105.	IV. Q.17.c Provider Reimbursement - Maximum Allowable Cost Program	153	Would the MCO be able to provide the information behind a secured connection on the MCO's website?	See response to Question #74.
106.	IV.R.8.d.iv Systems and Technical Requirements - Provider Enrollment	157	Please specify what, beyond including a provider's NPI, what specific "NPI requirements" must be included in the provider enrollment system?	Any NPI requirement that is transmitted to the MCO through State interface file must be included in the provider enrollment system.
107.	IV.S.15.f.i Third-Party Liability	176	Does the 365 day timeframe apply to overpayment recoveries for any reason, or only circumstances where TPL recoveries have not been successful?	The MCO is expected to recover overpayments for any reason within 365 days. If the MCO is unsuccessful in recovery after 365 days, MLTC may pursue recovery.
108.	IV.T.3.b Reporting and Deliverables - Information Related to Business Transactions	177	Please clarify what will constitute "full and complete information" that must be provided regarding ownership of subcontractors. Also, what would MLTC consider a "significant business transaction" between the MCO and a wholly owned supplier?	Full and complete information includes all information necessary to address disclosure requirements in IV.T.3.b.i and IV.T.3.b.ii. "Significant business transaction" is specified in IV.T.3.c.

109.	V.A.2.j Proposal Submission - Corporate Overview	198	Is there a threshold (percentage of revenue or dollar amount) that would apply to Subcontractors that should be identified for this requirement? Is this requirement limited to Subcontracts for certain services (e.g. care management or coordination services)? Does this requirement exclude providers contracted for participation in the Managed Care Organization's provider network?	Providers are not considered subcontractors. Bidders should address subcontracting in Attachment 19 on Questions #56 and #57.
110.	Attachment 6: Reporting Requirements Provider Grievances	Attachment 6, p.2 of 10	Please clarify that the Provider Grievance System (Appeals and State Fair Hearing) are intended to report the provider filing on the member's behalf only.	The Provider Grievance System reports for Appeals and State Fair Hearings are meant to summarize provider-related appeals and provider-related state fair hearings. Providers acting on behalf of members in appeals and state fair hearing proceedings would be summarized in the Member Grievance System reports.
111.	Attachment 11 – Rates	Attachment 11, Page 1 of 1	What are the dollar values of the transplant costs included in the Medical PMPMs shown in Attachment 11 – Rates?	The dollar value of the transplant costs in the medical PMPMs is $5.5 million in Rating Region 1 and $1.6 million in Rating Region 2.
112.	Attachment 11 – Rates	Attachment 11, Page 1 of 1	Please show the components of the Maternity and Katie Beckett non-medical loads separately by Admin, Quality Improvement, Performance Guarantee and Profit/Risk/Contingency as	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region.

			shown for the composites in the Optumas Bidders' Conference Rate Presentation page 15.	
113.	Attachment 12 - Historical Transplant Cost Distribution Data	Attachment 12, Page 1 of 1	Are the transplant costs shown in Attachment 12 for the four-year period SFY2010-SFY2014 in total? If so, what are the costs by each SFY? What are the costs by Region?	Transplant costs in Attachment 12 are for the five year period SFY10 to SFY14. Transplant costs by year are: $5.4 million in FY10, $4.5 million in FY11, $7.1 million in FY12, $7.6 million in FY13, and $6.0 million in FY14. Costs by Region are not available.
114.	Attachment 13 Neb. Rev. Stat. 71-831	Attachment 13, p.1 of 1	Please verify that the restrictions contained in this statue apply specifically to behavioral health services and not to the broader scope of services to be provided by the Medicaid Managed Care Organization.	As the statute is currently written, the provisions of the statute would apply to the full scope of services.
115.	Attachment 13 Neb. Rev. Stat. 71-832	Attachment 13, p.1 of 1	"(2) Provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that (a) profit shall not exceed three percent per year and (b) losses shall not exceed three percent per year, as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidy companies and risk-bearing partners, under the contract;" Please verify that the	This restriction is limited to only those revenues derived from this specific contract. The State will determine the compliance review process during readiness review.

			restrictions on profits and losses applies to the contractor and related parties, including parent and subsidy (sic) companies. Please clarify that this restriction is limited to only those revenues derived from this specific contract. How will the State measure or validate compliance with this requirement?	
116.	Attachment 15 - Medical Loss Ratio	Attachment 15, Pages 1 and 2 of 2	Will the 85% Minimum MLR requirement be calculated as an aggregate of Regions 1 and 2 or separately for each region?	The 85% Minimum MLR requirement will be calculated as an aggregate of Regions 1 and 2.
117.	Attachment 15 - Medical Loss Ratio	Attachment 15, Pages 1 and 2 of 2	Will the 85% Minimum MLR be aggregated over all categories of aid or separated for LTSS versus Non-LTSS subgroups?	The 85% Minimum MLR requirement will be calculated as an aggregate of all categories of aid.
118.	General - Capitation Rate Development	N/A	Please provide an example for the calculations flow from base data to final capitation rates, including how adjustments and trends are applied.	All adjustments applied to the base data to develop the final capitation rates have been provided to the bidders as part of the pre-proposal conference presentation. See Attachment 20: “COA-level Rate Development” for the step-by-step application of these adjustment values to the base data. The Effective Trend Days shown in this document represent the effective number of days needed to trend the base data to the contract period given the different base periods for Physical Health, Behavioral Health, and Behavioral Health Foster Care. Trend is applied at a COS-level, with each COS being trended for the appropriate number of days.
119.	Attachment 19	Attachment	For those questions with	Attachments will not count toward the questions' page limits as

	Proposal Statements and Questions	19	page limits, would attachment(s) count towards the question's page limit? Is there a page limit on attachments?	there is not page limits on attachments.
120.	Attachment 19 Proposal Statements and Questions	Attachment 19 p.2 of 21	Please confirm that the correct RFP Section Reference for Question#10 should read "IV.C Business Requirements" (and not IV.B).	The RFP Section Reference for Question #10 is hereby amended as follows: "IV.C Business Requirements."
121.	Attachment 19 Proposal Statements and Questions	Attachment 19 Page 1 of 21	Please confirm that the correct reference for question #5 is Section III. F., not III.G.	The RFP Section Reference for Question #5 is correct as listed. The RFP Section Reference for Question #4 in Attachment 19 is hereby amended as follows: "Section III.F Insurance Requirements".
122.	5151Z1 Evaluation Criteria Attachment	Evaluation Criteria p.2	Please verify that only the “top-scoring bidders” may be invited for oral presentations at the State’s discretion as stated in Section II.G on page 3. If the State opts to proceed with oral presentations, will all “top-scoring bidders” be invited for oral presentations in order to allow for an equitable opportunity among “top-scoring bidders” to earn the 150 points identified in the Evaluation Criteria Attachment?	The State reserves the right to select only the top scoring bidders for oral presentations.
123.	Proposal Statement and Questions	Attachment 19, page 4	Is the work plan requested in this question part of the larger transition/implementation plan, or a stand alone?	The work plan requested should stand alone as a plan for implementation of Pharmacy Services as described in the RFP. It may also be a component of a bidder's larger transition/implementation plan.

124.	Proposal Statement and Questions	Attachment 19, page 5	Will the examples of information that will be available on the member website be counted in the 6-page limit?	Examples of information that will be available on the member website will not be counted in the page limit.
125.	Proposal Statement and Questions	Attachment 19, page 5	Will the examples of member education be counted in the 10-page limit?	Examples of member education will not be counted in the page limit.
126.	Proposal Statement and Questions	Attachment 19, page 5	Will the flowchart be counted in the page limit? If not, please consider extending the page limit as three pages to provide a "comprehensive written description" and flow chart are not likely to be sufficient.	The flowchart will not be counted in the page limit.
127.	Proposal Statement and Questions	Attachment 19, page 11	Please confirm that the page limit excludes the proposed health risk assessment template.	The proposed health risk assessment template will not counted in the page limit.
128.	Proposal Statement and Questions	Attachment 19, page 12	Will the proposed QAPI work plan be included in the 10-page limit?	The proposed QAPI work plan will not be counted in the page limit.
129.	Proposal Statement and Questions	Attachment 19, pg 17	How does the state define "30% of its provider network"? 30% of providers? 30% of contracts? 30% of spend? Other?	See response to Question #102.
130.		Attachment 19	Attachment 19 does not contain any questions related	Confirmed.

			to section IV.G Member Marketing of the RFP (pages 82-87). Please confirm that this correct.	
131.	III.	Page 7	Please confirm that rates are applicable for the initial contract term of six months (1/1/17-6/30/17).	The initial contract term will be 12 months, 1/1/17 – 12/31/17. This is consistent with the rates in Attachment 11, which represent a Calendar Year 2017 contract period.
132.	III.F.3.	Page 10	Please provide details regarding the underlying medical claims so that we may comply with III.F.3.d. For example, please provide member-specific annual spend levels for the over-certain attachment points (e.g., 50K, 100K, 150K, 200K).	The details requested in this question are not available.
133.	III.EE	Page 19	The performance bond amount of $50M appears to be for entire program. How will the amount applicable to each bidder be determined?	Each contract awarded from this RFP will require a $50 Million performance bond. See the response to Question #11.
134.	IV.A.1.f.iii	Page 31	Who is the current enrollment broker?	The current enrollment broker is The Medicaid Enrollment Center
135.	IV.A.1.g.ii.	Page 31	This states that the “Inclusion of pharmacy service in the core benefit package and the MCO capitation rate at a date to be determined by MLTC”; however, Attachments 10A-10D appears to have pharmacy included. Do the	Rates provided include pharmacy. See response to Question #61.

			rates provided include pharmacy? What is the timeline for the pharmacy inclusion?	
136.	IV.B.4.b.ii.and iii	Page 35	This section states that the MCO will not be responsible for services rendered to a member prior to the date of enrollment; however, IV.B.4.h. states that the MCO is responsible for member care on the first day of the month in which eligibility was determined. Will there be a limited amount of time that a member's eligibility will be retro'ed onto managed care?	See response to Question #19.
137.	IV.B.4.c	Page 35	Does the MCO have sole authority to manage and report member status changes or will members still be reporting changes directly to ACCESSNebraska? When contradictory information is reported, what information will be used?	The MCO is responsible for providing information to ACCESSNebraska as set forth in Section IV.B.4.c.i of the RFP. The member is responsible for contacting ACCESSNebraska to report all status changes. The ACCESSNebraska will validate the information when reported.
138.	IV.B.5.d & e	Page 36	Item 5.d outlines conditions for PCP auto-assignments (d.i - d.iii). In 5.e the requirement notes that two situations require the MCO to reach out to the member and ask him/her to make an alternate PCP selection,	The first sentence of Section IV.B.5.e is hereby amended as follows: "If either of the two (2) situations set forth in provision IV.B.5.d.ii or IV.B.5.d.iii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection."

			referring to d.i and d.ii; however, the conditions would suggest that this should actually refer to d.ii and d.iii, since those conditions concern members who have made a PCP selection, whereas d.i concerns members who have not made a selection. Please confirm that requirement 5.e should read: "If either of the two (2) situations set forth in provision d.ii or d.iii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection..."	
139.	IV.E.11.b.vi.	Page 59	Will the state make available and be ready to accept new procedure codes and have rates established so that the MCOs can meet this standard?	The State will accept all valid procedure codes and establish rates so that the MCO can meet this standard.
140.	IV.E.11.b.ix.a	Page 59	Does this requirement intend that all appeal rights would need to be available / exercised within one business day?	Member appeal rights are provided in Section IV.H.
141.	IV.E.12.c	Page 61	In instances in which the MCO must authorize a service not included in the State Plan, would the state be	The State's MMIS accepts any valid procedure codes. Any criteria not previously posted for these determinations must be developed and submitted to MLTC for review and approval in accordance with Section IV.N.4.c. of the RFP.

			able to accept all procedure codes not currently utilized and accept all associated rates? Additionally, would the MCO be supported in utilizing Medical Necessity Criteria not previously posted for these determinations?	
142.	IV.E.28.a.	Page 66	Are NEMT included in the contractor's rates? Are the contractors responsible for NEMT?	See response to Question #82.
143.	IV.E.29.d	Page 67	Please confirm that services rendered in school settings would be excluded.	Per Section IV.E.29, school-based services are excluded.
144.	IV.F.4.d and IV.F.13.b.i	Page 70 and page 80	The requirement for distributing new member materials appears to be within 30 calendar days of enrollment (page 70). However, there is further instruction (page 80) to send welcome packets to new members within 10 business days of receiving the new member file. Please clarify the difference in these requirements.	The first sentence of Section IV.4.d is hereby amended as follows: "The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment." Welcome packets are required to be distributed within ten (10) business days of receiving the member file. Please see Section IV.F.13.b for included requirements. New member materials may be other materials not specified in Section IV.F.13.b and must be distributed within 30 calendar days of enrollment.
145.	IV.H.6.i.b.iii	Pg. 92	Assuming all services will be ordered by an authorized provider, is the intention of this language that a continuation of benefits is	See Section IV.H.6.a. for when the MCO must continue a member's benefits.

			required for all appeals?	
146.	IV.I.2.a	Pg. 94	Does this requirement intend to state that the MCO cannot pay providers of different licensing status different rates? Additionally, does this requirement prevent an MCO from restricting the services eligible for reimbursement for licensed providers when service delivery is within the scope of the practitioner's license?	This requirement is not intended to prevent an MCO from negotiating payment rates based on license type. The MCO may not restrict the services eligible for licensed providers when service delivery is within the scope of the practitioner's license.
147.	IV.J.4.c.ii	Pg. 106	Does this requirement mandate that all services must have online authorization request capability?	Online authorization capability is required for the services the MCO identifies as requiring prior authorization.
148.	IV.L.5.f	Pg. 116	As members are typically not eligible for Medicaid care during a State hospital stay (n accordance with IMD regulation), does this language mandate MCOs to coordinate care for members not eligible for managed care or is the intention to enroll members into managed care while still in State hospitals? Does this expectation extend to transition plans for youth transitioning out of State-run PRTF facilities as well?	Section IV.L.5.f requires the MCO to develop, implement, and evaluate written policies and process consistent with existing State policies and procedures regarding continuity of care. This includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. The expectation for care coordination and transition planning does include youth transitioning out of a State-run PRTF.

149.	IV.N.6.b	Pg. 129	Does this requirement mandate the use of specific set of Medical Necessity Criteria (clinical guidelines) for continued Inpatient stay specifically?	MLTC is not mandating the use of a specific set of Medical Necessity Criteria.
150.	IV.O.1.e.	Page 133	This section requires the MCO to report any suspicion of fraud to NMPI immediately. Section IV. O.12.b. (Page 138) requires reporting of tips and referrals a minimum of every two weeks. Can you clarify the reporting expectation regarding early suspicion of possible fraud?	The MCO is required to immediately report suspicion of fraud via email and on a template developed by MLTC.
151.	IV.O.1.j	Page 133	Section IV.O.1.j requires a minimum of one investigator for every 50,000 or fewer members. Section IV.D.3.i (Page 51) requires one investigator for every 100,000 members. Please clarify the staffing requirement for investigators.	See response to Question #95.
152.	IV.O.6.e	Page 136	If MFPAU chooses to intervene in an MCO hearing or review of sanctions against a provider, will the MCO be notified of this intervention in writing?	Yes, MFPAU will notify the MCO in writing of intention to intervene.
153.	IV.O.6.e	Page 136	Will MLTC consider placing a reasonable limit on the	MFPAU has the right to intervene in proceeding and suspend until the MFPAU's investigation is complete.

			amount of time the MCO may be required to suspend proceedings, particularly as provider appeals may need to be processed according to specific timeframes to maintain required accreditation?	
154.	IV.O.11.b	Page 139	Will MLTC provide the MCO with any available data regarding recipients' dates of death or dates of incarceration to facilitate the required quarterly audit?	This information will be provided via the member enrollment files.
155.	IV.O.15.b	Page 140	Is the intent of this section that the MCO will investigate cases of suspected fraud for periods of time prior to the current contract?	See response to Question #97.
156.	IV.O.17	Page 141	Section IV.O.17 requires consultation with NMPI and MFPAU prior to recoupment in "these circumstances". Section IV.O.1.f (Page 133) requires the MCO to pursue "all recovery of payments identified as FWA" and other sections require the pursuit of overpayments when TPL is identified. Please provide a definition of the specific circumstances under which NMPI/NMFPAU consultation is required prior to recouping	The first sentence of Section IV.O.17 is hereby amended as follows: "If the MCO thinks that it is appropriate to initiate a recoupment or withholding action against a provider, the MCO must consult with both NMPI and MFPAU to ensure that such action is permissible."

			identified overpayments.	
157.	IV.P.2	Page 142	Please provide enough detail to determine how rates are figured, including each step of the process, from determining base to final rate.	See response the Question #48.
158.	IV.P.2.e.xx.	Page 143	What is the rationale for coordinated care savings and amount of adjustment applied to the rates?	The only program change similar to a coordinated care saving is the service delivery adjustment applied to the dual population. Individuals dually eligible for Medicaid and Medicare were previously not enrolled in physical health managed care. The non-nursing home level of care duals represent a significant opportunity for care savings. Inpatient utilization was reduced by 10%, Outpatient utilization was reduced by 15%, and Emergency Room utilization rates were reduced by 25%. The aggregate impact of these changes to this dual population is a reduction of 5.4%. Outside of the dual population, there are no assumed savings due to coordinated care used in creating rate ranges.
159.	IV.P.2.k.	Page 143	When will the narrative on the capitation rate be available?	See Attachment 22: "Heritage Health Rate Development Narrative", for an overview of the rate setting methodology.
160.	IV.P.5	Page 144	Can you confirm that the maternity supplemental payments made to the MCO will be counted as Qualifying revenue for both the risk corridor calculation and the administrative cap calculation?	Confirmed.
161.	IV.P.5/ Attachment 10	RFP Page 144, Attachment 10 maternity cohort	Can you provide any detail on the rate for the maternity supplemental payments? Also, can you provide any databook information on the number of qualifying births in	The rate for the maternity supplemental payments is shown as the "Maternity" category of aid on the rate exhibits. Similarly, the "member months" for this aid category represent the qualifying deliveries.

			the State?	
162.	IV.P.12	Page 147	Please provide claims volume for the most recent two fiscal years. Identify electronic receipt versus paper.	The State cannot respond to this request without additional information. Submit question with specific claim type information in order to respond to this question. Please submit further detail during the second round of questions.
163.	IV.P.12	Page 147	Please provide call volume, delineated between business hours versus after hours for the two most recent fiscal years.	The State needs additional information on the type of call volume. Please submit further detail during the second round of questions.
164.	IV.P.12	Page 147	What services need prior authorization and what are the volumes related to those services for the two most recent fiscal years.	The State needs additional information on the prior authoirizations for fee for service. Please submit further detail during the second round of questions.
165.	IV.P.12	Page 147	Since the administrative cap calculation includes the hold-back, will it just be calculated as "gross" revenue in each month, or will the hold-back only be included when settled a the end of each fiscal year? If it's only included at the end of the fiscal year, for which fiscal year will it appear in the calculation?	The capitation rates have been developed such that the administrative cap calculation is gross of the 1.5% hold-back, so that to the extent the MCO earns back the entire 1.5% hold-back at the end of the fiscal year, the administrative load provided to the MCO will remain under the required cap. It would be calculated in the fiscal year in which the hold-back occurs.
166.	IV.Q.13	Page 154	This section states that the MCO must reimburse a member for any payments made by the member, for services rendered during a period of retro eligibility. Would this apply to situations	All services that would have been covered by the Medicaid FFS program must be covered by the MCO, retroactive to eligibility. To clarify the process for member reimbursement, IV.Q.13 is hereby amended as follows: "The MCO is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility. The MCO must reimburse a provider and that provider must

			in which services previously rendered are determined to not be medically necessary?	reimburse a member for payments already made by a member for Medicaid covered services during the retroactive eligibility period. The date of enrollment in a MCO will match the Medicaid eligibility date."
167.	IV.R.1.c	Page 154	Approximately how many MLTC staff will require access to the MCO's systems? Will all staff require the same type of access or will individual staff access vary based on the role of the individual user?	Currently, the State does not have access to the MCOs systems. This will be determined during the readiness review process with awarded MCOs. Access wil vary based on the individual user.
168.	IV.S.3.ii	Page 164	Does this language only extend to the MCOs contracted by the State of Nebraska or would it extend to timely filing processes for other primary payers?	This language would extend to timely filing process for other primary payers.
169.	IV. S.15.b.ii	Page 174	Please clarify if the MCO may choose to pay and chase for the three listed categories of claims or if the MCO is mandated to pay and chase rather than cost avoid in these cases.	The MCO may choose to pay and chase for the three listed categories of claims.
170.	IV. S.15.b.ii.c	Page 175	Will MLTC provide an indicator to the MCO identifying Title IV-D child support individuals to assist in appropriate COB efforts?	Yes, this indicator will be provided via the enrollment files.
171.	A.2.h	Page 197	The instructions note that the State will use no more than three narrative project	See the response to Question #44.

			descriptions during proposal evaluation. Are we limited to describing three similar projects? If not, how will the State select the three to consider in the evaluation?	
172.	V. Proposal Instructions	Pages 196-198	There are several questions where additional information is specifically requested to be attached (e.g., copy of COA, work plans, sample materials). Is it permissible to include attachments that are not specifically requested?	Attachments that are not specifically requested may not be considered in the evaluation process.
173.	A.2.h	Page 197	Can bidders include experience from affiliate organizations/sister companies?	Yes.
174.	A.2.h	Page 197	Please clarify what "budget" information the state would like us to include (e.g., contract value)?	Per Section V.A.2.h.i.e, "Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget." The budget as indicated above refers to the project budget verus the actual budget.
175.	N/A	Page 1	The Key Staff Resumes item from Attachment 5 requests that resumes be included in the proposal only for key personnel. However, Item	The State would prefer resumes for key personnel.

			A.2.i Summary of Bidder's Proposed Personnel/Management Approach on page 198 of the RFP requests that resumes be provided for all proposed personnel. Which does the state prefer?	
176.			What are the metric definitions associated with the measures outlined in this attachment?	All measures included in Attachment 7 are nationally recognized quality measures. More information can be found on the Adult Core Set Measures and Child Core Set Measures by visiting the CMS website at www.cms.gov. HEDIS measures can be found on the NCQA website at www.ncqa.org.
177.			For the Rx factors of 6.5% and 6.7%, could the underlying assumptions used be provided? i.e. Inflation, utilization, drug-mix, off-patent, new medications etc.	The State's actuary will conduct these analyses when developing actuarially sound rates in early 2016. At that time, this information will be available.
178.	Item 4	Page 1	Please define QI admin expenses allowed with the additional 3% admin cap and explain how those expenses differ from the expenses allowed in the MLR calculation	The Glossary of Terms is amended to add: **Quality Improvement (QI) Expenses**: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as: **1.** Effective case management, Care coordination, and Chronic Disease Management, including: **a.** Patient centered intervention such as: **i.** Making/verifying appointments; **ii.** Medication and care compliance initiatives; **iii.** Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation

				center); **iv.** Programs to support shared decision making with patients, their families and the patient's representatives; **v.** Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers; **vi.** Incorporating feedback from the insured to effectively monitor compliance; **vii.** Providing coaching or other support to encourage compliance with evidence based medicine; **viii.** Activities to identify and encourage evidence based medicine; **ix.** Activities to prevent avoidable hospital admissions; **x.** Education and participation in self-management programs; and **xi.** Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance. **b.** Improve patient safety; **c.** Wellness and health promotion activities; **d.** Health Information Technology (HIT) expenses related to Quality Improvement Activities: **i.** Data extraction, analysis and transmission in support of the activities described above; and **ii.** Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care. **2.** The following items are broadly excluded as not meeting the definitions above:

				a. All retrospective and concurrent Utilization Review; **b.** Fraud Prevention activities; **c.** The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network; **d.** Provider Credentialing; **e.** Marketing expenses; **f.** All Accreditation Fees; **g.** Costs associated with establishing or maintaining a claims adjudication system; **h.** Costs associated with calculating and administering individual enrollee or employee incentives; and **i.** Any function or activity not expressly listed as approved.
179.	Item 4	Page 1	Can you confirm that if QI expenses are allowed for the numerator MLR calculations, they would then be classified as medical costs and not count towards the 10% administration cap.	The QI expenses allowed for the numerator would count towards the 10% administrative cap per state statute.
180.	Bidders Conference Rate Presentation	All pages	Is cost settlement for PRTF payments to Hastings Regional Center and Lincoln Regional Center included in this program? If so, why is it not included in the rate development?	Yes, the cost settlement for PRTF payments to Hastings Regional Center and Lincoln Regional Center is included in the developed rates. It is included as part of the “Other Policy Changes” in the NE Heritage Health Bidder's Conference Rate Presentation (Optumas) on slide 11 of 20.
181.	Bidders Conference Rate Presentation		Please detail what the service delivery adjustments are and how they were created	Please see the response to Question #158.

182.	Bidders Conference Rate Presentation		Please detail the immediate enrollment policy adjustment. How was this adjustment developed?	The impact of this program change was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the managed care program after the policy was implemented.
183.	Bidders Conference Rate Presentation		Please detail all other policy changes (APR-DRG, FQHC APM, BH Provider Increase) – how were these developed?	APR DRG: On July 1, 2014 the State of Nebraska moved from using the AP DRG payment methodology to the APR DRG payment methodology for inpatient hospital claims. This change impacts all hospitals that are reimbursed on a DRG basis; this excludes hospitals reimbursed on a per diem basis such as Critical Access Hospitals (CAHs) and rehab facilities. The impact of this change was calculated by first re-pricing all impacted inpatient hospital claims in the SFY14 base data, at the AP DRG version 27 weights and SFY14 hospital rates specific to each hospital. This was done to ensure that the comparison between the AP DRG and APR DRG reimbursement would not be influenced by any contracting or payment differences between the MCO reimbursement and the State AP DRG fee schedule. The State's actuaries then assigned an APR DRG and severity level to all inpatient hospital claims included in the analysis based on version 31 of the grouper. This was done by utilizing software from 3M who developed the APR DRG grouper. These claims were then re-priced using the APR DRG version 31 weights and SFY15 hospital rates. The final impact was calculated by comparing the percentage change from the SFY14 AP DRG re-priced amount to the SFY15 APR DRG re-priced amount for each category of aid and MCO. The transition to the APR DRG payment methodology was intended to be budget neutral at a global level, however it should be recognized that this may break down between health plans and especially between rate cells. The overall results do show that the

				impact is close to budget neutral in aggregate but does show increases and decreases by rate cell. FQHC APM: Effective 1/1/2016 the State will begin paying Federally Qualified Health Centers (FQHCs) a new Alternative Payment Methodology (APM) rate. To account for the impact this reimbursement change will have on the Heritage Health capitation rates, the State's actuaries identified all FQHC utilization in the base data and priced it at the new APM rate. The pricing was done separately for the FY14 and FY15 base data sets, and the resulting impact was blended together at a 50/50 rate consistent with the overall rate development. BH Provider Increase: The behavioral health provider increase is a legislatively-mandated fee schedule change applicable to behavioral health providers. Recently this change has been a 2.25% increase to behavioral health provider reimbursement, but that has not always been the case and is not guaranteed to continue. For projection to the Heritage Health contract period the State's actuaries assumed the 2.25% annual increase will remain consistent. The provider increase was applied by increasing data to reflect the number of fee schedule changes between the data time period and the contract period. For example, FY14 reimbursement was increased by 2.25% to reflect FY15 reimbursement levels. Then, the combined FY14/FY15 base (already adjusted to be at FY15 legislatively-mandated reimbursement levels) was increased for two more 2.25% fee schedule changes, one effective July 2015 and another anticipated to be effective July 2016. Finally, due to the 12-month calendar year contract period, one-half of the 2.25% program change anticipated to be effective July 2017 was applied.
184.	Bidders Conference Rate Presentation		Were the same trends by Category of service applied to each category of aid? Were unit cost and utilization trends	Attachment 23:"COS and COA Trends" contains the trends by category of service and major category of aid. The trend model used to develop these figures is not available. The development process consisted of reviewing FY13, FY14, and FY15 data by

			created separately? Please provide the trend analysis to support the chosen trend numbers.	month, category of service, and major category of aid. Data was controlled for membership mix by rolling up sub-categories of aid on the most recent month's membership mix to create major categories of aid. Data was also controlled for known policy changes by increasing data prior to the policy change to be consistent with the value after the policy change became effective. Nebraska data was the primary source for trend development, but the State's actuary's national and regional experience was also used to inform trend values. Additional details, such as utilization trend and unit cost trend, will be provided when rates are updated in the spring.
185.	Bidders Conference Rate Presentation		Please provide the detail behind the UNMC PMPM adjustment.	The University of Nebraska Medical Center (UNMC) providers are reimbursed at commercial fee levels. MCOs contract at levels more commensurate with Medicaid reimbursement, a supplemental payment is required to be paid to UNMC by each MCO to make these providers whole. The State includes this supplemental payment as part of the capitation rates, which is then passed through from the MCOs to UNMC. To develop this rate pass-through the State's actuaries receive a list of UNMC Provider IDs from the State as well as the current managed care entities. These lists were used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently un-managed populations and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC.
186.	Bidders Conference Rate Presentation		Please provide the development of the 2.9% NML for Katie Beckett and	See Response to Question #112.

			Maternity categories. How does this account for the quality initiatives and profit?	
187.	Bidders Conference Rate Presentation		Please provide the build of NMT for each rate cell.	Effective 7/1/2015, the Non-Emergency Transportation-Ambulance service will be provided as part of the managed care contract. This service was not a required benefit under the managed care contract during the duration of the base data period (SFY14-15). While very low utilization was included within some of the base data, historical Nebraska FFS data (SFY08-10) was trended to the contract period and used to supplement the base data. The PMPM added in by cohort and Rating Region for NEMT-Ambulance services can be found in Attachment 24: "NEMT-Ambulance Rates."
188.	Bidders Conference Rate Presentation		Will the retro adjustment be included in the revised rate that will be provided in the spring?	Yes.
189.	I.A.Schedule of Events	1	Given the short time to review the RFP in advance of the first Pre-Proposal Conference, we believe a second bidders' conference would be beneficial and most efficient for all. This will ensure that all bidders have an opportunity to understand the proposal in its entirety and result in the best possible bidding process. Please confirm the State will hold the second conference on 11/19.	See Addendum 2-Revised Schedule of Events.
190.	I.A.Schedule of Events	1	It is our understanding that the Attachment 11 rates are not final. Given the	See section IV.P.2 for a detailed description of the Capitation Rate Determination Process.

			anticipated large rate adjustments that will be made in the Spring, how will the winning MCOs be involved in determining the final rates for 1/1/17-6/30/17?	
191.	III QQ. Prices	24	Please confirm that bidding MCOs will not be required to submit anything, besides QQ, as part of their acceptance of the rates under the contract.	Confirmed. No cost proposal is required.
192.	IV. A.1 b. Program Description	30	This section states: "Nebraska Medicaid currently provides health care coverage for approximately 239,000 individuals each month at an annual cost of approximately $1.8 billion." However, Attachment 11 has an average of 228,000 eligibles that produce $1.1 billion in revenue including the UNMC supplemental payment. Please describe the difference. Are the rates presented in Attachment 11 capturing all of the expenses?	The difference is caused by populations and services excluded from Heritage Health. The rates presented in Attachment 11 are capturing expenses for the included populations and services.
193.	IV. A.1 d. Program Description	30	Please describe all current and anticipated CMS waivers under which this program will operate.	The current managed care program and Heritage Health will operate under State Plan and 1915(b) Waiver authority.
194.	IV.A.11. Excluded	32	This section states that the	The details requested in this question are not available. The members with a share of cost will be contained in the LTSS data

	Populations		following members are excluded: ""Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost (SOC) obligation to a nursing facility or for HCBS Waiver services."" Therefore, please confirm the following about the members with SOC that are the MCOs' responsibility: a) Please provide a separate databook/amounts for the members who will be the MCOs' responsibility and have SOC by fiscal year, region, and rate cell. b) Please describe all administrative obligations of MCOs with respect to the collection of this share of cost. c) Please describe the manner in which rates are developed with regard to share of cost: is the rate developed in total, with the share of cost flowing through the state to the MCOs? Is the rate developed net of the share of cost obligation? Is	book, but the State's actuaries cannot presently isolate only those members with a share of cost obligation. The share of cost payments are paid to nursing facilities or HCBS providers that are outside of the benefits package of Heritage Health. Rates are developed net of the members' cost share obligation.

			there a settlement of some kind?"	
195.	IV.B.2.f. Member Enrollment/ Assignment	33	"Please clarify the MCOs' responsibility with regards to the retroactive time period: a) Please provide the membership, expenses, and utilization (by region, category of aid and category of service) associated for the total retroactive time period that the MCOs will be responsible for covering. b) Please provide the average length of the retroactive period by category of aid and region. c) Please describe the differences between the retroactive time period and the immediate enrollment. d) Is there a maximum retroactive period that MCOs would be responsible for? e) Is there any limitation on the types of services MCOs would be responsible for retroactive from enrollment date to retroactive eligibility date?"	Please see the response to Question #19 regarding a MCO's responsibility for retroactive time periods. Data analysis will be conducted to determine the cost of retroactive time periods compared to regular enrollment time periods. As discussed during the first pre-proposal conference and stated on the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)" retroactive time period analyses have not been conducted yet. The State's actuary will conduct these analyses when developing actuarially sound rates in early 2016. At that time, splits in the data as requested in parts a), b), and c) will be available.
196.	IV.B.2.f. Member Enrollment/	33	Please confirm that any retroactive liability will only go	See response to Question #19.

	Assignment		back to 1/1/17. For example, if a health plan is assigned a member on 4/1/17 whose eligibility date is 7/1/16, is the health responsible for claims incurred back to 7/1/16 or 1/1/17?	
197.	IV.B.2.f. Member Enrollment/ Assignment	33	In Optumas' presentation during the Pre-Proposal Conference, it was stated that there is limited credibility for the ABAD members under 1, such that it would be difficult to develop an actuarially sound rate cell for only these members. It was also stated during that meeting that an adjustment would be developed at a later date to capture any additional costs for retroactivity. We feel that the retroactive requirement could be particularly volatile for this population, and therefore, the retroactive adjustment would likely be difficult to calculate and have a significant impact on plan financial stability. Please consider covering retroactive costs for this population under fee for service, rather than making it the responsibility of winning MCOs	During rate development the contracted actuary separates AABD members under 1 from other AABD members. This allows for analysis of the population's spend and credibility. The contracted actuary will continue a similar practice with regards to retroactive enrollment expenses for AABD infants. While it is not anticipated that this population will become credible enough to stand alone for rate setting. The contracted actuary will continue to analyze it and develop rates to mitigate this population's volatility as much as possible.

198.	IV.3. Member Enrollment/ Assignment	34	Please confirm that there are no firm enrollment floors or caps to prevent certain MCOs from having more than or less than a certain percentage of total enrollment.	See Section IV.B.3. regarding the auto-assignment algorithm.
199.	IV.E.7. Telehealth and Telemonitoring Services	54	Please describe where the costs for these services are incorporated into the base data. Also provide the utilization and unit cost assumptions (by region and rate cell) for this service embedded in the capitation rates.	Telehealth services are currently submitted using a procedure code modifier. The claim associated with telehealth services is grouped into service categories based on different service type indicators, such as provider type, place of service, etc. The telehealth services predominantly fall into professional service categories including PCP, Specialist, and Other Practitioner. The contracted actuary does not have summaries for detailed line telehealth services available.
200.	IV.E.22. Medical Services for Special Populations	65	"Please provide the following related to the SHCN population: a) a separate data book (including membership, expenses and utilization by region, rate cell, and category of service) for the SHCN population. b) Please explain why the SHCN population is not included as a separate category of aid c) Please provide the process through which new MCOs (without historical claims data) are expected to identify	This level of detail is not available. The SHCN population is too small and volatile to maintain rating credibility as a separate category of aid. The State's actuary will continue reviewing this population to determine if it becomes credible. Historical pharmacy claims data will be provided.

			these members."	
201.	IV.I.7. Patient-Centeredness/Patient-Centered Medical Homes	97	Please describe where the costs for these services are incorporated into the base data. Please also provide the assumptions associated with these requirement in the development of the capitation rates.	Costs for services provided under a PCMH system are not itemized separately from services provided outside of a PCMH system. The non-medical loading applied to the rate is sufficient to fund health plan administrative efforts necessary to support PCMH programs.
202.	IV. I. 8. c. Pharmacy Network	98	For purposes of the provisions related to specialty pharmacies and specialty drugs, please provide a listing of NDC codes that are considered to be specialty drugs, as well as a description of the process of updating this list.	See response to Question #75.
203.	IV.L.2. Health-Risk Screening/Assessment	112	Please describe where the costs for these services are incorporated into the base data. Please also provide the assumptions built into the rates for this requirement.	The costs are considered in the admin portion of the capitation rates as they are not direct services.
204.	IV. P.2 Capitation Rate Determination Process	142	This section states that capitation rates will be in effect for the initial six month contract period beginning with the program start date. Later, it is stated that MLTC and its actuary will develop actuarially sound capitation rates. Please confirm that the	Section IV.P.2.c is amended to read: “Capitation rates will be in effect for the initial twelve (12) month contract period beginning at the contractor start date.”

			capitation rates shown in attachment 11 will be in effect from 1/1/2017 through 6/30/2017.	
205.	IV. P.2 Capitation Rate Determination Process	142	Please confirm whether the next set of capitation rates will be developed for the period 7/1/2017 through 6/30/2018 or through 12/31/2017.	The next set of capitation rates will be effective for Calendar Year 2018, 1/1/2018 – 12/31/2018.
206.	IV. P.2 Capitation Rate Determination Process	143	Please describe any adjustments made in the initial (1/1/17-6/30/17) capitation rate development to account for breakthrough therapies which have newly gained FDA approval and/ or are expected to gain FDA approval during the rating period.	No adjustments were made for breakthrough therapies. These treatments are reflected in the capitation rate to the extent they were provided in the base data. In addition, the pharmacy trend is higher than historical, in part due to the emergence of breakthrough therapies.
207.	IV. P.2 Capitation Rate Determination Process	143	Please describe any analyses/monitoring expected to be performed to measure and/ or predict the impact of breakthrough therapies which have newly gained FDA approval and/ or are expected to gain FDA approval as part of future rate development processes.	Prior to development of the final rate the State's actuary will reexamine emerging treatments that could be impactful on MCO pharmacy expenses. Historic experience will be adjusted as necessary to appropriately account for the anticipated impact of breakthrough treatments.
208.	IV. P.2 Capitation Rate Determination Process	143	One of the adjustments listed as being considered as part of the rate development is	See response to Question # 158.

			"Coordinated Care Savings." Please clarify these items and their values reflected in the initial rate development. If there are any such adjustments included within the initial rate development, please separate them between those adjustments applied to the existing managed care data and FFS, and further break down by region, category of service, and category of aid for both utilization and unit cost.	
209.	IV. P.2 e. Capitation Rate Determination Process	143	"This section of the RFP states that ""Capitation rates are developed using encounter data, fee-for-service data, and supplementary financial information, from each MCO under contract at the time of this RFP's release, for the eligible populations from State fiscal years 2013, 2014, and 2015." a) Please provide a detailed narrative and numerical exhibits (by fiscal year, data source, and rate cell) to describe the ways in which these multiple data sources were incorporated.	FY2013 data was only used for trend development. FY14 and FY15 data was blended together to create the two-year base data. Supplementary financial statements were used to validate the Managed Care Entity encounter data and to build in supplement, non-claims expense (such as CAH settlement payments). The data sources are used as follows: Physical Health Encounters are used for Physical Health services for populations currently enrolled in Physical Health managed care. Behavioral Health Encounters are used for Behavioral Health services for all populations. Fee-for-service data is used for pharmacy data for all populations and Physical Health services for populations not currently enrolled in Physical Health managed care (e.g. Duals, LTSS, Women with Cancer). More details can be found in Attachment 22: "Heritage Health Rate Development Narrative". Data was not adjusted for underreporting. IBNR adjustment values can be found in Attachment 25: "IBNR Assumptions by Source". Current MCOs were involved in validating the encounter data to ensure it was fully reported and consistent with their financial statements. The IBNR estimates reported on the financial statements were also

			b) Please clarify the values used to adjust each of these data sources for both IBNP and underreporting, and describe how the current MCOs provided input into these estimates. c) Please list and provide values for additional adjustments made to create the base data shown in Attachments 10-A and 10-B. d) Please describe how 2013 data is used to develop the initial rates. e) Please describe how the data was validated/reconciled, the sources used, and the results of the validation/reconciliation. f) Please describe how FY2015 and FY2016 data was adjusted and merged together. g) Please provide detailed information regarding any non-encounter based costs included in the base data such as provider incentives or value based agreements"	used to verify the accuracy of the IBNR adjustments, and these values were discussed with current MCOs. The only adjustments made to the encounter data to create the base data shown in Attachment 10-A and 10-B are IBRN, Supplemental Payments, and Subcapitation Expenses. IBNR is detailed in Attachment 25: "IBNR Assumptions by Source". Across both FY14 and FY15 Supplemental Payments are worth $11.2 million on a statewide basis and Subcapitation Expenses are work $13.8 million on a statewide basis. Subcapitation represents predominantly Vision subcapitated agreements, while Supplemental Payments represent non-claims payments, such as CAH settlements. FY13 data is used only in the development of trend. Current MCOs were involved in validating the encounter data to ensure it was fully reported and consistent with their financial statement. The IBNR estimates reported on the financial statements were also used to verify the accuracy of IBNR adjustments, and these values were discussed with current MCOs. FY16 data was not used. FY15 data was blended with FY14 data to develop the base data. Non-encounter expenditures such as CAH settlements or PCP shared risk agreements are included as part of the Supplemental Payments adjustment described earlier in the question response.
210.	IV. A.1.a	page 30	The RFP states that DHHS is	RFP 5151 Z1 only applies to the MLTC division.

			comprised of 6 divisions. Please describe the process used to capture all of the expenses from each division.	
211.	IV. A.1.a	page 30	The RFP states that DHHS is comprised of 6 divisions. What reconciliation process did DHHS and Optumas use to ensure all expenses were captured from each of these divisions?	See response to Question #210.
212.	IV. A.1.a	page 30	The RFP states that DHHS is comprised of 6 divisions. Please provide the reconciliation used to ensure all expenses were captured from each of these divisions.	See response to Question #210.
213.	IV.P.2. Capitation Rate Determination Process	143	A number of detailed analyses and narratives are described in this section related to the certification of capitation rates. We appreciate that this detail will be provided to MCOs and we understand that the final documents for the initial rate period will not be available until after the contract is awarded. However, in order to understand the development of the rates, we need to have a draft version of all of these documents that would tie out to the rates	See Attachment 22: "Heritage Health Rate Development Narrative", and Attachment 20: "COA-level Rate Development" for additional detail into the rate development process.

			shown in attachment 11, and which would include all adjustments, data, and trends to the level of detail used by the actuary as soon as possible. In particular, a number of disclosure requirements are outlined in the 2016 Medicaid Managed Care Rate Development Guide. Please ensure that your documentation reflects these requirements in order for bidders' to fully understand the rate development.	
214.	IV. P.2 h. Capitation Rate Determination Process	143	"This section states that the annual capitation review will include ""an analysis of any anticipated fee schedule changes or other programmatic changes to the HERITAGE HEALTH."" a) Please confirm that the intent of this analysis is to update rates proactively in advance of anticipated policy changes or fee schedule changes. b) Please provide this analysis, particularly of anticipated fee schedule and other programmatic changes, and how they have been	Capitation rates will be developed inclusive of any known or anticipated policy changes and fee schedule changes. The fee schedule changes built in to these rates include a 2.25% annual increase in reimbursement for Behavioral Health services and a 2% annual increase in reimbursement for Physical Health services. The provider increases are legislatively-mandated fee schedule changes. Recently these changes have been 2.25% and 2.0% for Behavioral Health and Physical Health services respectively, but that has not always been the case and is not guaranteed to continue. For projection to the Heritage Health contract period the contracted actuary assumed the annual increases will remain consistent. The Behavioral Health provider increase was applied by increasing data to reflect the number of fee schedule changes between the data time period and the contract period. For example, FY14 reimbursement was increased by 2.25% to reflect FY15 reimbursement levels. Then, the combined FY14/FY15 base (already adjusted to be at FY15 legislatively-mandated reimbursement levels) was increased for two more 2.25% fee schedule changes, one effective July 2015

			incorporated into this initial rate development. c) Please list and provide historical values and anticipated effective dates of any automatic fee schedule updates."	and another anticipated to be effective July 2016. Finally, due to the 12-month calendar year contract period, one-half of the 2.25% program change anticipated to be effective July 2017 was applied. The Physical Health provider increase was applied as unit cost trend for Physical Health Services. Recently the Behavioral Health fee schedule change has been 2.25% annually and the Physical Health fee schedule change has been 2.0% annually. The current rate development assumes these values will remain in effect until the CY2017 contract period. If the values are changed by future legislative sessions rates will be updated accordingly.
215.	IV P.5. Supplemental Delivery Payments	144	"Questions related to delivery payments: a) Please comment on the decision not to pay a supplemental kick for stillbirths, especially given the fact that the payment covers the mother's prenatal care, postpartum care, and the delivery, which can be the same or higher than a healthy delivery in the event of a stillbirth. b) Please also confirm that the rate was built exactly how the payment policy is outlined."	The supplemental maternity payment rate is established based on MLTC policy.
216.	IV P.5. Supplemental Delivery Payments	144	Please confirm payment of the maternity kick payment when there is no hospital	In the absence of a hospital inpatient stay, the MCO may submit other inpatient or outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment. Costs associated with inpatient and outpatient maternity care are

			inpatient stay (e.g., situations when the mother deliveries at a birth center (non-inpatient) or at home), but a baby was delivered. Please also clarify how these types of events were reflected in the data.	included in capitation rate development.
217.	IV P.5. Supplemental Delivery Payments	144	"Please confirm which services are covered by the supplemental delivery payment: a) would all services (e.g., visits for broken leg) provided during the prenatal and postpartum period be covered, or only maternity related costs? b) If all costs are included within the supplemental delivery payment, please explain how the capitation rates for the relevant categories of aid are reduced for this payment. c) If only maternity related costs are included within the supplemental delivery payment, please explain why the exhibit for maternity services includes many of the same services covered by the monthly capitation rate payments (e.g. home health	a) All services b) The delivery window (5 months pre-delivery and 2 months post-delivery) is identified in the claims data. Any medical expense that falls within that window is re-classified from the original category of aid and into the Maternity case rate. c) See a above.

			and vision)."	
218.	IV. P.3 b Capitation Rates And Payment	144	Please describe in greater detail how partial months of enrollment are calculated for capitation payment purposes	Enrollment into managed care is monthly.
219.	IV. P.3 b Capitation Rates And Payment	144	Please confirm that member months are calculated in an identical fashion for the data book, capitation rate development and capitation payment purposes.	Confirmed.
220.	IV. P.8 Risk Adjustment	145	The RFP states: "For subsequent years of the contract, each MCO's proposed base capitation rates will be risk-adjusted based on the MCO's risk score…" Please clarify whether risk adjustment will start on 1/1/18 or 7/1/17.	The risk adjustment tool will be considered for the second contract period, beginning 1/1/18.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM FIVE
REVISED SCHEDULE OF EVENTS

Date: November 18, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 16, 2015~~ **November 18, 2015**
6	Form B Notification of Intent to Attend Second Pre-Proposal Conference	November 17, 2015
7	Second Pre-Proposal Conference will be held at Location: Lincoln Medical Educational Partnership 4600 Valley Road Lincoln, NE 68510 **Attendance at Pre-Proposal Conference is optional** Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 4533256#	November 19, 2015 1:00 PM - 4:00 PM Central Time
8	Last day to submit Second Round written questions	November 23, 2015
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
11	Review for conformance of mandatory requirements	December 22, 2015
12	Evaluation period	January 6, 2016 – January 22, 2016
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016

	ACTIVITY	DATE/TIME
15	Contract finalization period	January 29, 2016 – February 29, 2016
16	Contract award	March 1, 2016
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM FOUR
REVISED SCHEDULE OF EVENTS

Date: November 17, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 16, 2015~~ **November 18, 2015**
6	Form B Notification of Intent to Attend Second Pre-Proposal Conference	November 17, 2015
7	Second Optional Pre-Proposal Conference Location: Lincoln Medical Educational Partnership 4600 Valley Road Lincoln, NE 68510 Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 4533256#	November 19, 2015 1:00 PM - 4:00 PM Central Time
8	Last day to submit Second Round written questions	November 23, 2015
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
11	Review for conformance of mandatory requirements	December 22, 2015
12	Evaluation period	January 6, 2016 – January 22, 2016
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016

	ACTIVITY	DATE/TIME
15	Contract finalization period	January 29, 2016 – February 29, 2016
16	Contract award	March 1, 2016
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM THREE
REVISIONS TO RFP

Date: November 10, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

The following is hereby amended as follows:

Document	Section	Change From:	Change to:
RFP	IV.E.29.h	Add new section	Non-emergency transportation (except as indicated in Section IV.E.8.a)
RFP	IV.B.3.e	In accordance with 42 Code of Federal Regulations (CFR) 438.50(f), the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment.	In accordance with 42 Code of Federal Regulations (CFR) 438.50(f), the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment during the initial Heritage Health enrollment period.
RFP	IV.A.11.f	Add new section	Inmates of public institutions.
RFP	IV.B.10.a.iv	Remove section	
RFP	IV.F.10.f	Us of proprietary items that would require use of a specific browser or other interface is not allowed.	Use of proprietary items that would require use of a specific browser or other interface is not allowed.

RFP	IV.C.1.b	On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. MLTC anticipates that the finalizing of this proposed rule will affect the contracts awarded as a result of this RFP. The MCO must include in its proposal: i. An analysis of the Proposed Rule that includes the MCO's interpretation of all provisions relevant to the contract requirements. ii. A plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.	On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. MLTC anticipates that the finalizing of this proposed rule will affect the contracts awarded as a result of this RFP. The MCO must submit 90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier), a plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.
RFP	Glossary of Terms	**Primary care provider (PCP):** A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.	**Primary care provider (PCP):** A medical professional chosen by or assigned to the member to provide primary care services. Provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, and physician assistants.
RFP	Glossary of Terms	**Primary care services:** All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.	**Primary care services:** All health care services and laboratory services customarily furnished by or through primary care provider, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Attachment 5		**Required with Proposal:** Proposed Rule Implementation Plan **Description:** Plan for complying with new CMS Medicaid managed care rules as described in Section IV.C – Business Requirements **Due Date:** Required with proposal	**90 Days Prior to Contract Start Date:** Proposed Rule Implementation Plan **Description:** Plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance. **Due Date:** 90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier).
Attachment 4	Core Competency 1	Core Competency 1: Facilitate ongoing patient relationship with physician in a physician-directed team.	Core Competency 1: Facilitate ongoing patient relationship with a primary care provider in a physician-directed team.
Attachment 4	Core Competency 1	6. Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.	6. Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care provider(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM TWO
REVISED SCHEDULE OF EVENTS

Date: November 9, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 16, 2015
6	**Form B Notification of Intent to Attend Second Pre-Proposal Conference**	**November 17, 2015**
7	Second **Optional** Pre-Proposal Conference Location: **Lincoln Medical Educational Partnership** **4600 Valley Road** **Lincoln, NE 68510** **Call-in information for those unable to be present is as follows:** **Conference Access Number: (888) 820-1398** **Attendee Code: 4533256#**	**November 19, 2015** **1:00 PM - 4:00 PM** **Central Time**
8	Last day to submit Second Round written questions	November 23, 2015
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
11	Review for conformance of mandatory requirements	December 22, 2015
12	Evaluation period	January 6, 2016 – January 22, 2016
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016

	ACTIVITY	DATE/TIME
15	Contract finalization period	January 29, 2016 – February 29, 2016
16	Contract award	March 1, 2016
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

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Form B

Notification of Intent to Attend Second Pre-Proposal Conference

Request for Proposal Number 5151 Z1

Bidder Name:	
Bidder Address:	
Contact Person:	
E-mail Address:	
Telephone Number:	
Fax Number:	
Number of Attendees:	

The "Notification of Intent to Attend Pre-Proposal Conference" form should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivered or US Mail by the date shown in the Schedule of Events.

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM ONE
QUESTIONS and ANSWERS

Date: October 23, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151 Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

QUESTIONS	ANSWERS
1. Is the Pre-Proposal Conference on Monday for Prospective Bidders only or may stakeholders such as my organization attend as well?	Anyone may attend the pre-proposal conference on Monday, October 26.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Attachment 19
Proposal Statements and Questions

No.	RFP Section	Statement/Question	Page Limit
1.	Not applicable	If applicable, describe the MCO's proposed risk bearing partnerships/relationships including designated functions of each entity, and how delegated functions will be overseen.	2 pages
2.	Not applicable	Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	Not applicable
3.	Not applicable	State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	Not applicable
4.	III.G. Insurance Requirements	Describe the risk analysis, assumptions, cost estimates and rationale supporting the MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship.	2 pages
5.	IV.B Eligibility and Enrollment	Provide a comprehensive discussion of the MCO's approach to maximizing the number of members who have a relationship with a PCP, including: • The strategy the MCO will use initially, and on an ongoing basis, to ensure PCP selection within 30 calendar days. • Examples of successful strategies and lessons learned in encouraging PCP relationships.	2 pages
6.	IV.B Eligibility and Enrollment	Describe the MCO's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership. Include the process for resolving discrepancies between these files and internal membership records.	1 page

No.	RFP Section	Statement/Question	Page Limit
7.	IV.B Eligibility and Enrollment	Describe the interventions the MCO will use prior to seeking to disenroll a member who requests disenrollment outside the annual open enrollment period. Provide examples of scenarios in which the MCO has effectively intervened to avert disenrollment of a member or members.	2 pages
8.	IV.B Eligibility and Enrollment	Describe the MCO's process to identify unborn individuals anticipated to begin coverage at the time of birth. Describe the operational process to obtain identifying information when the unborn status changes to newborn.	1 page
9.	IV.B Eligibility and Enrollment	Describe the MCO's approach to working with other MCOs in the event a member changes his/her MCO during ongoing operations of the program. Describe how the MCO will work with other MCOs to ensure a seamless transition and transfer of relevant information.	1 page
10.	IV.B Business Requirements	Describe the approach the MCO will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.	Not applicable
11.	IV.C Business Requirements	Describe how the bidder meets the Federal definition of a MCO. Include a copy of the COA from the Department of Insurance.	1 page, excluding copy of COA
12.	IV.C Business Requirements	Describe the MCO's proposed approach for collaboration with other entities and programs, as required in Section IV.C.6.	3 pages
13.	IV.C Business Requirements	Describe if any of the MCO's Medicaid MCOs are accredited by NCQA and, if not currently accredited in Nebraska, how it will attain accreditation for its Nebraska MCO. Please describe any unsuccessful accreditation attempts in other states.	1 page
14.	IV.C Business Requirements	If applicable, describe any restriction of coverage for counseling or referral services the MCO is required to provide because of moral or religious obligation. Describe how the MCO will provide members with access to those services.	1 page
15.	IV.D Staffing Requirements	Describe the organization's number of employees, lines of business, and office locations. Submit an organizational chart showing the structure and lines of responsibility and authority in the company. Include the organization's parent organization, affiliates, and subsidiaries that will support this contract.	3 pages, excluding organizational chart
16.	IV.D Staffing Requirements	Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational	Not applicable

No.	RFP Section	Statement/Question	Page Limit
		Chart."	
17.	IV.D Staffing Requirements	In table format, indicate the proposed number of FTEs for each key staff and additional required staff for discrete time periods (no longer than 3 month intervals) from contract award through 6 months after the start date of operations and whether or not positions are located in Nebraska. Label this table "Proposed FTEs by Time Period."	Not applicable
18.	IV.D Staffing Requirements	Provide job descriptions (including education and experience qualifications) of employees in key staff positions.	1 page per job description
19.	IV.D Staffing Requirements	Describe how the MCO's administrative structure and practices will support the integration of the delivery of physical health, behavioral health, and pharmacy services.	4 pages
20.	IV.D Staffing Requirements	Describe how the MCO will train staff on issues that affect its members, including: issues related to housing, education, food, physical and sexual abuse, violence, food security; behavioral health risk and protective factors; finding community resources and making referrals to these agencies and other programs; and meeting the needs of the LTSS population, including individuals with developmental disabilities and mental health concerns.	6 pages
21.	IV.D Staffing Requirements	Describe how the MCO will coordinate with the MLTC Dental Benefits Manager, including processes for reciprocal referral for needed services. Include the MCO's plan to identify a dental services liaison.	2 pages
22.	IV.E. Covered Services and Benefits	Provide the MCO's definition of medical necessity. Describe the process for developing and periodically reviewing and revising the definition. Describe the degree to which the definition is consistent with or differs from MLTC's definition of medically necessity per 471 NAC 1-002.02A.	3 pages
23.	IV.E Covered Services and Benefits	Provide a description of the value added services the MCO proposes to offer to members. For each service: • Define and describe the service. • Identify the category or group of members eligible to receive the service if it is not appropriate for all members. • Note any limitations or restrictions that apply to the service. • Identify the types of providers responsible for providing the service. • Propose how and when members and providers will	Not applicable

No.	RFP Section	Statement/Question	Page Limit
		be notified of the service's availability. • Describe how a member may obtain/access the service. • Describe how the MCO will identify the expanded benefit in administrative or encounter data.	
24.	IV.E Covered Services and Benefits	Describe the MCO's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the MCO's system for tracking each member's screening, diagnosis and treatment to ensure services are delivered within the established timeframes.	4 pages
25.	IV.E Covered Services and Benefits	Describe the MCO's plan to utilize telehealth for any services in the benefits package, including how the MCO will incorporate member preference for in-person or telehealth service, how it will be operationalized throughout the state, and how its use relates to the MCO's utilization management strategies.	3 pages
26.	IV.E Covered Services and Benefits	Describe the MCO's experience with an integrated pharmacy benefit in other states and specify the type of plan and enrollment. Provide a preliminary work plan identifying key milestones, tasks, and accountability for implementation of Pharmacy Services as described in the RFP.	3 pages, excluding preliminary work plan
27.	IV.E Covered Services and Benefits	Describe how the MCO will ensure compliance with the Mental Health Parity and Addiction Equity Act, including how the MCO will evaluate and measure its compliance.	3 pages
28.	IV.F Member Services and Education	Describe member services processes including: • Training of customer service staff (both initial and ongoing). • Routing calls to appropriate persons, including escalation. • Making information available to customer service staff (the type of information and how it is provided, e.g. hard copy or on-line search capacity). • Handling calls from members with limited English proficiency and persons who are hearing impaired. • Monitoring and ensuring the quality and accuracy of information provided to members. • Monitoring and ensuring adherence to performance standards. • How MSRs will interact with other organizations including MLTC, other MCOs, and other programs/social service entities (e.g., WIC, housing assistance, and homeless shelters). • After hours procedures.	6 pages
29.	IV.F Member Services	Describe the informational materials the MCO proposes	2 pages

No.	RFP Section	Statement/Question	Page Limit
	and Education	to send to new members.	
30.	IV.F Member Services and Education	Describe the approach the MCO will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the MCO will ensure that materials are at the appropriate reading level.	2 pages
31.	IV.F Member Services and Education	Provide an overview of the MCO's proposed member website, including how it will satisfy requirements in this RFP. Provide examples of information that will be available on the website and on portals for members.	6 pages
32.	IV.F Member Services and Education	Discuss the MCO's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the MCO would use to effectively welcome members.	3 pages
33.	IV.F Member Services and Education	Detail the strategies the MCO will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles.	5 pages
34.	IV.F Member Services and Education	Describe the processes the MCO will put in place to ensure the MCO does not restrict the choice of providers from whom the member may receive family planning services and supplies.	1 page
35.	IV.F Member Services and Education	Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the MCO has used for member education. Describe how the MCO will provide equitable member education throughout the State. Provide examples and descriptions of how member education will be used to improve service coordination including: • Integration of physical, behavioral health and pharmacy services. • EPSDT compliance. • Appropriate emergency room utilization. • The use of prenatal services. • The use of technological tools, including social media and mobile technology. • Partnership with community-based organizations for education and outreach.	10 pages
36.	IV.H Grievances and Appeals	Provide a flowchart and comprehensive written description of the MCO's member grievance and appeals process, including the approach for meeting the general requirements and plan to: • Ensure individuals who make decisions about grievances and appeals have the appropriate	3 pages

No.	RFP Section	Statement/Question	Page Limit
		expertise and were not involved in any previous level of review. • Ensure an expedited process exists when taking the standard time could seriously jeopardize the member's health. As part of this process, explain how the MCO will determine when the expedited process is necessary. • Use data from the grievance and appeals system to improve the MCO's operational performance.	
37.	IV.H Grievances and Appeals	Describe the approach the MCO will take to provide members with grievance, appeal, and State fair hearing information. Address how the MCO will ensure the grievance and appeals system policies and procedures, and all notices, will be available in the member's primary language and that reasonable assistance will be given to members to file a grievance or appeal.	2 pages
38.	IV.I Provider Network Requirements	Describe the MCO's proposed provider network outreach approach and recruitment strategy. Provide a detailed work plan for developing an adequate network within the timeframe described in Section IV.I. Describe the method the MCO plans to use on an ongoing basis to assess and ensure that MLTC's network standards are maintained, including standards related to: • Distance. • Appointment access. • Cultural competency. • After-hours access. • Inclusion of PCPs. • Inclusion of behavioral health providers. • Inclusion of high volume specialists. • Inclusion of FQHCs and RHCs. • Inclusion of urgent care centers. • Inclusion of pharmacies. • Inclusion of hospitals.	6 pages, excluding plan for developing an adequate network
39.	IV.I Provider Network Requirements	Describe the MCO's required PCP responsibilities and how the MCO will verify PCPs are performing them.	2 pages
40.	IV.I Provider Network Requirements	Describe innovative strategies the MCO's intends to use to identify specialty types for which member access is limited. Describe the MCO's intended initiatives for increasing the number of specialists within those specialty types that participate in the MCO's network. Identify potential challenges the MCO anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the MCO will mitigate those challenges.	3 pages

No.	RFP Section	Statement/Question	Page Limit
41.	IV.I Provider Network Requirements	Describe the MCO's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times.	2 pages
42.	IV.I Provider Network Requirements	Describe the MCO's approach to promoting and facilitating the capacity of its providers to provide: • Patient-centered care. • Improved health outcomes. • Member compliance. • Member satisfaction. Discuss the MCO's successes with patient-centeredness in other Medicaid programs, what lessons have been learned, and the MCO's planned approach in Nebraska.	3 pages
43.	IV.I Provider Network Requirements	Describe how the MCO's network development plan will establish patient-centered medical homes consistent with the requirements included in Section IV.I Provider Network Requirements. The description must address requirements in the RFP including: • Promoting and facilitating provider capacity to meet PCMH standards. • Maintaining contact with members throughout their interactions with the health care system. • Managing referrals. • Illness and disease prevention. • Encouraging active participation of the member or family/guardian/authorized representative in health care decision-making • Encouraging the use of specialty services and supports. • Providing access to care outside normal business hours. • Facilitating open scheduling and same-day appointments where possible.	5 pages
44.	IV.I Provider Network Requirements	Describe how the MCO would respond to the network termination or loss of a large-scale provider group or health system. Take the following areas into consideration in the response: • Notification to MLTC. • Coordination with the PBM. • The automated systems and membership supports used to assist affected members with provider transitions. • Systems and policies used for continuity of care of members experiencing provider transitions. • Impact if the loss is in a geographic area where other providers of the same provider type are not available and the MCO's response to that impact.	3 pages

No.	RFP Section	Statement/Question	Page Limit
45.	IV.I Provider Network Requirements	Describe the MCO's credentialing and re-credentialing process including: • Ensuring that providers are enrolled in Medicaid and have a valid identification number. • Obtaining information on ownership and control. • Identifying excluded providers and persons convicted of crimes searches. • Using quality and utilization measures in the recredentialing process.	3 pages
46.	IV.I Provider Network Requirements	Explain the process the MCO will put in place to maintain the provider file with detailed information on each provider sufficient to support provider payment, including issuance of IRS 1099 forms, meeting all federal and MLTC reporting requirements, and cross referencing State and Federal identification numbers to ensure excluded providers are identified.	2 pages
47.	IV.J Provider Services	Provide a description of the MCO's provider services program/department and how the MCO intends to partner with the provider community to deliver covered services. Include: • Information available in the provider handbook or other media. • Description of any committees the MCO will form for providers to offer input regarding issues such as the MCO's service delivery, MCO/provider interactions, and potential opportunities/ innovations for improved health outcomes. • Description of how the MCO will develop, establish and maintain its provider advisory committee, with representation as identified in this RFP. • Sample provider outreach methods.	4 pages
48.	IV.J Provider Services	Describe the MCO's Provider Services toll-free telephone line, including: • How the MCO will provide a fully-staffed line between the hours of 7:00 a.m. and 8:00 p.m. CST. Monday through Friday, to address non-emergency issues and how the MCO will provide a clinical pharmacist staffed at all times during the hours of 8:00 a.m. and 8:00 p.m. CST Monday through Friday. • How the MCO will ensure that provider calls are acknowledged and resolved within three business days of receipt. • The location of operations, and if out of state, describe how the MCO will accommodate services for Nebraska. • How the MCO will measure and monitor the	3 pages

No.	RFP Section	Statement/Question	Page Limit
		accuracy of responses provided by call center staff, as well as caller satisfaction.	
49.	IV.J Provider Services	Provide an overview of the MCO's proposed provider website, including examples of information that will be available on the website and on portals for providers. Include proposed resources and tools that will be of use to providers. Please provide a description of technology that will be used to enhance the provider website.	5 pages excluding sample resources, tools and materials
50.	IV.J Provider Services	Describe the MCO's proposed provider education and training program, including: • A description of the training program. • A work plan that outlines education and training activities, including frequency of office visits to conduct activities. • A listing of the types of materials and content the MCO will distribute (include three samples of materials). • How the MCO will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.	5 pages, excluding sample materials
51.	IV.J Provider Services	Describe the MCO's proposed approach to promoting communication between providers and the MCO. Include a discussion of how the MCO will work with providers to improve administrative efficiencies, and engage providers in developing and monitoring clinical policies and operational issues. Discuss how the provider network liaison will work with the Provider Advisory Committee to respond to provider concerns, develop provider trainings, and enhance MCO-provider communication strategies. Provide examples of how the MCO has successfully collaborated with providers to identify necessary changes and how these changes have been implemented.	2 pages
52.	IV.J Provider Services	Provide a description of the MCO's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as timeframes in which the MCO will acknowledge and resolve inquiries and grievances. Explain how the MCO will track provider complaints and how the MCO will use this type of information to improve provider services. Include a description of any type of internal reporting the MCO will perform, and how the MCO will use reporting information to influence the activities of the MCO's provider services representatives.	3 pages
53.	IV.J	Describe the MCO's plans and ability to support network providers' "meaningful use" of electronic health records	1 page

No.	RFP Section	Statement/Question	Page Limit
	Provider Services	and current/future Federal IT requirements.	
54.	IV.J Provider Services	Discuss how the MCO will engage and educate PCPs about their role in the provision of behavioral health services and the coordination of co-existing conditions.	2 pages
55.	IV.J Provider Services	Describe the approach the MCO will take to assess provider satisfaction, including tools the MCO plans to use, frequency of assessment, and responsible parties. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.	5 pages
56.	IV.K Subcontracting Requirements	For each subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following: • The date the company was formed, established or created. • Ownership structure (whether public, partnership, subsidiary, or specified other). • Organizational chart. • Total number of employees. • Whether the subcontractor is currently providing services for the MCO in other states and the subcontractor's location.	1 page per subcontracting organization
57.	IV.K Subcontracting Requirements	For subcontracted roles included in the proposal, describe the MCO's process for monitoring and evaluating performance and compliance, including but not limited to how the MCO will: • Ensure receipt of all required data including encounter data. • Ensure that utilization of health care services is at an appropriate level. • Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP. • Ensure adherence to required grievance policies and procedures. • Ensure that subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service unless a request has been submitted to and approved by MLTC.	8 pages
58.	IV.L Care Management	Provide a comprehensive discussion of the MCO's care management program, including: • Coordination of services using person-centered strategies.	Not applicable

No.	RFP Section	Statement/Question	Page Limit
		• Interventions focused on the whole person. • Management of co-morbidities. • Incorporation of best practices for behavioral health. • Member engagement in self-management strategies. • Social determinants of health, including risk and protective factors for behavioral health concerns. • Identification and tracking of members whose clinical conditions or social factors place them at an increased risk for circumstances necessitating a higher level of care management services. Provide case studies and experience from other states illustrating the MCO's ability to successfully address community differences in its care management approach.	
59.	IV.L Care Management	Describe the MCO's approach for identifying members in need of care management services, including: • The proposed process for providing a health risk screening to all members upon enrollment to identify and assess members potentially eligible for care management services, including those who have or are likely to experience catastrophic or other high-cost or high-risk conditions. • A description of the algorithms and methodologies the MCO will use to identify members potentially eligible for care management. • The proposed process for conducting health risk assessments for members identified as potentially eligible for care management. Submit the proposed health risk assessment template that the MCO plans to use.	5 pages
60.	IV.L Care Management	Describe the specific types of services members will receive at each risk level. Provide recommendations for additional innovative care management strategies, if any, MLTC may want to consider.	5 pages
61.	IV.L Care Management	Describe how the MCO will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover.	2 pages
62.	IV.L Care Management	Describe the MCO's strategy to address the unique challenges when coordinating care for dual-eligible individuals who receive their services from both Medicare and Medicaid.	2 pages
63.	IV.L Care Management	Describe the process for care coordination for members who are Tribal members or are otherwise eligible for care through Indian Health Services.	1 page
64.	IV.L	Describe how the MCO will coordinate service planning, service delivery, and post-discharge care among	4 pages

No.	RFP Section	Statement/Question	Page Limit
	Care Management	discharge planners (including State psychiatric hospitals) and home health and other service providers. Include the MCO's approach to care management for youth discharged from residential care. Explain how the MCO will monitor the post-discharge care of members who receive services in remote areas.	
65.	IV.L Care Management	Describe how the MCO will use data and evidence-based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies. Discuss how these tools and data and systems will be integrated to implement outcome- and value-oriented payment models. Describe the MCO's experience and specific results.	5 pages
66.	IV.L Care Management	Provide a proposed plan for coordinating efforts for members who may be involved in multiple State programs, including those enrolled in HCBS waivers. Describe how the MCO will deploy care management activities under this RFP in a manner that will not duplicate the activities provided under HCBS waivers and will facilitate sharing of information across DHHS-administered programs.	3 pages
67.	IV.L Care Management	Describe the MCO's outreach program to encourage women to seek prenatal services during their first trimester of pregnancy and how the MCO will implement required health risk screening and follow up, when applicable, for pregnant members.	2 pages
68.	IV.M Quality Management	Provide a description of the MCO's proposed QAPI program. Include the following in the description: • The proposed structure, and policies and procedures that explain the accountability of each organizational unit. • The program's infrastructure, including coordination with subcontractors and corporate entities, if applicable. • Proposed QAPIC membership and committee responsibilities. • How the MCO will comply with and support MLTC's quality strategy. • How focus areas will be selected, including how data will be used in the selection process. • The proposed QAPI work plan, including planned initiatives.	10 pages
69.	IV.M Quality	Describe how the MCO will measure and track the outcome of individual quality improvement interventions	3 pages

No.	RFP Section	Statement/Question	Page Limit
	Management	over time.	
70.	IV.M Quality Management	Describe experience in using results of performance measures, member satisfaction surveys, and other data to drive improvements and positive affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes.	5 pages
71.	IV.M Quality Management	Describe how the MCO will assess the quality and appropriateness of care furnished to members with special health care needs, members with co-occuring physical and behavioral health concerns, and dual-eligible members.	3 pages
72.	IV.M Quality Management	Describe the MCO's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the MCO's quality of care.	2 pages
73.	IV.M Quality Management	Describe the MCO's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the MCO, and how operations improved because of their results. Discuss how the MCO will collaborate with MLTC and other MCOs to conduct statewide PIPs.	3 pages
74.	IV.M Quality Management	Discuss the MCO's approaches to annual member satisfaction surveys. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.	1 page
75.	IV.M Quality Management	Discuss the MCO's experience with submitting HEDIS measures. Indicate whether the measures were reported for a State Medicaid, CHIP, or commercial product line.	1 page
76.	IV.M Quality Management	Provide the MCO's vision for the MCO's Clinical Advisory Committee. Discuss how the requirements of the RFP will be met.	2 pages
77.	IV.M Quality Management	Describe the MCO's practice of profiling the quality of care delivered by PCPs, specialists, and hospitals, including the methodology for determining which and how many providers will be profiled. • Submit sample quality reports. • Describe the rationale for selected the measures that are gathered/reported. • Describe the proposed frequency of profiling activities.	3 pages, excluding sample quality reports

No.	RFP Section	Statement/Question	Page Limit
78.	IV.M Quality Management	How will the MCO use the Member Advisory Committee to improve quality of care and direct quality and operational changes? What representation does the MCO plan to have on each committee (e.g., stakeholder types, from what geographic areas)? How will the MCO identify participants of the Member Advisory Committees? Provide examples from other states where the MCO has collaborated with members for program improvement.	5 pages
79.	IV.M Quality Management	Describe the information the MCO will provide to members and providers about the QAPI program.	2 pages
80.	IV.N Utilization Management	Describe the MCO's approach to utilization management, including: • Innovations and automation the MCO will use for its UM program. • Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers. • Mechanisms to detect and document over- and under-utilization of medical services. • Processes and resources used to develop and regularly review utilization review criteria. • How the MCO will use its UM Committee to support UM activities.	5 pages
81.	IV.N Utilization Management	Describe the process the MCO will have in place to determine appropriate practice guidelines (including for behavioral health), notify providers of new practice guidelines, and monitor implementation of those guidelines.	2 pages
82.	IV.N Utilization Management	As one of the largest payers in Nebraska, MLTC has an important role to play to move the health care system to a more cost-effective model that improves outcomes. Provide specific initiatives the MCO will pursue to deal with "waste" in the existing system and improve outcomes. Provide specific information regarding the initiatives that will be pursued to improve quality and enhance cost containment (including the stakeholders involved, the timelines, and the desired outcomes).	4 pages
83.	IV.N Utilization Management	Describe the MCO's proposed approach to prior authorization, including: • The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated. Describe what will be considered in the reevaluation	4 pages

No.	RFP Section	Statement/Question	Page Limit
		of need for current prior authorization requirements. • The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization. • The role of the Clinical Advisory Committee in developing service authorization procedures. • The MCO's process for notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.	
84.	IV.N Utilization Management	Provide a listing of services for which the MCO will require prior authorization and describe how the MCO will communicate this information, as well as the results of authorization decisions, to providers and members.	2 pages excluding the listing of services
85.	IV.N Utilization Management	Describe how the MCO will ensure members receive written and timely notice of action relating to adverse actions taken by the MCO.	1 page
86.	IV.N Utilization Management	Describe the MCO's process for conducting concurrent reviews for inpatient services.	2 pages
87.	IV.N Utilization Management	Describe the MCO's process for conducting retrospective reviews to examine trends, issues, and problems in utilization.	2 pages
88.	IV.N Utilization Management	Describe the initiatives the MCO will implement to control unnecessary ED utilization, avoidable hospitalizations, and hospital readmissions. Discuss how the MCO will ensure that care is provided in the most appropriate and cost effective setting. Include strategies that address access to primary care services through patient centeredness principles; the use of urgent care centers and retail clinics; and, interventions targeted to super-utilizers, such as patients with asthma, diabetes, chronic pain, and/or behavioral health conditions.	6 pages
89.	IV.N Utilization Management	Describe the MCO's proposed MTM program, including a description of the inclusion criteria that the MCO proposes to use. Also, include any vendor(s) that will be subcontracted by the MCO to perform or support MTM services. Provide a detailed description of tools the MCO will use to ensure the active engagement of the retail pharmacies in the MTM program.	4 pages
90.	IV.N Utilization Management	Describe the MCO's DUR program including prospective and retrospective DUR activities. Include a description of: • Prescriber and pharmacy education programs.	3 pages

No.	RFP Section	Statement/Question	Page Limit
		• Collaboration with MLTC's DUR. • How DUR results will be used to inform MTM education and outreach.	
91.	IV.N Utilization Management	Describe the MCO's proposed psychotropic drug oversight program to ensure appropriate utilization, including a description of the inclusion criteria that the MCO proposes to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of: • Tools to monitor and measure psychotropic prescribing patterns and usage. • Processes to actively engage retail pharmacies and pharmacists in the oversight program. • Plans for prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member. • Processes to ensure that psychotropic medications prescribed to children are being used appropriately and for the indicated diagnosis.	4 pages
92.	IV.N Utilization Management	Describe the MCO's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities.	2 pages
93.	IV.O Program Integrity	Describe the MCO's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the MCO has utilized in other states.	4 pages
94.	IV.O Program Integrity	Describe how the MCO currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the MCO apply methods in Nebraska?	2 pages
95.	IV.O Program Integrity	Currently, how does the MCO educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the MCO apply methods in Nebraska?	3 pages
96.	IV.O Program Integrity	Describe the MCO's method and process for capturing TPL and payment information from its claims system. Explain how the MCO will use this information.	3 pages
97.	IV.Q Provider Reimbursement	Provide a detailed description of the MCO's approach to implementing a value-based purchasing model with providers. Include at a minimum the MCO's:	6 pages

No.	RFP Section	Statement/Question	Page Limit
		• Philosophy regarding value-based purchasing and risk-sharing agreements and evidence of effective use in Nebraska or other markets • Approach to identifying initiatives and performance measures on which to focus, proposed engagement strategies to encourage provider participation, incentives the MCO will use, and methodology and timing for determining if providers have met requirements • Plan for entering into value-based purchasing agreements with 30% of its provider network by December 31, 2019. • Discussion of best practices and lessons learned.	
98.	IV.Q Provider Reimbursement	Provide a description of the MCO's proposed MAC program, including methods for setting MAC prices, criteria used to select covered MAC drugs, process for resolving disputes regarding the MAC value, how the MCO will evaluate its MAC program, and any other program components the MCO considers important for achieving the State's NMMCP goals. Describe the MCO's experience with establishing MAC programs in other states, and highlight strengths and challenges.	6 pages
99.	IV.Q Provider Reimbursement	Describe the MCO's approach to ensuring that out of network prior authorization and payment issues are resolved expeditiously in instances when the MCO is unable to provide necessary services to a member within its network.	2 pages
100.	IV.Q Provider Reimbursement	Describe the MCO's proposed process for the annual year-end cost settlement process with critical access hospitals.	1 page

No.	RFP Section	Statement/Question	Page Limit
101.	IV.R Systems and Technical Requirements	Provide a general system description that details how each component of the MCO's health information system will support the major functional areas of NMMCP. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements. Describe how the MCO's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the MCO's systems. If modifications or updates or updates are required, describe them and the MCO's plan for completion prior to program operations.	12 pages, not including the systems diagram
102.	IV.R Systems and Technical Requirements	Provide a description of how the MCO will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the MCO's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the MCO's internal membership records, including differences in members' addresses.	3 pages
103.	IV.R Systems and Technical Requirements	Describe the MCO's approach to monitoring system availability issues and the resolution process. Provide a description of the MCO's system help desk. Include the MCO's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to MCO management within one business day of recognition and are promptly corrected.	2 pages
104.	IV.R Systems and Technical Requirements	Provide a description of the MCO's eligibility and enrollment database. Include a description of how the MCO will: • Complete updates within the timeframes specified in the contract. • Identify members across multiple populations and systems. • Monitor, track, and resolve any discrepancies between the enrollment files and the MCO's system (e.g., duplication of records and information mismatches).	2 pages

No.	RFP Section	Statement/Question	Page Limit
105.	IV.R Systems and Technical Requirements	Provide a description of the MCO's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities.	3 pages
106.	IV.R Systems and Technical Requirements	Describe the MCO's business continuity, contingency, and recovery planning. Attach a copy of the MCO's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery: • Operational and system redundancy in place to reduce the risk of down-time. • System and operational back-up sites. • Contingency and recovery planning including resumption of operations. • Prioritized business functions for resumption of operations and responsible key personnel. • Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable. • Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith. • Testing approach and regular schedule to improve and update the plan over time.	3 pages, excluding sample plan
107.	IV.S Claims Management	Describe the MCO's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the MCO's strategy for identifying problem areas, and how the MCO will ensure rapid response.	2 pages
108.	IV.S Claims Management	Describe the MCO's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address: • The process for auditing claims samples. • Documentation of the results of these audits. • The processes for implementing any necessary corrective actions resulting from the audit.	3 pages
109.	IV.S Claims	Describe in detail how the MCO will verify that services were actually provided including:	3 pages

No.	RFP Section	Statement/Question	Page Limit
	Management	• Minimum sampling criteria to ensure a representative sample. • How results of monitoring will be reported to the State quarterly.	
110.	IV.S Claims Management	Describe the drug reference database used in pharmacy claims processing, and the update schedule, including term dates, obsolete dates, and rebate status.	2 pages
111.	IV.S Claims Management	Describe how the State Medicaid PDL will be integrated into the MCO pharmacy claims system.	2 pages
112.	IV.S Claims Management	Describe the MCO's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the MCO proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor.	5 pages
113.	IV.S Claims Management	Describe the MCO's proposed processes for coordination of benefits for dually-eligible members.	2 pages
114.	IV.T Reporting and Deliverables	Provide an example of dashboards that the MCO will use to track MCO performance for MCO leadership and the QAPI Committee.	Not applicable
115.	IV.T Reporting and Deliverables	Provide examples of the following reports: Member Grievance System Performance Improvement Projects Care Management How will the MCO use required reports in its day to day management and operations?	Not applicable
116.	IV.X Transition and Implementation	Describe how the MCO will coordinate the initial transition of individuals in the follow situations to ensure continuity of care: • From another MCO. • From FFS , including specific approaches for the aged and disabled populations who are new to managed care. Include processes for engaging existing providers in the transition.	5 pages
117.	IV.Z FFS Claims Management and Processing	Provide a detailed description of the MCO's approach to implementing the necessary functionality to support FFS claims processing.	Not applicable

No.	RFP Section	Statement/Question	Page Limit
118.	IV.Z FFS Claims Management and Processing	Describe the level of effort necessary to support Nebraska program and policy changes, including but not limited to new covered services, prior authorization requirements, or additional populations.	Not applicable
119.	IV.Z FFS Claims Management and Processing	Describe how the MCO will maintain a distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system.	Not applicable
120.	IV.Z FFS Claims Management and Processing	Provide an explanation of the MCO's plan and approach for business operations to support the FFS volume vs. the risk-based volume. Will the plan have separate or joint business operations units for some or all processes?	Not applicable
121.	IV.Z FFS Claims Management and Processing	Provide an explanation of the significant risks associated with the implementation and ongoing operation of claims broker services, and provide mitigation strategies for those risks.	Not applicable
122.	IV.Z FFS Claims Management and Processing	Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.	Not applicable

Attachment 18 – Liquidated Damages

Failed Deliverable	Penalty
Readiness Review	MLTC will conduct a formal review of the MCO's readiness to implement all required services described in this RFP. Should the MCO fail the review, MLTC may assess damages of $5,000 for each calendar day until such time as MLTC certifies that the MCO has met all readiness requirements.
Date of Implementation	Should the MCO fail to begin full operations on the contract start date, and should MLTC determine that the MCO is responsible for the delay, MLTC may assess damages of $10,000.00 per calendar day for each day beyond the contract start date that the MCO fails to begin full operations.
Network Performance Requirement	The MCO must have a contracted provider network in place and submit the required attestation of network sufficiency 90 calendar days prior to the contract start date. A penalty of $1,000.00 shall be assessed, at MLTC' discretion, per calendar day for each day that the provider network is not adequate to meet the service needs of the covered populations as described in Section X - Provider Network and the attestation of network sufficiency has not been received.
Employment of Key Personnel	The MCO must meet all key personnel requirements specified in Section X of this RFP. MLTC may assess a penalty of $1,000 per day, per position, for each day after the 30 allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.
Excessive Reversals on Appeal	If the MCO exceeds 10% of member appeals overturned upon final appeal over a 12-month period (January-December or the first twelve months that the contract is in effect), a penalty of $25,000 may be imposed for every additional overturned appeal. This penalty may also be assessed for each occurrence in which the MCO does not provide the medical services or requirements set forth in an administrative decision by MLTC or a state fair hearing.
Ongoing and Ad Hoc Reporting	As detailed in Attachment 6, MLTC may assess a penalty of $1,000 for each calendar day that a report is late, inaccurate, includes less than the required copies, or is not in the approved format.

Encounter Data	$10,000 per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications required by MLTC. $10,000 per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the MCO for correction because submission data was in excess of the 5% error rate threshold, until acceptance of the data. $10,000 per return of re-submission of encounter data that was returned to the MCO, as submission data was in excess of the 5% error rate threshold, for correction and was rejected for the second time. $10,000 per calendar day for inability to reconcile financial statement of medical expenses paid with the total dollars submitted through encounter data for that quarter within 10% for 2017 and 5% for 2018. $10,000 per occurrence of medical record review by MLTC or its designee where the MCO or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.
Claims Processing	90% of all clean claims must be paid within 15 business days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard. 99% of all clean claims must be paid within 60 calendar days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.
Pharmacy Claims Processing	90% of all clean claims must be paid within 7 calendar days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard. 99% of all clean claims must be paid within 14 calendar days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.
PCP Assignment	$5,000 per calendar day for failure to assign a PCP within one month of the effective date of enrollment until the assignment is made.

Member Services	$5,000 per calendar day for failure to provide member services functions from 8 a.m. to 5 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.
Provider Services	$5,000 per calendar day for failure to furnish provider services functions from 7 a.m. to 8 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members and for failure to handle emergent provider issues on a 24 hours a day, 7 days a week basis.
Intermediate Sanctions	
Per 42 CFR 438.704(b)(1): A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; marketing violations.	
Per 42 CFR 438.704(b)(2): A maximum of $100,000 for each determination of discrimination; misrepresentation or false statements to CMS or the State or any such action or inaction that the State deems a violation that merits a fine consistent with this section.	
Per 42 CFR 438.704(b)(3): A maximum of $15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above) or any such action or inaction that the State deems a violation that merits a fine consistent with this section.	
Per 42 CFR 438.704(c): A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program; or any such action or inaction that the State deems a violation that merits a fine consistent with this section. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).	

Attachment 17
2015 Health Care Acquired Conditions

A HAC can be defied by a single diagnosis code, a combination of a diagnosis code and a surgical procedure, or a combination of a diagnosis code, a surgical procedure, and a principal diagnosis code.

CC: Complications and comorbidities
MCC: Major complications and comorbidities

Foreign Object Retained After Surgery		
(CC)	T81.509A	Unspecified complication of foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.519A	Adhesions due to foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.529A	Obstruction due to foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.539A	Perforation due to foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.61XA	Aseptic peritonitis due to foreign substance accidentally left during a procedure, initial encounter
(CC)	T81.69XA	Other acute reaction to foreign substance accidentally left during a procedure, initial encounter
Air Embolism	T80.0XXA	Air embolism following infusion, transfusion and therapeutic injection, initial encounter
Blood Incompatibility		
(CC)	T80.30XA	ABO incompatibility reaction due to transfusion of blood or blood products, unspecified, initial encounter
(CC)	T80.319A	ABO incompatibility with hemolytic transfusion reaction, unspecified, initial encounter
(CC)	T80.310A	ABO incompatibility with acute hemolytic transfusion reaction, initial encounter
(CC)	T80.311A	ABO incompatibility with delayed hemolytic transfusion reaction, initial encounter
(CC)	T80.39XA	Other ABO incompatibility reaction due to transfusion of blood or blood products, initial encounter
Pressure Ulcer Stages III & IV		
(MCC)	L89003	Pressure ulcer of unspecified elbow, stage 3

(MCC)	L89004	Pressure ulcer of unspecified elbow, stage 4
(MCC)	L89013	Pressure ulcer of right elbow, stage 3
(MCC)	L89014	Pressure ulcer of right elbow, stage 4
(MCC)	L89023	Pressure ulcer of left elbow, stage 3
(MCC)	L89024	Pressure ulcer of left elbow, stage 4
(MCC)	L89103	Pressure ulcer of unspecified part of back, stage 3
(MCC)	L89104	Pressure ulcer of unspecified part of back, stage 4
(MCC)	L89113	Pressure ulcer of right upper back, stage 3
(MCC)	L89114	Pressure ulcer of right upper back, stage 4
(MCC)	L89123	Pressure ulcer of left upper back, stage 3
(MCC)	L89124	Pressure ulcer of left upper back, stage 4
(MCC)	L89133	Pressure ulcer of right lower back, stage 3
(MCC)	L89134	Pressure ulcer of right lower back, stage 4
(MCC)	L89143	Pressure ulcer of left lower back, stage 3
(MCC)	L89144	Pressure ulcer of left lower back, stage 4
(MCC)	L89153	Pressure ulcer of sacral region, stage 3
(MCC)	L89154	Pressure ulcer of sacral region, stage 4
(MCC)	L89203	Pressure ulcer of unspecified hip, stage 3
(MCC)	L89204	Pressure ulcer of unspecified hip, stage 4
(MCC)	L89213	Pressure ulcer of right hip, stage 3
(MCC)	L89214	Pressure ulcer of right hip, stage 4
(MCC)	L89223	Pressure ulcer of left hip, stage 3
(MCC)	L89224	Pressure ulcer of left hip, stage 4
(MCC)	L89303	Pressure ulcer of unspecified buttock, stage 3
(MCC)	L89304	Pressure ulcer of unspecified buttock, stage 4
(MCC)	L89313	Pressure ulcer of right buttock, stage 3
(MCC)	L89314	Pressure ulcer of right buttock, stage 4
(MCC)	L89323	Pressure ulcer of left buttock, stage 3
(MCC)	L89324	Pressure ulcer of left buttock, stage 4
(MCC)	L8943	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
(MCC)	L8944	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
(MCC)	L89503	Pressure ulcer of unspecified ankle, stage 3

(MCC)	L89504	Pressure ulcer of unspecified ankle, stage 4
(MCC)	L89513	Pressure ulcer of right ankle, stage 3
(MCC)	L89514	Pressure ulcer of right ankle, stage 4
(MCC)	L89523	Pressure ulcer of left ankle, stage 3
(MCC)	L89524	Pressure ulcer of left ankle, stage 4
(MCC)	L89603	Pressure ulcer of unspecified heel, stage 3
(MCC)	L89604	Pressure ulcer of unspecified heel, stage 4
(MCC)	L89613	Pressure ulcer of right heel, stage 3
(MCC)	L89614	Pressure ulcer of right heel, stage 4
(MCC)	L89623	Pressure ulcer of left heel, stage 3
(MCC)	L89624	Pressure ulcer of left heel, stage 4
(MCC)	L89813	Pressure ulcer of head, stage 3
(MCC)	L89814	Pressure ulcer of head, stage 4
(MCC)	L89893	Pressure ulcer of other site, stage 3
(MCC)	L89894	Pressure ulcer of other site, stage 4
(MCC)	L8993	Pressure ulcer of unspecified site, stage 3
(MCC)	L8994	Pressure ulcer of unspecified site, stage 4

Falls and Trauma:

Codes within these ranges on the CC/MCC list:

Fracture	S02.0XXA - T14.8
Dislocation	S03.0XXA - T14.90
Intracranial Injury	S06.0X0A - (S06.890A or S06.899A or S01.90XA)
Crushing Injury	(S07.0XXA or S07.8XXA) - S77.20XA
Burn	T26.50XA - (T30.0 or T30.4)
Other Injuries	(T33.09XA or T34.09XA) - (T73.8XXA or T73.9XXA or T75.89XA)

Catheter-Associated Urinary Tract Infection (UTI)

(CC)	T83.51XA	Infection and inflammatory reaction due to indwelling urinary catheter, initial encounter

Also excludes the following from acting as a CC/MCC:

(CC)	B37.42	Candidal balanitis
(CC)	B37.49	Other urogenital candidiasis

(CC)	N10	Acute tubulo-interstitial nephritis
(MCC)	N10	Acute tubulo-interstitial nephritis
(MCC)	N15.1	Renal and perinephric abscess
(CC)	N28.84	Pyelitis cystica
(CC)	N28.85	Pyeloureteritis cystica
(CC)	N28.86	Ureteritis cystica
(CC)	N12	Tubulo-interstitial nephritis, not specified as acute or chronic
(CC)	N16	Renal tubulo-interstitial disorders in diseases classified elsewhere
(CC)	N30.00	Acute cystitis without hematuria
(CC)	N30.01	Acute cystitis with hematuria
(CC)	N34.0	Urethral abscess
(CC)	N39.0	Urinary tract infection, site not specified
Vascular Catheter-Associated Infection		
(CC)	T80.219A	Unspecified infection due to central venous catheter, initial encounter
(CC)	T80.211A	Bloodstream infection due to central venous catheter, initial encounter
(CC)	T80.212A	Local infection due to central venous catheter, initial encounter
Manifestations of Poor Glycemic Control		
(MCC)	E11.69	Type 2 diabetes mellitus with other specified complication
(MCC)	E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
(MCC)	E11.69	Type 2 diabetes mellitus with other specified complication
(MCC)	E11.65	Type 2 diabetes mellitus with hyperglycemia
(MCC)	E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
(MCC)	E10.65	Type 1 diabetes mellitus with hyperglycemia
(MCC)	E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
(MCC)	E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
(MCC)	E10.69	Type 1 diabetes mellitus with other specified complication
(MCC)	E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
(MCC)	E11.65	Type 2 diabetes mellitus with hyperglycemia
(MCC)	E10.69	Type 1 diabetes mellitus with other specified complication
(MCC)	E10.65	Type 1 diabetes mellitus with hyperglycemia
(CC)	E15	Nondiabetic hypoglycemic coma

(MCC)	E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
(MCC)	E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
(MCC)	E13.10	Other specified diabetes mellitus with ketoacidosis without coma
(MCC)	E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
(MCC)	E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma with
(MCC)	E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
(MCC)	E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
(MCC)	E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
(MCC)	E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
(MCC)	E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
(MCC)	E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma with
(MCC)	E08.65	Diabetes mellitus due to underlying condition with hyperglycemia

Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)

(MCC)	J98.5	Diseases of mediastinum, not elsewhere classified

And one of the following procedure codes:

0210093	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Open Approach
02100A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Open Approach
02100J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Open Approach
02100K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Open Approach
02100Z3	Bypass Coronary Artery, One Site from Coronary Artery, Open Approach
0210493	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach

02104A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104Z3	Bypass Coronary Artery, One Site from Coronary Artery, Percutaneous Endoscopic Approach
021009W	Bypass Coronary Artery, One Site from Aorta with Autologous Venous Tissue, Open Approach
02100AW	Bypass Coronary Artery, One Site from Aorta with Autologous Arterial Tissue, Open Approach
02100JW	Bypass Coronary Artery, One Site from Aorta with Synthetic Substitute, Open Approach
02100KW	Bypass Coronary Artery, One Site from Aorta with Nonautologous Tissue Substitute, Open Approach
021049W	Bypass Coronary Artery, One Site from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104AW	Bypass Coronary Artery, One Site from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104JW	Bypass Coronary Artery, One Site from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach
02104KW	Bypass Coronary Artery, One Site from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021109W	Bypass Coronary Artery, Two Sites from Aorta with Autologous Venous Tissue, Open Approach
02110AW	Bypass Coronary Artery, Two Sites from Aorta with Autologous Arterial Tissue, Open Approach
02110JW	Bypass Coronary Artery, Two Sites from Aorta with Synthetic Substitute, Open Approach
02110KW	Bypass Coronary Artery, Two Sites from Aorta with Nonautologous Tissue Substitute, Open Approach
021149W	Bypass Coronary Artery, Two Sites from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02114AW	Bypass Coronary Artery, Two Sites from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114JW	Bypass Coronary Artery, Two Sites from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach

02114KW	Bypass Coronary Artery, Two Sites from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021209W	Bypass Coronary Artery, Three Sites from Aorta with Autologous Venous Tissue, Open Approach
02120AW	Bypass Coronary Artery, Three Sites from Aorta with Autologous Arterial Tissue, Open Approach
02120JW	Bypass Coronary Artery, Three Sites from Aorta with Synthetic Substitute, Open Approach
02120KW	Bypass Coronary Artery, Three Sites from Aorta with Nonautologous Tissue Substitute, Open Approach
021249W	Bypass Coronary Artery, Three Sites from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02124AW	Bypass Coronary Artery, Three Sites from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02124JW	Bypass Coronary Artery, Three Sites from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach
02124KW	Bypass Coronary Artery, Three Sites from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021309W	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Venous Tissue, Open Approach
02130AW	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Arterial Tissue, Open Approach
02130JW	Bypass Coronary Artery, Four or More Sites from Aorta with Synthetic Substitute, Open Approach
02130KW	Bypass Coronary Artery, Four or More Sites from Aorta with Nonautologous Tissue Substitute, Open Approach
021349W	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02134AW	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02134JW	Bypass Coronary Artery, Four or More Sites from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach
02134KW	Bypass Coronary Artery, Four or More Sites from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0210098	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Venous Tissue, Open Approach
0210099	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Venous Tissue, Open Approach

021009C	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Venous Tissue, Open Approach
02100A8	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Arterial Tissue, Open Approach
02100A9	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Arterial Tissue, Open Approach
02100AC	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02100J8	Bypass Coronary Artery, One Site from Right Internal Mammary with Synthetic Substitute, Open Approach
02100J9	Bypass Coronary Artery, One Site from Left Internal Mammary with Synthetic Substitute, Open Approach
02100JC	Bypass Coronary Artery, One Site from Thoracic Artery with Synthetic Substitute, Open Approach
02100K8	Bypass Coronary Artery, One Site from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach
02100K9	Bypass Coronary Artery, One Site from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach
02100KC	Bypass Coronary Artery, One Site from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02100Z8	Bypass Coronary Artery, One Site from Right Internal Mammary, Open Approach
02100Z9	Bypass Coronary Artery, One Site from Left Internal Mammary, Open Approach
02100ZC	Bypass Coronary Artery, One Site from Thoracic Artery, Open Approach
0210498	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
0210499	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
021049C	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104A8	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104A9	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104AC	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104J8	Bypass Coronary Artery, One Site from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach

02104J9	Bypass Coronary Artery, One Site from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach
02104JC	Bypass Coronary Artery, One Site from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104K8	Bypass Coronary Artery, One Site from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104K9	Bypass Coronary Artery, One Site from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104KC	Bypass Coronary Artery, One Site from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104Z8	Bypass Coronary Artery, One Site from Right Internal Mammary, Percutaneous Endoscopic Approach
02104Z9	Bypass Coronary Artery, One Site from Left Internal Mammary, Percutaneous Endoscopic Approach
02104ZC	Bypass Coronary Artery, One Site from Thoracic Artery, Percutaneous Endoscopic Approach
0211098	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach
0211099	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach
021109C	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Venous Tissue, Open Approach
02110A8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Arterial Tissue, Open Approach
02110A9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Arterial Tissue, Open Approach
02110AC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02110J8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Synthetic Substitute, Open Approach
02110J9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Synthetic Substitute, Open Approach
02110JC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Synthetic Substitute, Open Approach
02110K8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach
02110K9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach

02110KC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02110Z8	Bypass Coronary Artery, Two Sites from Right Internal Mammary, Open Approach
02110Z9	Bypass Coronary Artery, Two Sites from Left Internal Mammary, Open Approach
02110ZC	Bypass Coronary Artery, Two Sites from Thoracic Artery, Open Approach
0211498	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
0211499	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
021149C	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02114A8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114A9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114AC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114J8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach
02114J9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach
02114JC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02114K8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02114K9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02114KC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02114Z8	Bypass Coronary Artery, Two Sites from Right Internal Mammary, Percutaneous Endoscopic Approach
02114Z9	Bypass Coronary Artery, Two Sites from Left Internal Mammary, Percutaneous Endoscopic Approach
02114ZC	Bypass Coronary Artery, Two Sites from Thoracic Artery, Percutaneous Endoscopic Approach
021209C	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Venous Tissue, Open Approach

02120AC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02120JC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Synthetic Substitute, Open Approach
02120KC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02120ZC	Bypass Coronary Artery, Three Sites from Thoracic Artery, Open Approach
021249C	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02124AC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02124JC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02124KC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02124ZC	Bypass Coronary Artery, Three Sites from Thoracic Artery, Percutaneous Endoscopic Approach
021309C	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Venous Tissue, Open Approach
02130AC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02130JC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Synthetic Substitute, Open Approach
02130KC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02130ZC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery, Open Approach
021349C	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02134AC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02134JC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02134KC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02134ZC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery, Percutaneous Endoscopic Approach
021009F	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Venous Tissue, Open Approach

02100AF	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Arterial Tissue, Open Approach
02100JF	Bypass Coronary Artery, One Site from Abdominal Artery with Synthetic Substitute, Open Approach
02100KF	Bypass Coronary Artery, One Site from Abdominal Artery with Nonautologous Tissue Substitute, Open Approach
02100ZF	Bypass Coronary Artery, One Site from Abdominal Artery, Open Approach
021049F	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104AF	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104JF	Bypass Coronary Artery, One Site from Abdominal Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104KF	Bypass Coronary Artery, One Site from Abdominal Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104ZF	Bypass Coronary Artery, One Site from Abdominal Artery, Percutaneous Endoscopic Approach
0210093	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Open Approach
02100A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Open Approach
02100J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Open Approach
02100K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Open Approach
02100Z3	Bypass Coronary Artery, One Site from Coronary Artery, Open Approach
0210493	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104Z3	Bypass Coronary Artery, One Site from Coronary Artery, Percutaneous Endoscopic Approach

Surgical Site Infection Following Certain Orthopedic Procedures

(CC)	T84.60XA	Infection and inflammatory reaction due to internal fixation device of unspecified site, initial encounter
(CC)	T84.7XXA	Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter
(CC)	K68.11	Postprocedural retroperitoneal abscess
(CC)	T81.4XXA	Infection following a procedure, initial encounter

And one of the following procedure codes:

0RG0070	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG0071	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG007J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Open Approach
0RG00Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Open Approach
0RG00ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Open Approach
0RG0370	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG0371	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG037J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach

0RG03J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0RG0470	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG0471	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG047J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0RG04Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1070	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG1370	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG1470	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG4070	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG4370	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach

0RG43J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG4470	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1071	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG1371	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG1471	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach

0RG4071	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG4371	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG4471	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG6070	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG6370	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach

0RG63Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG6470	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA070	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RGA370	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA470	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG6071	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach

0RG60K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG6371	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG6471	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA071	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RGA371	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA471	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach

0RGA4J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG0070	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0SG0370	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG0470	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG3070	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Open Approach

0SG3370	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG3470	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG0071	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0SG0371	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG0471	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach

0SG04Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG3071	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Open Approach
0SG3371	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG3471	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG007J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Open Approach
0SG037J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach

0SG03KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG047J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG307J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Open Approach
0SG337J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG347J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG704Z	Fusion of Right Sacroiliac Joint with Internal Fixation Device, Open Approach
0SG707Z	Fusion of Right Sacroiliac Joint with Autologous Tissue Substitute, Open Approach
0SG70JZ	Fusion of Right Sacroiliac Joint with Synthetic Substitute, Open Approach

0SG70KZ	Fusion of Right Sacroiliac Joint with Nonautologous Tissue Substitute, Open Approach
0SG70ZZ	Fusion of Right Sacroiliac Joint, Open Approach
0SG734Z	Fusion of Right Sacroiliac Joint with Internal Fixation Device, Percutaneous Approach
0SG737Z	Fusion of Right Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Approach
0SG73JZ	Fusion of Right Sacroiliac Joint with Synthetic Substitute, Percutaneous Approach
0SG73KZ	Fusion of Right Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SG73ZZ	Fusion of Right Sacroiliac Joint, Percutaneous Approach
0SG744Z	Fusion of Right Sacroiliac Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SG747Z	Fusion of Right Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG74JZ	Fusion of Right Sacroiliac Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SG74KZ	Fusion of Right Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG74ZZ	Fusion of Right Sacroiliac Joint, Percutaneous Endoscopic Approach
0SG804Z	Fusion of Left Sacroiliac Joint with Internal Fixation Device, Open Approach
0SG807Z	Fusion of Left Sacroiliac Joint with Autologous Tissue Substitute, Open Approach
0SG80JZ	Fusion of Left Sacroiliac Joint with Synthetic Substitute, Open Approach
0SG80KZ	Fusion of Left Sacroiliac Joint with Nonautologous Tissue Substitute, Open Approach
0SG80ZZ	Fusion of Left Sacroiliac Joint, Open Approach
0SG834Z	Fusion of Left Sacroiliac Joint with Internal Fixation Device, Percutaneous Approach
0SG837Z	Fusion of Left Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Approach
0SG83JZ	Fusion of Left Sacroiliac Joint with Synthetic Substitute, Percutaneous Approach
0SG83KZ	Fusion of Left Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SG83ZZ	Fusion of Left Sacroiliac Joint, Percutaneous Approach
0SG844Z	Fusion of Left Sacroiliac Joint with Internal Fixation Device, Percutaneous Endoscopic Approach

0SG847Z	Fusion of Left Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG84JZ	Fusion of Left Sacroiliac Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SG84KZ	Fusion of Left Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG84ZZ	Fusion of Left Sacroiliac Joint, Percutaneous Endoscopic Approach
0RGJ04Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Open Approach
0RGJ07Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGJ0JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Open Approach
0RGJ0KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGJ0ZZ	Fusion of Right Shoulder Joint, Open Approach
0RGJ34Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGJ37Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGJ3JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGJ3KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGJ3ZZ	Fusion of Right Shoulder Joint, Percutaneous Approach
0RGJ44Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGJ47Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGJ4JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGJ4KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGJ4ZZ	Fusion of Right Shoulder Joint, Percutaneous Endoscopic Approach
0RGK04Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Open Approach
0RGK07Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGK0JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Open Approach
0RGK0KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGK0ZZ	Fusion of Left Shoulder Joint, Open Approach

0RGK34Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGK37Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGK3JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGK3KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGK3ZZ	Fusion of Left Shoulder Joint, Percutaneous Approach
0RGK44Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGK47Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGK4JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGK4KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGK4ZZ	Fusion of Left Shoulder Joint, Percutaneous Endoscopic Approach
0RGL04Z	Fusion of Right Elbow Joint with Internal Fixation Device, Open Approach
0RGL05Z	Fusion of Right Elbow Joint with External Fixation Device, Open Approach
0RGL07Z	Fusion of Right Elbow Joint with Autologous Tissue Substitute, Open Approach
0RGL0JZ	Fusion of Right Elbow Joint with Synthetic Substitute, Open Approach
0RGL0KZ	Fusion of Right Elbow Joint with Nonautologous Tissue Substitute, Open Approach
0RGL0ZZ	Fusion of Right Elbow Joint, Open Approach
0RGL34Z	Fusion of Right Elbow Joint with Internal Fixation Device, Percutaneous Approach
0RGL35Z	Fusion of Right Elbow Joint with External Fixation Device, Percutaneous Approach
0RGL37Z	Fusion of Right Elbow Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGL3JZ	Fusion of Right Elbow Joint with Synthetic Substitute, Percutaneous Approach
0RGL3KZ	Fusion of Right Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGL3ZZ	Fusion of Right Elbow Joint, Percutaneous Approach
0RGL44Z	Fusion of Right Elbow Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGL45Z	Fusion of Right Elbow Joint with External Fixation Device, Percutaneous Endoscopic Approach

0RGL47Z	Fusion of Right Elbow Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGL4JZ	Fusion of Right Elbow Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGL4KZ	Fusion of Right Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGL4ZZ	Fusion of Right Elbow Joint, Percutaneous Endoscopic Approach
0RGM04Z	Fusion of Left Elbow Joint with Internal Fixation Device, Open Approach
0RGM05Z	Fusion of Left Elbow Joint with External Fixation Device, Open Approach
0RGM07Z	Fusion of Left Elbow Joint with Autologous Tissue Substitute, Open Approach
0RGM0JZ	Fusion of Left Elbow Joint with Synthetic Substitute, Open Approach
0RGM0KZ	Fusion of Left Elbow Joint with Nonautologous Tissue Substitute, Open Approach
0RGM0ZZ	Fusion of Left Elbow Joint, Open Approach
0RGM34Z	Fusion of Left Elbow Joint with Internal Fixation Device, Percutaneous Approach
0RGM35Z	Fusion of Left Elbow Joint with External Fixation Device, Percutaneous Approach
0RGM37Z	Fusion of Left Elbow Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGM3JZ	Fusion of Left Elbow Joint with Synthetic Substitute, Percutaneous Approach
0RGM3KZ	Fusion of Left Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGM3ZZ	Fusion of Left Elbow Joint, Percutaneous Approach
0RGM44Z	Fusion of Left Elbow Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGM45Z	Fusion of Left Elbow Joint with External Fixation Device, Percutaneous Endoscopic Approach
0RGM47Z	Fusion of Left Elbow Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGM4JZ	Fusion of Left Elbow Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGM4KZ	Fusion of Left Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGM4ZZ	Fusion of Left Elbow Joint, Percutaneous Endoscopic Approach
0RG0070	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG0071	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach

0RG007J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Open Approach
0RG00Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Open Approach
0RG00ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Open Approach
0RG0370	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG0371	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG037J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach

0RG03Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0RG0470	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG0471	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG047J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1070	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Open Approach

0RG1370	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG1470	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG4070	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG4370	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG4470	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0RG44Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1071	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG1371	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG1471	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG4071	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG4371	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach

0RG43K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG4471	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG6070	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG6370	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG6470	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA070	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach

0RGA0J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RGA370	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA470	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG6071	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG6371	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach

0RG6471	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA071	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RGA371	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA471	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG0070	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach

0SG00Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0SG0370	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG0470	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG3070	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Open Approach
0SG3370	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG3470	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0SG34K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG0071	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0SG0371	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG0471	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG3071	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Open Approach
0SG3371	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach

0SG33J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG3471	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG007J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Open Approach
0SG037J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG047J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0SG307J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Open Approach
0SG337J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG347J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RQE0ZZ	Repair Right Sternoclavicular Joint, Open Approach
0RQE3ZZ	Repair Right Sternoclavicular Joint, Percutaneous Approach
0RQE4ZZ	Repair Right Sternoclavicular Joint, Percutaneous Endoscopic Approach
0RQEXZZ	Repair Right Sternoclavicular Joint, External Approach
0RQF0ZZ	Repair Left Sternoclavicular Joint, Open Approach
0RQF3ZZ	Repair Left Sternoclavicular Joint, Percutaneous Approach
0RQF4ZZ	Repair Left Sternoclavicular Joint, Percutaneous Endoscopic Approach
0RQFXZZ	Repair Left Sternoclavicular Joint, External Approach
0RQG0ZZ	Repair Right Acromioclavicular Joint, Open Approach
0RQG3ZZ	Repair Right Acromioclavicular Joint, Percutaneous Approach
0RQG4ZZ	Repair Right Acromioclavicular Joint, Percutaneous Endoscopic Approach
0RQGXZZ	Repair Right Acromioclavicular Joint, External Approach
0RQH0ZZ	Repair Left Acromioclavicular Joint, Open Approach

	0RQH3ZZ	Repair Left Acromioclavicular Joint, Percutaneous Approach
	0RQH4ZZ	Repair Left Acromioclavicular Joint, Percutaneous Endoscopic Approach
	0RQHXZZ	Repair Left Acromioclavicular Joint, External Approach
	0RQJ0ZZ	Repair Right Shoulder Joint, Open Approach
	0RQJ3ZZ	Repair Right Shoulder Joint, Percutaneous Approach
	0RQJ4ZZ	Repair Right Shoulder Joint, Percutaneous Endoscopic Approach
	0RQJXZZ	Repair Right Shoulder Joint, External Approach
	0RQK0ZZ	Repair Left Shoulder Joint, Open Approach
	0RQK3ZZ	Repair Left Shoulder Joint, Percutaneous Approach
	0RQK4ZZ	Repair Left Shoulder Joint, Percutaneous Endoscopic Approach
	0RQKXZZ	Repair Left Shoulder Joint, External Approach
	0RQL0ZZ	Repair Right Elbow Joint, Open Approach
	0RQL3ZZ	Repair Right Elbow Joint, Percutaneous Approach
	0RQL4ZZ	Repair Right Elbow Joint, Percutaneous Endoscopic Approach
	0RQLXZZ	Repair Right Elbow Joint, External Approach
	0RQM0ZZ	Repair Left Elbow Joint, Open Approach
	0RQM3ZZ	Repair Left Elbow Joint, Percutaneous Approach
	0RQM4ZZ	Repair Left Elbow Joint, Percutaneous Endoscopic Approach
	0RQMXZZ	Repair Left Elbow Joint, External Approach

Surgical Site Infection Following Bariatric Surgery for Obesity

Principal Diagnosis	E66.01	Morbid (severe) obesity due to excess calories
(CC)	K95.01	Infection due to gastric band procedure
(CC)	K95.81	Infection due to other bariatric procedure
(CC)	K68.11	Postprocedural retroperitoneal abscess
(CC)	T81.4XXA	Infection following a procedure, initial encounter

And one of the following procedure codes:

0D16479	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164J9	Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach

0D164JA	Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164Z9	Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D16079	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach
0D1607A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach
0D160J9	Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach
0D160JA	Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach
0D160K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D160KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D160Z9	Bypass Stomach to Duodenum, Open Approach
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D16879	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1687A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168J9	Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168JA	Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168Z9	Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic
0D168ZA	Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic
0DV64CZ	Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach

Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

(CC)	T82.6XXA	Infection and inflammatory reaction due to cardiac valve prosthesis, initial encounter
(CC)	T82.7XXA	Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, initial encounter
(CC)	K68.11	Postprocedural retroperitoneal abscess
(CC)	T81.4XXA	Infection following a procedure, initial encounter

And one of the following procedure codes:

0JH607Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH637Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH807Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH837Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
02HK0JZ	Insertion of Pacemaker Lead into Right Ventricle, Open Approach
02HK3JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Approach
02HK4JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0JZ	Insertion of Pacemaker Lead into Left Ventricle, Open Approach
02HL3JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Approach
02HL4JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Endoscopic Approach
With:	02H40JZ Insertion of Pacemaker Lead into Coronary Vein, Open Approach
02H43JZ	Insertion of Pacemaker Lead into Coronary Vein, Percutaneous Approach
02H44JZ	Insertion of Pacemaker Lead into Coronary Vein, Percutaneous Endoscopic Approach
With:	02H60JZ Insertion of Pacemaker Lead into Right Atrium, Open Approach
02H63JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Approach
02H64JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Endoscopic Approach
0JH609Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH639Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach

0JH809Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH839Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	02HK0KZ Insertion of Defibrillator Lead into Right Ventricle, Open Approach
02HK3KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
02HK4KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0KZ	Insertion of Defibrillator Lead into Left Ventricle, Open Approach
02HL3KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Approach
02HL4KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Endoscopic Approach
02H43JZ	Insertion of Pacemaker Lead into Coronary Vein, Percutaneous Approach
02H43KZ	Insertion of Defibrillator Lead into Coronary Vein, Percutaneous Approach
02H43MZ	Insertion of Cardiac Lead into Coronary Vein, Percutaneous Approach
Alternatively:	
02H43KZ	Insertion of Defibrillator Lead into Coronary Vein, Percutaneous Approach
02H43MZ	Insertion of Cardiac Lead into Coronary Vein, Percutaneous Approach
With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
0JH607Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH637Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH807Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH837Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Alternatively:	
0JH607Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH637Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach

	With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH609Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH639Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH809Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH839Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Alternatively:		
	0JH609Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH639Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH60PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH63PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH80PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH83PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Alternatively:		
	0JH60PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH63PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH80PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH83PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach

With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH604Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH634Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH804Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH834Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH605Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH635Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH805Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH835Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH606Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH636Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH806Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH836Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH604Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH634Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH804Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH834Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach

0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH605Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH635Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH805Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH835Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH606Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH636Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH806Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH836Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach

With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
02PAXMZ	Removal of Cardiac Lead from Heart, External Approach
With:	02H60KZ Insertion of Defibrillator Lead into Right Atrium, Open Approach
02H63KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Approach
02H64KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Endoscopic Approach
02H70KZ	Insertion of Defibrillator Lead into Left Atrium, Open Approach
02H73KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Approach
02H74KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Endoscopic Approach
02HK0KZ	Insertion of Defibrillator Lead into Right Ventricle, Open Approach
02HK3KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
02HK4KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0KZ	Insertion of Defibrillator Lead into Left Ventricle, Open Approach
02HL3KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Approach
02HL4KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Endoscopic Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	02H60KZ Insertion of Defibrillator Lead into Right Atrium, Open Approach
02H63KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Approach
02H64KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Endoscopic Approach
02H70KZ	Insertion of Defibrillator Lead into Left Atrium, Open Approach
02H73KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Approach
02H74KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Endoscopic Approach
02HK0KZ	Insertion of Defibrillator Lead into Right Ventricle, Open Approach

02HK3KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
02HK4KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0KZ	Insertion of Defibrillator Lead into Left Ventricle, Open Approach
02HL3KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Approach
02HL4KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Endoscopic Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
02HN0JZ	Insertion of Pacemaker Lead into Pericardium, Open Approach
02HN0MZ	Insertion of Cardiac Lead into Pericardium, Open Approach
02HN3JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Approach
02HN3MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Approach
02HN4JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Endoscopic Approach
02HN4MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Endoscopic Approach

Alternatively:

02HN0JZ	Insertion of Pacemaker Lead into Pericardium, Open Approach
02HN0MZ	Insertion of Cardiac Lead into Pericardium, Open Approach

	02HN3JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Approach
	02HN3MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Approach
	02HN4JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Endoscopic Approach
	02HN4MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Endoscopic Approach
	With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
	02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
	02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
	02PAXMZ	Removal of Cardiac Lead from Heart, External Approach
	02WA0MZ	Revision of Cardiac Lead in Heart, Open Approach
	02WA3MZ	Revision of Cardiac Lead in Heart, Percutaneous Approach
	02WA4MZ	Revision of Cardiac Lead in Heart, Percutaneous Endoscopic Approach
	02H63JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Approach
	02H63MZ	Insertion of Cardiac Lead into Right Atrium, Percutaneous Approach
	02H73JZ	Insertion of Pacemaker Lead into Left Atrium, Percutaneous Approach
	02H73MZ	Insertion of Cardiac Lead into Left Atrium, Percutaneous Approach
	02HK3JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Approach
	02HL3JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Approach
Alternatively:		
	02H63JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Approach
	02H73JZ	Insertion of Pacemaker Lead into Left Atrium, Percutaneous Approach
	02HK3JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Approach
	02HK3MZ	Insertion of Cardiac Lead into Right Ventricle, Percutaneous Approach
	02HL3JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Approach
	02HL3MZ	Insertion of Cardiac Lead into Left Ventricle, Percutaneous Approach
	With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
	02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
	02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
	02PAXMZ	Removal of Cardiac Lead from Heart, External Approach
	02PA0MZ	Removal of Cardiac Lead from Heart, Open Approach
	02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
	02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
	02PAXMZ	Removal of Cardiac Lead from Heart, External Approach

	0JWT0PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JWT3PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JPT0PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JWT0PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JWT3PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures		
(MCC)	T80.0XXA	Air embolism following infusion, transfusion and therapeutic injection, initial encounter
(MCC)	T81.718A	Complication of other artery following a procedure, not elsewhere classified, initial encounter
(MCC)	T81.72XA	Complication of vein following a procedure, not elsewhere classified, initial encounter
(MCC)	T82.817A	Embolism of cardiac prosthetic devices, implants and grafts, initial encounter
(MCC)	T82.818A	Embolism of vascular prosthetic devices, implants and grafts, initial encounter
(MCC)	With:	I26.90 Septic pulmonary embolism without acute cor pulmonale
(MCC)	I26.99	Other pulmonary embolism without acute cor pulmonale
(MCC)	I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale
(MCC)	I26.99	Other pulmonary embolism without acute cor pulmonale
(CC)	I82.409	Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
(CC)	I82.419	Acute embolism and thrombosis of unspecified femoral vein
(CC)	I82.429	Acute embolism and thrombosis of unspecified iliac vein
(CC)	I82.439	Acute embolism and thrombosis of unspecified popliteal vein
(CC)	I82.4Y9	Acute embolism and thrombosis of unspecified deep veins of unspecified proximal lower extremity
(CC)	I82.449	Acute embolism and thrombosis of unspecified tibial vein
(CC)	I82.499	Acute embolism and thrombosis of other specified deep vein of unspecified lower extremity

(CC)	I82.4Z9	Acute embolism and thrombosis of unspecified deep veins of unspecified distal lower extremity

And one of the following procedure codes:

0SUR0BZ	Supplement Right Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
With:	0SUA0BZ Supplement Right Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SUS0BZ	Supplement Left Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
With:	0SUE0BZ Supplement Left Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SUR0BZ	Supplement Right Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
0SUS0BZ	Supplement Left Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
0SUA0BZ	Supplement Right Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SUE0BZ	Supplement Left Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRA009	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRA00A	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRA00Z	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRA019	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach

0SRA01A	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRA01Z	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRA039	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRA03A	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRA03Z	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRA07Z	Replacement of Right Hip Joint, Acetabular Surface with Autologous Tissue Substitute, Open Approach
0SRA0J9	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRA0JA	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRA0JZ	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRA0KZ	Replacement of Right Hip Joint, Acetabular Surface with Nonautologous Tissue Substitute, Open Approach
0SRE009	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRE00A	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRE00Z	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRE019	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRE01A	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRE01Z	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRE039	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRE03A	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRE03Z	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach

0SRE07Z	Replacement of Left Hip Joint, Acetabular Surface with Autologous Tissue Substitute, Open Approach
0SRE0J9	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRE0JA	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRE0JZ	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRE0KZ	Replacement of Left Hip Joint, Acetabular Surface with Nonautologous Tissue Substitute, Open Approach
0SRR019	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRR01A	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRR01Z	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Open Approach
0SRR039	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRR03A	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRR03Z	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Open Approach
0SRR07Z	Replacement of Right Hip Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRR0J9	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRR0JA	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRR0JZ	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRR0KZ	Replacement of Right Hip Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRS019	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRS01A	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRS01Z	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Open Approach

0SRS039	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRS03A	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRS03Z	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Open Approach
0SRS07Z	Replacement of Left Hip Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRS0J9	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRS0JA	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRS0JZ	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRS0KZ	Replacement of Left Hip Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRC07Z	Replacement of Right Knee Joint with Autologous Tissue Substitute, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRC0KZ	Replacement of Right Knee Joint with Nonautologous Tissue Substitute, Open Approach
0SRD07Z	Replacement of Left Knee Joint with Autologous Tissue Substitute, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
0SRD0KZ	Replacement of Left Knee Joint with Nonautologous Tissue Substitute, Open Approach
0SRT07Z	Replacement of Right Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRT0JZ	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRT0KZ	Replacement of Right Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRU07Z	Replacement of Left Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRU0JZ	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRU0KZ	Replacement of Left Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach

	0SRV07Z	Replacement of Right Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
	0SRV0JZ	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
	0SRV0KZ	Replacement of Right Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach
	0SRW07Z	Replacement of Left Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
	0SRW0JZ	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
	0SRW0KZ	Replacement of Left Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach
Iatrogenic Pneumothorax with Venous Catheterization		
(CC)	J95.811	Postprocedural pneumothorax
	05HY03Z	Insertion of Infusion Device into Upper Vein, Open Approach
	05HY33Z	Insertion of Infusion Device into Upper Vein, Percutaneous Approach
	05HY43Z	Insertion of Infusion Device into Upper Vein, Percutaneous Endoscopic Approach
	06HY03Z	Insertion of Infusion Device into Lower Vein, Open Approach
	06HY33Z	Insertion of Infusion Device into Lower Vein, Percutaneous Approach
	06HY43Z	Insertion of Infusion Device into Lower Vein, Percutaneous Endoscopic Approach
	0JH60XZ	Insertion of Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH63XZ	Insertion of Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH80XZ	Insertion of Vascular Access Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH83XZ	Insertion of Vascular Access Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JHD0XZ	Insertion of Vascular Access Device into Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach
	0JHD3XZ	Insertion of Vascular Access Device into Right Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JHF0XZ	Insertion of Vascular Access Device into Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach
	0JHF3XZ	Insertion of Vascular Access Device into Left Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach

0JHG0XZ	Insertion of Vascular Access Device into Right Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JHG3XZ	Insertion of Vascular Access Device into Right Lower Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHH0XZ	Insertion of Vascular Access Device into Left Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JHH3XZ	Insertion of Vascular Access Device into Left Lower Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHL0XZ	Insertion of Vascular Access Device into Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JHL3XZ	Insertion of Vascular Access Device into Right Upper Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHM0XZ	Insertion of Vascular Access Device into Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JHM3XZ	Insertion of Vascular Access Device into Left Upper Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHN0XZ	Insertion of Vascular Access Device into Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JHN3XZ	Insertion of Vascular Access Device into Right Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHP0XZ	Insertion of Vascular Access Device into Left Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JHP3XZ	Insertion of Vascular Access Device into Left Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach

Exempt Providers

The table below lists the types of providers that are exempt from POA reporting, per CMS http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/AffectedHospitals.html.

1	Critical Access Hospitals	These providers have a Peer Group 7 in the MMIS and are therefore included in the group of providers that will be defined as exempt from POA reporting.
2	Long Term Care Hospitals	Nebraska has two providers that fall into this category. The providers will be added to the Validate Value table: 1. Select Specialty (100256413-00) 2. Madonna Rehabilitation (100251802-00)
3	Maryland Waiver Hospitals	State/Postal Code = MD **Note**: Maryland is the only State that has a Medicare Waiver. Under this agreement, Medicare reimburses Maryland hospitals according to Healthcare Services Cost Review Commission (HSCRC) rates. Based on a federal waiver from Medicare, the HSCRC sets rates for all payers: private insurance companies, HMOs, Medicare, and Medicaid. This system is referred to as the "all-payer" system because all payers pay for their fair share of hospital costs.
4	Cancer Hospitals	These providers would be added to the Validate Value table as they manually identify themselves. This would most likely occur because the MMIS reported they must submit POA and they respond advising they are POA exempt.
5	Children's Inpatient Facilities	The word 'child' will be queried in the provider names and the identified providers will be added to the Validate Value table.
6	Rural Health Clinics	This provider type does not submit claim types 07 or 10 and therefore will be indirectly excluded from being required to submit POA information.
7	Federally Qualified Health Centers	This provider type does not submit claim types 07 or 10 and therefore will be indirectly excluded from being required to submit POA information.
8	Religious Non-Medical Health Care Institutions	These providers would be added to the Validate Value table as they manually identify themselves. This would most likely occur because the MMIS reported they must submit POA and they respond advising they are POA exempt.
9	Inpatient Psychiatric Hospitals	These providers would be identified by Specialty = 26 and either included in the code as exempt providers or added to the Validate Value table.
10	Inpatient Rehabilitation Facilities	These providers have a Peer Group 5 in the MMIS and are therefore included in the group of providers that will be defined as exempt from POA reporting.

11	VA/Department of Defense Hospitals	These providers are paid from federal funds and do not submit claims to State Medicaid agencies.

Categories and Codes
Exempt from
Diagnosis Present on Admission Requirement
ICD-10-CM Official Guidelines for Coding and Reporting FY 2015

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

Code categories below are exempt from "diagnosis present on admission."

B90–B94, Sequelae of infectious and parasitic diseases

E64, Sequelae of malnutrition and other nutritional deficiencies

I25.2, Old myocardial infarction

I69, Sequelae of cerebrovascular disease

O09, Supervision of high risk pregnancy

O66.5, Attempted application of vacuum extractor and forceps

O80, Encounter for full-term uncomplicated delivery

O94, Sequelae of complication of pregnancy, childbirth, and the puerperium

P00, Newborn (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy

Q00 – Q99, Congenital malformations, deformations and chromosomal abnormalities

S00-T88.9, Injury, poisoning and certain other consequences of external causes with 7th character representing subsequent encounter or sequela

V00- V09, Pedestrian injured in transport accident

Except V00.81-, Accident with wheelchair (powered)

V00.83-, Accident with motorized mobility scooter

V10-V19, Pedal cycle rider injured in transport accident

V20-V29, Motorcycle rider injured in transport accident

V30-V39, Occupant of three-wheeled motor vehicle injured in transport accident

V40-V49, Car occupant injured in transport accident

V50-V59, Occupant of pick-up truck or van injured in transport accident

V60-V69, Occupant of heavy transport vehicle injured in transport accident

V70-V79, Bus occupant injured in transport accident

V80-V89, Other land transport accidents

V90-V94, Water transport accidents

V95-V97, Air and space transport accidents

V98-V99, Other and unspecified transport accidents

W09, Fall on and from playground equipment

W14, Fall from tree

W15, Fall from cliff

W17.0, Fall into well

W17.1, Fall into storm drain or manhole

W18.01 Striking against sports equipment with subsequent fall

W21, Striking against or struck by sports equipment

W30, Contact with agricultural machinery

W31, Contact with other and unspecified machinery

W32-W34, Accidental handgun discharge and malfunction

W35- W40, Exposure to inanimate mechanical forces

W52, Crushed, pushed or stepped on by crowd or human stampede

W56, Contact with nonvenomous marine animal

W58, Contact with crocodile or alligator

W61, Contact with birds (domestic) (wild)

W62, Contact with nonvenomous amphibians

W89, Exposure to man-made visible and ultraviolet light

X02, Exposure to controlled fire in building or structure

X03, Exposure to controlled fire, not in building or structure

X04, Exposure to ignition of highly flammable material

X52, Prolonged stay in weightless environment

X71, Intentional self-harm by drowning and submersion

Except X71.0-, Intentional self-harm by drowning and submersion while in bath tub

X72, Intentional self-harm by handgun discharge

X73, Intentional self-harm by rifle, shotgun and larger firearm discharge

X74, Intentional self-harm by other and unspecified firearm and gun discharge

X75, Intentional self-harm by explosive material

X76, Intentional self-harm by smoke, fire and flames

X77, Intentional self-harm by steam, hot vapors and hot objects

X81, Intentional self-harm by jumping or lying in front of moving object

X82, Intentional self-harm by crashing of motor vehicle

X83, Intentional self-harm by other specified means

Y03, Assault by crashing of motor vehicle

Y07, Perpetrator of assault, maltreatment and neglect

Y08.8, Assault by strike by sports equipment

Y21, Drowning and submersion, undetermined intent

Y22, Handgun discharge, undetermined intent

Y23, Rifle, shotgun and larger firearm discharge, undetermined intent

Y24, Other and unspecified firearm discharge, undetermined intent

Y30, Falling, jumping or pushed from a high place, undetermined intent

Y32, Assault by crashing of motor vehicle, undetermined intent

Y37, Military operations

Y36, Operations of war

Y92, Place of occurrence of the external cause

Y93, Activity code

Y99, External cause status

Z00, Encounter for general examination without complaint, suspected or reported diagnosis

Z01, Encounter for other special examination without complaint, suspected or reported diagnosis

Z02, Encounter for administrative examination

Z03, Encounter for medical observation for suspected diseases and conditions ruled out

Z08, Encounter for follow-up examination following completed treatment for malignant neoplasm

Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z11, Encounter for screening for infectious and parasitic diseases

Z11.8, Encounter for screening for other infectious and parasitic diseases

Z12, Encounter for screening for malignant neoplasms

Z13, Encounter for screening for other diseases and disorders

Z13.4, Encounter for screening for certain developmental disorders in childhood

Z13.5, Encounter for screening for eye and ear disorders

Z13.6, Encounter for screening for cardiovascular disorders

Z13.83, Encounter for screening for respiratory disorder NEC

Z13.89, Encounter for screening for other disorder

Z13.89, Encounter for screening for other disorder

Z14, Genetic carrier

Z15, Genetic susceptibility to disease

Z17, Estrogen receptor status

Z18, Retained foreign body fragments

Z22, Carrier of infectious disease

Z23, Encounter for immunization

Z28, Immunization not carried out and underimmunization status

Z28.3, Underimmunization status

Z30, Encounter for contraceptive management

Z31, Encounter for procreative management

Z34, Encounter for supervision of normal pregnancy

Z36, Encounter for antenatal screening of mother

Z37, Outcome of delivery

Z38, Liveborn infants according to place of birth and type of delivery

Z39, Encounter for maternal postpartum care and examination

Z41, Encounter for procedures for purposes other than remedying health state

Z42, Encounter for plastic and reconstructive surgery following medical procedure or healed injury

Z43, Encounter for attention to artificial openings

Z44, Encounter for fitting and adjustment of external prosthetic device

Z45, Encounter for adjustment and management of implanted device

Z46, Encounter for fitting and adjustment of other devices

Z47.8, Encounter for other orthopedic aftercare

Z49, Encounter for care involving renal dialysis

Z51, Encounter for other aftercare

Z51.5, Encounter for palliative care

Z51.8, Encounter for other specified aftercare

Z52, Donors of organs and tissues

Z59, Problems related to housing and economic circumstances

Z63, Other problems related to primary support group, including family circumstances

Z65, Problems related to other psychosocial circumstances

Z65.8 Other specified problems related to psychosocial circumstances

Z67.1 – Z67.9 Blood type

Z68, Body mass index (BMI)

Z72, Problems related to lifestyle

Z74.01, Bed confinement status

Z76, Persons encountering health services in other circumstances

Z77.110- Z77.128, Environmental pollution and hazards in the physical environment

Z78, Other specified health status

Z79, Long term (current) drug therapy

Z80, Family history of primary malignant neoplasm

Z81, Family history of mental and behavioral disorders

Z82, Family history of certain disabilities and chronic diseases (leading to disablement)

Z83, Family history of other specific disorders

Z84, Family history of other conditions

Z85, Personal history of primary malignant neoplasm

Z86, Personal history of certain other diseases

Z87, Personal history of other diseases and conditions

Z87.828, Personal history of other (healed) physical injury and trauma

Z87.891, Personal history of nicotine dependence

Z88, Allergy status to drugs, medicaments and biological substances

Z89, Acquired absence of limb

Z90.710, Acquired absence of both cervix and uterus

Z91.0, Allergy status, other than to drugs and biological substances

Z91.4, Personal history of psychological trauma, not elsewhere classified

Z91.5, Personal history of self-harm

Z91.8, Other specified risk factors, not elsewhere classified

Z92, Personal history of medical treatment

Z93, Artificial opening status

Z94, Transplanted organ and tissue status

Z95, Presence of cardiac and vascular implants and grafts

Z97, Presence of other devices

Z98, Other postprocedural states

Z99, Dependence on enabling machines and devices, not elsewhere classified

PROVIDER NUMBER		BUSINESS NAME	LINE 1 ADDRESS	LINE 2 ADDRESS	CITY NAME	POSTAL CODE	OFFICE ZIP CODE	
100252968	00	TILDEN COMMUNITY HOSPITAL	PO BOX 340		TILDEN	NE	68781	0340
100254997	00	OAKLAND MERCY HOSPITAL	601 EAST 2ND ST		OAKLAND	NE	68045	1499
100259444	00	AVERA CREIGHTON HOSPITAL	1503 MAIN ST	PO BOX 186	CREIGHTON	NE	68729	0186
100261871	00	ALEGENT CREIGHTON HLTH-PLAINVIEW HS	704 N 3RD ST		PLAINVIEW	NE	68769	2047
237161473	00	OSMOND GEN HOSP	402 NORTH MAPLE ST	PO BOX 429	OSMOND	NE	68765	0429
363169688	00	PAWNEE CO MEM HOSP	600 I ST	PO BOX 433	PAWNEE CITY	NE	68420	0433
456029692	00	LEXINGTON REGIONAL HEALTH CENTER	1201 ERIE	PO BOX 980	LEXINGTON	NE	68850	1571
470366569	00	HENDERSON HEALTH CARE SERVICES,INC	1621 FRONT ST		HENDERSON	NE	68371	8902
470375220	00	MEM HOSP-SEWARD	300 N COLUMBIA AVE		SEWARD	NE	68434	2299
470379039	02	YORK GEN HOSP INC	2222 LINCOLN AVE		YORK	NE	68467	1030
470379834	00	BEATRICE COMM HOSP & HEALTH CT	4800 HOSPITAL PKWY		BEATRICE	NE	68310	6906
470388012	00	BRODSTONE MEM-NUCKOLLS CO HOSP	520 E 10TH STREET	PO BOX 187	SUPERIOR	NE	68978	0187
470393176	01	ANTELOPE MEM HOSP	102 W 9TH ST	BOX 229	NELIGH	NE	68756	0229
470395787	00	HARLAN COUNTY HEALTH SYSTEM	717 NORTH BROWN		ALMA	NE	68920	2132
470395795	00	OGALLALA COMMUNITY HOSPITAL	2601 N SPRUCE ST		OGALLALA	NE	69153	2465
470399853	00	ALEGENT HLTH MEMORIAL HOSP-SCHUYLER	104 W 17TH ST		SCHUYLER	NE	68661	1304
470408242	00	SIDNEY REGIONAL MEDICAL CENTER	645 OSAGE ST		SIDNEY	NE	69162	1714
470421272	00	COMMUNITY MEDICAL CENTER INC	PO BOX 399	3307 BARADA ST	FALLS CITY	NE	68355	2470
470426285	00	BLAIR MEM COMM HOSP	810 N 22ND ST		BLAIR	NE	68008	1128
470426530	00	JENNIE M MELHAM MEM MED CTR	145 MEMORIAL DR	PO BOX 250	BROKEN BOW	NE	68822	0250
470443636	00	ST MARYS HOSP-NE CITY	1301 GRUNDMAN BLVD		NEBRASKA CIT	NE	68410	3319
470461859	01	AURORA MEM HOSP	1423 7TH ST		AURORA	NE	68818	1141
470463911	00	AVERA ST ANTHONYS HOSP-ONEILL	PO BOX 270	300 N 2ND ST	ONEILL	NE	68763	1514
470466032	00	WEBSTER CO COMM HOSP	6TH & FRANKLIN STS	PO BOX 465	RED CLOUD	NE	68970	0465
470468078	01	JEFFERSON COMMUNITY HEALTH CENTER	2200 H ST	BOX 277	FAIRBURY	NE	68352	1119
470471042	00	NEMAHA CO HOSP	2022 13TH ST		AUBURN	NE	68305	1799
470481628	00	PHELPS MEM HLTH CTR	1215 TIBBALS STREET		HOLDREGE	NE	68949	1255
470482234	00	CHADRON COMM HOSP & HLTH SERVICES	825 CENTENNIAL DR		CHADRON	NE	69337	9400
470485275	00	VALLEY COUNTY HOSPITAL	2707 L ST		ORD	NE	68862	1275
470486026	00	ST FRANCIS MEMORIAL HOSP-WEST POINT	430 N MONITOR ST		WEST POINT	NE	68788	1595
470487831	00	DUNDY CO HOSP	1313 N CHEYENNE ST	PO BOX 626	BENKELMAN	NE	69021	0626
470529089	00	FILLMORE COUNTY HOSPITAL	1900 F ST		GENEVA	NE	68361	2229
470532256	00	BROWN CO HOSP	945 E ZERO		AINSWORTH	NE	69210	1556
470532605	00	GOTHENBURG MEM HOSP	910 20TH ST		GOTHENBURG	NE	69138	0469
470533032	00	GORDON MEM HOSP-GORDON	300 E 8TH ST		GORDON	NE	69343	1123
470533373	00	COMMUNITY HOSPITAL-MCCOOK	1301 EAST H ST	PO BOX 1328	MCCOOK	NE	69001	3482
470533576	00	CALLAWAY DISTRICT HOSPITAL	211 EAST KIMBALL ST		CALLAWAY	NE	68825	2597
470537192	00	NIOBRARA VALLEY HOSP-LYNCH	BOX 118		LYNCH	NE	68746	0118
470538792	00	CHERRY CO HOSP	510 N GREEN ST	PO BOX 410	VALENTINE	NE	69201	1932
470544098	00	WEST HOLT MEM HOSP	406 WEST NEELY ST		ATKINSON	NE	68713	4801
470547317	00	MORRILL CO COMM HOSP	1313 S ST		BRIDGEPORT	NE	69336	2563
470551144	00	BUTLER CO HEALTH CARE CTR HOSP	372 S 9TH ST		DAVID CITY	NE	68632	2116
470557565	00	BOX BUTTE GEN HOSP	2101 BOX BUTTE AVE	PO BOX 810	ALLIANCE	NE	69301	0810
470566524	00	PROVIDENCE MED CTR-WAYNE	1200 PROVIDENCE RD		WAYNE	NE	68787	1212
470627838	10	THAYER CO MEM HOSP	120 PARK AVE		HEBRON	NE	68370	2019
470681056	00	HOWARD COUNTY MEDICAL CENTER	1113 SHERMAN ST	PO BOX 406	ST PAUL	NE	68873	0406
470711662	00	PENDER COMM HOSP	100 HOSPITAL DR	PO BOX 100	PENDER	NE	68047	5020
470761817	00	COMM MEM HOSP-SYRACUSE	1579 MIDLAND STREET	BOX N	SYRACUSE	NE	68446	0518

PROVIDER NUMBER		BUSINESS NAME	LINE 1 ADDRESS	LINE 2 ADDRESS	CITY NAME	POSTAL CODE	OFFICE ZIP CODE	
470765991	00	LITZENBERG MEM CO HOSP	1715 26TH ST		CENTRAL CITY	NE	68826	9501
470841285	00	CRETE AREA MEDICAL CENTER	2910 BETTEN DR		CRETE	NE	68333	3084
476000549	01	WARREN MEM HOSP	905 2ND ST		FRIEND	NE	68359	1133
476000611	00	BOONE CO HLTH CTR	723 W FAIRVIEW ST	PO BOX 151	ALBION	NE	68620	0151
476000710	00	ANNIE JEFFREY MEM CO HOSP	531 BEEBE ST	BOX 428	OSCEOLA	NE	68651	0428
476000803	01	CHASE CO COMM HOSP	600 W 12TH ST		IMPERIAL	NE	69033	3131
476000874	00	JOHNSON CO HOSP	202 HIGH ST		TECUMSEH	NE	68450	5990
476000999	00	ROCK CO HOSP	102 E SOUTH ST		BASSETT	NE	68714	5512
476006197	01	CITY OF GENOA DBA GENOA COMM HOSP	706 EWING AVE		GENOA	NE	68640	0310
476007155	00	KIMBALL CO HOSP	ATTN INS DEPT	505 S BURG	KIMBALL	NE	69145	1313
476007158	00	SAUNDERS MEDICAL CENTER	1760 COUNTY RD J		WAHOO	NE	68066	4152
476007436	00	FRANKLIN CO MEM HOSP	1406 Q ST	PO BOX 315	FRANKLIN	NE	68939	0315
476007486	00	COZAD COMMUNITY HOSPITAL	300 E 12TH ST	PO BOX 108	COZAD	NE	69130	1505
476014070	00	KEARNEY CO HLTH SVCS	727 E 1ST ST		MINDEN	NE	68959	1705
476014365	00	PERKINS CO COMM HOSP	900 LINCOLN AVE		GRANT	NE	69140	3095
476028103	00	CAMBRIDGE MEM HOSP	1305 HIGHWAY 6 & 34		CAMBRIDGE	NE	69022	0488
							*As of 8/11/2015	

Attachment 15 redacted

Attachment 14
Quality Performance Program Measures – Contract Year One

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the claim.	95% within 15 days	20%
Pharmacy Claims Processing Timeliness - 7 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims from pharmacy providers for covered services within seven days of receipt. The date of receipt is the date the MCO receives the claim.	95% within 7 days	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 30 days	10%
Grievance Resolution Timeliness: The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance.	95% within 60 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%

Attachment 13 redacted

Attachment 12
Historical Transplant Cost Distribution Data

SFY2010 - SFY2014 Transplant Cost Distribution (Includes all costs incurred 3 months pre-transplant and 6 months post-transplant)

Transplant Type	Count
Heart	19
Bone Marrow/Stem Cell	52
Lung	4
Intestine and/or multivisceral	31
Kidney	15
Pancreas+Kidney	3
Total	**124**

Cohort	Count
CHIP M&F	5
AABD 00-20 M&F	34
AABD 21+ M&F	66
Family Under 1 M&F	3
Family 01-05 M&F	9
Family 06-20 F	2
Family 21+ M&F	4
Foster Care M&F	1
Total	**124**

Heart	
Rank	Cost
1	$ 1,843,415
2	$ 1,664,386
3	$ 862,119
4	$ 725,747
5	$ 459,912
6	$ 439,098
7	$ 430,384
8	$ 359,632
9	$ 339,912
10	$ 316,740
11	$ 304,950
12	$ 236,275
13	$ 235,756
14	$ 229,710
15	$ 194,606
16	$ 177,521
17	$ 167,799
18	$ 158,563
19	$ 147,202

Bone Marrow/Stem Cell	
Rank	Cost
1	$ 877,332
2	$ 632,422
3	$ 531,069
4	$ 504,091
5	$ 488,557
6	$ 381,914
7	$ 377,934
8	$ 334,005
9	$ 312,461
10	$ 291,962
11	$ 285,385
12	$ 267,608
13	$ 249,152
14	$ 224,812
15	$ 212,188
16	$ 208,497
17	$ 206,085
18	$ 190,365
19	$ 184,959
20	$ 184,690
21	$ 184,470
22	$ 182,629
23	$ 179,030
24	$ 177,291
25	$ 176,417
26	$ 174,747
27	$ 168,474
28	$ 162,828
29	$ 158,860
30	$ 155,672
31	$ 154,041
32	$ 153,028
33	$ 151,876
34	$ 134,560
35	$ 131,454
36	$ 126,462
37	$ 117,818
38	$ 117,662
39	$ 112,237
40	$ 105,850
41	$ 104,860
42	$ 102,751
43	$ 101,320
44	$ 97,735
45	$ 94,492
46	$ 87,681
47	$ 87,322
48	$ 78,791
49	$ 76,945
50	$ 55,928
51	$ 47,986
52	$ 46,559

Lung	
Rank	Cost
1	$ 673,769
2	$ 495,988
3	$ 386,653
4	$ 246,727

Intestine and/or multivisceral	
Rank	Cost
1	$ 766,153
2	$ 448,698
3	$ 390,869
4	$ 354,430
5	$ 346,833
6	$ 335,171
7	$ 318,247
8	$ 251,180
9	$ 231,423
10	$ 218,689
11	$ 217,596
12	$ 200,021
13	$ 195,237
14	$ 186,868
15	$ 156,389
16	$ 154,246
17	$ 145,258
18	$ 143,301
19	$ 139,122
20	$ 138,977
21	$ 136,592
22	$ 133,467
23	$ 123,065
24	$ 111,424
25	$ 101,147
26	$ 97,571
27	$ 92,197
28	$ 91,864
29	$ 77,982
30	$ 66,342
31	$ 65,899

Kidney	
Rank	Cost
1	$ 292,755
2	$ 223,785
3	$ 160,179
4	$ 157,250
5	$ 141,681
6	$ 113,673
7	$ 111,164
8	$ 108,476
9	$ 105,916
10	$ 85,337
11	$ 83,407
12	$ 78,457
13	$ 77,969
14	$ 74,902
15	$ 61,217

Pancreas+Kidney	
Rank	Cost
1	$ 101,670
2	$ 87,625
3	$ 78,506

Attachment 11
Rates*

	Rating Region 1						Rating Region 2					
COA	**FY15 MMs**	**Medical PMPM**	**NML**	**Developed Rate**	**UNMC PMPM**	**Total Rate**	**FY15 MMs**	**Medical PMPM**	**NML**	**Developed Rate**	**UNMC PMPM**	**Total Rate**
AABD 00-20 M&F	35,303	$ 976.29	11.7%	$ 1,106.12	$ 16.28	$ 1,122.40	9,807	$ 1,123.17	11.7%	$ 1,272.16	$ 10.21	$ 1,282.37
AABD 21+ M&F	106,576	$ 1,406.62	11.8%	$ 1,595.12	$ 25.27	$ 1,620.39	27,407	$ 1,571.78	11.8%	$ 1,781.30	$ 8.23	$ 1,789.53
AABD 21+ M&F-WWC	1,109	$ 2,201.95	11.7%	$ 2,492.50	$ 108.11	$ 2,600.61	451	$ 2,532.75	11.6%	$ 2,866.19	$ 21.60	$ 2,887.79
CHIP M&F	317,346	$ 155.04	14.5%	$ 181.32	$ 4.64	$ 185.96	107,941	$ 153.32	14.5%	$ 179.26	$ 1.30	$ 180.56
Family Under 1 M&F	106,184	$ 460.76	10.7%	$ 516.26	$ 16.49	$ 532.75	32,855	$ 413.76	10.7%	$ 463.59	$ 3.97	$ 467.56
Family 01-05 M&F	332,138	$ 129.13	14.4%	$ 150.77	$ 5.44	$ 156.22	94,254	$ 137.24	14.3%	$ 160.21	$ 1.41	$ 161.62
Family 06-20 F	284,805	$ 149.92	14.6%	$ 175.51	$ 4.00	$ 179.51	82,972	$ 158.84	14.6%	$ 185.90	$ 1.18	$ 187.07
Family 06-20 M	272,407	$ 161.93	14.6%	$ 189.60	$ 3.52	$ 193.13	79,831	$ 164.67	14.6%	$ 192.82	$ 1.11	$ 193.93
Family 21+ M&F	224,680	$ 377.16	14.4%	$ 440.77	$ 10.89	$ 451.66	63,516	$ 461.18	14.4%	$ 538.94	$ 3.74	$ 542.68
Foster Care M&F	82,203	$ 452.29	11.3%	$ 509.67	$ 6.34	$ 516.01	22,223	$ 415.70	11.1%	$ 467.82	$ 3.24	$ 471.06
Katie Beckett 00-18 M&F	412	$ 12,654.24	2.9%	$ 13,031.59	$ 37.83	$ 13,069.41	412	$ 12,654.24	2.9%	$ 13,031.59	$ 37.83	$ 13,069.41
Maternity	6,649	$ 7,687.83	2.9%	$ 7,917.08	$ 332.23	$ 8,249.31	2,211	$ 7,504.02	2.9%	$ 7,727.79	$ 58.40	$ 7,786.19
LTSS (Institutional) - Dual	59,908	$ 230.31	11.8%	$ 261.00	$ -	$ 261.00	23,676	$ 195.31	11.7%	$ 221.28	$ -	$ 221.28
LTSS (Institutional) - Non-Dual	5,638	$ 2,876.09	11.7%	$ 3,256.61	$ -	$ 3,256.61	1,916	$ 1,974.47	11.7%	$ 2,235.72	$ -	$ 2,235.72
LTSS (Home and Community Based) - Dual	49,366	$ 271.09	11.8%	$ 307.35	$ 7.85	$ 315.20	22,675	$ 247.43	11.8%	$ 280.44	$ 1.69	$ 282.14
LTSS (Home and Community Based) - Non-Dual	28,342	$ 1,465.82	11.8%	$ 1,661.18	$ 15.60	$ 1,676.77	6,774	$ 1,340.45	11.7%	$ 1,518.85	$ 10.05	$ 1,528.90
Dual	193,309	$ 282.66	12.2%	$ 321.88	$ 7.08	$ 328.96	65,329	$ 239.11	12.1%	$ 271.97	$ 0.84	$ 272.81
Total (FY15 Mix)	**2,099,726**	**$ 348.84**	**12.1%**	**$ 396.86**	**$ 8.53**	**$ 405.39**	**642,039**	**$ 348.41**	**12.0%**	**$ 395.79**	**$ 2.40**	**$ 398.19**

*Rates will be updated with more recent data.

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	LTSS (Institutional)	DME/Supplies	59,908	$ 464,485	3,453	692	$ 134.50	$ 7.75
1	Dual	LTSS (Institutional)	Emergency Room	59,908	$ 518,769	2,376	476	$ 218.31	$ 8.66
1	Dual	LTSS (Institutional)	Emergency Transportation	59,908	$ 4,195	38	8	$ 109.70	$ 0.07
1	Dual	LTSS (Institutional)	EPSDT	59,908	$ -	-	-	$ -	$ -
1	Dual	LTSS (Institutional)	Family Planning	59,908	$ 89	5	1	$ 16.95	$ 0.00
1	Dual	LTSS (Institutional)	FQHC/RHC	59,908	$ 265,026	8,260	1,654	$ 32.09	$ 4.42
1	Dual	LTSS (Institutional)	Home Health	59,908	$ 378,175	96,936	19,417	$ 3.90	$ 6.31
1	Dual	LTSS (Institutional)	Hospice	59,908	$ 71,800	15,920	3,189	$ 4.51	$ 1.20
1	Dual	LTSS (Institutional)	Inpatient Hospital	59,908	$ 2,425,071	3,721	745	$ 651.73	$ 40.48
1	Dual	LTSS (Institutional)	Lab and Radiology	59,908	$ 19,280	3,766	754	$ 5.12	$ 0.32
1	Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	59,908	$ 11,415	111	22	$ 102.94	$ 0.19
1	Dual	LTSS (Institutional)	Other Care	59,908	$ 93,226	6,763	1,355	$ 13.78	$ 1.56
1	Dual	LTSS (Institutional)	Other Professional	59,908	$ 19,334	427	86	$ 45.27	$ 0.32
1	Dual	LTSS (Institutional)	Outpatient Hospital	59,908	$ 4,190,317	19,208	3,848	$ 218.15	$ 69.95
1	Dual	LTSS (Institutional)	PCP	59,908	$ 2,509,763	90,852	18,198	$ 27.62	$ 41.89
1	Dual	LTSS (Institutional)	Specialist	59,908	$ 7,613	200	40	$ 38.09	$ 0.13
1	Dual	LTSS (Institutional)	Vision	59,908	$ 246,515	1,569	314	$ 157.14	$ 4.11
1	Dual	LTSS (Institutional)	Rx	59,908	$ 473,227	173,610	34,775	$ 2.73	$ 7.90
1	Dual	LTSS (Institutional)	Behavioral Health - IP	59,908	$ 171,905	3,349	671	$ 51.33	$ 2.87
1	Dual	LTSS (Institutional)	Behavioral Health - OP	59,908	$ 437,876	8,370	1,677	$ 52.31	$ 7.31
1	Dual	LTSS (Institutional)	Behavioral Health - Other	59,908	$ 84,742	2,800	561	$ 30.27	$ 1.41
1	Dual	LTSS (Institutional)	Behavioral Health - Residential	59,908	$ 92,691	356	71	$ 260.71	$ 1.55
1	Non-Dual	LTSS (Institutional)	DME/Supplies	5,638	$ 214,491	677	1,441	$ 316.83	$ 38.04
1	Non-Dual	LTSS (Institutional)	Emergency Room	5,638	$ 264,461	370	787	$ 715.52	$ 46.91
1	Non-Dual	LTSS (Institutional)	Emergency Transportation	5,638	$ 63,905	212	450	$ 301.93	$ 11.33
1	Non-Dual	LTSS (Institutional)	EPSDT	5,638	$ 317	3	6	$ 104.60	$ 0.06
1	Non-Dual	LTSS (Institutional)	Family Planning	5,638	$ 159	6	12	$ 28.60	$ 0.03
1	Non-Dual	LTSS (Institutional)	FQHC/RHC	5,638	$ 85,028	678	1,443	$ 125.40	$ 15.08
1	Non-Dual	LTSS (Institutional)	Home Health	5,638	$ 24,769	10,274	21,868	$ 2.41	$ 4.39
1	Non-Dual	LTSS (Institutional)	Hospice	5,638	$ 604,511	135,740	288,911	$ 4.45	$ 107.22
1	Non-Dual	LTSS (Institutional)	Inpatient Hospital	5,638	$ 5,859,513	433	922	$ 13,528.44	$ 1,039.29
1	Non-Dual	LTSS (Institutional)	Lab and Radiology	5,638	$ 123,251	6,892	14,670	$ 17.88	$ 21.86
1	Non-Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	5,638	$ 87,737	353	752	$ 248.24	$ 15.56
1	Non-Dual	LTSS (Institutional)	Other Care	5,638	$ 720,833	3,374	7,182	$ 213.62	$ 127.85
1	Non-Dual	LTSS (Institutional)	Other Professional	5,638	$ 57,113	577	1,229	$ 98.91	$ 10.13
1	Non-Dual	LTSS (Institutional)	Outpatient Hospital	5,638	$ 1,288,623	4,642	9,880	$ 277.61	$ 228.56
1	Non-Dual	LTSS (Institutional)	PCP	5,638	$ 902,983	8,996	19,147	$ 100.38	$ 160.16
1	Non-Dual	LTSS (Institutional)	Specialist	5,638	$ 216,118	1,462	3,112	$ 147.79	$ 38.33
1	Non-Dual	LTSS (Institutional)	Vision	5,638	$ 37,128	457	972	$ 81.29	$ 6.59
1	Non-Dual	LTSS (Institutional)	Rx	5,638	$ 3,839,095	70,810	150,713	$ 54.22	$ 680.93
1	Non-Dual	LTSS (Institutional)	Behavioral Health - IP	5,638	$ 128,404	786	1,673	$ 163.34	$ 22.77
1	Non-Dual	LTSS (Institutional)	Behavioral Health - OP	5,638	$ 135,856	1,885	4,013	$ 72.06	$ 24.10
1	Non-Dual	LTSS (Institutional)	Behavioral Health - Other	5,638	$ 39,627	5,082	10,817	$ 7.80	$ 7.03
1	Non-Dual	LTSS (Institutional)	Behavioral Health - Residential	5,638	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	LTSS (Home and Community Based)	DME/Supplies	49,366	$ 1,976,640	20,886	5,077	$ 94.64	$ 40.04
1	Dual	LTSS (Home and Community Based)	Emergency Room	49,366	$ 392,201	2,652	645	$ 147.87	$ 7.94
1	Dual	LTSS (Home and Community Based)	Emergency Transportation	49,366	$ 2,150	20	5	$ 108.39	$ 0.04
1	Dual	LTSS (Home and Community Based)	EPSDT	49,366	$ 77	1	0	$ 73.94	$ 0.00
1	Dual	LTSS (Home and Community Based)	Family Planning	49,366	$ 8,364	228	55	$ 36.65	$ 0.17
1	Dual	LTSS (Home and Community Based)	FQHC/RHC	49,366	$ 120,604	3,594	874	$ 33.55	$ 2.44
1	Dual	LTSS (Home and Community Based)	Home Health	49,366	$ 1,904,454	650,132	158,035	$ 2.93	$ 38.58
1	Dual	LTSS (Home and Community Based)	Hospice	49,366	$ 6,110	666	162	$ 9.17	$ 0.12
1	Dual	LTSS (Home and Community Based)	Inpatient Hospital	49,366	$ 1,114,123	1,255	305	$ 887.81	$ 22.57
1	Dual	LTSS (Home and Community Based)	Lab and Radiology	49,366	$ 15,660	4,078	991	$ 3.84	$ 0.32
1	Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	49,366	$ 2,324	25	6	$ 92.76	$ 0.05
1	Dual	LTSS (Home and Community Based)	Other Care	49,366	$ 998,633	22,555	5,483	$ 44.28	$ 20.23
1	Dual	LTSS (Home and Community Based)	Other Professional	49,366	$ 56,818	882	214	$ 64.45	$ 1.15
1	Dual	LTSS (Home and Community Based)	Outpatient Hospital	49,366	$ 1,618,741	9,536	2,318	$ 169.75	$ 32.79
1	Dual	LTSS (Home and Community Based)	PCP	49,366	$ 2,442,662	82,042	19,943	$ 29.77	$ 49.48
1	Dual	LTSS (Home and Community Based)	Specialist	49,366	$ 5,035	214	52	$ 23.52	$ 0.10
1	Dual	LTSS (Home and Community Based)	Vision	49,366	$ 254,293	2,347	570	$ 108.37	$ 5.15
1	Dual	LTSS (Home and Community Based)	Rx	49,366	$ 370,632	104,629	25,433	$ 3.54	$ 7.51
1	Dual	LTSS (Home and Community Based)	Behavioral Health - IP	49,366	$ 72,744	374	91	$ 194.34	$ 1.47
1	Dual	LTSS (Home and Community Based)	Behavioral Health - OP	49,366	$ 836,032	16,982	4,128	$ 49.23	$ 16.94
1	Dual	LTSS (Home and Community Based)	Behavioral Health - Other	49,366	$ 101,432	8,653	2,103	$ 11.72	$ 2.05
1	Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	49,366	$ 15,999	51	12	$ 315.04	$ 0.32
1	Non-Dual	LTSS (Home and Community Based)	DME/Supplies	28,342	$ 5,356,758	24,693	10,455	$ 216.93	$ 189.00
1	Non-Dual	LTSS (Home and Community Based)	Emergency Room	28,342	$ 522,598	1,448	613	$ 360.99	$ 18.44
1	Non-Dual	LTSS (Home and Community Based)	Emergency Transportation	28,342	$ 67,649	243	103	$ 277.84	$ 2.39
1	Non-Dual	LTSS (Home and Community Based)	EPSDT	28,342	$ 8,248	81	34	$ 101.56	$ 0.29
1	Non-Dual	LTSS (Home and Community Based)	Family Planning	28,342	$ 20,577	292	123	$ 70.55	$ 0.73
1	Non-Dual	LTSS (Home and Community Based)	FQHC/RHC	28,342	$ 110,846	1,027	435	$ 107.96	$ 3.91
1	Non-Dual	LTSS (Home and Community Based)	Home Health	28,342	$ 2,780,799	399,977	169,350	$ 6.95	$ 98.12
1	Non-Dual	LTSS (Home and Community Based)	Hospice	28,342	$ 187,735	36,217	15,334	$ 5.18	$ 6.62
1	Non-Dual	LTSS (Home and Community Based)	Inpatient Hospital	28,342	$ 6,053,571	478	202	$ 12,668.78	$ 213.59
1	Non-Dual	LTSS (Home and Community Based)	Lab and Radiology	28,342	$ 222,352	12,306	5,210	$ 18.07	$ 7.85
1	Non-Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	28,342	$ 32,109	130	55	$ 247.13	$ 1.13
1	Non-Dual	LTSS (Home and Community Based)	Other Care	28,342	$ 1,389,632	23,343	9,883	$ 59.53	$ 49.03
1	Non-Dual	LTSS (Home and Community Based)	Other Professional	28,342	$ 187,103	1,705	722	$ 109.77	$ 6.60
1	Non-Dual	LTSS (Home and Community Based)	Outpatient Hospital	28,342	$ 2,481,349	7,311	3,095	$ 339.41	$ 87.55
1	Non-Dual	LTSS (Home and Community Based)	PCP	28,342	$ 1,574,524	19,378	8,205	$ 81.25	$ 55.55
1	Non-Dual	LTSS (Home and Community Based)	Specialist	28,342	$ 365,732	2,524	1,069	$ 144.88	$ 12.90
1	Non-Dual	LTSS (Home and Community Based)	Vision	28,342	$ 117,733	1,481	627	$ 79.50	$ 4.15
1	Non-Dual	LTSS (Home and Community Based)	Rx	28,342	$ 13,483,094	136,465	57,779	$ 98.80	$ 475.73
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - IP	28,342	$ 287,128	567	240	$ 506.19	$ 10.13
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - OP	28,342	$ 885,134	12,397	5,249	$ 71.40	$ 31.23
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Other	28,342	$ 159,851	16,651	7,050	$ 9.60	$ 5.64
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	28,342	$ 5,643	16	7	$ 349.62	$ 0.20

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
2	Dual	LTSS (Institutional)	DME/Supplies	23,676	$ 163,989	1,748	886	$ 93.80	$ 6.93
2	Dual	LTSS (Institutional)	Emergency Room	23,676	$ 294,245	963	488	$ 305.68	$ 12.43
2	Dual	LTSS (Institutional)	Emergency Transportation	23,676	$ 1,288	7	3	$ 195.62	$ 0.05
2	Dual	LTSS (Institutional)	EPSDT	23,676	$ -	-	-	$ -	$ -
2	Dual	LTSS (Institutional)	Family Planning	23,676	$ -	-	-	$ -	$ -
2	Dual	LTSS (Institutional)	FQHC/RHC	23,676	$ 133,708	4,586	2,324	$ 29.16	$ 5.65
2	Dual	LTSS (Institutional)	Home Health	23,676	$ 51,628	20,353	10,316	$ 2.54	$ 2.18
2	Dual	LTSS (Institutional)	Hospice	23,676	$ -	-	-	$ -	$ -
2	Dual	LTSS (Institutional)	Inpatient Hospital	23,676	$ 799,101	1,364	691	$ 585.87	$ 33.75
2	Dual	LTSS (Institutional)	Lab and Radiology	23,676	$ 2,849	620	314	$ 4.59	$ 0.12
2	Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	23,676	$ 7,832	41	21	$ 191.40	$ 0.33
2	Dual	LTSS (Institutional)	Other Care	23,676	$ 11,775	1,608	815	$ 7.32	$ 0.50
2	Dual	LTSS (Institutional)	Other Professional	23,676	$ 2,421	71	36	$ 34.22	$ 0.10
2	Dual	LTSS (Institutional)	Outpatient Hospital	23,676	$ 1,375,311	6,676	3,384	$ 206.00	$ 58.09
2	Dual	LTSS (Institutional)	PCP	23,676	$ 800,954	30,076	15,244	$ 26.63	$ 33.83
2	Dual	LTSS (Institutional)	Specialist	23,676	$ 3,104	61	31	$ 51.01	$ 0.13
2	Dual	LTSS (Institutional)	Vision	23,676	$ 97,754	475	241	$ 205.58	$ 4.13
2	Dual	LTSS (Institutional)	Rx	23,676	$ 187,389	67,291	34,106	$ 2.78	$ 7.91
2	Dual	LTSS (Institutional)	Behavioral Health - IP	23,676	$ 56,424	704	357	$ 80.11	$ 2.38
2	Dual	LTSS (Institutional)	Behavioral Health - OP	23,676	$ 135,154	2,645	1,341	$ 51.09	$ 5.71
2	Dual	LTSS (Institutional)	Behavioral Health - Other	23,676	$ 8,124	403	204	$ 20.15	$ 0.34
2	Dual	LTSS (Institutional)	Behavioral Health - Residential	23,676	$ 24,408	72	36	$ 340.56	$ 1.03
2	Non-Dual	LTSS (Institutional)	DME/Supplies	1,916	$ 33,788	281	1,763	$ 120.06	$ 17.63
2	Non-Dual	LTSS (Institutional)	Emergency Room	1,916	$ 70,520	86	541	$ 816.37	$ 36.81
2	Non-Dual	LTSS (Institutional)	Emergency Transportation	1,916	$ 17,936	35	219	$ 512.56	$ 9.36
2	Non-Dual	LTSS (Institutional)	EPSDT	1,916	$ 169	1	9	$ 114.78	$ 0.09
2	Non-Dual	LTSS (Institutional)	Family Planning	1,916	$ -	-	-	$ -	$ -
2	Non-Dual	LTSS (Institutional)	FQHC/RHC	1,916	$ 17,161	234	1,467	$ 73.25	$ 8.96
2	Non-Dual	LTSS (Institutional)	Home Health	1,916	$ 2,191	1,691	10,591	$ 1.30	$ 1.14
2	Non-Dual	LTSS (Institutional)	Hospice	1,916	$ 50,037	10,976	68,741	$ 4.56	$ 26.12
2	Non-Dual	LTSS (Institutional)	Inpatient Hospital	1,916	$ 1,083,015	99	622	$ 10,911.34	$ 565.25
2	Non-Dual	LTSS (Institutional)	Lab and Radiology	1,916	$ 25,832	1,180	7,393	$ 21.88	$ 13.48
2	Non-Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	1,916	$ 20,846	52	327	$ 399.01	$ 10.88
2	Non-Dual	LTSS (Institutional)	Other Care	1,916	$ 62,036	531	3,325	$ 116.87	$ 32.38
2	Non-Dual	LTSS (Institutional)	Other Professional	1,916	$ 16,475	181	1,131	$ 91.21	$ 8.60
2	Non-Dual	LTSS (Institutional)	Outpatient Hospital	1,916	$ 385,939	1,423	8,910	$ 271.29	$ 201.43
2	Non-Dual	LTSS (Institutional)	PCP	1,916	$ 216,653	2,146	13,440	$ 100.96	$ 113.08
2	Non-Dual	LTSS (Institutional)	Specialist	1,916	$ 33,863	234	1,467	$ 144.54	$ 17.67
2	Non-Dual	LTSS (Institutional)	Vision	1,916	$ 9,584	80	500	$ 120.04	$ 5.00
2	Non-Dual	LTSS (Institutional)	Rx	1,916	$ 1,237,537	21,383	133,924	$ 57.87	$ 645.90
2	Non-Dual	LTSS (Institutional)	Behavioral Health - IP	1,916	$ 19,573	103	647	$ 189.49	$ 10.22
2	Non-Dual	LTSS (Institutional)	Behavioral Health - OP	1,916	$ 33,226	707	4,430	$ 46.98	$ 17.34
2	Non-Dual	LTSS (Institutional)	Behavioral Health - Other	1,916	$ 604	17	105	$ 35.93	$ 0.32
2	Non-Dual	LTSS (Institutional)	Behavioral Health - Residential	1,916	$ 4,517	28	173	$ 163.30	$ 2.36

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
2	Dual	LTSS (Home and Community Based)	DME/Supplies	22,675	$ 647,375	9,275	4,909	$ 69.80	$ 28.55
2	Dual	LTSS (Home and Community Based)	Emergency Room	22,675	$ 290,713	1,202	636	$ 241.88	$ 12.82
2	Dual	LTSS (Home and Community Based)	Emergency Transportation	22,675	$ 251	6	3	$ 43.68	$ 0.01
2	Dual	LTSS (Home and Community Based)	EPSDT	22,675	$ -	-	-	$ -	$ -
2	Dual	LTSS (Home and Community Based)	Family Planning	22,675	$ 3,189	99	52	$ 32.24	$ 0.14
2	Dual	LTSS (Home and Community Based)	FQHC/RHC	22,675	$ 89,258	2,756	1,458	$ 32.39	$ 3.94
2	Dual	LTSS (Home and Community Based)	Home Health	22,675	$ 234,491	76,484	40,477	$ 3.07	$ 10.34
2	Dual	LTSS (Home and Community Based)	Hospice	22,675	$ -	-	33	$ -	$ -
2	Dual	LTSS (Home and Community Based)	Inpatient Hospital	22,675	$ 557,247	629	333	$ 885.24	$ 24.58
2	Dual	LTSS (Home and Community Based)	Lab and Radiology	22,675	$ 2,917	1,254	664	$ 2.33	$ 0.13
2	Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	22,675	$ 3,147	19	10	$ 167.45	$ 0.14
2	Dual	LTSS (Home and Community Based)	Other Care	22,675	$ 141,504	3,953	2,092	$ 35.80	$ 6.24
2	Dual	LTSS (Home and Community Based)	Other Professional	22,675	$ 5,041	106	56	$ 47.45	$ 0.22
2	Dual	LTSS (Home and Community Based)	Outpatient Hospital	22,675	$ 1,272,089	6,449	3,413	$ 197.26	$ 56.10
2	Dual	LTSS (Home and Community Based)	PCP	22,675	$ 1,219,729	44,268	23,427	$ 27.55	$ 53.79
2	Dual	LTSS (Home and Community Based)	Specialist	22,675	$ 2,701	67	35	$ 40.31	$ 0.12
2	Dual	LTSS (Home and Community Based)	Vision	22,675	$ 128,230	1,026	543	$ 125.01	$ 5.66
2	Dual	LTSS (Home and Community Based)	Rx	22,675	$ 152,107	48,305	25,564	$ 3.15	$ 6.71
2	Dual	LTSS (Home and Community Based)	Behavioral Health - IP	22,675	$ 26,113	149	79	$ 174.74	$ 1.15
2	Dual	LTSS (Home and Community Based)	Behavioral Health - OP	22,675	$ 284,349	4,746	2,512	$ 59.91	$ 12.54
2	Dual	LTSS (Home and Community Based)	Behavioral Health - Other	22,675	$ 50,912	2,173	1,150	$ 23.43	$ 2.25
2	Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	22,675	$ 4,134	12	6	$ 347.50	$ 0.18
2	Non-Dual	LTSS (Home and Community Based)	DME/Supplies	6,774	$ 1,447,140	6,257	11,084	$ 231.29	$ 213.63
2	Non-Dual	LTSS (Home and Community Based)	Emergency Room	6,774	$ 194,621	315	558	$ 617.69	$ 28.73
2	Non-Dual	LTSS (Home and Community Based)	Emergency Transportation	6,774	$ 15,701	59	105	$ 265.21	$ 2.32
2	Non-Dual	LTSS (Home and Community Based)	EPSDT	6,774	$ 1,035	14	26	$ 71.86	$ 0.15
2	Non-Dual	LTSS (Home and Community Based)	Family Planning	6,774	$ 6,570	91	161	$ 72.27	$ 0.97
2	Non-Dual	LTSS (Home and Community Based)	FQHC/RHC	6,774	$ 54,774	534	946	$ 102.57	$ 8.09
2	Non-Dual	LTSS (Home and Community Based)	Home Health	6,774	$ 155,110	38,927	68,958	$ 3.98	$ 22.90
2	Non-Dual	LTSS (Home and Community Based)	Hospice	6,774	$ 8,149	1,768	3,132	$ 4.61	$ 1.20
2	Non-Dual	LTSS (Home and Community Based)	Inpatient Hospital	6,774	$ 1,287,510	119	211	$ 10,816.48	$ 190.07
2	Non-Dual	LTSS (Home and Community Based)	Lab and Radiology	6,774	$ 54,398	2,718	4,815	$ 20.01	$ 8.03
2	Non-Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	6,774	$ 17,067	28	50	$ 601.89	$ 2.52
2	Non-Dual	LTSS (Home and Community Based)	Other Care	6,774	$ 329,671	5,859	10,379	$ 56.27	$ 48.67
2	Non-Dual	LTSS (Home and Community Based)	Other Professional	6,774	$ 34,424	399	707	$ 86.29	$ 5.08
2	Non-Dual	LTSS (Home and Community Based)	Outpatient Hospital	6,774	$ 984,451	2,317	4,104	$ 424.94	$ 145.33
2	Non-Dual	LTSS (Home and Community Based)	PCP	6,774	$ 420,637	5,060	8,963	$ 83.13	$ 62.10
2	Non-Dual	LTSS (Home and Community Based)	Specialist	6,774	$ 70,729	677	1,199	$ 104.53	$ 10.44
2	Non-Dual	LTSS (Home and Community Based)	Vision	6,774	$ 35,880	381	675	$ 94.16	$ 5.30
2	Non-Dual	LTSS (Home and Community Based)	Rx	6,774	$ 2,559,655	39,072	69,215	$ 65.51	$ 377.86
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - IP	6,774	$ 56,533	138	244	$ 411.15	$ 8.35
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - OP	6,774	$ 191,494	2,525	4,474	$ 75.83	$ 28.27
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Other	6,774	$ 25,252	2,706	4,794	$ 9.33	$ 3.73
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	6,774	$ 880	3	4	$ 347.50	$ 0.13

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	LTSS (Institutional)	ALL	59,908	$ 12,485,515	442,091	88,554	$ 28.24	$ 208.41
1	Non-Dual	LTSS (Institutional)	ALL	5,638	$ 14,693,920	253,710	540,001	$ 57.92	$ 2,606.23
1	Dual	LTSS (Home and Community Based)	ALL	49,366	$ 12,315,729	931,801	226,504	$ 13.22	$ 249.48
1	Non-Dual	LTSS (Home and Community Based)	ALL	28,342	$ 36,300,166	698,729	295,842	$ 51.95	$ 1,280.79
2	Dual	LTSS (Institutional)	ALL	23,676	$ 4,157,457	139,764	70,838	$ 29.75	$ 175.60
2	Non-Dual	LTSS (Institutional)	ALL	1,916	$ 3,341,502	41,469	259,724	$ 80.58	$ 1,744.00
2	Dual	LTSS (Home and Community Based)	ALL	22,675	$ 5,115,497	202,979	107,420	$ 25.20	$ 225.60
2	Non-Dual	LTSS (Home and Community Based)	ALL	6,774	$ 7,951,683	109,966	194,803	$ 72.31	$ 1,173.85
Total				**198,295**	**$ 96,361,468**	**2,820,510**	**170,686**	**$ 34.16**	**$ 485.95**

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-C
Dual Databook

			Base Data*					
Rating Region	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	DME/Supplies	193,309	$ 1,790,811	20,167	1,252	$ 88.80	$ 9.26
1	Dual	Emergency Room	193,309	$ 2,425,161	18,330	1,138	$ 132.31	$ 12.55
1	Dual	Emergency Transportation	193,309	$ 18,116	128	8	$ 141.64	$ 0.09
1	Dual	EPSDT	193,309	$ -	-	0	$ -	$ -
1	Dual	Family Planning	193,309	$ 31,904	298	19	$ 106.93	$ 0.17
1	Dual	FQHC/RHC	193,309	$ 643,229	18,512	1,149	$ 34.75	$ 3.33
1	Dual	Home Health	193,309	$ 4,782,498	1,835,032	113,913	$ 2.61	$ 24.74
1	Dual	Hospice	193,309	$ 11,380	2,226	138	$ 5.11	$ 0.06
1	Dual	Inpatient Hospital	193,309	$ 5,259,466	5,929	368	$ 887.06	$ 27.21
1	Dual	Lab and Radiology	193,309	$ 103,643	19,743	1,226	$ 5.25	$ 0.54
1	Dual	Non-Emergency Transportation - Ambulance	193,309	$ 9,871	78	5	$ 126.96	$ 0.05
1	Dual	Other Care	193,309	$ 228,959	23,022	1,429	$ 9.95	$ 1.18
1	Dual	Other Professional	193,309	$ 104,470	1,813	113	$ 57.61	$ 0.54
1	Dual	Outpatient Hospital	193,309	$ 9,360,528	48,478	3,009	$ 193.09	$ 48.42
1	Dual	PCP	193,309	$ 11,470,508	357,053	22,165	$ 32.13	$ 59.34
1	Dual	Specialist	193,309	$ 49,825	988	61	$ 50.42	$ 0.26
1	Dual	Vision	193,309	$ 744,234	6,651	413	$ 111.89	$ 3.85
1	Dual	Rx	193,309	$ 278,206	58,789	3,649	$ 4.73	$ 1.44
1	Dual	Behavioral Health - IP	193,309	$ 1,659,599	5,752	357	$ 288.53	$ 8.59
1	Dual	Behavioral Health - OP	193,309	$ 2,764,553	54,115	3,359	$ 51.09	$ 14.30
1	Dual	Behavioral Health - Other	193,309	$ 6,083,035	312,681	19,410	$ 19.45	$ 31.47
1	Dual	Behavioral Health - Residential	193,309	$ 4,742,089	30,133	1,871	$ 157.37	$ 24.53
2	Dual	DME/Supplies	65,329	$ 480,087	6,028	1,107	$ 79.64	$ 7.35
2	Dual	Emergency Room	65,329	$ 979,309	4,800	882	$ 204.01	$ 14.99
2	Dual	Emergency Transportation	65,329	$ 1,944	22	4	$ 88.20	$ 0.03
2	Dual	EPSDT	65,329	$ -	-	-	$ -	$ -
2	Dual	Family Planning	65,329	$ 12,502	108	20	$ 115.74	$ 0.19
2	Dual	FQHC/RHC	65,329	$ 289,968	8,780	1,613	$ 33.03	$ 4.44
2	Dual	Home Health	65,329	$ 192,297	65,531	12,037	$ 2.93	$ 2.94
2	Dual	Hospice	65,329	$ 8,003	1,382	254	$ 5.79	$ 0.12
2	Dual	Inpatient Hospital	65,329	$ 1,534,949	1,681	309	$ 913.24	$ 23.50
2	Dual	Lab and Radiology	65,329	$ 20,227	4,089	751	$ 4.95	$ 0.31
2	Dual	Non-Emergency Transportation - Ambulance	65,329	$ 10,012	54	10	$ 186.83	$ 0.15
2	Dual	Other Care	65,329	$ 36,743	4,649	854	$ 7.90	$ 0.56
2	Dual	Other Professional	65,329	$ 10,057	216	40	$ 46.66	$ 0.15
2	Dual	Outpatient Hospital	65,329	$ 4,116,370	18,616	3,420	$ 221.12	$ 63.01
2	Dual	PCP	65,329	$ 3,625,552	128,701	23,641	$ 28.17	$ 55.50
2	Dual	Specialist	65,329	$ 12,670	265	49	$ 47.85	$ 0.19
2	Dual	Vision	65,329	$ 296,669	2,344	431	$ 126.54	$ 4.54
2	Dual	Rx	65,329	$ 97,049	19,153	3,518	$ 5.07	$ 1.49
2	Dual	Behavioral Health - IP	65,329	$ 276,518	1,447	266	$ 191.11	$ 4.23
2	Dual	Behavioral Health - OP	65,329	$ 1,088,004	19,817	3,640	$ 54.90	$ 16.65
2	Dual	Behavioral Health - Other	65,329	$ 1,871,991	98,575	18,107	$ 18.99	$ 28.65
2	Dual	Behavioral Health - Residential	65,329	$ 294,729	1,591	292	$ 185.28	$ 4.51

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-C
Dual Databook

		Base Data*					
Rating Region	Population	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	193,309	$ 52,562,084	2,819,919	175,051	$ 18.64	$ 271.91
2	Dual	65,329	$ 15,255,650	387,847	71,242	$ 39.33	$ 233.52
Total		**258,638**	**$ 67,817,734**	**3,207,767**	**148,830**	**$ 21.14**	**$ 262.21**

		Base Data*					
Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
Dual	DME/Supplies	258,638	$ 2,270,898	26,195	1,215	$ 86.69	$ 8.78
Dual	Emergency Room	258,638	$ 3,404,470	23,130	1,073	$ 147.19	$ 13.16
Dual	Emergency Transportation	258,638	$ 20,060	150	7	$ 133.78	$ 0.08
Dual	EPSDT	258,638	$ -	-	-	$ -	$ -
Dual	Family Planning	258,638	$ 44,406	406	19	$ 109.27	$ 0.17
Dual	FQHC/RHC	258,638	$ 933,197	27,292	1,266	$ 34.19	$ 3.61
Dual	Home Health	258,638	$ 4,974,795	1,900,563	88,180	$ 2.62	$ 19.23
Dual	Hospice	258,638	$ 19,383	3,608	167	$ 5.37	$ 0.07
Dual	Inpatient Hospital	258,638	$ 6,794,414	7,610	353	$ 892.84	$ 26.27
Dual	Lab and Radiology	258,638	$ 123,870	23,832	1,106	$ 5.20	$ 0.48
Dual	Non-Emergency Transportation - Ambulance	258,638	$ 19,883	131	6	$ 151.39	$ 0.08
Dual	Other Care	258,638	$ 265,701	27,670	1,284	$ 9.60	$ 1.03
Dual	Other Professional	258,638	$ 114,528	2,029	94	$ 56.45	$ 0.44
Dual	Outpatient Hospital	258,638	$ 13,476,898	67,095	3,113	$ 200.86	$ 52.11
Dual	PCP	258,638	$ 15,096,060	485,754	22,537	$ 31.08	$ 58.37
Dual	Specialist	258,638	$ 62,495	1,253	58	$ 49.88	$ 0.24
Dual	Vision	258,638	$ 1,040,902	8,996	417	$ 115.71	$ 4.02
Dual	Rx	258,638	$ 375,255	77,942	3,616	$ 4.81	$ 1.45
Dual	Behavioral Health - IP	258,638	$ 1,936,117	7,199	334	$ 268.95	$ 7.49
Dual	Behavioral Health - OP	258,638	$ 3,852,558	73,933	3,430	$ 52.11	$ 14.90
Dual	Behavioral Health - Other	258,638	$ 7,955,026	411,256	19,081	$ 19.34	$ 30.76
Dual	Behavioral Health - Residential	258,638	$ 5,036,817	31,724	1,472	$ 158.77	$ 19.47
Total		**258,638**	**$ 67,817,734**	**3,207,767**	**148,830**	**$ 21.14**	**$ 262.21**

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 00-20 M&F	DME/Supplies	9,807	$ 804,393	2,205	2,697	$ 364.89	$ 82.02
2	AABD 00-20 M&F	Emergency Room	9,807	$ 231,828	579	708	$ 400.56	$ 23.64
2	AABD 00-20 M&F	Emergency Transportation	9,807	$ 58,575	50	61	$ 1,167.31	$ 5.97
2	AABD 00-20 M&F	EPSDT	9,807	$ 21,537	185	226	$ 116.55	$ 2.20
2	AABD 00-20 M&F	Family Planning	9,807	$ 2,067	31	37	$ 67.55	$ 0.21
2	AABD 00-20 M&F	FQHC/RHC	9,807	$ 52,285	469	574	$ 111.42	$ 5.33
2	AABD 00-20 M&F	Home Health	9,807	$ 403,926	2,632	3,220	$ 153.48	$ 41.19
2	AABD 00-20 M&F	Hospice	9,807	$ 2,189	15	18	$ 150.10	$ 0.22
2	AABD 00-20 M&F	Inpatient Hospital	9,807	$ 1,754,990	84	103	$ 20,793.42	$ 178.95
2	AABD 00-20 M&F	Lab and Radiology	9,807	$ 40,858	963	1,179	$ 42.41	$ 4.17
2	AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	9,807	$ 3,198	5	6	$ 647.23	$ 0.33
2	AABD 00-20 M&F	Other Care	9,807	$ 407,598	3,811	4,664	$ 106.94	$ 41.56
2	AABD 00-20 M&F	Other Professional	9,807	$ 120,386	1,449	1,772	$ 83.11	$ 12.28
2	AABD 00-20 M&F	Outpatient Hospital	9,807	$ 1,492,441	1,833	2,243	$ 814.08	$ 152.18
2	AABD 00-20 M&F	PCP	9,807	$ 669,621	9,748	11,928	$ 68.69	$ 68.28
2	AABD 00-20 M&F	Specialist	9,807	$ 260,878	1,695	2,074	$ 153.90	$ 26.60
2	AABD 00-20 M&F	Vision	9,807	$ 48,105	297	363	$ 162.01	$ 4.91
2	AABD 00-20 M&F	Rx	9,807	$ 3,045,990	19,911	24,363	$ 152.98	$ 310.59
2	AABD 00-20 M&F	Behavioral Health - IP	9,807	$ 82,513	164	201	$ 502.89	$ 8.41
2	AABD 00-20 M&F	Behavioral Health - OP	9,807	$ 347,359	4,721	5,776	$ 73.58	$ 35.42
2	AABD 00-20 M&F	Behavioral Health - Residential	9,807	$ -	-	-	$ -	$ -
2	AABD 00-20 M&F	Behavioral Health - Other	9,807	$ 7,287	522	638	$ 13.97	$ 0.74

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 21+ M&F	DME/Supplies	27,407	$ 1,418,362	7,437	3,256	$ 190.71	$ 51.75
2	AABD 21+ M&F	Emergency Room	27,407	$ 2,065,790	2,844	1,245	$ 726.34	$ 75.37
2	AABD 21+ M&F	Emergency Transportation	27,407	$ 251,350	571	250	$ 440.18	$ 9.17
2	AABD 21+ M&F	EPSDT	27,407	$ -	-	-	$ -	$ -
2	AABD 21+ M&F	Family Planning	27,407	$ 11,665	100	44	$ 116.56	$ 0.43
2	AABD 21+ M&F	FQHC/RHC	27,407	$ 352,795	2,793	1,223	$ 126.29	$ 12.87
2	AABD 21+ M&F	Home Health	27,407	$ 195,640	5,885	2,577	$ 33.25	$ 7.14
2	AABD 21+ M&F	Hospice	27,407	$ 169,370	1,157	507	$ 146.37	$ 6.18
2	AABD 21+ M&F	Inpatient Hospital	27,407	$ 7,565,210	740	324	$ 10,225.35	$ 276.03
2	AABD 21+ M&F	Lab and Radiology	27,407	$ 311,123	14,156	6,198	$ 21.98	$ 11.35
2	AABD 21+ M&F	Non-Emergency Transportation - Ambulance	27,407	$ 17,567	31	14	$ 563.35	$ 0.64
2	AABD 21+ M&F	Other Care	27,407	$ 244,635	2,239	981	$ 109.24	$ 8.93
2	AABD 21+ M&F	Other Professional	27,407	$ 555,609	6,848	2,998	$ 81.13	$ 20.27
2	AABD 21+ M&F	Outpatient Hospital	27,407	$ 5,631,738	10,337	4,526	$ 544.81	$ 205.49
2	AABD 21+ M&F	PCP	27,407	$ 2,120,863	19,007	8,322	$ 111.58	$ 77.38
2	AABD 21+ M&F	Specialist	27,407	$ 1,439,431	10,975	4,805	$ 131.16	$ 52.52
2	AABD 21+ M&F	Vision	27,407	$ 181,328	933	408	$ 194.39	$ 6.62
2	AABD 21+ M&F	Rx	27,407	$ 12,734,264	125,641	55,011	$ 101.35	$ 464.64
2	AABD 21+ M&F	Behavioral Health - IP	27,407	$ 628,935	1,371	600	$ 458.75	$ 22.95
2	AABD 21+ M&F	Behavioral Health - OP	27,407	$ 864,757	12,841	5,622	$ 67.34	$ 31.55
2	AABD 21+ M&F	Behavioral Health - Residential	27,407	$ 200,651	1,251	548	$ 160.35	$ 7.32
2	AABD 21+ M&F	Behavioral Health - Other	27,407	$ 1,141,840	74,623	32,673	$ 15.30	$ 41.66

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 21+ M&F-WWC	DME/Supplies	451	$ 20,587	63	1,681	$ 325.93	$ 45.65
2	AABD 21+ M&F-WWC	Emergency Room	451	$ 21,489	27	711	$ 803.65	$ 47.65
2	AABD 21+ M&F-WWC	Emergency Transportation	451	$ 1,012	2	59	$ 457.08	$ 2.25
2	AABD 21+ M&F-WWC	EPSDT	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Family Planning	451	$ 28	1	24	$ 31.36	$ 0.06
2	AABD 21+ M&F-WWC	FQHC/RHC	451	$ 7,103	56	1,491	$ 126.78	$ 15.75
2	AABD 21+ M&F-WWC	Home Health	451	$ 1,411	41	1,087	$ 34.56	$ 3.13
2	AABD 21+ M&F-WWC	Hospice	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Inpatient Hospital	451	$ 142,561	18	467	$ 8,129.84	$ 316.10
2	AABD 21+ M&F-WWC	Lab and Radiology	451	$ 30,821	825	21,961	$ 37.34	$ 68.34
2	AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	451	$ 310	1	13	$ 618.66	$ 0.69
2	AABD 21+ M&F-WWC	Other Care	451	$ 13,116	127	3,388	$ 103.01	$ 29.08
2	AABD 21+ M&F-WWC	Other Professional	451	$ 5,654	38	1,001	$ 150.31	$ 12.54
2	AABD 21+ M&F-WWC	Outpatient Hospital	451	$ 546,460	489	13,006	$ 1,117.95	$ 1,211.66
2	AABD 21+ M&F-WWC	PCP	451	$ 148,233	658	17,508	$ 225.28	$ 328.68
2	AABD 21+ M&F-WWC	Specialist	451	$ 43,129	140	3,731	$ 307.58	$ 95.63
2	AABD 21+ M&F-WWC	Vision	451	$ 2,252	22	582	$ 102.89	$ 4.99
2	AABD 21+ M&F-WWC	Rx	451	$ 78,566	1,993	53,031	$ 39.42	$ 174.20
2	AABD 21+ M&F-WWC	Behavioral Health - IP	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Behavioral Health - OP	451	$ 666	9	252	$ 70.28	$ 1.48
2	AABD 21+ M&F-WWC	Behavioral Health - Residential	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Behavioral Health - Other	451	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	CHIP M&F	DME/Supplies	107,941	$ 202,464	1,115	124	$ 181.64	$ 1.88
2	CHIP M&F	Emergency Room	107,941	$ 1,113,100	2,782	309	$ 400.07	$ 10.31
2	CHIP M&F	Emergency Transportation	107,941	$ 37,313	67	7	$ 559.86	$ 0.35
2	CHIP M&F	EPSDT	107,941	$ 342,284	2,748	305	$ 124.57	$ 3.17
2	CHIP M&F	Family Planning	107,941	$ 21,253	163	18	$ 130.35	$ 0.20
2	CHIP M&F	FQHC/RHC	107,941	$ 458,337	4,079	453	$ 112.36	$ 4.25
2	CHIP M&F	Home Health	107,941	$ 6,331	98	11	$ 64.71	$ 0.06
2	CHIP M&F	Hospice	107,941	$ -	-	-	$ -	$ -
2	CHIP M&F	Inpatient Hospital	107,941	$ 968,202	137	15	$ 7,092.71	$ 8.97
2	CHIP M&F	Lab and Radiology	107,941	$ 113,234	4,613	513	$ 24.55	$ 1.05
2	CHIP M&F	Non-Emergency Transportation - Ambulance	107,941	$ 4,050	5	1	$ 754.23	$ 0.04
2	CHIP M&F	Other Care	107,941	$ 202,145	2,380	265	$ 84.93	$ 1.87
2	CHIP M&F	Other Professional	107,941	$ 624,978	10,351	1,151	$ 60.38	$ 5.79
2	CHIP M&F	Outpatient Hospital	107,941	$ 2,384,896	5,713	635	$ 417.43	$ 22.09
2	CHIP M&F	PCP	107,941	$ 2,081,934	26,435	2,939	$ 78.76	$ 19.29
2	CHIP M&F	Specialist	107,941	$ 541,009	5,466	608	$ 98.97	$ 5.01
2	CHIP M&F	Vision	107,941	$ 319,056	2,100	233	$ 151.94	$ 2.96
2	CHIP M&F	Rx	107,941	$ 3,806,639	53,881	5,990	$ 70.65	$ 35.27
2	CHIP M&F	Behavioral Health - IP	107,941	$ 185,228	356	40	$ 520.15	$ 1.72
2	CHIP M&F	Behavioral Health - OP	107,941	$ 1,191,195	16,371	1,820	$ 72.76	$ 11.04
2	CHIP M&F	Behavioral Health - Residential	107,941	$ 45,352	178	20	$ 255.17	$ 0.42
2	CHIP M&F	Behavioral Health - Other	107,941	$ 158	6	1	$ 24.60	$ 0.00

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family Under 1 M&F	DME/Supplies	32,855	$ 143,784	1,397	510	$ 102.89	$ 4.38
2	Family Under 1 M&F	Emergency Room	32,855	$ 636,570	3,446	1,259	$ 184.71	$ 19.38
2	Family Under 1 M&F	Emergency Transportation	32,855	$ 124,216	94	34	$ 1,318.64	$ 3.78
2	Family Under 1 M&F	EPSDT	32,855	$ 947,352	10,074	3,680	$ 94.04	$ 28.83
2	Family Under 1 M&F	Family Planning	32,855	$ -	-	-	$ -	$ -
2	Family Under 1 M&F	FQHC/RHC	32,855	$ 185,510	1,992	728	$ 93.12	$ 5.65
2	Family Under 1 M&F	Home Health	32,855	$ 24,687	1,528	558	$ 16.16	$ 0.75
2	Family Under 1 M&F	Hospice	32,855	$ 1,177	8	3	$ 155.29	$ 0.04
2	Family Under 1 M&F	Inpatient Hospital	32,855	$ 5,003,818	1,666	609	$ 3,002.71	$ 152.30
2	Family Under 1 M&F	Lab and Radiology	32,855	$ 39,772	2,578	942	$ 15.42	$ 1.21
2	Family Under 1 M&F	Non-Emergency Transportation - Ambulance	32,855	$ 6,222	8	3	$ 828.47	$ 0.19
2	Family Under 1 M&F	Other Care	32,855	$ 267,095	1,194	436	$ 223.74	$ 8.13
2	Family Under 1 M&F	Other Professional	32,855	$ 295,074	4,635	1,693	$ 63.66	$ 8.98
2	Family Under 1 M&F	Outpatient Hospital	32,855	$ 1,009,604	3,096	1,131	$ 326.15	$ 30.73
2	Family Under 1 M&F	PCP	32,855	$ 2,310,648	29,669	10,836	$ 77.88	$ 70.33
2	Family Under 1 M&F	Specialist	32,855	$ 491,443	4,027	1,471	$ 122.04	$ 14.96
2	Family Under 1 M&F	Vision	32,855	$ 60,420	129	47	$ 466.94	$ 1.84
2	Family Under 1 M&F	Rx	32,855	$ 413,485	17,854	6,521	$ 23.16	$ 12.59
2	Family Under 1 M&F	Behavioral Health - IP	32,855	$ -	-	-	$ -	$ -
2	Family Under 1 M&F	Behavioral Health - OP	32,855	$ 698	8	3	$ 87.59	$ 0.02
2	Family Under 1 M&F	Behavioral Health - Residential	32,855	$ -	-	-	$ -	$ -
2	Family Under 1 M&F	Behavioral Health - Other	32,855	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 01-05 M&F	DME/Supplies	94,254	$ 142,938	980	125	$ 145.82	$ 1.52
2	Family 01-05 M&F	Emergency Room	94,254	$ 1,242,306	4,714	600	$ 263.54	$ 13.18
2	Family 01-05 M&F	Emergency Transportation	94,254	$ 89,605	81	10	$ 1,110.67	$ 0.95
2	Family 01-05 M&F	EPSDT	94,254	$ 541,280	4,429	564	$ 122.20	$ 5.74
2	Family 01-05 M&F	Family Planning	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	FQHC/RHC	94,254	$ 355,637	3,230	411	$ 110.12	$ 3.77
2	Family 01-05 M&F	Home Health	94,254	$ 26,211	415	53	$ 63.17	$ 0.28
2	Family 01-05 M&F	Hospice	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	Inpatient Hospital	94,254	$ 1,099,602	165	21	$ 6,660.44	$ 11.67
2	Family 01-05 M&F	Lab and Radiology	94,254	$ 60,401	3,069	391	$ 19.68	$ 0.64
2	Family 01-05 M&F	Non-Emergency Transportation - Ambulance	94,254	$ 3,102	5	1	$ 685.37	$ 0.03
2	Family 01-05 M&F	Other Care	94,254	$ 197,034	2,525	321	$ 78.04	$ 2.09
2	Family 01-05 M&F	Other Professional	94,254	$ 665,291	8,837	1,125	$ 75.29	$ 7.06
2	Family 01-05 M&F	Outpatient Hospital	94,254	$ 2,127,562	4,822	614	$ 441.21	$ 22.57
2	Family 01-05 M&F	PCP	94,254	$ 2,479,416	31,526	4,014	$ 78.65	$ 26.31
2	Family 01-05 M&F	Specialist	94,254	$ 434,398	4,282	545	$ 101.44	$ 4.61
2	Family 01-05 M&F	Vision	94,254	$ 190,411	959	122	$ 198.63	$ 2.02
2	Family 01-05 M&F	Rx	94,254	$ 1,600,718	42,380	5,396	$ 37.77	$ 16.98
2	Family 01-05 M&F	Behavioral Health - IP	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	Behavioral Health - OP	94,254	$ 247,496	2,776	353	$ 89.15	$ 2.63
2	Family 01-05 M&F	Behavioral Health - Residential	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	Behavioral Health - Other	94,254	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 06-20 F	DME/Supplies	82,972	$ 142,125	808	117	$ 175.99	$ 1.71
2	Family 06-20 F	Emergency Room	82,972	$ 1,224,505	2,831	409	$ 432.60	$ 14.76
2	Family 06-20 F	Emergency Transportation	82,972	$ 64,279	100	15	$ 640.94	$ 0.77
2	Family 06-20 F	EPSDT	82,972	$ 112,342	964	139	$ 116.59	$ 1.35
2	Family 06-20 F	Family Planning	82,972	$ 66,325	495	72	$ 133.99	$ 0.80
2	Family 06-20 F	FQHC/RHC	82,972	$ 315,642	2,879	416	$ 109.62	$ 3.80
2	Family 06-20 F	Home Health	82,972	$ 5,189	324	47	$ 16.04	$ 0.06
2	Family 06-20 F	Hospice	82,972	$ -	-	-	$ -	$ -
2	Family 06-20 F	Inpatient Hospital	82,972	$ 605,244	92	13	$ 6,570.92	$ 7.29
2	Family 06-20 F	Lab and Radiology	82,972	$ 141,529	5,784	837	$ 24.47	$ 1.71
2	Family 06-20 F	Non-Emergency Transportation - Ambulance	82,972	$ 2,060	5	1	$ 391.85	$ 0.02
2	Family 06-20 F	Other Care	82,972	$ 103,219	1,265	183	$ 81.60	$ 1.24
2	Family 06-20 F	Other Professional	82,972	$ 479,017	7,845	1,135	$ 61.06	$ 5.77
2	Family 06-20 F	Outpatient Hospital	82,972	$ 1,688,443	4,880	706	$ 345.96	$ 20.35
2	Family 06-20 F	PCP	82,972	$ 1,569,980	20,127	2,911	$ 78.00	$ 18.92
2	Family 06-20 F	Specialist	82,972	$ 348,090	3,791	548	$ 91.83	$ 4.20
2	Family 06-20 F	Vision	82,972	$ 300,747	2,084	301	$ 144.29	$ 3.62
2	Family 06-20 F	Rx	82,972	$ 2,729,461	45,431	6,571	$ 60.08	$ 32.90
2	Family 06-20 F	Behavioral Health - IP	82,972	$ 294,519	565	82	$ 521.04	$ 3.55
2	Family 06-20 F	Behavioral Health - OP	82,972	$ 1,309,909	18,043	2,609	$ 72.60	$ 15.79
2	Family 06-20 F	Behavioral Health - Residential	82,972	$ 81,583	319	46	$ 255.99	$ 0.98
2	Family 06-20 F	Behavioral Health - Other	82,972	$ 4,583	338	49	$ 13.57	$ 0.06

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 06-20 M	DME/Supplies	79,831	$ 107,395	689	104	$ 155.81	$ 1.35
2	Family 06-20 M	Emergency Room	79,831	$ 899,280	2,227	335	$ 403.84	$ 11.26
2	Family 06-20 M	Emergency Transportation	79,831	$ 48,424	73	11	$ 659.88	$ 0.61
2	Family 06-20 M	EPSDT	79,831	$ 119,248	1,034	155	$ 115.30	$ 1.49
2	Family 06-20 M	Family Planning	79,831	$ 62	1	0	$ 122.00	$ 0.00
2	Family 06-20 M	FQHC/RHC	79,831	$ 263,968	2,363	355	$ 111.70	$ 3.31
2	Family 06-20 M	Home Health	79,831	$ 1,461	83	12	$ 17.61	$ 0.02
2	Family 06-20 M	Hospice	79,831	$ -	-	-	$ -	$ -
2	Family 06-20 M	Inpatient Hospital	79,831	$ 623,413	67	10	$ 9,237.09	$ 7.81
2	Family 06-20 M	Lab and Radiology	79,831	$ 70,561	3,390	510	$ 20.82	$ 0.88
2	Family 06-20 M	Non-Emergency Transportation - Ambulance	79,831	$ 1,255	2	0	$ 815.80	$ 0.02
2	Family 06-20 M	Other Care	79,831	$ 152,369	1,536	231	$ 99.23	$ 1.91
2	Family 06-20 M	Other Professional	79,831	$ 389,404	6,281	944	$ 62.00	$ 4.88
2	Family 06-20 M	Outpatient Hospital	79,831	$ 1,208,057	3,033	456	$ 398.30	$ 15.13
2	Family 06-20 M	PCP	79,831	$ 1,279,738	16,488	2,478	$ 77.62	$ 16.03
2	Family 06-20 M	Specialist	79,831	$ 312,180	3,306	497	$ 94.42	$ 3.91
2	Family 06-20 M	Vision	79,831	$ 262,406	1,709	257	$ 153.52	$ 3.29
2	Family 06-20 M	Rx	79,831	$ 3,785,820	43,914	6,601	$ 86.21	$ 47.42
2	Family 06-20 M	Behavioral Health - IP	79,831	$ 196,347	386	58	$ 508.15	$ 2.46
2	Family 06-20 M	Behavioral Health - OP	79,831	$ 1,498,682	21,510	3,233	$ 69.67	$ 18.77
2	Family 06-20 M	Behavioral Health - Residential	79,831	$ 214,634	831	125	$ 258.14	$ 2.69
2	Family 06-20 M	Behavioral Health - Other	79,831	$ 5,714	259	39	$ 22.05	$ 0.07

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 21+ M&F	DME/Supplies	63,516	$ 407,099	2,585	488	$ 157.50	$ 6.41
2	Family 21+ M&F	Emergency Room	63,516	$ 2,642,054	4,495	849	$ 587.77	$ 41.60
2	Family 21+ M&F	Emergency Transportation	63,516	$ 105,440	207	39	$ 509.68	$ 1.66
2	Family 21+ M&F	EPSDT	63,516	$ -	-	-	$ -	$ -
2	Family 21+ M&F	Family Planning	63,516	$ 198,120	731	138	$ 270.97	$ 3.12
2	Family 21+ M&F	FQHC/RHC	63,516	$ 414,665	3,399	642	$ 121.99	$ 6.53
2	Family 21+ M&F	Home Health	63,516	$ 11,075	380	72	$ 29.16	$ 0.17
2	Family 21+ M&F	Hospice	63,516	$ 1,923	12	2	$ 160.21	$ 0.03
2	Family 21+ M&F	Inpatient Hospital	63,516	$ 3,140,567	412	78	$ 7,613.55	$ 49.45
2	Family 21+ M&F	Lab and Radiology	63,516	$ 497,592	18,481	3,492	$ 26.92	$ 7.83
2	Family 21+ M&F	Non-Emergency Transportation - Ambulance	63,516	$ 7,064	11	2	$ 662.54	$ 0.11
2	Family 21+ M&F	Other Care	63,516	$ 161,567	1,476	279	$ 109.48	$ 2.54
2	Family 21+ M&F	Other Professional	63,516	$ 832,190	11,573	2,186	$ 71.91	$ 13.10
2	Family 21+ M&F	Outpatient Hospital	63,516	$ 5,340,775	11,490	2,171	$ 464.80	$ 84.09
2	Family 21+ M&F	PCP	63,516	$ 2,701,836	27,417	5,180	$ 98.55	$ 42.54
2	Family 21+ M&F	Specialist	63,516	$ 1,227,702	10,235	1,934	$ 119.95	$ 19.33
2	Family 21+ M&F	Vision	63,516	$ 194,866	1,220	231	$ 159.70	$ 3.07
2	Family 21+ M&F	Rx	63,516	$ 5,825,467	99,166	18,735	$ 58.74	$ 91.72
2	Family 21+ M&F	Behavioral Health - IP	63,516	$ 270,129	581	110	$ 464.58	$ 4.25
2	Family 21+ M&F	Behavioral Health - OP	63,516	$ 1,039,186	14,185	2,680	$ 73.26	$ 16.36
2	Family 21+ M&F	Behavioral Health - Residential	63,516	$ 561,376	3,263	617	$ 172.02	$ 8.84
2	Family 21+ M&F	Behavioral Health - Other	63,516	$ 129,923	6,565	1,240	$ 19.79	$ 2.05

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Foster Care M&F	DME/Supplies	22,223	$ 131,518	619	334	$ 212.51	$ 5.92
2	Foster Care M&F	Emergency Room	22,223	$ 283,320	701	378	$ 404.38	$ 12.75
2	Foster Care M&F	Emergency Transportation	22,223	$ 27,023	44	24	$ 609.79	$ 1.22
2	Foster Care M&F	EPSDT	22,223	$ 85,575	755	408	$ 113.32	$ 3.85
2	Foster Care M&F	Family Planning	22,223	$ 9,641	78	42	$ 123.09	$ 0.43
2	Foster Care M&F	FQHC/RHC	22,223	$ 70,614	672	363	$ 105.07	$ 3.18
2	Foster Care M&F	Home Health	22,223	$ 14,045	438	237	$ 32.04	$ 0.63
2	Foster Care M&F	Hospice	22,223	$ -	-	-	$ -	$ -
2	Foster Care M&F	Inpatient Hospital	22,223	$ 516,028	77	42	$ 6,683.36	$ 23.22
2	Foster Care M&F	Lab and Radiology	22,223	$ 52,512	2,245	1,212	$ 23.39	$ 2.36
2	Foster Care M&F	Non-Emergency Transportation - Ambulance	22,223	$ 3,458	5	2	$ 761.84	$ 0.16
2	Foster Care M&F	Other Care	22,223	$ 270,742	3,574	1,930	$ 75.75	$ 12.18
2	Foster Care M&F	Other Professional	22,223	$ 117,867	1,588	858	$ 74.21	$ 5.30
2	Foster Care M&F	Outpatient Hospital	22,223	$ 564,864	1,407	760	$ 401.33	$ 25.42
2	Foster Care M&F	PCP	22,223	$ 671,525	8,627	4,659	$ 77.84	$ 30.22
2	Foster Care M&F	Specialist	22,223	$ 132,623	1,295	699	$ 102.41	$ 5.97
2	Foster Care M&F	Vision	22,223	$ 88,539	944	510	$ 93.78	$ 3.98
2	Foster Care M&F	Rx	22,223	$ 3,151,130	23,148	12,499	$ 136.13	$ 141.80
2	Foster Care M&F	Behavioral Health - IP	22,223	$ 194,313	363	196	$ 535.37	$ 8.74
2	Foster Care M&F	Behavioral Health - OP	22,223	$ 1,433,863	19,209	10,372	$ 74.65	$ 64.52
2	Foster Care M&F	Behavioral Health - Residential	22,223	$ 222,296	791	427	$ 281.08	$ 10.00
2	Foster Care M&F	Behavioral Health - Other	22,223	$ 2,673	62	34	$ 42.80	$ 0.12

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Katie Beckett 00-18 M&F	DME/Supplies	412	$ 314,037	1,064	30,982	$ 295.23	$ 762.22
2	Katie Beckett 00-18 M&F	Emergency Room	412	$ 11,919	20	596	$ 582.11	$ 28.93
2	Katie Beckett 00-18 M&F	Emergency Transportation	412	$ 638	1	43	$ 427.65	$ 1.55
2	Katie Beckett 00-18 M&F	EPSDT	412	$ 489	4	130	$ 109.76	$ 1.19
2	Katie Beckett 00-18 M&F	Family Planning	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	FQHC/RHC	412	$ 357	2	65	$ 160.71	$ 0.87
2	Katie Beckett 00-18 M&F	Home Health	412	$ 4,011,030	9,534	277,677	$ 420.73	$ 9,735.51
2	Katie Beckett 00-18 M&F	Hospice	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Inpatient Hospital	412	$ 293,970	14	421	$ 20,345.27	$ 713.52
2	Katie Beckett 00-18 M&F	Lab and Radiology	412	$ 610	43	1,256	$ 14.15	$ 1.48
2	Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Other Care	412	$ 28,369	249	7,252	$ 113.94	$ 68.86
2	Katie Beckett 00-18 M&F	Other Professional	412	$ 37,808	50	1,451	$ 758.98	$ 91.77
2	Katie Beckett 00-18 M&F	Outpatient Hospital	412	$ 65,515	76	2,200	$ 867.36	$ 159.02
2	Katie Beckett 00-18 M&F	PCP	412	$ 24,364	233	6,780	$ 104.67	$ 59.14
2	Katie Beckett 00-18 M&F	Specialist	412	$ 13,986	106	3,094	$ 131.67	$ 33.95
2	Katie Beckett 00-18 M&F	Vision	412	$ 1,963	10	289	$ 197.73	$ 4.77
2	Katie Beckett 00-18 M&F	Rx	412	$ 55,391	1,283	37,364	$ 43.18	$ 134.44
2	Katie Beckett 00-18 M&F	Behavioral Health - IP	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Behavioral Health - OP	412	$ 173	3	73	$ 68.58	$ 0.42
2	Katie Beckett 00-18 M&F	Behavioral Health - Residential	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Behavioral Health - Other	412	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Maternity	DME/Supplies	2,211	$ 126,479	890	4,829	$ 142.14	$ 57.20
2	Maternity	Emergency Room	2,211	$ 429,073	1,026	5,569	$ 418.12	$ 194.05
2	Maternity	Emergency Transportation	2,211	$ 72,373	66	356	$ 1,102.58	$ 32.73
2	Maternity	EPSDT	2,211	$ 361	3	18	$ 111.48	$ 0.16
2	Maternity	Family Planning	2,211	$ 247,541	556	3,019	$ 444.91	$ 111.95
2	Maternity	FQHC/RHC	2,211	$ 66,833	574	3,116	$ 116.42	$ 30.23
2	Maternity	Home Health	2,211	$ 881	47	254	$ 18.86	$ 0.40
2	Maternity	Hospice	2,211	$ -	-	-	$ -	$ -
2	Maternity	Inpatient Hospital	2,211	$ 7,099,810	2,124	11,527	$ 3,342.53	$ 3,210.88
2	Maternity	Lab and Radiology	2,211	$ 250,684	7,089	38,471	$ 35.36	$ 113.37
2	Maternity	Non-Emergency Transportation - Ambulance	2,211	$ 3,838	8	43	$ 486.48	$ 1.74
2	Maternity	Other Care	2,211	$ 96,421	289	1,569	$ 333.61	$ 43.61
2	Maternity	Other Professional	2,211	$ 541,194	3,698	20,069	$ 146.35	$ 244.75
2	Maternity	Outpatient Hospital	2,211	$ 1,338,372	6,166	33,463	$ 217.06	$ 605.28
2	Maternity	PCP	2,211	$ 4,250,509	15,925	86,425	$ 266.91	$ 1,922.28
2	Maternity	Specialist	2,211	$ 207,220	2,564	13,912	$ 80.83	$ 93.72
2	Maternity	Vision	2,211	$ 34,941	239	1,296	$ 146.32	$ 15.80
2	Maternity	Rx	2,211	$ -	-	-	$ -	$ -
2	Maternity	Behavioral Health - IP						
2	Maternity	Behavioral Health - OP						
2	Maternity	Behavioral Health - Residential						
2	Maternity	Behavioral Health - Other						

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 00-20 M&F	ALL	9,807	$ 9,858,022	51,368	62,855	$ 191.91	$ 1,005.20
2	AABD 21+ M&F	ALL	27,407	$ 38,102,924	301,781	132,133	$ 126.26	$ 1,390.26
2	AABD 21+ M&F-WWC	ALL	451	$ 1,063,397	4,510	119,992	$ 235.80	$ 2,357.86
2	CHIP M&F	ALL	107,941	$ 14,649,156	139,045	15,458	$ 105.36	$ 135.71
2	Family Under 1 M&F	ALL	32,855	$ 11,961,575	83,404	30,463	$ 143.42	$ 364.07
2	Family 01-05 M&F	ALL	94,254	$ 11,503,407	115,194	14,666	$ 99.86	$ 122.05
2	Family 06-20 F	ALL	82,972	$ 11,588,791	118,969	17,206	$ 97.41	$ 139.67
2	Family 06-20 M	ALL	79,831	$ 11,440,416	109,183	16,412	$ 104.78	$ 143.31
2	Family 21+ M&F	ALL	63,516	$ 25,710,617	217,884	41,165	$ 118.00	$ 404.79
2	Foster Care M&F	ALL	22,223	$ 8,044,170	66,643	35,986	$ 120.71	$ 361.97
2	Katie Beckett 00-18 M&F	ALL	412	$ 4,860,618	12,692	369,673	$ 382.96	$ 11,797.62
2	Maternity	ALL	2,211	$ 14,766,531	41,264	223,936	$ 357.86	$ 6,678.14
Total			**521,669**	**$ 163,549,624**	**1,261,937**	**29,028**	**$ 129.60**	**$ 313.51**

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	ALL	DME/Supplies	521,669	$ 3,961,180	19,851	457	$ 199.54	$ 7.59
2	ALL	Emergency Room	521,669	$ 10,801,233	25,692	591	$ 420.41	$ 20.71
2	ALL	Emergency Transportation	521,669	$ 880,249	1,357	31	$ 648.71	$ 1.69
2	ALL	EPSDT	521,669	$ 2,170,468	20,197	465	$ 107.46	$ 4.16
2	ALL	Family Planning	521,669	$ 556,704	2,156	50	$ 258.22	$ 1.07
2	ALL	FQHC/RHC	521,669	$ 2,543,746	22,510	518	$ 113.01	$ 4.88
2	ALL	Home Health	521,669	$ 4,701,888	21,403	492	$ 219.68	$ 9.01
2	ALL	Hospice	521,669	$ 174,658	1,191	27	$ 146.61	$ 0.33
2	ALL	Inpatient Hospital	521,669	$ 28,813,416	5,598	129	$ 5,147.40	$ 55.23
2	ALL	Lab and Radiology	521,669	$ 1,609,697	63,236	1,455	$ 25.46	$ 3.09
2	ALL	Non-Emergency Transportation - Ambulance	521,669	$ 52,124	84	2	$ 621.13	$ 0.10
2	ALL	Other Care	521,669	$ 2,144,311	20,665	475	$ 103.76	$ 4.11
2	ALL	Other Professional	521,669	$ 4,664,471	63,192	1,454	$ 73.81	$ 8.94
2	ALL	Outpatient Hospital	521,669	$ 23,398,727	53,343	1,227	$ 438.65	$ 44.85
2	ALL	PCP	521,669	$ 20,308,669	205,861	4,735	$ 98.65	$ 38.93
2	ALL	Specialist	521,669	$ 5,452,087	47,882	1,101	$ 113.86	$ 10.45
2	ALL	Vision	521,669	$ 1,685,033	10,646	245	$ 158.28	$ 3.23
2	ALL	Rx	521,669	$ 37,226,930	474,601	10,917	$ 78.44	$ 71.36
2	ALL	Behavioral Health - IP	521,669	$ 1,851,982	3,787	87	$ 489.01	$ 3.55
2	ALL	Behavioral Health - OP	521,669	$ 7,933,982	109,675	2,523	$ 72.34	$ 15.21
2	ALL	Behavioral Health - Residential	521,669	$ 1,325,891	6,633	153	$ 199.88	$ 2.54
2	ALL	Behavioral Health - Other	521,669	$ 1,292,177	82,375	1,895	$ 15.69	$ 2.48
Total			**521,669**	**$ 163,549,624**	**1,261,937**	**29,028**	**$ 129.60**	**$ 313.51**

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 00-20 M&F	DME/Supplies	35,303	$ 2,704,086	8,259	2,807	$ 327.40	$ 76.60
1	AABD 00-20 M&F	Emergency Room	35,303	$ 743,766	2,204	749	$ 337.42	$ 21.07
1	AABD 00-20 M&F	Emergency Transportation	35,303	$ 93,227	185	63	$ 503.94	$ 2.64
1	AABD 00-20 M&F	EPSDT	35,303	$ 141,976	1,087	369	$ 130.66	$ 4.02
1	AABD 00-20 M&F	Family Planning	35,303	$ 11,983	115	39	$ 104.17	$ 0.34
1	AABD 00-20 M&F	FQHC/RHC	35,303	$ 145,295	1,140	387	$ 127.47	$ 4.12
1	AABD 00-20 M&F	Home Health	35,303	$ 3,127,933	9,501	3,230	$ 329.22	$ 88.60
1	AABD 00-20 M&F	Hospice	35,303	$ 29,821	173	59	$ 172.57	$ 0.84
1	AABD 00-20 M&F	Inpatient Hospital	35,303	$ 6,409,348	298	101	$ 21,499.47	$ 181.55
1	AABD 00-20 M&F	Lab and Radiology	35,303	$ 118,103	3,205	1,090	$ 36.85	$ 3.35
1	AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	35,303	$ 2,687	7	2	$ 381.26	$ 0.08
1	AABD 00-20 M&F	Other Care	35,303	$ 1,070,976	5,586	1,899	$ 191.73	$ 30.34
1	AABD 00-20 M&F	Other Professional	35,303	$ 530,918	2,974	1,011	$ 178.51	$ 15.04
1	AABD 00-20 M&F	Outpatient Hospital	35,303	$ 3,503,565	6,836	2,324	$ 512.52	$ 99.24
1	AABD 00-20 M&F	PCP	35,303	$ 1,799,724	18,023	6,126	$ 99.86	$ 50.98
1	AABD 00-20 M&F	Specialist	35,303	$ 835,461	6,597	2,243	$ 126.64	$ 23.67
1	AABD 00-20 M&F	Vision	35,303	$ 156,212	663	225	$ 235.56	$ 4.42
1	AABD 00-20 M&F	Rx	35,303	$ 7,969,545	56,173	19,094	$ 141.87	$ 225.75
1	AABD 00-20 M&F	Behavioral Health - IP	35,303	$ 447,682	872	296	$ 513.56	$ 12.68
1	AABD 00-20 M&F	Behavioral Health - OP	35,303	$ 1,129,691	17,246	5,862	$ 65.51	$ 32.00
1	AABD 00-20 M&F	Behavioral Health - Residential	35,303	$ 163,209	783	266	$ 208.39	$ 4.62
1	AABD 00-20 M&F	Behavioral Health - Other	35,303	$ 81,250	4,051	1,377	$ 20.06	$ 2.30

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 21+ M&F	DME/Supplies	106,576	$ 3,908,382	19,510	2,197	$ 200.33	$ 36.67
1	AABD 21+ M&F	Emergency Room	106,576	$ 7,868,868	14,586	1,642	$ 539.49	$ 73.83
1	AABD 21+ M&F	Emergency Transportation	106,576	$ 1,008,988	3,393	382	$ 297.36	$ 9.47
1	AABD 21+ M&F	EPSDT	106,576	$ 131	1	0	$ 123.40	$ 0.00
1	AABD 21+ M&F	Family Planning	106,576	$ 73,360	454	51	$ 161.70	$ 0.69
1	AABD 21+ M&F	FQHC/RHC	106,576	$ 1,201,898	8,753	986	$ 137.31	$ 11.28
1	AABD 21+ M&F	Home Health	106,576	$ 1,624,160	20,315	2,287	$ 79.95	$ 15.24
1	AABD 21+ M&F	Hospice	106,576	$ 616,029	3,857	434	$ 159.70	$ 5.78
1	AABD 21+ M&F	Inpatient Hospital	106,576	$ 27,576,547	2,866	323	$ 9,622.94	$ 258.75
1	AABD 21+ M&F	Lab and Radiology	106,576	$ 1,369,263	40,732	4,586	$ 33.62	$ 12.85
1	AABD 21+ M&F	Non-Emergency Transportation - Ambulance	106,576	$ 33,687	105	12	$ 319.99	$ 0.32
1	AABD 21+ M&F	Other Care	106,576	$ 2,417,352	15,907	1,791	$ 151.96	$ 22.68
1	AABD 21+ M&F	Other Professional	106,576	$ 1,400,848	12,701	1,430	$ 110.29	$ 13.14
1	AABD 21+ M&F	Outpatient Hospital	106,576	$ 15,665,650	34,110	3,841	$ 459.27	$ 146.99
1	AABD 21+ M&F	PCP	106,576	$ 9,711,655	83,514	9,403	$ 116.29	$ 91.12
1	AABD 21+ M&F	Specialist	106,576	$ 5,441,306	35,214	3,965	$ 154.52	$ 51.06
1	AABD 21+ M&F	Vision	106,576	$ 658,420	2,935	330	$ 224.34	$ 6.18
1	AABD 21+ M&F	Rx	106,576	$ 39,957,794	421,916	47,506	$ 94.71	$ 374.92
1	AABD 21+ M&F	Behavioral Health - IP	106,576	$ 4,591,014	7,481	842	$ 613.73	$ 43.08
1	AABD 21+ M&F	Behavioral Health - OP	106,576	$ 3,153,116	46,460	5,231	$ 67.87	$ 29.59
1	AABD 21+ M&F	Behavioral Health - Residential	106,576	$ 2,718,732	17,654	1,988	$ 154.00	$ 25.51
1	AABD 21+ M&F	Behavioral Health - Other	106,576	$ 3,556,217	275,651	31,037	$ 12.90	$ 33.37

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 21+ M&F-WWC	DME/Supplies	1,109	$ 34,065	139	1,506	$ 244.70	$ 30.72
1	AABD 21+ M&F-WWC	Emergency Room	1,109	$ 49,534	77	829	$ 646.57	$ 44.67
1	AABD 21+ M&F-WWC	Emergency Transportation	1,109	$ 2,232	5	58	$ 416.93	$ 2.01
1	AABD 21+ M&F-WWC	EPSDT	1,109	$ -	-	-	$ -	$ -
1	AABD 21+ M&F-WWC	Family Planning	1,109	$ 750	4	39	$ 209.05	$ 0.68
1	AABD 21+ M&F-WWC	FQHC/RHC	1,109	$ 14,568	96	1,034	$ 152.44	$ 13.14
1	AABD 21+ M&F-WWC	Home Health	1,109	$ 3,366	190	2,054	$ 17.73	$ 3.04
1	AABD 21+ M&F-WWC	Hospice	1,109	$ -	-	-	$ -	$ -
1	AABD 21+ M&F-WWC	Inpatient Hospital	1,109	$ 336,210	39	419	$ 8,677.77	$ 303.17
1	AABD 21+ M&F-WWC	Lab and Radiology	1,109	$ 116,561	1,758	19,027	$ 66.29	$ 105.10
1	AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	1,109	$ -	-	-	$ -	$ -
1	AABD 21+ M&F-WWC	Other Care	1,109	$ 30,954	203	2,201	$ 152.18	$ 27.91
1	AABD 21+ M&F-WWC	Other Professional	1,109	$ 17,925	106	1,151	$ 168.56	$ 16.16
1	AABD 21+ M&F-WWC	Outpatient Hospital	1,109	$ 747,660	859	9,290	$ 870.86	$ 674.17
1	AABD 21+ M&F-WWC	PCP	1,109	$ 412,796	1,408	15,233	$ 293.23	$ 372.22
1	AABD 21+ M&F-WWC	Specialist	1,109	$ 321,307	591	6,399	$ 543.36	$ 289.73
1	AABD 21+ M&F-WWC	Vision	1,109	$ 6,568	59	642	$ 110.73	$ 5.92
1	AABD 21+ M&F-WWC	Rx	1,109	$ 177,134	3,693	39,963	$ 47.96	$ 159.72
1	AABD 21+ M&F-WWC	Behavioral Health - IP	1,109	$ 3,747	7	81	$ 502.48	$ 3.38
1	AABD 21+ M&F-WWC	Behavioral Health - OP	1,109	$ 19,284	252	2,724	$ 76.60	$ 17.39
1	AABD 21+ M&F-WWC	Behavioral Health - Residential	1,109	$ 6,361	32	350	$ 196.48	$ 5.74
1	AABD 21+ M&F-WWC	Behavioral Health - Other	1,109	$ 301	15	157	$ 20.68	$ 0.27

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	CHIP M&F	DME/Supplies	317,346	$ 562,576	2,993	113	$ 187.94	$ 1.77
1	CHIP M&F	Emergency Room	317,346	$ 2,712,890	9,164	347	$ 296.04	$ 8.55
1	CHIP M&F	Emergency Transportation	317,346	$ 121,177	298	11	$ 407.11	$ 0.38
1	CHIP M&F	EPSDT	317,346	$ 1,757,189	13,280	502	$ 132.32	$ 5.54
1	CHIP M&F	Family Planning	317,346	$ 87,770	708	27	$ 123.93	$ 0.28
1	CHIP M&F	FQHC/RHC	317,346	$ 1,357,979	10,476	396	$ 129.63	$ 4.28
1	CHIP M&F	Home Health	317,346	$ 122,856	611	23	$ 200.95	$ 0.39
1	CHIP M&F	Hospice	317,346	$ -	-	-	$ -	$ -
1	CHIP M&F	Inpatient Hospital	317,346	$ 2,143,553	287	11	$ 7,457.77	$ 6.75
1	CHIP M&F	Lab and Radiology	317,346	$ 319,504	13,371	506	$ 23.89	$ 1.01
1	CHIP M&F	Non-Emergency Transportation - Ambulance	317,346	$ 6,143	14	1	$ 425.11	$ 0.02
1	CHIP M&F	Other Care	317,346	$ 579,437	5,122	194	$ 113.12	$ 1.83
1	CHIP M&F	Other Professional	317,346	$ 1,208,062	17,449	660	$ 69.23	$ 3.81
1	CHIP M&F	Outpatient Hospital	317,346	$ 6,421,250	16,121	610	$ 398.31	$ 20.23
1	CHIP M&F	PCP	317,346	$ 5,769,581	73,856	2,793	$ 78.12	$ 18.18
1	CHIP M&F	Specialist	317,346	$ 1,410,568	15,865	600	$ 88.91	$ 4.44
1	CHIP M&F	Vision	317,346	$ 1,078,760	2,166	82	$ 498.04	$ 3.40
1	CHIP M&F	Rx	317,346	$ 12,795,955	143,493	5,426	$ 89.17	$ 40.32
1	CHIP M&F	Behavioral Health - IP	317,346	$ 630,526	1,311	50	$ 481.10	$ 1.99
1	CHIP M&F	Behavioral Health - OP	317,346	$ 3,751,795	67,645	2,558	$ 55.46	$ 11.82
1	CHIP M&F	Behavioral Health - Residential	317,346	$ 291,010	1,174	44	$ 247.81	$ 0.92
1	CHIP M&F	Behavioral Health - Other	317,346	$ 113,073	2,661	101	$ 42.49	$ 0.36

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family Under 1 M&F	DME/Supplies	106,184	$ 544,963	4,616	522	$ 118.06	$ 5.13
1	Family Under 1 M&F	Emergency Room	106,184	$ 2,024,821	10,900	1,232	$ 185.76	$ 19.07
1	Family Under 1 M&F	Emergency Transportation	106,184	$ 136,796	252	29	$ 541.78	$ 1.29
1	Family Under 1 M&F	EPSDT	106,184	$ 4,867,452	35,936	4,061	$ 135.45	$ 45.84
1	Family Under 1 M&F	Family Planning	106,184	$ 149	1	0	$ 143.37	$ 0.00
1	Family Under 1 M&F	FQHC/RHC	106,184	$ 849,867	6,282	710	$ 135.29	$ 8.00
1	Family Under 1 M&F	Home Health	106,184	$ 188,040	4,109	464	$ 45.77	$ 1.77
1	Family Under 1 M&F	Hospice	106,184	$ 11,438	70	8	$ 162.39	$ 0.11
1	Family Under 1 M&F	Inpatient Hospital	106,184	$ 19,806,111	3,896	440	$ 5,083.68	$ 186.53
1	Family Under 1 M&F	Lab and Radiology	106,184	$ 165,860	7,974	901	$ 20.80	$ 1.56
1	Family Under 1 M&F	Non-Emergency Transportation - Ambulance	106,184	$ 4,713	9	1	$ 528.40	$ 0.04
1	Family Under 1 M&F	Other Care	106,184	$ 1,212,661	3,287	372	$ 368.89	$ 11.42
1	Family Under 1 M&F	Other Professional	106,184	$ 650,692	7,766	878	$ 83.79	$ 6.13
1	Family Under 1 M&F	Outpatient Hospital	106,184	$ 2,656,398	10,187	1,151	$ 260.76	$ 25.02
1	Family Under 1 M&F	PCP	106,184	$ 6,333,898	69,103	7,809	$ 91.66	$ 59.65
1	Family Under 1 M&F	Specialist	106,184	$ 1,702,822	10,063	1,137	$ 169.22	$ 16.04
1	Family Under 1 M&F	Vision	106,184	$ 309,351	230	26	$ 1,346.01	$ 2.91
1	Family Under 1 M&F	Rx	106,184	$ 1,592,495	60,507	6,838	$ 26.32	$ 15.00
1	Family Under 1 M&F	Behavioral Health - IP	106,184	$ -	-	-	$ -	$ -
1	Family Under 1 M&F	Behavioral Health - OP	106,184	$ 1,920	20	2	$ 97.99	$ 0.02
1	Family Under 1 M&F	Behavioral Health - Residential	106,184	$ -	-	-	$ -	$ -
1	Family Under 1 M&F	Behavioral Health - Other	106,184	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 01-05 M&F	DME/Supplies	332,138	$ 484,653	3,518	127	$ 137.74	$ 1.46
1	Family 01-05 M&F	Emergency Room	332,138	$ 3,389,784	18,075	653	$ 187.54	$ 10.21
1	Family 01-05 M&F	Emergency Transportation	332,138	$ 151,061	359	13	$ 420.39	$ 0.45
1	Family 01-05 M&F	EPSDT	332,138	$ 3,109,607	23,305	842	$ 133.43	$ 9.36
1	Family 01-05 M&F	Family Planning	332,138	$ 149	1	0	$ 147.87	$ 0.00
1	Family 01-05 M&F	FQHC/RHC	332,138	$ 1,807,973	13,404	484	$ 134.88	$ 5.44
1	Family 01-05 M&F	Home Health	332,138	$ 158,300	802	29	$ 197.36	$ 0.48
1	Family 01-05 M&F	Hospice	332,138	$ -	-	-	$ -	$ -
1	Family 01-05 M&F	Inpatient Hospital	332,138	$ 2,975,100	384	14	$ 7,742.75	$ 8.96
1	Family 01-05 M&F	Lab and Radiology	332,138	$ 247,748	13,606	492	$ 18.21	$ 0.75
1	Family 01-05 M&F	Non-Emergency Transportation - Ambulance	332,138	$ 4,671	10	0	$ 450.86	$ 0.01
1	Family 01-05 M&F	Other Care	332,138	$ 642,901	6,053	219	$ 106.21	$ 1.94
1	Family 01-05 M&F	Other Professional	332,138	$ 1,511,578	17,374	628	$ 87.00	$ 4.55
1	Family 01-05 M&F	Outpatient Hospital	332,138	$ 7,187,521	20,057	725	$ 358.35	$ 21.64
1	Family 01-05 M&F	PCP	332,138	$ 7,584,858	96,390	3,483	$ 78.69	$ 22.84
1	Family 01-05 M&F	Specialist	332,138	$ 1,198,289	13,377	483	$ 89.58	$ 3.61
1	Family 01-05 M&F	Vision	332,138	$ 987,001	1,168	42	$ 845.18	$ 2.97
1	Family 01-05 M&F	Rx	332,138	$ 5,502,189	135,795	4,906	$ 40.52	$ 16.57
1	Family 01-05 M&F	Behavioral Health - IP	332,138	$ 1,973	3	0	$ 610.91	$ 0.01
1	Family 01-05 M&F	Behavioral Health - OP	332,138	$ 1,258,132	38,874	1,404	$ 32.36	$ 3.79
1	Family 01-05 M&F	Behavioral Health - Residential	332,138	$ -	-	-	$ -	$ -
1	Family 01-05 M&F	Behavioral Health - Other	332,138	$ 1,477	132	5	$ 11.18	$ 0.00

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 06-20 F	DME/Supplies	284,805	$ 375,241	2,488	105	$ 150.82	$ 1.32
1	Family 06-20 F	Emergency Room	284,805	$ 3,108,988	10,387	438	$ 299.31	$ 10.92
1	Family 06-20 F	Emergency Transportation	284,805	$ 129,150	400	17	$ 322.60	$ 0.45
1	Family 06-20 F	EPSDT	284,805	$ 832,229	6,476	273	$ 128.52	$ 2.92
1	Family 06-20 F	Family Planning	284,805	$ 320,966	2,204	93	$ 145.65	$ 1.13
1	Family 06-20 F	FQHC/RHC	284,805	$ 1,142,430	8,706	367	$ 131.22	$ 4.01
1	Family 06-20 F	Home Health	284,805	$ 93,924	525	22	$ 179.03	$ 0.33
1	Family 06-20 F	Hospice	284,805	$ -	-	-	$ -	$ -
1	Family 06-20 F	Inpatient Hospital	284,805	$ 2,217,133	262	11	$ 8,455.36	$ 7.78
1	Family 06-20 F	Lab and Radiology	284,805	$ 424,984	15,990	674	$ 26.58	$ 1.49
1	Family 06-20 F	Non-Emergency Transportation - Ambulance	284,805	$ 5,466	14	1	$ 381.93	$ 0.02
1	Family 06-20 F	Other Care	284,805	$ 349,504	3,598	152	$ 97.15	$ 1.23
1	Family 06-20 F	Other Professional	284,805	$ 965,083	13,785	581	$ 70.01	$ 3.39
1	Family 06-20 F	Outpatient Hospital	284,805	$ 4,828,027	14,700	619	$ 328.43	$ 16.95
1	Family 06-20 F	PCP	284,805	$ 4,604,608	59,354	2,501	$ 77.58	$ 16.17
1	Family 06-20 F	Specialist	284,805	$ 1,048,916	11,861	500	$ 88.43	$ 3.68
1	Family 06-20 F	Vision	284,805	$ 940,699	2,098	88	$ 448.42	$ 3.30
1	Family 06-20 F	Rx	284,805	$ 10,017,659	138,283	5,826	$ 72.44	$ 35.17
1	Family 06-20 F	Behavioral Health - IP	284,805	$ 1,124,843	2,300	97	$ 489.17	$ 3.95
1	Family 06-20 F	Behavioral Health - OP	284,805	$ 4,299,862	67,099	2,827	$ 64.08	$ 15.10
1	Family 06-20 F	Behavioral Health - Residential	284,805	$ 405,719	1,659	70	$ 244.54	$ 1.42
1	Family 06-20 F	Behavioral Health - Other	284,805	$ 120,008	3,531	149	$ 33.98	$ 0.42

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 06-20 M	DME/Supplies	272,407	$ 372,520	2,476	109	$ 150.47	$ 1.37
1	Family 06-20 M	Emergency Room	272,407	$ 2,488,674	8,224	362	$ 302.59	$ 9.14
1	Family 06-20 M	Emergency Transportation	272,407	$ 119,056	335	15	$ 355.27	$ 0.44
1	Family 06-20 M	EPSDT	272,407	$ 897,938	7,026	309	$ 127.81	$ 3.30
1	Family 06-20 M	Family Planning	272,407	$ 82	1	0	$ 151.89	$ 0.00
1	Family 06-20 M	FQHC/RHC	272,407	$ 934,280	7,177	316	$ 130.18	$ 3.43
1	Family 06-20 M	Home Health	272,407	$ 99,863	838	37	$ 119.22	$ 0.37
1	Family 06-20 M	Hospice	272,407	$ -	-	-	$ -	$ -
1	Family 06-20 M	Inpatient Hospital	272,407	$ 1,503,141	169	7	$ 8,914.60	$ 5.52
1	Family 06-20 M	Lab and Radiology	272,407	$ 203,359	8,388	369	$ 24.25	$ 0.75
1	Family 06-20 M	Non-Emergency Transportation - Ambulance	272,407	$ 3,153	7	0	$ 448.55	$ 0.01
1	Family 06-20 M	Other Care	272,407	$ 414,830	4,141	182	$ 100.18	$ 1.52
1	Family 06-20 M	Other Professional	272,407	$ 782,822	10,707	472	$ 73.11	$ 2.87
1	Family 06-20 M	Outpatient Hospital	272,407	$ 4,058,049	10,208	450	$ 397.52	$ 14.90
1	Family 06-20 M	PCP	272,407	$ 3,885,738	50,039	2,204	$ 77.65	$ 14.26
1	Family 06-20 M	Specialist	272,407	$ 942,275	11,312	498	$ 83.30	$ 3.46
1	Family 06-20 M	Vision	272,407	$ 880,641	1,635	72	$ 538.69	$ 3.23
1	Family 06-20 M	Rx	272,407	$ 14,074,780	131,490	5,792	$ 107.04	$ 51.67
1	Family 06-20 M	Behavioral Health - IP	272,407	$ 706,713	1,528	67	$ 462.63	$ 2.59
1	Family 06-20 M	Behavioral Health - OP	272,407	$ 5,180,498	101,842	4,486	$ 50.87	$ 19.02
1	Family 06-20 M	Behavioral Health - Residential	272,407	$ 518,015	2,621	115	$ 197.61	$ 1.90
1	Family 06-20 M	Behavioral Health - Other	272,407	$ 94,743	3,248	143	$ 29.17	$ 0.35

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 21+ M&F	DME/Supplies	224,680	$ 1,060,176	7,059	377	$ 150.18	$ 4.72
1	Family 21+ M&F	Emergency Room	224,680	$ 8,872,055	19,647	1,049	$ 451.58	$ 39.49
1	Family 21+ M&F	Emergency Transportation	224,680	$ 342,354	1,032	55	$ 331.61	$ 1.52
1	Family 21+ M&F	EPSDT	224,680	$ 1,137	6	0	$ 196.08	$ 0.01
1	Family 21+ M&F	Family Planning	224,680	$ 1,015,267	4,004	214	$ 253.56	$ 4.52
1	Family 21+ M&F	FQHC/RHC	224,680	$ 1,319,949	9,820	524	$ 134.41	$ 5.87
1	Family 21+ M&F	Home Health	224,680	$ 118,349	2,190	117	$ 54.04	$ 0.53
1	Family 21+ M&F	Hospice	224,680	$ 6,806	42	2	$ 161.57	$ 0.03
1	Family 21+ M&F	Inpatient Hospital	224,680	$ 8,602,672	1,150	61	$ 7,482.85	$ 38.29
1	Family 21+ M&F	Lab and Radiology	224,680	$ 1,766,308	49,085	2,622	$ 35.98	$ 7.86
1	Family 21+ M&F	Non-Emergency Transportation - Ambulance	224,680	$ 9,812	27	1	$ 367.81	$ 0.04
1	Family 21+ M&F	Other Care	224,680	$ 796,121	6,940	371	$ 114.72	$ 3.54
1	Family 21+ M&F	Other Professional	224,680	$ 1,843,207	21,825	1,166	$ 84.45	$ 8.20
1	Family 21+ M&F	Outpatient Hospital	224,680	$ 12,774,997	34,633	1,850	$ 368.87	$ 56.86
1	Family 21+ M&F	PCP	224,680	$ 8,818,283	94,622	5,054	$ 93.19	$ 39.25
1	Family 21+ M&F	Specialist	224,680	$ 3,829,112	29,570	1,579	$ 129.50	$ 17.04
1	Family 21+ M&F	Vision	224,680	$ 795,910	1,964	105	$ 405.22	$ 3.54
1	Family 21+ M&F	Rx	224,680	$ 17,376,111	318,799	17,027	$ 54.50	$ 77.34
1	Family 21+ M&F	Behavioral Health - IP	224,680	$ 816,912	1,540	82	$ 530.44	$ 3.64
1	Family 21+ M&F	Behavioral Health - OP	224,680	$ 3,474,391	50,785	2,712	$ 68.41	$ 15.46
1	Family 21+ M&F	Behavioral Health - Residential	224,680	$ 1,321,658	7,979	426	$ 165.63	$ 5.88
1	Family 21+ M&F	Behavioral Health - Other	224,680	$ 253,179	15,051	804	$ 16.82	$ 1.13

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Foster Care M&F	DME/Supplies	82,203	$ 899,235	3,397	496	$ 264.73	$ 10.94
1	Foster Care M&F	Emergency Room	82,203	$ 960,254	3,290	480	$ 291.86	$ 11.68
1	Foster Care M&F	Emergency Transportation	82,203	$ 75,990	184	27	$ 412.59	$ 0.92
1	Foster Care M&F	EPSDT	82,203	$ 468,158	3,679	537	$ 127.26	$ 5.70
1	Foster Care M&F	Family Planning	82,203	$ 39,861	312	46	$ 127.62	$ 0.48
1	Foster Care M&F	FQHC/RHC	82,203	$ 257,606	2,060	301	$ 125.03	$ 3.13
1	Foster Care M&F	Home Health	82,203	$ 504,876	3,572	521	$ 141.33	$ 6.14
1	Foster Care M&F	Hospice	82,203	$ 2,035	12	2	$ 172.06	$ 0.02
1	Foster Care M&F	Inpatient Hospital	82,203	$ 3,782,006	224	33	$ 16,860.74	$ 46.01
1	Foster Care M&F	Lab and Radiology	82,203	$ 160,186	7,129	1,041	$ 22.47	$ 1.95
1	Foster Care M&F	Non-Emergency Transportation - Ambulance	82,203	$ 9,050	20	3	$ 454.62	$ 0.11
1	Foster Care M&F	Other Care	82,203	$ 802,052	7,875	1,150	$ 101.85	$ 9.76
1	Foster Care M&F	Other Professional	82,203	$ 318,062	3,460	505	$ 91.91	$ 3.87
1	Foster Care M&F	Outpatient Hospital	82,203	$ 1,897,257	6,206	906	$ 305.73	$ 23.08
1	Foster Care M&F	PCP	82,203	$ 1,931,697	23,495	3,430	$ 82.22	$ 23.50
1	Foster Care M&F	Specialist	82,203	$ 448,780	4,253	621	$ 105.53	$ 5.46
1	Foster Care M&F	Vision	82,203	$ 283,324	2,284	333	$ 124.05	$ 3.45
1	Foster Care M&F	Rx	82,203	$ 10,112,318	89,116	13,009	$ 113.47	$ 123.02
1	Foster Care M&F	Behavioral Health - IP	82,203	$ 1,434,795	3,164	462	$ 453.52	$ 17.45
1	Foster Care M&F	Behavioral Health - OP	82,203	$ 6,666,763	132,183	19,296	$ 50.44	$ 81.10
1	Foster Care M&F	Behavioral Health - Residential	82,203	$ 1,396,617	3,887	567	$ 359.28	$ 16.99
1	Foster Care M&F	Behavioral Health - Other	82,203	$ 148,204	4,888	714	$ 30.32	$ 1.80

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Katie Beckett 00-18 M&F	DME/Supplies	412	$ 314,037	1,064	30,982	$ 295.23	$ 762.22
1	Katie Beckett 00-18 M&F	Emergency Room	412	$ 11,919	20	596	$ 582.11	$ 28.93
1	Katie Beckett 00-18 M&F	Emergency Transportation	412	$ 638	1	43	$ 427.65	$ 1.55
1	Katie Beckett 00-18 M&F	EPSDT	412	$ 489	4	130	$ 109.76	$ 1.19
1	Katie Beckett 00-18 M&F	Family Planning	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	FQHC/RHC	412	$ 357	2	65	$ 160.71	$ 0.87
1	Katie Beckett 00-18 M&F	Home Health	412	$ 4,011,030	9,534	277,677	$ 420.73	$ 9,735.51
1	Katie Beckett 00-18 M&F	Hospice	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Inpatient Hospital	412	$ 293,970	14	421	$ 20,345.27	$ 713.52
1	Katie Beckett 00-18 M&F	Lab and Radiology	412	$ 610	43	1,256	$ 14.15	$ 1.48
1	Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Other Care	412	$ 28,369	249	7,252	$ 113.94	$ 68.86
1	Katie Beckett 00-18 M&F	Other Professional	412	$ 37,808	50	1,451	$ 758.98	$ 91.77
1	Katie Beckett 00-18 M&F	Outpatient Hospital	412	$ 65,515	76	2,200	$ 867.36	$ 159.02
1	Katie Beckett 00-18 M&F	PCP	412	$ 24,364	233	6,780	$ 104.67	$ 59.14
1	Katie Beckett 00-18 M&F	Specialist	412	$ 13,986	106	3,094	$ 131.67	$ 33.95
1	Katie Beckett 00-18 M&F	Vision	412	$ 1,963	10	289	$ 197.73	$ 4.77
1	Katie Beckett 00-18 M&F	Rx	412	$ 55,391	1,283	37,364	$ 43.18	$ 134.44
1	Katie Beckett 00-18 M&F	Behavioral Health - IP	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Behavioral Health - OP	412	$ 173	3	73	$ 68.58	$ 0.42
1	Katie Beckett 00-18 M&F	Behavioral Health - Residential	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Behavioral Health - Other	412	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Maternity	DME/Supplies	6,649	$ 446,302	3,761	6,789	$ 118.66	$ 67.13
1	Maternity	Emergency Room	6,649	$ 1,221,430	3,039	5,485	$ 401.94	$ 183.71
1	Maternity	Emergency Transportation	6,649	$ 123,469	384	694	$ 321.12	$ 18.57
1	Maternity	EPSDT	6,649	$ 825	6	11	$ 131.81	$ 0.12
1	Maternity	Family Planning	6,649	$ 982,129	2,254	4,068	$ 435.72	$ 147.72
1	Maternity	FQHC/RHC	6,649	$ 411,650	2,917	5,265	$ 141.11	$ 61.92
1	Maternity	Home Health	6,649	$ 27,582	542	978	$ 50.88	$ 4.15
1	Maternity	Hospice	6,649	$ -	-	-	$ -	$ -
1	Maternity	Inpatient Hospital	6,649	$ 23,093,051	6,971	12,581	$ 3,312.91	$ 3,473.41
1	Maternity	Lab and Radiology	6,649	$ 939,380	20,507	37,013	$ 45.81	$ 141.29
1	Maternity	Non-Emergency Transportation - Ambulance	6,649	$ 7,466	21	38	$ 351.58	$ 1.12
1	Maternity	Other Care	6,649	$ 354,347	1,604	2,895	$ 220.88	$ 53.30
1	Maternity	Other Professional	6,649	$ 2,094,209	8,503	15,346	$ 246.30	$ 314.99
1	Maternity	Outpatient Hospital	6,649	$ 3,138,141	19,083	34,443	$ 164.45	$ 472.01
1	Maternity	PCP	6,649	$ 11,546,969	38,402	69,311	$ 300.69	$ 1,736.77
1	Maternity	Specialist	6,649	$ 1,128,937	8,695	15,694	$ 129.84	$ 169.80
1	Maternity	Vision	6,649	$ 56,353	236	426	$ 238.66	$ 8.48
1	Maternity	Rx	6,649	$ -	-	-	$ -	$ -
1	Maternity	Behavioral Health - IP						
1	Maternity	Behavioral Health - OP						
1	Maternity	Behavioral Health - Residential						
1	Maternity	Behavioral Health - Other						

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 00-20 M&F	ALL	35,303	$ 31,216,458	145,979	49,620	$ 213.84	$ 884.24
1	AABD 21+ M&F	ALL	106,576	$ 134,553,416	1,068,116	120,265	$ 125.97	$ 1,262.51
1	AABD 21+ M&F-WWC	ALL	1,109	$ 2,301,323	9,533	103,156	$ 241.40	$ 2,075.13
1	CHIP M&F	ALL	317,346	$ 43,241,653	398,067	15,052	$ 108.63	$ 136.26
1	Family Under 1 M&F	ALL	106,184	$ 43,060,447	235,208	26,581	$ 183.07	$ 405.53
1	Family 01-05 M&F	ALL	332,138	$ 38,204,966	402,690	14,549	$ 94.87	$ 115.03
1	Family 06-20 F	ALL	284,805	$ 37,355,441	365,720	15,409	$ 102.14	$ 131.16
1	Family 06-20 M	ALL	272,407	$ 38,161,170	363,409	16,009	$ 105.01	$ 140.09
1	Family 21+ M&F	ALL	224,680	$ 75,214,765	677,770	36,199	$ 110.97	$ 334.76
1	Foster Care M&F	ALL	82,203	$ 32,599,124	304,691	44,479	$ 106.99	$ 396.57
1	Katie Beckett 00-18 M&F	ALL	412	$ 4,860,618	12,692	369,673	$ 382.96	$ 11,797.62
1	Maternity	ALL	6,649	$ 45,572,242	116,926	211,040	$ 389.75	$ 6,854.49
Total			**1,763,163**	**$ 526,341,622**	**4,100,801**	**27,910**	**$ 128.35**	**$ 298.52**

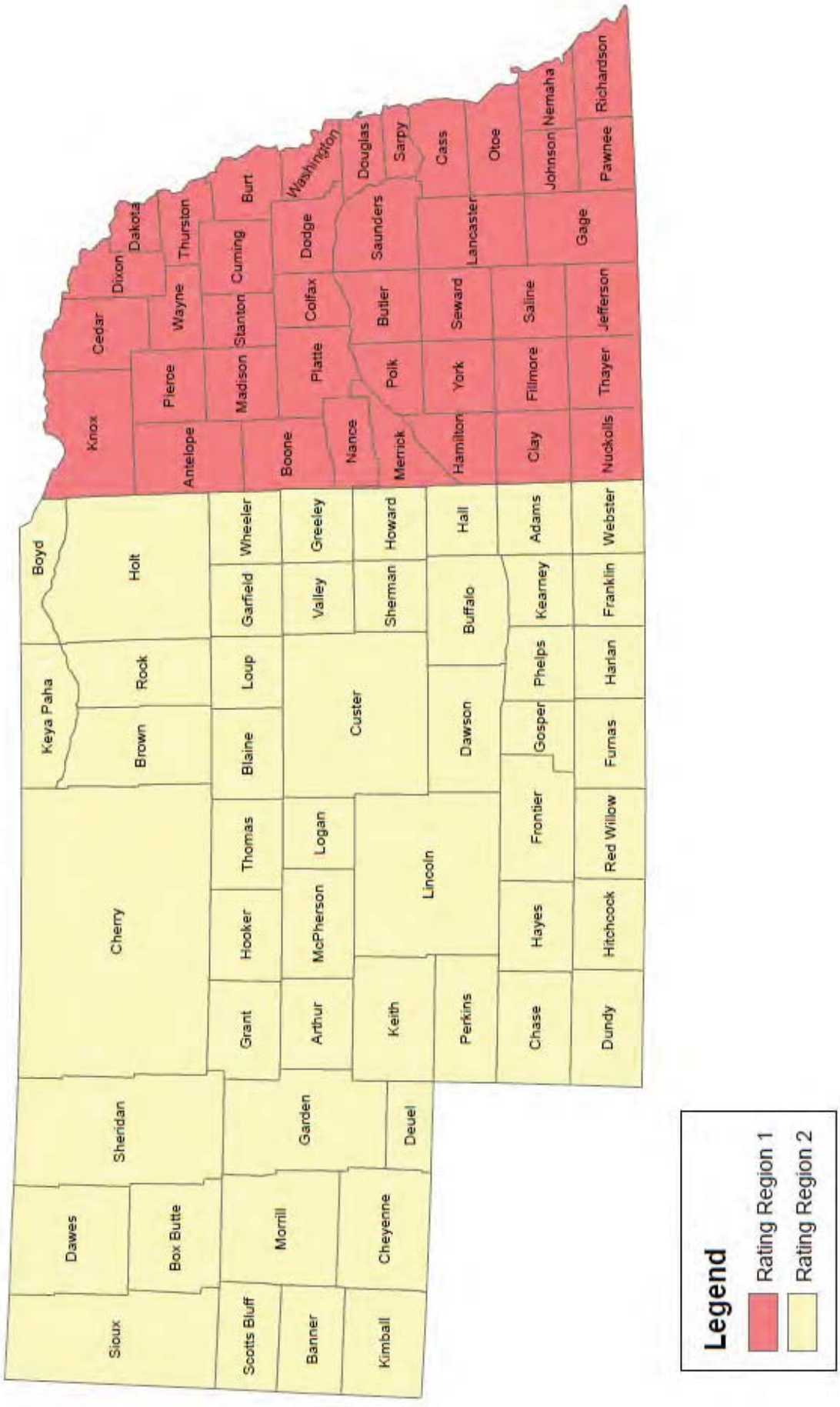
*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	ALL	DME/Supplies	1,763,163	$ 11,706,234	59,281	403	$ 197.47	$ 6.64
1	ALL	Emergency Room	1,763,163	$ 33,452,981	99,614	678	$ 335.83	$ 18.97
1	ALL	Emergency Transportation	1,763,163	$ 2,304,139	6,831	46	$ 337.31	$ 1.31
1	ALL	EPSDT	1,763,163	$ 12,077,130	90,806	618	$ 133.00	$ 6.85
1	ALL	Family Planning	1,763,163	$ 2,532,465	10,057	68	$ 251.81	$ 1.44
1	ALL	FQHC/RHC	1,763,163	$ 9,443,852	70,834	482	$ 133.32	$ 5.36
1	ALL	Home Health	1,763,163	$ 10,080,279	52,728	359	$ 191.17	$ 5.72
1	ALL	Hospice	1,763,163	$ 666,128	4,155	28	$ 160.33	$ 0.38
1	ALL	Inpatient Hospital	1,763,163	$ 98,738,842	16,560	113	$ 5,962.45	$ 56.00
1	ALL	Lab and Radiology	1,763,163	$ 5,831,868	181,789	1,237	$ 32.08	$ 3.31
1	ALL	Non-Emergency Transportation - Ambulance	1,763,163	$ 86,849	235	2	$ 369.23	$ 0.05
1	ALL	Other Care	1,763,163	$ 8,699,506	60,566	412	$ 143.64	$ 4.93
1	ALL	Other Professional	1,763,163	$ 11,361,214	116,700	794	$ 97.35	$ 6.44
1	ALL	Outpatient Hospital	1,763,163	$ 62,944,030	173,076	1,178	$ 363.68	$ 35.70
1	ALL	PCP	1,763,163	$ 62,424,170	608,437	4,141	$ 102.60	$ 35.40
1	ALL	Specialist	1,763,163	$ 18,321,760	147,504	1,004	$ 124.21	$ 10.39
1	ALL	Vision	1,763,163	$ 6,155,202	15,448	105	$ 398.45	$ 3.49
1	ALL	Rx	1,763,163	$ 119,631,370	1,500,548	10,213	$ 79.73	$ 67.85
1	ALL	Behavioral Health - IP	1,763,163	$ 9,758,207	18,204	124	$ 536.04	$ 5.53
1	ALL	Behavioral Health - OP	1,763,163	$ 28,935,624	522,406	3,555	$ 55.39	$ 16.41
1	ALL	Behavioral Health - Residential	1,763,163	$ 6,821,319	35,792	244	$ 190.58	$ 3.87
1	ALL	Behavioral Health - Other	1,763,163	$ 4,368,453	309,229	2,105	$ 14.13	$ 2.48
Total			**1,763,163**	**$ 526,341,622**	**4,100,801**	**27,910**	**$ 128.35**	**$ 298.52**

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 9
Rating Regions



Attachment 8 redacted

Adult Core Measures
Cervical Cancer Screening (CCS)
Chlamydia Screening in Women (CHL)
Flu Vaccinations for Adults Age 18 and Older (FVA)
Screening for Clinical Depression and Follow-Up Plan (CDF)
Breast Cancer Screening (BCS)
Adult Body Mass Index Assessment (ABA)
PC-01: Elective Delivery (PC01)
PC-03: Antenatal Steroids (PC03)
Prenatal & Postpartum Care: Postpartum Care Rate (PPC)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
Antidepressant Medication Management (AMM)
Follow-Up After Hospitalization for Mental Illness (FUH)
Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)
Controlling High Blood Pressure (CBP)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)*
PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)
PQI 08: Heart Failure Admission Rate (PQI08)
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)
PQI 15: Asthma in Younger Adults Admission Rate (PQI15)
Plan All-Cause Readmissions (PCR)
HIV Viral Load Suppression (HVL)
Annual Monitoring for Patients on Persistent Medications (MPM)
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA)
Child Core Measures
Child and Adolescents' Access to Primary Care Practitioners (CAP)
Chlamydia Screening in Women (CHL)
Childhood Immunization Status (CIS)
Well-Child Visits in the First 15 Months of Life (W15)
Immunizations for Adolescents (IMA)
Developmental Screening in the First Three Years of Life (DEV)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Human Papillomavirus Vaccine for Female Adolescents (HPV)
Adolescent Well-Care Visit (AWC)
Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
PC-02: Cesarean Section (PC02)
Live Births Weighing Less Than 2,500 Grams (LBW)
Frequency of Ongoing Prenatal Care (FPC)
Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)
Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)
Follow-Up After Hospitalization for Mental Illness (FUH)
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)
Medication Management for People with Asthma (MMA)
Ambulatory Care – Emergency Department (ED) Visits (AMB)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)
HEDIS Measures
Comprehensive Diabetes Care
Medication Management for People with Asthma (Adults)
Lead Screening in Children
Appropriate Testing for Children with Pharyngitis
Race/Ethnicity Diversity of Membership
Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Pharmacotherapy Management of COPD Exacerbation
Use of Appropriate Medications for People with Asthma
Annual Monitoring for Patients with Persistent Medications
Adults' Access to Preventative/Ambulatory Health Services
Antibiotic Utilization
Frequency of Ongoing Prenatal Care
Timeliness of Prenatal Care

Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day. All reports must be submitted in an MLTC provided template or in a format approved by MLTC.

Monthly Deliverables	Description	Due Date
Claims Processing and Timely Payment of Claims	Summary data on claims payment activity and reasons for claims denials, per reporting requirements provided by MLTC. Include the disposition of every adjudicated and adjusted claim for each claim type.	15th day of the following calendar month
Provider Termination	All provider terminations by category and termination cause.	15th day of the following calendar month
Third Party Resource	All instances in which a TPR was identified for a member as described in Section IV.P - MCO Reimbursement.	15th day of the following calendar month
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	15th day of the following calendar month
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
New Referrals of Potential Fraud, Waste, Abuse and Erroneous Payments	Summary of new referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month

All Referrals of Fraud, Waste, Abuse, and Erroneous Payments Under Review by the MCO	Summary of all referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Overpayments Identified and Collected	Summary of overpayments as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Provider Who Have Left the MCO Network	Summary of provider network departures as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Miscellaneous Fraud Prevention Efforts	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Pharmacy Prior Authorizations	Prior authorizations summary, including clinical and technical prior authorizations, peer review, and peer to peer consultation statistics.	15th day of the following calendar month
Pharmacy Technical and Clinical Call Center	Performance summary for call center metrics, pharmacy services, prior authorization request turnaround time, and training issues.	15th day of the following calendar month
Pharmacy Claims Processing	Summary data and analysis on pharmacy claims processing including: generic analysis (will be detailed by MLTC), MAC priced medications, claims adjudication system availability and payment statistics, number of prescriptions dispensed by public retail pharmacies (mail order pharmacies and specialty pharmacies included but delineated), total members utilizing pharmacy claims system, and total membership.	15th day of the following calendar month
Psychotropic Medications for Youth	Summary of prior authorization and utilization relating to clinical edits.	15th day of the following calendar month
PDL Load	Data documenting that the PDL file was received and loaded weekly.	15th day of the following calendar month
Behavioral Health Residential Wait List	Summary data, by member, of the number of days before a member is accepted into a program and, by member, the number of days before the member is admitted to the program.	15th day of the following calendar month
Out of State Placement	Summary data of the number of members placed in out of state residential treatment.	15th day of the following calendar month
Eligible and Number Authorized	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	15th day of the following calendar month

Welcome Calls	Results of welcome calls to new members as described in Section IV.F - Members Services and Education.	15th day of the following calendar month
Hospice	Data summarizing hospice admissions.	15th day of the following calendar month
Medically Necessary State Wards in Residential Treatment	Data summarizing the number of state wards deemed "medically necessary" who are in residential treatment.	15th day of the following calendar month
Claims Adjudicated	Data summarizing claims adjudicated to finalization in the previous calendar month as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Member/Provider Call Center	Data summarizing MCO member/provider call center performance, including call abandonment rate and average speed to answer.	15th day of the following calendar month
Quarterly Deliverables	**Description**	**Due Date**
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter

Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Drug Utilization Management Retrospective Educational Intervention Project	Project update in a format approved by MLTC.	45 calendar days following the most recent quarter
Prospective DUR Statistics	DUR statistics to support preparation of MLTC's annual CMS DUR report.	45 calendar days following the most recent quarter
Pharmacy Financial Report	Summary data on committed pharmacy dollars, pharmacy total claims dollars, MCO supplemental rebate dollars, and MAC savings.	45 calendar days following the most recent quarter
Pharmacy Utilization Management	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	45 calendar days following the most recent quarter
PDL Compliance	Data documenting accuracy in dispensing medications in PDL categories.	45 calendar days following the most recent quarter
Care Management Report	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Enrollment and Disenrollment Report	Summary of disenrollments as described in Section IV.B - Eligibility and Enrollment.	45 calendar days following the most recent quarter

Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	45 calendar days following the most recent quarter
Provider Network Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Network Adequacy	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Network Cultural Competency Access	Summary data and metrics on cultural competency access as determined by MLTC.	45 calendar days following the most recent quarter
Provider Network PCP Access	Summary data and metrics on PCP access as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Credentialing	Data and metrics summarizing the number of providers credentialed by licensure type, their location, and the status of pending credentials.	45 calendar days following the most recent quarter
Quality Oversight Committee	Committee activity summary as described in Section IV.M - Quality Management.	45 calendar days following the most recent quarter
Service Verification Detail	Data detailing service verifications as described in Section IV.S - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Service Verification Summary	Service verification summary as described in Section X - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Utilization Management - Authorization	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter

Utilization Management - Claims	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Quality Performance	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Restraint and Seclusion	Data summarized, by behavioral health provider, on the number of incidents of restraint or seclusion by program type and location.	45 calendar days following the most recent quarter
Contracted Residential Beds	Summary data on the number of behavioral health-related residential beds available state-wide.	45 calendar days following the most recent quarter
Critical Incident Reporting	Summary data on the number of critical incident reports by behavioral health facility and location.	45 calendar days following the most recent quarter
Quarterly Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	45 calendar days following the most recent quarter
30 day Ambulatory/Inpatient Readmission Rates	Summary data on the number of individuals readmitted to the emergency room 30 or more days post the prior admission.	45 calendar days following the most recent quarter
7 and 30 Day Ambulatory Follow-up Following Residential Discharge	Summary data on the number of individuals presenting to the emergency room 30 days after discharge from Acute Psych or SUD.	45 calendar days following the most recent quarter
Admissions and Readmits to Psych Inpatient	Data summarizing the number of admissions and readmits to psych inpatient, including Psychiatric Residential Treatment Facilities and Therapeutic Group Homes.	45 calendar days following the most recent quarter
Value-Added Services	Summary of value added services as agreed upon by the MCO and MLTC.	45 calendar days following the most recent quarter

Indian Health Services	Data and metrics summarizing Indian Health Service delivery.	45 calendar days following the most recent quarter
Medication Therapy Management	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	45 calendar days following the most recent quarter
Subrogation	Data summarizing new and ongoing instances of subrogation.	45 calendar days following the most recent quarter
Top Ten Diagnoses by Service Category	Data summarizing the top ten diagnoses by service category.	45 calendar days following the most recent quarter
Semi-Annual Deliverables	**Description**	**Due Date**
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
Paid Claims Audit	Results of error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims as described in Section IV.O - Program Integrity.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Quality Management Program Description and Work Plan	Discussion of the MCO's quality goals, initiatives and work plan as described in Section IV.M – Quality Management.	30 calendar days following the 12th month of the contract year
Quality Management Program Evaluation	Data and analysis summarizing the results of the annual quality work plan as described in Section IV.M - Quality.	30 calendar days following the 12th month of the contract year
Member Satisfaction Survey	Data and analysis summarizing results of the annual member satisfaction survey.	30 calendar days following the 12th month of the contract year

Deficiency CAP Reports (All Provider Types)	Results and status of all corrective action plans by provider type.	30 calendar days following the 12th month of the contract year
Direct Medical Education/Indirect Medical Education Verification	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Due date to be provided prior to contract start
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	30 calendar days following the 12th month of the contract year
HEDIS Report	HEDIS results.	45 calendar days following the 12th month of the contract year
CHIPRA Quality Measures	CHIPRA performance measure results.	45 calendar days following the 12th month of the contract year
Adult Core Measures	Adult Core Measures results.	45 calendar days following the 12th month of the contract year
Provider Survey	Data and analysis summarizing results of the annual provider satisfaction survey. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	30 calendar days following the 12th month of the contract year
Facility Satisfaction Survey	Data and analysis summarizing results of the annual facility provider satisfaction survey.	30 calendar days following the 12th month of the contract year
Audited Financial Statement	Independent annual financial audit as detailed in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the contract year
Annual Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the contract year

Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Last day of the contract year
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	December 31
Department of Insurance Financial Report	Copy of annual audited financial statement submitted to the Nebraska Department of Insurance.	30 calendar days following the 12th month of the contract year
Network Development Plan	Details of the MCO's network, including GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.O - Provider Network.	November 1
Utilization Management Program Review	Data and analysis summarizing the MCO's annual evaluation of its UM program.	30 calendar days following the 12th month of the contract year
Legislative Reports	**Description**	**Due Date**
LB 1063 - Children's Health and Treatment Act	Data and Geo Access reports related to youth Medicaid mental health authorization requests (all children ages 0-19) and Medicaid mental health authorization requests (all age groups reported by ages 0-18 years, 19-64 years, and 65+ years)	Quarterly reports submitted to Nebraska Legislature on January 1, April 1, July 1, and October 1 by MLTC.
LB 1160 Legislative Report	Number of state wards receiving behavioral health services as of September 1 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Upon DHHS request.

Required with Proposal	Description	Due Date
Proposed Rule Implementation Plan	Plan for complying with new CMS Medicaid managed care rules as described in Section IV.C - Business Requirements.	Required with proposal
Provider Contract Template	Submit provider contract template as described in Section IV.I - Provider Network.	Required with proposal
Network Development Plan	Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.	Required with proposal
Key Staff Resumes	As possible, submit resumes of proposed key staff as described in Section IV.X - Transition and Implementation.	Required with proposal
Preliminary Implementation Plan	Submit preliminary implementation plan as described in Section IV.X - Transition and Implementation.	Required with proposal
Draft Member Handbook	Submit a draft copy of the member handbook as described in Section IV.F – Member Services and Education.	Required with proposal
Contract Award Period	**Description**	**Due Date**
Implementation Plan	Submit contract implementation plan as described in Section IV.X - Transition and Implementation.	30 calendar days after contract award
Pharmacy Transition Plan	Submit plan for transitioning from the MLTC FFS program to the MCO pharmacy plan as described in Section IV.X - Transition and Implementation.	30 calendar days after contract award
120 Days Prior to Contract Start Date	**Description**	**Due Date**
Member Handbook	Submit member handbook for approval as described in Section IV.J - Provider Services.	120 days prior to contract start date

Marketing Plan	Submit plan detailing proposed marketing activities and materials as described in Section IV.G - Member Marketing.	120 days prior to contract start date
Welcome Packet Contents	Submit welcome packet materials as described in Section IV.F - Member Services and Education	120 days prior to contract start date
Welcome Call Script	Submit script for member welcome calls as described in Section IV.F - Member Services and Education.	120 days prior to contract start date
Member Education Plan	Submit member education plan as described in Section IV.F - Member Services and Education.	120 days prior to contract start date
Enrollment Broker	Submit policies and procedures for receiving file submissions from the Enrollment Broker as described in Section IV.B - Eligibility and Enrollment.	120 days prior to contract start date
90 Days Prior to Contract Start Date	**Description**	**Due Date**
Provider Network List	Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network.	90 days prior to contract start date
Provider Network Sufficiency Attestation	Submit data and analysis attesting to the sufficiency of the MCOs network as described in Section IV.I - Provider Network.	90 days prior to contract start date
Subcontracts	Submit all subcontracts for the provision of any services for prior review and approval as described in Section IV.K - Subcontracting.	90 days prior to contract start date
MCO Provider Website	As detailed in Section IV.J - Provider Services, the MCO's provider website is considered marketing material and must be submitted for review and approval.	90 days prior to contract start date

Provider Training Handbook and Training Schedule	Submit a copy of the provider training handbook and training schedule as described in Section IV.J - Provider Services	90 days prior to contract start date
Provider Handbook	Submit provider handbook for approval as described in Section IV.J - Provider Services	90 days prior to contract start date
Pharmacy Claims	Submit policies and procedures for pharmacy claims as described in Section IV.S - Claims Management	90 days prior to contract start date
Pharmacy Pricing Rules and Algorithms	Submit pricing rules and algorithms for pharmacy claims as Section IV.S - Claims Management.	90 days prior to contract start date
MAC Pricing	Submit policies and procedures for MAC pricing as described in Section IV.S - Claims Management.	90 days prior to contract start date
Care Management Program	Submit program description, policies and procedures for Care Management as described in Section IV.L - Care Management.	90 days prior to contract start date
Continuity of Care	Submit policies and procedures for continuity of care as described in Section IV.L - Care Management.	90 days prior to contract start date
HCBS Coordination	Submit policies and procedures for coordinating with HCBS case managers as described in Section IV.L - Case Management.	90 days prior to contract start date
Pharmacy Coverage Policies and Procedures	Submit pharmacy coverage policies and procedures as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date
Extemporaneously Compound Drugs	Submit policies for extemporaneously compound drugs as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date
Formulary	Submit formulary for review as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date

OTC Drug List	Submit list of covered OTC drugs as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date
60 Days Prior to Contract Start Date	**Description**	**Due Date**
QAPI Committee Description	Submit a description and detail the composition of the QAPI Committee (QAPIC) as described in Section IV.M - Quality Management.	60 days prior to contract start date
QM Program Description and Goals	Submit overview of QM program as described in Section IV.M - Quality Management	60 days prior to contract start date
Remedial Action Policy and Procedures	Submit procedures for remedial action to address deficiencies as described in Section IV.M - Quality Management.	60 days prior to contract start date
Corrective Action Triggers	Submit description of deficiencies that require corrective action as described in Section IV.M - Quality Management.	60 days prior to contract start date
Corrective Action Monitoring	Submit policies and procedures for evaluating corrective actions.	60 days prior to contract start date
Provider Review	Submit procedures for provider review.	60 days prior to contract start date
SHCN Care Quality Assessment	Submit procedures for assessing the quality and appropriateness of care furnished to members with SHCNs.	60 days prior to contract start date
Clinical Advisory Committee	Submit plan for the development of the Clinical Advisory Committee as described in Section IV.M - Quality Management.	60 days prior to contract start date
Member Advisory Committee	Submit plan for the development of the Member Advisory Committee including meetings schedule and objectives s described in Section IV.M - Quality Management.	60 days prior to contract start date

Tribal Members Coordination	Submit policies and procedures for coordination and collaboration with qualified members as described in Section IV.L - Care Management.	60 days prior to contract start date
Coordination with Division of Family Services	Submit policies and procedures for coordinating with the DHHS Division of Children and Family Services as described in Section IV.L - Care Management.	60 days prior to contract start date
Health Risk Assessment Algorithms and Methodologies	Submit proposed methodology and algorithms for health risk assessment as described in Section IV.L - Care Management.	60 days prior to contract start date
PBM Independence Assurance	Submit procedures and assurances regarding PBM independence as described in Section IV.L - Care Management.	60 days prior to contract start date
PBM Oversight Plan	Submit plan for monitoring PBM performance as described in Section IV.S - Claims Management.	60 days prior to contract start date
Claims Dispute Process	Submit policies and procedures for addressing claims disputes as described in Section IV.S - Claims Management.	60 days prior to contract start date
Physician Incentive Plan Contract Templates	Submit contract templates for Physician Incentive Plan participants as described in Section IV.Q - Provider Reimbursement.	60 days prior to contract start date
Service Authorization	Submit policies and procedures for service authorization as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Retrospective UR Functions	Submit policies for retrospective UR functions as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Utilization Management Program Description	Submit UM program description as described in Section IV.N - Utilization Management.	60 days prior to contract start date

Drug Utilization Review Program Guidelines	Submit guidelines for DUR program as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Clinical Criteria for Drug Prior Authorization	Submit criteria for drug prior authorization as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Grievances and Appeals	Submit policies and procedures for the handling of member/provider grievances and appeals as described in Section IV.H - Grievances and Appeals.	60 days prior to contract start date
45 Days Prior to Contract Start Date	**Description**	**Due Date**
Amount, Duration, and Scope Policies	Submit amount, duration and scope policies as described in Section IV.E - Covered Services and Benefits.	45 days prior to contract start date
Lab Services Authorization Policies	Submit policies for lab services authorization as described in Section IV.E - Covered Services and Benefits.	45 days prior to contract start date
Value-Added Services	Provide a description of the expanded services/benefits the MCO will provided as described in Section IV.E - Covered Services and Benefits	45 days prior to contract start date
Provider Complaint System	Submit policies and procedures detailing the MCO's provider complaint system as described in Section IV.J - Provider Services.	45 days prior to contract start date
Provider Directory Template	Submit templates for the provider directory as described in Section IV.E - Members Services and Education.	45 days prior to contract start date
Human Resources and Staffing Plan	Submit a plan detailing how the MCO will obtain and maintain appropriate staffing levels as described in Section IV.D - Staffing.	45 days prior to contract start date

Key Staff List	Submit the names, resumes and contact info for all key staff as described in Section IV.D - Staffing	45 days prior to contract start date
Credentialing/Recredentialing	Submit policies and procedures for credentialing and recredentialing providers as described in Section IV.I - Provider Network.	45 days prior to contract start date
Provisional Credentialing for Behavioral Health	Submit policies and procedures for the provisional credentialing of behavioral health providers.	45 days prior to contract start date
Network - Communication of Change	Submit procedures for communicating contractual and/or program changes to providers.	45 days prior to contract start date
Network Compliance	Submit procedures for ensuring provider compliance with State and MCO policies as described in Section IV.I - Provider Network.	45 days prior to contract start date
Network Service	Submit procedures for evaluating the quality of services provided by the network.	45 days prior to contract start date
Network Insufficiency	Submit policies and procedures for arranging for medically necessary services in the event of temporary network insufficiency as described in Section IV.I - Provider Network.	45 days prior to contract start date
Network Monitoring	Submit procedures for monitoring the adequacy, accessibility and availability of network providers as described in Section IV.I - Provider Network.	45 days prior to contract start date
Specialty Drug List	Submit list of specialty drugs as described in Section IV.I - Provider Network.	45 days prior to contract start date
Compliance Plan	Submit fraud, waste, abuse and erroneous payments compliance plan as described in Section IV.O - Program Integrity.	45 days prior to contract start date

Fraud, Waste, Abuse and Erroneous Payments	Submit fraud, waste, abuse and erroneous payments policies as described in Section IV.O - Program Integrity.	45 days prior to contract start date
Advance Directives	Submit policies and procedures for Advance Directives as described in Section IV.F - Member Services and Education	45 days prior to contract start date
Timely Access	Submit policies and procedures for the monitoring of timely access requirements as described in Attachment 2 - Access Standards.	45 days prior to contract start date
Selection and Retention of Providers	Submit policies for the selection and retention of providers as described in Section IV.I - Provider Network.	45 days prior to contract start date
Member Privacy	Submit policies and procedures for protecting member privacy	45 days prior to contract start date
PCP Assignment	Submit policies and procedures for PCP assignment as described in Section IV.B - Eligibility and Enrollment.	45 days prior to contract start date
Second Opinions	Submit policies and procedures regarding ensuring member access to a second opinion.	45 days prior to contract start date
Restricted Services	Submit policies and procedures for restricted services as described in Section IV.N - Utilization Management	45 days prior to contract start date
30 Days Prior to Contract Start Date	**Description**	**Due Date**
Subcontractor Evaluation	Submit copies of subcontractor evaluations as described in Section IV.C - Business Requirements.	30 days prior to contract start date
Third Party Liability	Submit procedures for identifying TPL and administrating payment as described in Section IV.P - MCO Reimbursement.	30 days prior to contract start date

Provider Preventable Conditions	Submit procedures for precluding payment to providers for provider preventable conditions as required in Section IV.P - Provider Reimbursement.	30 days prior to contract start date
Clinical Practice Guidelines	Submit clinical practice guidelines developed in accordance with requirements in Section IV.N - Utilization Management.	30 days prior to contract start date
Emergency Medical and Post-Stabilization Services.	Submit policies and procedures for emergency medical and post-stabilization services as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Family Planning Services	Submit policies and procedures for family planning services as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Indian Health Protections	Submit policies and procedures for Indian health protections as described in Section IV.F - Members Services and Education.	30 days prior to contract start date
Direct Access to Women's Health Specialists	Submit policies and procedures for guaranteeing female members direct access to women's health specialists as described in Section IV.I - Provider Network.	30 days prior to contract start date
EPSDT Services	Submit policies and procedures for EPSDT services as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Staffing	Submit policies and procedures for staffing as described in Section IV.D - Staffing.	30 days prior to contract start date
Maintenance of Medical Records	Submit policies and procedures for the maintenance of medical records as described in Section IV.E - Member Services and Education.	30 days prior to contract start date

Medical Record Confidentiality	Submit policies and procedures regarding maintaining the confidentiality of member medical records.	30 days prior to contract start date
Transportation	Submit policies for transportation as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Dual Eligibles	Submit policies and procedures for addressing needs of dual eligible members.	30 days prior to contract start date
Member Calls	Submit policies and procedures for managing member calls as described in Section IV.F - Member Services and Education.	30 days prior to contract start date
Referrals	Submit policies and procedures on referrals for specialty care and other benefits not provided by the member's PCP.	30 days prior to contract start date
Brand Name Products	Submit policies and procedures for brand name products as described in Section IV.Q - Provider Reimbursement.	30 days prior to contract start date
After Contract Start Date	**Description**	**Due Date**
PCMH Implementation Plan	Submit plan for PCMH implementation as described in Section IV.I - Provider Network.	90 days after contract start date
Value-Based Contracting Plan	Submit plan for implementing value-based purchasing agreements as described in Section IV.Q - Provider Reimbursement.	Due by December 17, 2017

Attachment 4
Patient-Centered Medical Home Standards

Core Competency 1: Facilitate ongoing patient relationship with physician in a physician-directed team.

1. Practice utilizes written plan for patient communication including accommodations for hearing and visually-impaired individuals and English as a second language patients.

2. Practice utilizes written materials for patients that explain the features and essential information related to the medical home; materials are published in primary language(s) of the community.

3. Practice utilizes patient-centered care planning (includes patient's goals, values, and priorities) to engage patients in their care. Practice plan can include a written after visit summary outlining future care plan and given to patient at every visit.

4. Practice utilizes reminder/notification system for health care services such as appointments, preventive care, preparation information for upcoming visits, follow-up with patients regarding periodic tests or screening, and for missed appointments.

5. Practice provides patient education and self-management tools and support for patients, families, and caregivers.

6. Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.

7. Practice creates and uses a written plan for the implementation of the medical home including a description of work flow for team members.

Core Competency 2: **Coordinate continuous patient-centered care across the health care system.**

1. Practice utilizes written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.

2. Practice provides care coordination and supports family participation in care including providing connections to community resources.

3. Practice utilizes a system to maintain and review a list of patient's medications.

4. Practice team tracks diagnostic tests and provides written and verbal follow-up on results with patient, plus follows up after referrals, specialist care, and other consultations.

5. Practice utilizes a patient registry.

6. Practice team defines and identifies high-risk patients in the practice who will benefit from care planning and provides a care plan to these individuals.

7. Practice team provides and coordinates Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

8. Practice team provides transitional care plan for patients transferring to another physician or medical provider.

9. Clinical data is organized in a paper or electronic format for each individual patient.

10. Practice utilizes a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the medical home.

1. Patient has on-call access to the medical home team 24 hours/day, 7 days/week.

2. Practice offers appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.

3. Practice utilizes a system to respond promptly to prescription refill requests and other patient inquiries.

4. Practice provides day-of-call appointments.

5. Practice utilizes written practice standards for patient access.

Core Competency 4: Foster efficiency of care by reducing unnecessary health care spending, reducing waste, and improving cost-effective use of health care services.

1. Practice implements interventions to reduce unnecessary care or preventable utilization that increases cost without improving health.

2. Practice establishes at least 2 out of 3 of the following waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions.

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

1. Practice has established a quality improvement team that, at a minimum, includes one or more clinicians who deliver services within the medical home;

one or more care coordinators; one or more patient representatives; and if a clinic, one or more representatives from administration/management.

2. Practice develops a formal plan to measure effectiveness of care management.

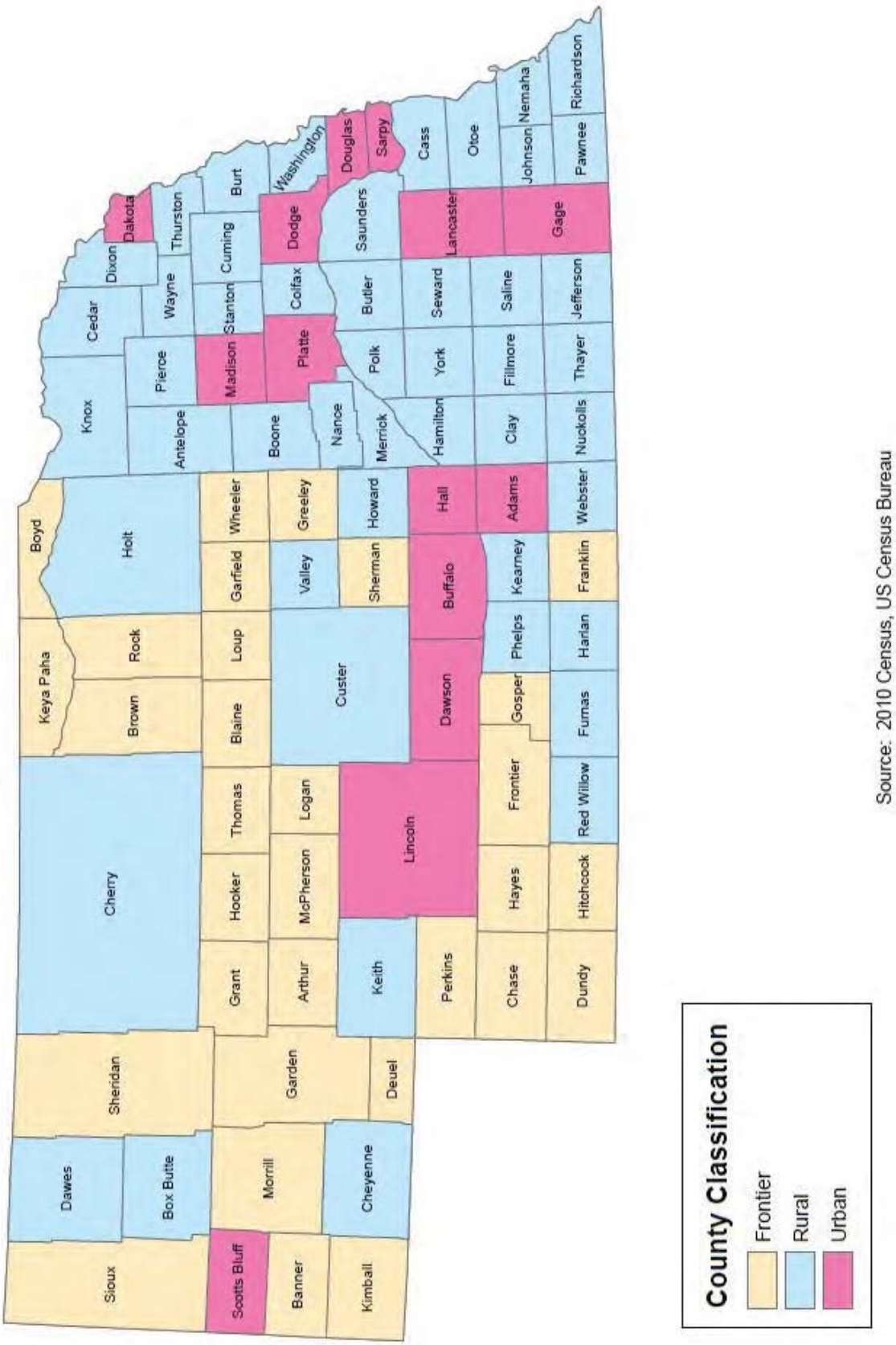
3. Practice develops an operational quality improvement plan for the practice with at least one focus area.

4. Practice utilizes a patient survey to assess their experience of care and sets a schedule for utilization (may be developed or provided by the MCO).

5. Practice identifies one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.

Attachment 3

Nebraska Counties Classified by Urban/Rural/Frontier Status



Source: 2010 Census, US Census Bureau

Attachment 2
Access Standards

Appointment Availability Access Standards

1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.

2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO.

3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation.

4. Family planning services must be available within seven calendar days.

5. Non-urgent, preventive care must be available within 4 weeks.

6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.

7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.

8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

Geographic Access Standards

1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties.

2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.

3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.

    a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences.

    b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences.

    c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.

4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.

5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census.

Attachment 1 redacted

State of Nebraska (State Purchasing Bureau)

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
Phone: 402-471-6500
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 5151 Z1	**October 21, 2015**
OPENING DATE AND TIME	PROCUREMENT CONTACT
December 22, 2015 2:00 p.m. Central Time	**Michelle Thompson / Teresa Fleming**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau, is issuing this Request for Proposal, RFP Number 5151 Z1 for the purpose of selecting a qualified contractor to provide full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services.

The State of Nebraska intends to award a minimum of two (2) and a maximum of three (3) MCO contracts for the scope of work as described in Section IV. A. Program Description through Y. Termination of MCO Contract. One of the awarded contracts will also include the scope of work as described in Section IV. Z. FFS Claims Management and Processing.

Written questions for the first round of questions are due no later than November 2, 2015. Written questions for the second round of questions are due no later than November 23, 2015. Questions should be submitted via e-mail to as.materielpurchasing@nebraska.gov or may be sent by facsimile to (402) 471-2089.

The First Pre-Proposal Conference will be held on October 26, 2015 from 1:00 PM – 5:00 PM CST at Nebraska State Office Building, 301 Centennial Mall South, Lower Level, Conference Room A, Lincoln, Nebraska 68508. Bidders may call into the First Pre-Proposal Conference by utilizing the conference access number: (888) 820-1398 and attendee code: 8559164#.

The Second Pre-Proposal Conference will be held at the discretion of the State. If conducted, information will be provided at a later date.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing Bureau by the date and time of proposal opening per the schedule of events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order for a bidder's proposal to be evaluated.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

Contractor hereby grants permission to the State of Nebraska and/or its agencies to reprint or republish any and all copyrighted documents related to Contractor's response to this Request for Proposal, and any and all figures, illustrations, photographs, charts, and other supplementary material on a website accessible by the public pursuant to Neb. Rev. Stat. §84-602.02. This waiver does not apply to proprietary information properly submitted in a separate sealed, package clearly marked "Proprietary."

Contractor represents and warrants that the contents of this response to Request for Proposal and all figures, illustrations, photographs, charts, and other supplementary material herein are original and do not libel anyone or infringe upon any patent, copyright, proprietary right, or any other right whatsoever of any other party. Contractor represents and warrants that Contractor has full power and authority to execute this Copyright Release and to grant the State of Nebraska and/or its agencies the right granted herein.

Contractor agrees to indemnify, defend, and hold harmless the State of Nebraska and/or its agencies against any and all claims, suits, and/or judgments, including costs, expenses, damages, and reasonable legal fees based upon and arising from Contractor's violation of the rights of others and/or by reason of a breach of any of the foregoing warranties.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat §73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. §73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME & TITLE OF SIGNER: _____

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GLOSSARY OF ACRONYMS

ACT: Assertive community treatment

BCP: Business continuity plan

CAC: Clinical Advisory Committee

CAH: Critical access hospital

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CAP: Corrective action plan

CCAA: Comprehensive child and adolescent assessment

CCC: Children with chronic conditions

CLIA: Clinical Laboratory Improvement Amendments

CFR: Code of Federal Regulations

CHCQM: Certified in health care quality management

CHIP: Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Reauthorization Act

CM: Care management

CME: Confirmation of MCO enrollment

CMS: Centers for Medicare & Medicaid Services

COA: Certificate of Authority

CPHQ: Certified professional in health care quality

CPT: Current procedural terminology

CTA: Community treatment aide

DBH: Division of Behavioral Health

DHHS: Nebraska Department of Health and Human Services

DME: Durable medical equipment

DRP: Disaster recovery plan

DUR: Drug utilization review

ECM: Electronic claims management

EOB: Explanation of benefits

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment

EQR: External quality review

EQRO: External quality review organization

Federal DHHS: U.S. Department of Health and Human Services

FFP: Federal financial participation

FFS: Fee-for-service

FQHC: Federally qualified health center

FWA: Fraud, waste, and abuse

GAO: General Accounting Office

HCBS: Home and community based services

HEDIS: Healthcare Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

HIPF: Health insurance providers' fee

HMO: Health maintenance organization

IHS: Indian Health Service

IS: Information systems

I/T/U: Indian Health Services/Tribal 638/Urban Indian Health

IVR: Interactive voice response

LTSS: Long-term services and supports

MAC: Maximum allowable costs

MCO: Managed care organization

MFPAU: Medicaid Fraud and Patient Abuse Unit

MH: Mental health

MHPAEA: Mental Health Parity and Addiction Equity Act

MLR: Medical loss ratio

MLTC: Nebraska DHHS, Division of Medicaid and Long-Term Care

MTM: Medication therapy management

NAC: Nebraska Administrative Code

NCPCP: National Council for Prescription Drug Programs

NCQA: National Committee for Quality Assurance

NMPI: Nebraska Medicaid Program Integrity Unit

NPI: National provider identifier

OEM: Original equipment manufacturer

PBM: Pharmacy benefit manager

PCMH: Patient-centered medical home

PCP: Primary care provider

PDL: Preferred drug list

PHI: Protected health information

PIP: Performance improvement project

PMPM: Per member per month

PPC: Provider preventable condition

QAPI: Quality assurance and performance improvement

QAPIC: Quality Assurance and Performance Improvement Committee

QI: Quality improvement

QM: Quality management

QPP: Quality performance program

RFP: Request for proposal

RHC: Rural health clinic

SDF: Software development firm

SHCN: Special health care needs

SHD: Systems help desk

SMI: Serious mental illness

SUD: Substance use disorder

TPL: Third party liability

TTY/TDD: Teletypewriter and telecommunications device for the deaf

UM: Utilization management

UR: Utilization review

VPN: Virtual private network

WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

GLOSSARY OF TERMS

ACCESSNebraska: The State service delivery system for public benefits, accessible through a toll-free telephone number and website.

Action: Defined in this RFP as the:

9. Denial or limited authorization of a requested service, including the type or level of service.
10. Reduction, suspension, or termination of a previously authorized service.
11. Denial, in whole or in part, of payment for a service.
12. Failure of a MCO to act within timeframes provided in this RFP or as directed by the State.
13. Failure of a MCO to process grievances, appeals, or expedited appeals within required timeframes.

Addendum: Something to be added or deleted to an existing document; a supplement.

Adjudicate: To pay or deny a claim.

Adjustment: Modification to an adjudicated claim.

Administrative cap: The upper limit of the rate a MCO may spend on administrative expenses.

Administrative expense rate: The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that would have been incurred in the contract year in the absence of any related-party relationship.

Advance directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Nebraska Constitution.

Agent/Representative: A person authorized to act on behalf of another.

Allowable quality improvement expense: A MCO's expenditure on qualified quality improvement activities described in Attachment 15 - Medical Loss Ratio Requirements of this RFP.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appeal: A request for review of an action.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Auto assignment: The process by which an enrollee, who does not select a MCO or PCP within a predetermined length of time during enrollment activities is automatically assigned to a MCO and PCP.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of a proposal, and do not improve a bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer: In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: An offer submitted by a vendor in a response to a RFP.

Bidder: A vendor who submits an offer bid in response to a RFP.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.
Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Capitation payment: A monthly payment by the State to a MCO on behalf of each member of a MCO for the provision of covered services under the contract. Payment is made regardless of whether any particular member receives services during the period covered by the payment.

Care management: A collaborative process of assessment, planning, facilitation, coordination, and advocacy for options and services that the MCO must conduct to meet an individual's health needs, through communication and provision of available resources to promote quality, cost-effective outcomes.

Children's Health Insurance Program (CHIP): Nebraska's CHIP program is a combination Medicaid CHIP state with a Medicaid CHIP expansion program under Title XXI called "Kid's Connection". Kid's Connection provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 200 percent of the federal poverty level. The separate CHIP program established July 19, 2012 provides Medicaid coverage for the unborn children of pregnant women who are otherwise not Medicaid eligible.

Choice counseling: The provision of information about available MCO's and unbiased decision support for selection of an MCO by the enrollment broker for Medicaid enrollees.

Clean claim: A claim, received by a MCO for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the MCO. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claim: A bill for services, a line item of service, or all services for one member within a bill.

Cold-call marketing: Any unsolicited personal contact by a MCO with a potential enrollee for the purpose of marketing.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Complaint: See grievance.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work that is in progress and unpublished, and other information that if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of a contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Core benefits and services: The minimum package of services to which a member is entitled under the Nebraska Medicaid State Plan and that must be provided by a MCO to members enrolled in the MCO.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice about those products

or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of a written solicitation or contract.

Disenroll: See Disenrollment, below.

Disenrollment: A change in the status of a member from being enrolled with a specific MCO to being enrolled with a different MCO, or a change from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

Dispensing fee: The fee paid by a MCO to reimburse the overhead and labor expense incurred by pharmacy providers, and the professional services provided by a pharmacist when dispensing a prescription.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the contractor to the users of the licensed software that will provide the State with sufficient information to operate, diagnose, and maintain the licensed software properly, safely, and efficiently.

Drug encounter: Submission by a MCO of prescriptions billed by a pharmacy or medical professionals.

Earned hold-back: The portion of the hold-back a MCO may keep based upon MLTC's determination of the MCO's results compared with identified performance measures.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.

Emergency services: Covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an emergency medical condition.

Encounter data: Line-level utilization and expenditure data for services furnished to members through a MCO.

Enrollee: An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act and under the rules for participation in the Nebraska Medical Assistance Program.

Enrollment: The process of an enrollee selecting a MCO.

Enrollment broker: The State's contracted entity for choice counseling and enrollment activities.

Enrollment file: A proprietary data file provided by the State to a MCO. It is the basis for monthly payments to the MCO.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals.

Extension: Continuance of a contract for a specified duration by agreement of the parties beyond the original Contract Period. Not to be confused with "renewal period".

Family planning services: Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

Federally qualified MCO: An MCO that CMS has determined is a qualified MCO under Section 1310(d) of the Public Health Services Act.

Fee-for-service: A method of provider reimbursement based on payments for each service rendered.

Forfeited hold-back: The portion of the hold-back a MCO must forfeit, based upon MLTC's determination of the MCO's results compared with identified performance measures. Forfeited hold-back may also be referred to as unearned hold-back.

Formulary: A list maintained by a MCO giving details of medications payable by the MCO's health plan.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Generally accepted actuarial principles: The common set of actuarial standards, as determined by the American Academy of Actuaries.

Grievance: A written or verbal expression of dissatisfaction about any matter other than an action.

Health care professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insurance providers fee: As required by Section 9010 of the Patient Protection and Affordable Care Act (ACA), the fee imposed on each covered entity engaged in the business of providing health insurance for United States health risks.

Health risk screening: A health questionnaire, used to provide individuals with an evaluation of their health risks and quality of life.

Health risk assessment: A more detailed assessment for those members who have been deemed to potentially qualify for care management services. The health risk assessment is used to collect information on a member's health status that includes, but is not limited to, member demographics, personal and family medical history, and lifestyle.

Hold-back: The portion of the MCO's revenue that the MCO must reserve in the reinvestment holding account and may potentially earn based upon MLTC's determination of the MCO's results on identified performance measures.

Hold-back account: The account a MCO must establish for the purpose of reserving the hold-back.

Information system(s): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data that may include digitized audio and video and documents, as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for purposes of enabling or facilitating a business process or related transaction.

Insolvency: A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Liquidated damages: Damages that may be assessed whenever a MCO, its providers, and/or subcontractor fail to achieve certain performance standards and other items defined in this contract.

Long-term services and supports: Specific Medicaid-covered services including intermediate care facility services for individuals with developmental disabilities, any institutional long-term care or nursing facility services at a custodial level of care, services provided via a Home and Community Based Waiver program, Targeted Case Management, or Medicaid State Plan Personal Assistance Services.

Managed Care Organization (MCO): A private entity that contracts with MLTC to provide benefits and services to Nebraska Medicaid enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Nebraska Department of Insurance with respect to licensure and financial solvency, and with respect to its products and services offered pursuant to the HERITAGE HEALTH is regulated by the Nebraska Department of Health and Human Services.

Mandatory/Must: Required, compulsory, or obligatory.

Marketing: Any communication from a MCO to a Medicaid enrollee who is not enrolled in that entity that can reasonably be interpreted as intended to influence the enrollee to enroll in that particular MCO or either to not enroll in or to disenroll from another MCO.

Marketing materials: Materials that are produced in any medium, by or on behalf of the MCO, and can reasonably be interpreted as intended to market to potential enrollees.
May: Discretionary, permitted; used to express possibility.

Meaningful use: Using certified electronic health records technology in a meaningful way, as established in the Health Information Technology for Economic and Clinical Health Act.

Medicaid fraud: Fraud is defined by Federal law (42 CFR 455.2) as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Medical incentive bonuses: Payments made by a MCO to providers and other unrelated risk sharing entities to share savings.

Medical loss ratio (MLR): The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for members and allowable QI expenses under this contract.

Medical necessity: Health care services and supplies that are medically appropriate and:
1. Necessary to meet the basic health needs of the member.
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
3. Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
4. Consistent with the diagnosis of the condition.
5. Required for means other than convenience of the client or his/her physician.
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
7. Of demonstrated value.
8. No more intensive level of service than can be safely provided.

Member: A Medicaid enrollee who is currently enrolled with a specific MCO.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See mandatory/must.

National Drug Code (NDC): The universal product identifier for human drugs.

Nebraska Medicaid Program (NE Medicaid or Medicaid): NE Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers NE Medicaid is administered by the Division of Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services (DHHS).

Net qualified medical expense (for the medical loss ratio): The sum of:
1. Claims incurred
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
3. Medical incentive bonuses
4. Reinsurance premiums less reinsurance recoveries
5. Activities that improve health care quality, per 45 CFR 158.150
6. Less related-party medical margin

Net qualified medical expense (for the risk corridor): The sum of:
1. Claims incurred
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
3. Medical incentive bonuses
4. Reinsurance premiums less reinsurance recoveries
5. Less related-party medical margin

Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses include:

1. Direct administration: customer service, enrollment, medical management, claims administration, etc.
2. Indirect administration: accounting, actuarial, legal, human resources, etc.
3. Net cost of reinsurance: reinsurance premium less projected reinsurance recoveries. Net cost of related party reinsurance is excluded.

Non-QI administrative expense rate: Non-QI Administrative Expenses divided by Qualifying Revenue.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.
Patient-centered medical home (PCMH): The Center for Medical Home Improvement defines PCMH as a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.

Patient centeredness: Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care. Patient centeredness focuses on the patient, not the illness, and is supported by good provider-patient relations.

Peer review: A process of evaluating work completed by practitioners in the same professional field.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that a Contractor fulfills any and all obligations under a contract.

Post stabilization care services: Covered services, related to an emergency medical condition, that are provided after an enrollee/member is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e), to improve or resolve the enrollee's/member's condition.

Provider-preventable condition: Preventable healthcare-acquired or other provider-preventable conditions and events identified by MLTC for non-payment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient, or the wrong surgical procedure performed on a patient.

Potential enrollee: A Medicaid recipient who is subject to mandatory enrollment with an HMO, but is not yet a member of a specific MCO.

Practitioner: A Medicaid enrolled provider who is licensed, registered, or certified by MLTC to practice in the State.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Prepaid inpatient health plan (PIHP): As defined by 44 NAC Sections 4701 to 4727, and 42 CFR 438.2, a PIHP is and entity that:
1. Provides medical services to enrollees under contract with MLTC on the basis of prepaid capitation payments or other payment arrangements that do not use Medicaid State Plan payment rates.
2. Provides, arranges for, or otherwise has responsibility for, the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract.

Preferred drug list (PDL): A list maintained by MLTC, in partnership with the State Pharmaceutical and Therapeutics Committee, that indicates whether drugs are preferred or non-preferred by the State and therefore also by the MCO under the terms of this RFP.

Primary care provider (PCP): A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.

Primary care services: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under a contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information that if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Protest: A complaint about a governmental action or decision related to an Invitation to Bid or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency under the FFS model, or for the managed care program, any individual or entity who/that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Qualifying revenue (for the risk corridor calculation): The aggregate of revenue earned by a MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. Any earned hold-back is not factored into the calculation.

Qualifying revenue (for the administrative cap calculation): The aggregate of revenue earned by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. The hold-back (earned and forfeited) is factored into the calculation.

Quality improvement (QI) administrative rate: Equals the QI Expenses divided by Qualifying Revenue.

Quality management: The continuous process of assuring appropriate, timely, accessible, available, and medically necessary delivery of services. Maintaining established guidelines and standards reflective of the current state of physical and behavioral health knowledge.

Readiness review: MLTC's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure, operational protocols, MCO standards, and MCO systems. This review may be done as a desk review, on-site review, or combination and may include interviews with pertinent MCO personnel.

Re-enrollment: The process by which the State automatically re-assigns a member who is disenrolled solely because he or she loses Medicaid eligibility, when a loss of eligibility does not exceed two months, into the same MCO.

Reinsurance: An insurance product, also known as stop-loss insurance, risk control, or excess insurance, which provides protection against catastrophic or unpredictable losses. An MCO may purchase reinsurance to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

Reinvestment account: The account a MCO must establish for any profits in excess of the contracted amount, performance contingencies imposed by MLTC, and any unearned hold-back funds, pursuant to Neb. Rev. Stat. §71-831-.

Related-party: The parent company of a MCO or an entity partially or wholly owned by the MCO or the MCO's parent company that receives any revenue from the MCO for Medicaid contracted services. Examples of related parties include a clinic wholly or partly owned by a MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract.

Related-party administrative expense: Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Such fees are not considered in the calculation of administrative expense under this contract.

Related-party administrative margin: Related-party administrative expense divided by qualifying revenue.

Related party medical margin: The difference between medical costs incurred, including a related-party relationship and those incurred in the absence of a related-party arrangement. An arrangement whereby a MCO pays a related party a sub-capitation. For example, because Medicaid medical expenses must reflect the costs that would have been incurred in the absence of any related-party relationship, the circumstance in which a MCO pays any related party a sub-capitation would necessitate calculation of the related party medical margin.

Release Date: The date of public release of the written solicitation to seek offers

Renewal Period: An optional contract period subsequent to the original contract period, for a specified duration, and with previously agreed-to terms and conditions. Not to be confused with an extension.

Representative: Includes an agent, an officer of a corporation or association, a trustee, executor or administrator of an estate, or any other person legally empowered to act for another.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to ensure good faith performance.

Responsive bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Restricted services: A method used by the State to limit the medical services of a client who has been determined to be abusing or inappropriately utilizing services provided by HERITAGE HEALTH.

Risk contract: A contract under which the contractor: (1) assumes risk for the cost of the services covered under the contract; and (2) incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk corridor: A risk sharing mechanism in which the State a MCO share in both profits and losses under a contract outside of a predetermined threshold amount, so that after an initial corridor in which the MCO is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses and receives a portion of any additional profits.

Risk corridor calculation: The computation of a MCO's profit or loss by MLTC's actuary, as a percentage of the aggregate of qualifying revenue for the MCO and related parties, including parent and subsidiary companies and risk-bearing parties under a contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.

Risk Corridor payment: Payment made by MLTC to a MCO to compensate the MCO for losses greater than 3%, as determined by the risk corridor calculation.

SCRIPT: A standard promulgated by the National Council for Prescription Drug Programs (NCPDP) for the electronic transmittal of prescription information in the United States.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Social determinants of health: Conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Solvency: The minimum standard of financial health for a MCO, where assets exceed liabilities and timely payment requirements can be met.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Solicitation: The process of notifying prospective bidders that the State wishes to receive proposals for furnishing services. The process may consist of public advertising, posting notices, or mailing RFPs or a RFP announcement letter to prospective bidders.

Specialty drug: A drug not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or which has a minimum of two (2) of the following characteristics:

1. Requires inventory management controls, including but not limited to, unique storage specifications, short shelf life, and special handling.
2. Must be administered, infused, or injected by a health care professional.
3. Is indicated primarily for the treatment or prevention of:
    a. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer, or rheumatoid arthritis.
    b. A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States.
4. The total monthly cost is $10,000 or more.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

State: The State of Nebraska or Nebraska, as the context may require.

State fair hearing: A request by a member or physician to appeal a decision made by a MCO, addressed to the State.

State share: A portion of funds originally contributed by the State, rather than the Federal government, to the operation of the Medicaid program.

Subcontractor: Any organization or person who provides a function or service for a MCO specifically related to securing or fulfilling the MCO's obligations under the terms of a contract. A subcontractor does not include a provider unless the provider is responsible for services other than those that could be covered by a provider agreement.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. Any obligation that may still be executory for either party is discharged, but any right based on prior breach or performance survives.

Third-party resource: Any individual, entity, or program that is or may be liable to pay all or part of the cost of any medical services furnished to a member.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product of service.

Value-added services: Those services a MCO provides in addition to a service covered under this contract because the MCO has determined that the health status and quality of life for the member is expected to be the same or better using the value-added health service as it would be using the covered service.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to a Contractor by the State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require a vendor to cure. Two reports or more may be cause for immediate termination, at the sole discretion of the State, which right is not waived by any particular instance in which it is not exercised.

Waiver of enrollment: A change in the status of a member from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

Will: See Shall/Will/Must

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau (hereafter known as State Purchasing Bureau), is issuing this Request for Proposal, RFP Number 5151 Z1 for the purpose of selecting a qualified Contractor to provide full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services. Any resulting contract is not an exclusive contract to furnish the services provided for in this Request for Proposal, and does not preclude the purchase of similar services from other sources.

A contract resulting from this Request for Proposal will be issued approximately for a period of five (5) years effective the date of award. The contract has the option to be renewed for two (2) additional one (1) year periods as mutually agreed upon by all parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Contractor and the State of Nebraska.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	October 21, 2015
2.	Last day to submit "Notification of Intent to Attend Pre-Proposal Conference"	October 23, 2015
3.	First Pre-Proposal Conference Location: Nebraska State Office Building 301 Centennial Mall South Lower Level, Conference Room A Lincoln, NE 68508 Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 8559164#	October 26, 2015 1:00 – 5:00 PM Central Time
4.	Last day to submit First Round of written questions	November 2, 2015
5.	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 16, 2015
6.	Second Pre-Proposal Conference (if needed) Location: Lincoln, NE *Room and specific time to be announced at a later date. This will be held at the option of the state.*	November 19, 2015
7.	Last day to submit Second Round written questions	November 23, 2015
8.	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
9.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
10.	Review for conformance of mandatory requirements	December 22, 2015
11.	Evaluation period	January 6, 2016 – January 22, 2016
12.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
13.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016
14.	Contract finalization period	January 29, 2016 – February 29, 2016
15.	Contract award	March 1, 2016
16.	Contractor start date	January 1, 2017

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name: Michelle Thompson / Teresa Fleming
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508

Telephone: 402-471-6500
Facsimile: 402-471-2089
E-Mail: as.materielpurchasing@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services. Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules, and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. CUSTOMER SERVICE

In addition to any specified service requirements contained in this agreement, the Contractor agrees and understands that satisfactory customer service is required. Contractor will develop or provide technology and business procedures designed to enhance the level of customer satisfaction and to provide the customer appropriate information given their situation. Contractor, its employees, Sub-Contractors, and agents must be accountable, responsive, reliable, patient, and have well-developed communication skills as set forth by the customer service industry's best practices and processes.

D. COMMUNICATION WITH STATE STAFF AND EVALUATORS

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the Contractor, contact regarding this project between potential Contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal. Bidders shall not have any communication with, or attempt to communicate with or influence in any way, any evaluator involved in this RFP.

Once a Contractor is preliminarily selected, as documented in the intent to contract, that Contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a Contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;
2. contacts made pursuant to any pre-existing contracts or obligations;
3. State staff and/or Contractor staff present at the Pre-Proposal Conference when recognized by the State Purchasing Bureau staff facilitating the meeting for the purpose of addressing questions; and
4. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

E. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5151 Z1; Medicaid Managed Care Program Questions". It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov Questions may also be sent by facsimile to 402-471-2089, but must include a cover sheet clearly indicating that the transmission is to the attention of Michelle Thompson / Teresa Fleming, showing the total number of pages transmitted, and clearly marked "RFP Number 5151 Z1; Medicaid Managed Care Program Questions".

It is recommended that Bidders submit questions sequentially numbered, include the RFP reference and page number using the following format.

Question Number	RFP Section Reference	RFP Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events.

F. PRE-PROPOSAL CONFERENCE

A pre-proposal conference will be held on the date, time, and location shown in the Schedule of Events. Bidders will have an opportunity to ask questions at the conference to assist in the clarification and understanding of the Request for Proposal requirements. The State will make every reasonable attempt to answer those questions before the end of the conference. Bidders attending the pre-proposal meeting may submit further questions in writing for questions which the bidder requires an official written response as shown in the Schedule of Events.

Written answers to written questions along with a list of conference attendees will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events. Verbal responses provided during the pre-proposal meeting shall not be binding on the State of Nebraska.

1. NOTIFICATION OF INTENT TO ATTEND PRE-PROPOSAL CONFERENCE

Notification of attendance should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivery or US mail by the date shown in the Schedule of Events. Potential bidders should utilize the "Notification of Intent to Attend Pre-Proposal Conference" (see Form B) that accompanies this document to the contact person shown on the cover page of the Request for Proposal Form. This form should be filled out in its entirety and returned no later than the date shown in the Schedule of Events.

G. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed the State reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

H. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling, and review by the State.

To facilitate the proposal evaluation process, one (1) original of the entire proposal should be submitted. Proposals must be submitted by the proposal due date and time. **A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials**. All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the Request for Proposal number and be sent to the specified address. Please note that the address label should appear as specified in Section II part A on the face of each container or bidder's bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The Request for Proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that the proposal will be rejected.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

The Technical Proposal should be presented in separate sections (loose-leaf binders are preferred) on standard 8 ½" x 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The State has proposed page limitations as set forth in Attachment 19 – Proposal Statements and Questions.

I. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time, and location shown in the Schedule of Events. Proposals will be available for viewing by those present at the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website.

J. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic, or any other reason(s).

K. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

L. EVALUATION OF PROPOSALS

All responses to this Request for Proposal which fulfill all mandatory requirements will be evaluated. Each category will have a maximum possible point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview shall include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Request for Proposal;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the quality of bidder performance on prior contracts;
- **e.** such other information that may be secured and that has a bearing on the decision to award the contract; and

2. Technical Approach.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a bid in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

a. Documentation from the United States Armed Forces confirming service;
b. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
c. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
d. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will become public information at the time of the Request for Proposal opening. Evaluation criteria and a list of respondents will be posted to the State Purchasing Bureau website at http://das.nebraska.gov/materiel/purchasing.html Evaluation criteria will not be released prior to the proposal opening.

M. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The Evaluation Committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not be published.

Prior to award, bidders are advised that only the point of contact indicated on the front cover of this Request for Proposal For Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State, or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

Any contact, or attempted contact, with an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions may be taken.

N. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Request for Proposal For Contractual Services form, signed in ink;
2. Section III Terms and Conditions;
3. Corporate Overview; and
4. Technical Approach.

O. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects. The State may use a third-party to conduct reference checks.

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: financial stability of the company, project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the reference would rehire the firm or individual. Only top scoring bidders may receive reference checks, and negative references may eliminate bidders from consideration for award.

P. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders should be authorized to transact business in the State of Nebraska. All bidders are expected to comply with all Nebraska Secretary of State Registration requirements. It is the responsibility of the bidder to comply with any registration requirements pertaining to types of business entities (e.g. person, partnership, foreign or domestic limited liability company, association, or foreign or domestic corporation or other type of business entity). The bidder who is the recipient of an Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its current (within ninety (90) calendar days), valid Certificate of Good Standing or Letter of Good Standing; or in the case of a sole proprietorship, provide written documentation of sole proprietorship. This must be accomplished prior to the award of the contract. Construction Contractors are expected to meet all applicable requirements of the Nebraska Contractor Registration Act and provide a current, valid certificate of registration. Further, all bidders shall comply with any and all other applicable Nebraska statutes regarding transacting business in the State of Nebraska. Bidders should submit the above certification(s) with their bid.

If a bank is registered with the Office of Comptroller of Currency, it is not required to register with the State. However, the Office of Comptroller of Currency does have a certificate of good standing/registration. The bank could provide that for verification. (Optional)

Q. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response**.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to

award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Sub-Contractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all sub-contracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Sub-Contractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Sub-Contractor(s). The Contractor is also responsible for ensuring Sub-Contractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Sub-Contractor to commence work on any Sub-Contract until all similar insurance required of the Sub-Contractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Sub-Contractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Sub-Contractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Sub-Contractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Sub-Contractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. REINSURANCE

a. The MCO must file all contracts of reinsurance, or a summary of the plan of self-insurance.

b. All reinsurance agreements or summaries of plans of self-insurance must be filed with MLTC and must remain in full force and effect for a minimum of 30 calendar days following written notice by registered mail of cancellation by either party. Pursuant to the Health Maintenance Organization Act, Neb. Rev. Stat. §44-3292 et seq. and other relevant laws.

c. The MCO must maintain reinsurance agreements throughout the contract period, including any extension(s) or renewal(s). The MCO must provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for any members enrolled in the MCO.

d. The MCO must provide to MLTC the risk analyses, assumptions, cost estimates, and rationales supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related-party relationship must be specifically disclosed.

4. INSURANCE COVERAGE AMOUNTS REQUIRED

a. WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. COMMERCIAL GENERAL LIABILITY

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. COMMERCIAL AUTOMOBILE LIABILITY

Bodily Injury/Property Damage $1,000,000 combined single limit

d. UMBRELLA/EXCESS LIABILITY

Over Primary Insurance $5,000,000 per occurrence

e. ERRORS AND OMISSIONS $10,000,000, per occurrence

f. CYBER LIABILITY

Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties
$10,000,000 each occurrence / aggregate

g. SUBROGRATION WAIVER

"Waiver of Subrogation on the Worker's Compensation in favor of the State of Nebraska."

h. LIABILITY WAIVER

"The State of Nebraska, Certificate holder, is an additionally insured, primary & noncontributory on the General Liability."

5. EVIDENCE OF COVERAGE

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

9. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.

10. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Sub-Contractor's services, the Sub-Contractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Sub-Contractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Sub-Contractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Sub-Contractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Sub-Contractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

9. any and all employment taxes and/or other payroll withholding;
10. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
11. damages incurred by Contractor's employees within the scope of their duties under the contract;
12. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
13. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project for a period of two years after the contract implementation date.

L. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

N. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

O. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

P. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

Q. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

S. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

T. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

U. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

V. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Sub-Contractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

X. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor.

3. Pursuant to 42 CFR §438.708 the State may enroll that Contractor's members in other MCOs or provide their benefits through other options included in the Medicaid State Plan if the State, at its sole discretion, determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

4. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

5. The State will provide the Contractor with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

6. The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

7. In accordance with 42 CFR §438.710, the State will conduct a pre-termination hearing upon the request of the MCO as outlined in the Notice to provide MCO the opportunity to contest the nature and basis of the sanction.

a. The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.

b. The MCO shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

8. The State will notify Medicaid members enrolled in the MCO in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.

9. The State may terminate the contract immediately for the following reasons:

a. if directed to do so by statute;

b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;

c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;

d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;

e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for a minimum of sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;

f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

g. Contractor intentionally discloses confidential information;

h. Contractor has or announces it will discontinue support of the deliverable;

i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

AA. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

BB. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

DD. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State has the option to invoke penalties as described in Section IV Project Description and Scope of Work.

EE. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a performance bond in an amount equal to $50,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to

nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;

b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;

c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;

d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and

e. The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

FF. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

GG. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not

limited to those kept by the Contractor, its employees, agents, assigns, successors, and Sub-Contractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of ten (10) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Sub-Contractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Sub-Contractors to the extent that those sub-contracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

II. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

JJ. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Sub-Contractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

KK. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, that this RFP must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to this RFP that are required to bring Nebraska in compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

LL. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

MM. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

NN. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

OO. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

PP. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

QQ. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Price information is provided under Section IV.P MCO Reimbursement.

RR. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Sub-Contractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Sub-Contractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. §81-15,159.

ZZ. POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all sub-contracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

EEE. LICENSE/SERVICE OR OTHER AGREEMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Any License/Service or other such agreements which the bidder may want the State to consider must be submitted with the bid. Any License/Service or other such agreements submitted to the State post bid opening may result in

the bid being rejected in its entirety. Any such agreement, if agreed to by the State, will be considered an addendum to the contract. Any terms and conditions contained in any such accepted agreement (addendum) must not conflict with or alter the State's Terms and Conditions (Terms and Conditions) as contained in the RFP and finalized in the contract. In the event of any conflict between the Terms and Conditions and any addendum the Terms and Conditions will prevail.

The State reserves the right to reject any submitted addendum and considers the submission of any such addendum to be a proposed alteration of the Terms and Conditions.

This clause does not apply to any third party license or service agreements.

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Request for Proposal.

A. PROGRAM DESCRIPTION

1. Description of Current Program

a. The State of Nebraska's Medicaid program is administered by the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC). DHHS is comprised of six (6) divisions:

i. The Division of Behavioral Health provides funding, oversight, and technical assistance to the six (6) local behavioral health regions. The regions contract with local programs to provide public inpatient, outpatient, emergency community mental health, and substance use disorder services.

ii. The Division of Children and Family Services administers child welfare, adult protective services, economic support programs, and the youth rehabilitation and treatment centers.

iii. The Division of Developmental Disabilities administers publicly-funded community-based disability services. The Division also operates several sites that provide services for individuals with developmental disabilities.

iv. MLTC administers the Medicaid program, which provides health care services to eligible elderly and disabled individuals, and low income pregnant women, children, and parents. The Division also administers non-institutional home and community-based services for qualified individuals, the aged, adults and children with disabilities, and infants and toddlers with special needs.

v. The Division of Public Health is responsible for preventive and community health programs and services. It also regulates and licenses health-related professionals, health care facilities, and services.

vi. The Division of Veterans' Homes oversees the State Veterans' Homes located in Bellevue, Norfolk, Grand Island and Scottsbluff.

b. Nebraska Medicaid currently provides health care coverage for approximately 239,000 individuals each month at an annual cost of approximately $1.8 billion. Attachment 1 – Medicaid Enrollees by County, State FY 2015 summarizes the number of Medicaid enrollees by county.

c. Heritage Health, implemented in July 1995, includes approximately 189,000 individuals enrolled in physical health managed care and approximately 229,000 individuals enrolled in behavioral health managed care. Those individuals who are enrolled in behavioral health managed care, but not physical health managed care, receive their physical health services from the Nebraska Medical Assistance Program under a fee-for-service (FFS) reimbursement model.

d. Heritage Health is authorized under section 1932 of the Social Security Act, which permits a state to operate a managed care program through its Medicaid State Plan. Additionally, Nebraska operates a 1915(b) waiver in order to require special needs children and Native Americans to participate in the managed care program. The 1915(b) waiver permits Nebraska Medicaid to operate the behavioral health managed care program.

e. Heritage Health currently includes:

i. Physical health managed care provided, through risk-comprehensive contracts that are fully-capitated and require the contracted entity to be a MCO or health insuring organization. "Comprehensive" means that the contracted entity is at financial risk to provide all the services in the core benefits package.

ii. Behavioral health managed care provided through a risk contract which is not comprehensive, but is fully-capitated, and requires that the managed care entity be a prepaid inpatient health plan (PIHP).

iii. Physical health managed care currently provided through:

a) Two (2) MCO networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.

b) Two (2) MCO networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.

iv. Behavioral health managed care provided through one statewide PIHP network.

f. MLTC currently contracts with vendors to perform the following services for the Heritage Health:

i. physical health managed care services
ii. behavioral health managed care services
iii. enrollment broker services
iv. external quality review services
v. actuarial services
vi. pharmacy benefit management services

g. With implementation of this contract, notable changes in the managed care program will include:

i. Integration of physical and behavioral health managed care through a minimum of two (2) and a maximum of three (3) MCO contracts for all 93 counties in the State of Nebraska.

ii. Inclusion of pharmacy services in the core benefit package and the MCO capitation rate, at a date to be determined by MLTC.

iii. Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for managed care physical health services.

iv. Expansion of enrollment broker services to complete the process of member enrollment.

9. Purpose of the Request for Proposal

a. Managed care was implemented in Nebraska to improve the health and wellness of Medicaid clients by increasing their access to comprehensive health services in a cost-effective manner. As behavioral health services are added to the physical health delivery system, additional goals for all members include decreased reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates that integrated physical and behavioral health managed care will achieve the following outcomes:

i. Improved health outcomes
ii. Enhanced integration of services and quality of care
iii. Emphasis on person-centered care, including enhanced preventive and care management (CM) services
iv. Reduced rate of costly and avoidable care
v. Improved financially sustainable system

b. MLTC intends to award a minimum of two (2) and a maximum of three (3) MCO contracts through this procurement process which will provide integrated managed care health services statewide for all 93 counties in the State.

10. Included Populations

Medicaid populations who are mandated to participate in the Nebraska Medicaid managed care program include:

a. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

b. Children, adults, and related populations who are eligible for Medicaid due to blindness or disability.

c. Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population.

d. Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, the Children's Health Insurance Program (CHIP).

e. Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

f. Medicaid beneficiaries who participate in a HCBS Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the State's 1915(c) waiver of the Social Security Act.

g. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters).

h. Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined.

i. Members eligible during a period of presumptive eligibility.

11. Excluded Populations

Within the groups identified above, the following categories of beneficiaries are excluded from managed care:

a. Aliens who are eligible for Medicaid for an emergency condition only.

b. Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services.

c. Beneficiaries who have received a disenrollment or waiver of enrollment.

d. Participants in the Program for All-Inclusive Care for the Elderly.

e. Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.

12. Changes to Population Groups and Services

MLTC may add, delete, or otherwise modify included and excluded population groups and services. If changed, the contract will be amended, and the MCO given as much advance notice as reasonably possible.

B. ELIGIBILITY AND ENROLLMENT

1. Eligibility

a. DHHS administers and manages eligibility for Medicaid and economic assistance programs through ACCESSNebraska. Individuals can apply for Medicaid benefits on the ACCESSNebraska website (ACCESSNebraska.ne.gov), over the telephone with dedicated Medicaid eligibility customer service staff, or by visiting designated local offices.

b. Regulations covering eligibility for Nebraska Medicaid are available in Title 477 of the Nebraska Administrative Code.

c. Renewals of Medicaid and CHIP eligibility are conducted annually.

2. Member Enrollment/Assignment

a. The MCO must comply with all enrollment and disenrollment procedures described in this section of the RFP.

b. The MCO and all its staff and subcontractors must have an understanding of the Medicaid population and the enrollment process. The MCO must work cooperatively with MLTC to resolve issues relating to enrollee participation and the enrollment process.

c. The State maintains responsibility for the enrollment of members into MCOs through a contractual arrangement with its enrollment broker. The State or its enrollment broker provides enrollees with access to a member guidebook, plan matrix, and provider directory to assist each enrollee in choosing a MCO plan and a PCP. The enrollment broker provides impartial choice counseling to assist each enrollee in choosing an MCO.

d. Enrollees are requested to enroll with a MCO plan and select a PCP within 15 calendar days of receipt of the MCO enrollment outreach letter, which is sent by either MLTC or its enrollment broker.

e. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of a MCO. The enrollment broker is responsible for notifying all managed care enrollees and MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section.

f. Potential enrollees determined mandatory for managed care will be immediately enrolled in managed care after the required choice period, retroactive to the first day of the first month of the member's eligibility for Medicaid.

g. The MCO must have the technological capability and resources to interface with the State's and the enrollment broker's systems as necessary to support all aspects of the enrollment and disenrollment processes.

h. The MCO's eligibility system must show the member's effective date with the MCO as the first day of the month in which the member is determined Medicaid eligible. For example, if the State's eligibility file indicates the member was determined Medicaid eligible on 3/2/2015, and assigned to the MCO on 3/11/2015, the MCO's eligibility system must reflect an eligibility and enrollment date of 3/1/2015.

i. For current Heritage Health members at the time of the effective date of this contract, the annual enrollment choice period will be aligned with the contract start date. For example, if a member was determined Medicaid eligible retroactive to November 1, 2016, the MCO enrollment date will be the contractor start date.

j. MLTC and its enrollment broker shall make every effort to ensure that Medicaid eligible individuals who are excluded from managed care are not enrolled in a MCO. To ensure that such individuals are not assigned to a MCO, the MCO must work with MLTC or its enrollment broker to identify these individuals. The MCO must also notify MLTC if it learns that a member is no longer Medicaid eligible.

k. The State will automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility, when a loss of eligibility does not exceed two months, into the same MCO (and assign the individual to the same PCP).

3. Auto-Assignment Algorithm

a. Prior to the contract start date, all current Heritage Health members and enrollees will be allowed an open enrollment period to select a MCO and choose a PCP. Current MCO members who do not select a MCO during that time frame will be assigned automatically to one as of the effective date of this contract.

b. Auto-assignment algorithms and decisions are at the sole discretion of MLTC and all MCOs must abide by the auto-assignment decisions.

c. The enrollment broker will auto-assign enrollees who do not select a specific MCO.

d. When an enrollee cannot be enrolled into his/her requested MCO because of a MLTC-imposed sanction or for another reason, the enrollee will be auto-assigned to another MCO.

e. In accordance with 42 Code of Federal Regulations (CFR) 438.50(f), the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment.

f. The automatic assignment methodology is based on the following considerations:

i. If an enrollee has immediate family or household members enrolled in a MCO, the enrollee will be enrolled in that MCO.

ii. If the member's PCP is not currently in-network, the enrollment broker will use a round robin method to determine the MCO assignment that maximizes the preservation of existing provider relationships.

iii. If a MCO's membership is comprised of 40% or more of total statewide enrollment at the end of any quarter, that plan will be removed from the auto-assignment round robin process for the following quarter but members can continue to pro-actively select that plan.

iv. In addition, the MCO's quality measures may be factored into the algorithm for auto-assignment, at the discretion of MLTC.

v. Auto-assignment will attempt to balance enrollment among the MCOs, but is not guaranteed.

4. MCO Enrollment Procedures

a. Acceptance of All Eligible Individuals

i. The MCO must accept all eligible individuals who select it or are assigned to it. The MCO must not discriminate against MCO members on the basis of their health history, health status, need for health care services, or adverse change in health status; or on the basis of age, religious belief, gender, sexual orientation, ethnicity, or language needs.

ii. This applies to enrollment, re-enrollment, or disenrollment from the MCO. The MCO may be subject to monetary penalties and other sanctions if it is determined by MLTC that the MCO has requested disenrollment for any of these reasons.

iii. The MCO must accept enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set by MLTC.

b. Effective Date of Enrollment

i. The effective date of enrollment in the MCO is the date provided on the outbound ANSI ASC X12 834 electronic transaction initiated by MLTC or the enrollment broker. In general, a member's effective date of enrollment in a MCO is the first day of the month of the member's eligibility for Medicaid.

ii. Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in a MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO being notified of the individual's enrollment.

iii. The MCO is not liable for the cost of any covered services provided to a Medicaid enrollee prior to the effective date of enrollment, but is responsible for the cost of covered services obtained on or after the effective date of enrollment.

c. Change in Status

i. The MCO must notify via ACCESSNebraska any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address, email address, and telephone number, in a manner and format required by MLTC.

ii. The MCO must initiate a request for disenrollment through the enrollment broker for other known changes in status, including but not limited to, death or, entry into involuntary custody or incarceration.

d. Newborn Enrollment

i. Once the State eligibility system is updated with a record of a live birth, the newborn will be immediately enrolled in either the mother's or an eligible sibling's MCO. The mother's MCO supersedes any sibling's, in the event that the mother and any sibling are enrolled in different MCOs.

ii. The MCO must contact members who are pregnant a minimum of 60 calendar days prior to the expected delivery date to encourage mothers to choose a PCP for their newborns. In the event that a pregnant member does not select a PCP, the MCO must give the member a minimum of 14 days after the birth to select a PCP prior to the MCO assigning one.

iii. A newborn may be inadvertently enrolled in a MCO different from its mother. When this situation is identified, MLTC will immediately:

a) Disenroll the newborn from the incorrect MCO.

b) Enroll the newborn in the same MCO as its mother with the same effective date.

c) Recoup any payments made to the incorrect MCO for the newborn.

d) Make payments to the correct MCO for the period of coverage.

iv. The MCO in which the newborn is correctly enrolled is responsible for the coverage of and payment for covered services provided to the newborn for the full period of eligibility. The MCO in which the newborn was incorrectly enrolled has no liability for the coverage of or payment for any services during the period in which the newborn was incorrectly assigned. MLTC is only liable for the capitation payment to the correct MCO.

v. The MCO is responsible for ensuring that hospital providers report births of members to the MCO within 24 hours of the birth. If the member makes a PCP selection during the hospital stay and one was not already identified, the MCO is responsible for ensuring the hospital provider reports this information to the MCO.

5. PCP Assignment

a. At initial enrollment, if an enrollee selects a MCO and a PCP, the assignment of the PCP will be included on the enrollment file sent to the MCO.

b. If no PCP selection is indicated on the enrollment file, the MCO must:

i. Contact the member within ten (10) business days of receiving the enrollment file to assist the member in selecting a PCP.

ii. Inform the member that each family member has the right to choose his/her own PCP, explaining the advantages of selecting the same PCP for all family members, as appropriate.

c. Members who do not choose a PCP within ten (10) days of enrollment with a MCO must be auto-assigned one by the MCO within one (1) month of the enrollment date, in compliance with 42 CFR 438.50(f).

d. The MCO is responsible for developing a PCP auto-assignment methodology in collaboration with the State to assign a member to a PCP when the member:

i. Does not make a PCP selection.

ii. Selects a PCP within the MCO's network that has reached his/her maximum physician/patient ratio or has a closed panel.

iii. Selects a PCP within the MCO's network that has restrictions or limitations (e.g., pediatric practice only).

e. If either of the two (2) situations set forth in provision d.i or d.ii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection. If the MCO cannot reach the member after three (3) attempts or the member does not wish to choose a different PCP, only then may the MCO auto-assign the member to a PCP.

f. If appropriate, assignment must be made to a PCP with whom the member had a historical provider relationship. If there is no historical PCP relationship, the member must be assigned to a provider who is the PCP for an immediate family member in the MCO. If there is no family or historical relationship, members must be auto-assigned a PCP using an algorithm developed by the MCO based on the age and sex of the member and geographic proximity.

g. If a member is a dual eligible individual, the MCO must not require him/her to choose a new PCP through the MCO, and must not prevent the member from receiving primary care services from the member's existing Medicare PCP.

h. The MCO must report all PCP assignments to either MLTC or the enrollment broker at a frequency defined by MLTC. Currently, the system interface is completed on a monthly basis. Future system interfaces may be required to be completed on a daily basis.

i. The MCO must have written policies and procedures for PCP assignment. These policies and procedures must be approved in advance of their implementation by MLTC.

6. MCO Changes

a. Each member will be given 90 calendar days from the effective date of MCO enrollment (or the postmark date of the member's notification of enrollment with the MCO, whichever is later) in which he or she may change to another MCO for any reason.

b. After the initial 90 calendar day period, Medicaid members will be locked into their MCO selection until the next annual open enrollment period. The annual open enrollment period will be aligned with the contract start date.

7. Disenrollment

a. Disenrollment is any action taken by MLTC or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by MLTC or its designee that the member is no longer eligible for Medicaid or the HERITAGE HEALTH.

b. The enrollment broker is the single point of contact with the MCO member regarding notification of disenrollment.

c. A member may initiate a request for disenrollment from a MCO as follows:

i. For cause, at any time, under the following circumstances:

a) The MCO does not, because of moral or religious objections, cover the service the member seeks.

b) The member needs related services to be performed at the same time, and not all the related services are available with the MCO, and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk.

c) The contract between the MCO and MLTC is terminated.

d) Lack of access to MCO benefits and services covered under the contract.

e) Other reasons, including but not limited to, poor quality of care, or lack of access to providers experienced in dealing with the member's health care needs.

ii. Without cause for the following reasons:

a) Once a year during the member's annual enrollment choice period.

b) Upon automatic re-enrollment under 42 CFR 438.56(g), if a temporary loss of Medicaid eligibility caused the member to miss the annual enrollment choice opportunity.

c) If MLTC imposes the intermediate sanction provisions specified in 42 CFR 438.702(a) (3) on the MCO.

iii. The member (or his or her representative) must submit a written request of disenrollment with cause to the enrollment broker for action by MLTC.

iv. If the member's request for disenrollment is denied, the member can appeal the decision through the State's fair hearing process.

8. MCO-Initiated Disenrollment

a. The MCO may not request disenrollment because of a member's health diagnosis; adverse change in health status; utilization of medical services; diminished medical capacity; pre-existing medical condition; refusal of medical care or diagnostic testing; uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the MCO's ability to furnish services to the member or other MCO members; or, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise her/her right to change, for cause, the PCP that he/she chose or was assigned. (42 CFR 438.56(b)(2)).

b. The following are the only reasons for which the MCO may request disenrollment of a member:

i. The MCO has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the member, including circumstances in which the member misuses or loans the member's ID card to another person to obtain services. If this occurs, the MCO must report it to MLTC.

ii. The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in the MCO seriously impairs the organization's ability to furnish services to either the member or other members.

c. The MCO must not request disenrollment for reasons other than those stated in this RFP. In accordance with 42 CFR 438.56(b)(3), MLTC will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the MCO disenrollment requests submitted to the enrollment broker and the quarterly disenrollment reports submitted by the MCO to MLTC.

d. The MCO must take reasonable measures, as determined by the State, to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

e. When the MCO requests a member disenrollment, it must notify the member in writing of this request, the reason for the request, and the date of anticipated disenrollment.

f. The MCO must submit disenrollment requests to the enrollment broker that should include, at a minimum, the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment. The MCO must send notification of the disenrollment request to the member at the same time the request is made to the enrollment broker. The MCO must include documentation with the disenrollment request, as indicated in 482 NAC 000-03.

g. The MCO must not submit a disenrollment request for an effective date earlier than 45 calendar days after the event that prompted the disenrollment request. The MCO must ensure that disenrollment documents are maintained in an identifiable member record.

h. All requests will be reviewed on a case-by-case basis and decisions are at the sole discretion of MLTC or its designee. All decisions are final and not subject to the State's dispute resolution process.

i. The enrollment broker will provide written notice of disenrollment to the member and request the member to choose a new MCO. The notice will include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has the right to file an appeal directly to the State through the fair hearing process.

j. Until the member is disenrolled by the enrollment broker, the MCO is responsible for the provision of all benefits and services to the member.

9. Disenrollment Effective Date

a. The effective date of disenrollment will be no later than the first day of the second month following the calendar month in which the request for disenrollment is filed.

b. If MLTC fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment was filed, the disenrollment is considered approved.

c. The MCO, the enrollment broker, and MLTC must reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon written procedure.

10. MLTC-Initiated Disenrollment

a. MLTC or the enrollment broker will notify the MCO of the member's disenrollment for the following reasons:

i. Member is no longer Medicaid eligible.

ii. Member's death.

iii. Member's intentional submission of fraudulent information.

iv. Member becomes an inmate in a public institution.

v. Member moves out-of-state.

vi. A disenrollment decision is made by a hearing officer or court of law.

11. Enrollment and Disenrollment Updates

a. MLTC's enrollment broker will notify each MCO at specified times each month of the Medicaid eligible individuals that are enrolled, re-enrolled, or disenrolled from the MCO for the following month. The MCO will receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

b. MLTC will use its best efforts to ensure that the MCO receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between MLTC and the MCO regarding enrollment, disenrollment, or termination, MLTC's decision is final.

12. Daily Updates

The enrollment broker will provide updates to the MCO daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction) of members newly enrolled with the MCO. The MCO must have written policies and procedures for receiving these updates, incorporating them into its management information system, and ensuring this information is available to its providers. Policies and procedures must be provided to MLTC for review and approval a minimum of 60 calendar days prior to the contract start date.

13. Weekly Reconciliation

a. The MCO is responsible for weekly reconciliation of the enrollment/disenrollment file received from the enrollment broker.

b. The MCO must provide written notification to the enrollment broker of any data inconsistencies within ten (10) calendar days of receipt of the file.

c. The MCO will receive a monthly electronic file (ASC X12N 820 transaction) from MLTC listing all members for whom the MCO received a capitation payment and the amount received. The MCO is responsible for reconciling this file against its internal records. It is the MCO's responsibility to notify MLTC of any discrepancies within three (3) months of file receipt. Lack of compliance with reconciliation requirements may result in the withholding of a portion of future monthly payments or other liquidated damages as defined in Section IV.V Contract Non-Compliance of the RFP.

C. BUSINESS REQUIREMENTS

1. Regulation and Guidance

a. The MCO must abide by all relevant provisions found in 42 CFR, Part 438, Managed Care; Title 471 Nebraska Administrative Code (NAC) Nebraska Medical Assistance Program Services; Title 477 NAC, Medicaid Eligibility; and Title 482 NAC, Nebraska Medicaid Managed Care.

b. On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. MLTC anticipates that the finalizing of this proposed rule will affect the contracts awarded as a result of this RFP. The MCO must include in its proposal:

i. An analysis of the Proposed Rule that includes the MCO's interpretation of all provisions relevant to the contract requirements.

ii. A plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.

The Proposed Rule can be reviewed at:
https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

2. Compliance with State and Federal Laws and Regulations

a. All contracts that result from this RFP must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act. The MCO must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

b. The MCO must comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff and affiliated providers also do this when furnishing services to members.

3. Managed Care Organization Licensure

The MCO must have a Certificate of Authority (COA) to transact the business of health insurance in Nebraska as a health maintenance organization (HMO) by the contract start date. If the MCO is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the MCO must attest that the appropriate licensure will be obtained prior to executing a contract with MLTC.

4. Accreditation

a. The MCO must attain health plan accreditation from the National Committee for Quality Assurance (NCQA). If the MCO is not currently accredited by NCQA, the MCO must attain NCQA accreditation within 18 months of the contract award.

b. The MCO's application for accreditation must be submitted as soon after the contract's start date as allowed by NCQA. The MCO must provide MLTC with a copy of all correspondence between the MCO and NCQA regarding the application process, the accreditation requirements, and the MCO's progress toward accreditation.

c. Achievement of provisional accreditation status will require a corrective action plan (CAP) within 30 calendar days of receipt of the final report from NCQA. Any failure to obtain full NCQA accreditation and to maintain the accreditation thereafter will be considered a breach of the contract and may result in contract termination at the sole discretion of the State.

5. Business Location

The MCO must establish and maintain a business office or work site within the State, staffed with the primary contract personnel and managers responsible for the services provided under the contract. The MCO is responsible for all costs related to securing and maintaining the facility for start-up and ongoing operations, including, but not limited to, hardware and software acquisition and maintenance, leasehold improvements, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance. If any activities are approved by MLTC to be performed offsite, then the MCO must provide toll-free communications with MLTC staff to conduct those business operations. The MCO must provide meeting space to MLTC as requested when onsite at the MCO's location.

6. Cooperation with Other Entities and Programs

a. The MCO must develop processes and procedures and designate points of contact for collaboration with other entities and programs that serve members including but not limited to:

i. Division of Behavioral Health funded programs.

ii. Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State.

iii. Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities.

iv. The Nebraska Department of Education Early Development Network.

v. Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices.

vi. The Office of Probation.

vii. Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

b. The MCO must collaborate with these entities and programs when serving members and identifying and responding to members' behavioral and physical health needs. It must address and attempt to resolve any coordination of care issues with other MCOs and other State agencies and their contractors, tribes, and other community providers as expeditiously as possible.

c. The MCO must also collaborate with these entities and programs and its network providers regarding planning initiatives and system transformation.

7. Service Orientation, Interoperability, and Data Exchange

The State's Medicaid program is undergoing significant modernization across many projects. In alignment with CMS-MITA guidance, key objectives shared by all MLTC projects include high levels of capability/maturity with respect to service orientation, interoperability, and data exchange. MLTC expects the MCO to transmit and receive data in compliance with all applicable Federal (including but not limited to HIPAA), and State standards and mandates, both currently and in the future. The MCO must work with MLTC to develop and support an effective data exchange between the MCO and all stakeholders involved in the Medicaid program, including MLTC. The MCO shall also provide to MLTC at its request reports via electronic data exchanges to support enhanced analytics and report drill-down capabilities.

8. Participation in the Nebraska Health Information Initiative

The MCO is required to attempt to enter into a participation agreement with the Nebraska Health Information Initiative (NeHII). NeHII is a non-profit organization that includes health care providers, payers, and the State. NeHII's purpose is to achieve health care transformation through the creation of a secure, web-based health information exchange to serve the State. Should the MCO be unable to reach a mutually agreeable arrangement for participation in NeHII within one year of the contract start date, it must notify MLTC.

More information on NeHII can be found at www.nehii.org.

9. Participation in the MLTC Committees

The MCO is required to participate in MLTC committees including, but not limited to, the Administrative Simplification Committee, the Behavioral Health Integration Advisory Committee, and the Quality Assurance Performance Improvement Committee. The Administrative Simplification Committee will include State, MCO, and provider representation, and seek to identify and implement common processes and forms for use by MCOs. The Committee's goal is to reduce administrative burden for MCOs and providers in areas that may include, but not be limited to credentialing/re-credentialing, prior authorization, and grievances and appeals. The Behavioral Health Integration Advisory Committee will include representatives from the DHHS Division of Behavioral Health, MLTC, behavioral health and primary care providers, and MCOs. The Advisory Committee's objective will be to identify and address areas of opportunity or concern regarding the integration of behavioral health and physical health services. A description of the Quality Assurance Performance Improvement Committee is found in Section IV.M Quality Management.

10. Financial Viability/Solvency Requirements

a. Insolvency

The MCO must provide that its Medicaid members are not held liable for:

i. The MCO's debts in the event of the MCO's insolvency.

ii. The cost of covered services provided to the member, for which MLTC does not pay the MCO.

iii. The cost of covered services provided to the member, for which MLTC or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

iv. Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the services directly.

b. Solvency

Each non-federally-qualified HMO must provide adequate assurances that Medicaid enrollees will not be liable for the entity's debt if the entity becomes insolvent.

c. Continue Services During Insolvency

The MCO must continue to cover services for members for the duration of time for which payment has been made, as well as for inpatient admissions up until discharge.

11. Merger, Reorganization, and Change of Ownership

a. A proposed merger, reorganization, or change in ownership of the MCO requires prior approval of MLTC and will require a contract amendment. MLTC may terminate this contract pursuant to Section III Terms and Conditions. If the MCO does not obtain prior approval or MLTC determines that a merger, reorganization, or change in ownership is not in the best interest of the State, MLTC may offer open enrollment to the members assigned to the MCO. MLTC will not permit one organization to own or manage more than one contract within the same program.

b. The MCO must submit notification to MLTC of a merger, reorganization, or change of ownership a minimum of 180 days prior to its proposed effective date. The MCO must also submit a detailed merger, reorganization, or transition plan to MLTC for review a minimum of 90 calendar days prior to the effective date of the proposed change. The purpose of the plan's review is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, and ensure that services to members are not diminished. In addition, the MCO must provide adequate assurances to MLTC that the major components of its organization and programs are not adversely affected by such merger, reorganization, or change in ownership.

12. Audit Requirements

a. The MCO must:

i. Maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, health records, and the administrative costs and expenses incurred pursuant to this contract as well as medical information relating to members as required for purposes of audit; or administrative, civil, or criminal investigations or prosecution per all retention requirements of this RFP. The MCO must ensure that this provision also applies to subcontractors, providers, or other entities providing goods or services under this contract. The MCO must provide MLTC with adequate assurances of its compliance with the immediately preceding sentence.

ii. Establish and maintain an internal audit function responsible for providing an independent review and evaluation of the MCO's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The MCO's internal audit function must perform audits to ensure the economical and efficient use of resources by all of its departments to accomplish the objectives and goals of each department. Further, the MCO's internal audit department is responsible for performing the claims payment accuracy tests described in Section IV.S Claims Management.

b. Audit Business Transaction

i. The MCO must obtain an audit of its business transactions from a licensed certified public accountant (CPA), including but not limited to, the financial transactions made under this contract.

ii. No later than December 1 of each year, the MCO must submit a copy of the fully executed engagement letter with the CPA to MLTC.

iii. No later than June 1 of each year, the MCO must submit a full and complete copy of the audit report to MLTC.

c. MLTC and CMS may inspect and audit any records of the MCO or its subcontractors. There is no restriction on the right of MLTC or the Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.

13. Access to Records

The MCO must allow Federal agencies to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Federal Procurement Policy. In addition, the US Department of Health and Human Services (DHHS) awarding agencies, the Federal DHHS Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of the MCO that are pertinent to the contract, in order to make audits, examinations, excerpts, transcripts, and copies of such documents.

14. Compliance

The MCO is responsible for compliance with all contract requirements, regardless of whether the MCO enters into a subcontract to delegate performance of the contract requirements. The MCO must submit all proposed subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 120 calendar days prior to their planned implementation. Prior to selecting a subcontractor, the MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated a minimum of 90 calendar days prior to the planned contract start date. MLTC reserves the right to participate in these evaluations, and the MCO must submit a copy of its findings to MLTC a minimum of 30 calendar days prior to the contract's start date. The MCO must monitor and formally review a subcontractor's performance on an ongoing basis.

15. Confidentiality

The MCO must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.

16. Protections Against Liability

Providers may not bill members any amount greater than would be owed if the MCO provided the services directly (i.e., no balance billing by providers is permitted).

17. Data Certification

Data submitted by the MCO to MLTC must be certified as required by 42 CFR 438.606:

a. The data that must be certified includes, but is not limited to, all documents specified by MLTC, enrollment information, encounter data, and other information contained in contracts and proposals. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the documents and data. The MCO must submit this certification concurrently with the certified data and documents.

b. Data and documents the MCO submits to MLTC must be certified by the MCO Chief Executive Officer, the MCO Chief Financial Officer, or an individual who has been delegated authority to sign for, and who reports directly to, the MCO Chief Executive Officer or Chief Financial Officer.

18. Moral or Religious Objections

a. A MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds.

b. If the MCO elects to not provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish this information to MLTC with its proposal to this RFP or whenever it adopts the policy during the term of the contract. The information provided must be consistent with the requirements of 42 CFR 438.10. The MCO's members and potential members must be informed of this policy before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service.

c. If the MCO elects to not provide, reimburse for, or provide coverage of a counseling or referral service, the MCO must inform the member where and how to access the covered service.

D. STAFFING REQUIREMENTS

1. General Requirements

a. The MCO must have in place organizational, operational, managerial, and administrative systems capable of fulfilling all contract requirements. The MCO must be staffed by qualified persons in numbers appropriate to the MCO's enrollment.

b. For the purposes of this contract, the MCO must not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), and 42 CFR 1003.102(a)(2)]. The MCO must screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal health care programs. The Federal DHHS Office of Inspector General website, which can be searched by the name of any individual, can be accessed at: https://oig.hhs.gov/exclusions/index.asp.

c. The MCO must employ sufficient staff and utilize appropriate resources to achieve contractual compliance. The MCO's resource allocation must be adequate to achieve required outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and MLTC policy requirements, including the requirement for providing culturally competent services. If the MCO does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by MLTC, including but not limited to, requiring the MCO to hire additional staff and application of monetary penalties as specified in this RFP.

d. The MCO must perform criminal background checks on all employees of the MCO and subcontractor staff assigned to, or proposed to be assigned to, any aspect of this contract and who have access to electronic protected health information on Medicaid applicants and recipients. The MCO must, upon request, provide MLTC with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for these MCO staff or subcontractor staff.

e. The MCO will be responsible for any additional costs associated with on-site audits or other oversight activities that result when required systems are located outside of the State.

f. The MCO must remove or reassign, upon written request from MLTC, any MCO employee or subcontractor's employee that MLTC deems at its sole discretion to be unacceptable. The MCO must hold MLTC harmless for actions taken as a result hereto.

2. Key Staff Positions

a. The MCO must comply with minimum key staffing requirements in Table 1 listed below.

i. For each key staff position marked with an asterisk in the table, the staff member must be based in the State.

ii. All positions listed in the table must be full-time, i.e. a minimum of 40 hours per week, with the exception of the Business Continuity Planning and Emergency Coordinator, which shall be an additional duty assignment.

b. An individual staff member may not occupy more than two (2) key staff positions listed below unless prior approval is obtained from MLTC. Exceptions include the Chief Executive Officer (CEO) and Medical Director (MD), who may only hold one (1) position.

c. A minimum of 45 calendar days prior to the contract start date, the MCO must submit to MLTC for review and approval a Human Resources and Staffing Plan. This plan must describe how the MCO will obtain and maintain the staffing level needed to accomplish the duties outlined in this RFP. The MCO is required to recruit, hire, train, supervise, and, if necessary, terminate, such professional and support personnel as are necessary to carry out the terms of this contract. All staff must have experience and expertise in working with the populations served by the Medicaid program.

d. The MCO must provide to MLTC, in writing, a list of all officers and members of the MCO's Board of Directors. This information must be provided to MLTC prior to the contract's start date. The MCO must notify MLTC, in writing, within ten (10) business days of any change to its officers or Board members.

e. The MCO must submit to MLTC the names, resumes, and contact information for all key staff listed below a minimum of 30 calendar days prior to the contract's start date.

f. In the event of a change of any key staff at any point during the contract's duration, the MCO must notify MLTC in writing within two business days of the change. The name of the interim contact person shall be included with this notification.

g. The MCO must replace any key staff member with a person of equivalent experience, knowledge, and talent. The name and resume of the new employee must be submitted to MLTC as soon as the new hire is made, along with a revised organizational chart complete with key staff time allocation to the MLTC contract.

h. Replacement of the CEO or MD requires prior written approval from MLTC. This approval will not be unreasonably withheld, provided a suitable candidate is proposed.

i. In addition to the key staff requirements, the MCO must have full-time clinical and support staff to conduct daily business in an efficient and effective manner. This includes, but is not limited to, administration; accounting and finance; fraud and abuse; utilization management; quality management and improvement; and, member services, education, and outreach, grievances and appeals, provider services, claims processing, and reporting.

Table 1. Key Staff

Title	Minimum Duties
Chief Executive Officer (CEO)*	The CEO must work full-time on this contract, a minimum of 40 hours per week. The CEO is responsible for: 1. Providing overall direction and prioritization for the MCO. 2. Developing and carrying out leadership strategies. 3. Ensuring that policies and contractual requirements are followed. 4. Providing operational oversight to ensure that goals are met. 5. Developing and implementing integration models that ensure coordination with system partners.

Title	Minimum Duties
Medical Director/Chief Medical Officer*	The Medical Director must be a currently practicing physician, with an unrestricted license in the State to practice medicine. The Medical Director must have a minimum of three (3) years of training in a medical specialty and five (5) years of experience providing clinical services. The Medical Director must devote a minimum of 40 hours per week to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director must be board certified in his/her specialty, and be actively involved in all major clinical, utilization management and quality management decisions of the MCO. When the Medical Director is unavailable, the MCO must have a physician staff person or subcontractor to provide competent medical direction at any time. The Medical Director is responsible for: 1. Developing, implementing, and interpreting medical policies and procedures. Duties may include, but are not limited to: service authorizations, claims review, discharge planning, credentialing, referral management, and medical review of grievances and appeals. 2. Administrating the medical management activities of the MCO. 3. Participating via telephone or in person (at MLTC's discretion) at every Quality meeting with MLTC and other system partners, and as requested by MLTC. 4. Leading the Utilization Management, Quality Assessment and Performance Improvement, Credentialing, and Provider Advisory committees.
Behavioral Health Clinical Director	The Behavioral Health Clinical Director must be a currently practicing psychiatrist or psychologist with an unrestricted license in the State. The Behavioral Health Clinical Director must have a minimum of five years of combined clinical experience in mental health and substance use disorder services and be knowledgeable about primary care/behavioral health integration. This individual must oversee and be responsible for all behavioral health activities within the MCO and take an active role in the MCO's medical management team, and in clinical and policy decisions. The Behavioral Health Clinical Director is responsible for: 1. Providing clinical case management consultations and clinical guidance for contracted PCPs treating behavioral health-related concerns not requiring referral to behavioral health specialists. 2. Developing comprehensive care management programs for youth and adults with behavioral health concerns, typically treated by PCPs, such as ADHD and depression; 3. Developing targeted education and training for the MCO's PCPs that commonly encounter behavioral health issues.
Behavioral Health Manager*	The Behavioral Health Manager must be a Nebraska licensed behavioral health professional, such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist, or mental health counselor. The responsibilities of the Behavioral Health Manager include, but are not limited to: 1. Ensuring that the MCO's behavioral health operations, providers, and any subcontractors are in compliance with the terms of this contract. 2. Coordinating all areas of the MCO, including quality management, utilization management, network development and management, provider services, member outreach and education, member services, contract compliance, and reporting.
Chief Operating Officer (COO)*	The COO is responsible for: 1. Managing the day-to-day operations of the MCO's departments, staff, and functions to ensure that performance measures and MLTC and Federal requirements are met. 2. May serve as the primary contact with MLTC for all MCO operational issues.
Chief Financial Officer (CFO)*	The CFO is responsible for overseeing all financial-related supervision of activities implemented by the MCO, including all audit activities, accounting systems, financial reporting, and budgeting.

Title	Minimum Duties
Program Integrity Officer*	The Program Integrity Officer must have experience in health care and/or risk management and report directly to the CEO. The Program Integrity Officer is responsible for: 1. Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse, (FWA) and erroneous payment compliance program. 2. Developing/overseeing methods to prevent and detect potential FWA and erroneous payments. 3. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans. 4. Reviewing records and referring suspected member FWA to MLTC and other duly authorized enforcement agencies. 5. Managing the MCO's Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit.
Grievance System Manager*	The Grievance System Manager is responsible for: 1. Managing/adjudicating member grievances, appeals, and requests for fair hearing. 2. Managing/adjudicating provider grievances and appeals.
Business Continuity Planning and Emergency Coordinator	The Business Continuity Planning and Emergency Coordinator is responsible for: 1. Ensuring continuity of benefits and services for members who may experience evacuation to other areas of the State, or out-of-state, during disasters. 2. Managing and overseeing the MCO's emergency management plan.
Contract Compliance Coordinator*	The Contract Compliance Coordinator will be the primary contact with MLTC on all MCO contract compliance issues. This individual is responsible for: 1. Coordinating the preparation and execution of contract requirements. 2. Coordinating the tracking and submission of all contract deliverables. 3. Answering inquiries from MLTC. 4. Coordinating/performing random and periodic audits and ad hoc visits.
Quality Management (QM) Coordinator*	The QM Coordinator must be a State-licensed registered nurse, physician, or physician's assistant; a Certified Professional in Health Care Quality (CPHQ), certified by the National Association for Health Care Quality, or certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. This position must be committed to this contract on a full-time basis (a minimum of 40 hours per week). The QM Coordinator must have quality management and improvement experience as described in 42 CFR 438.200 - 438.242. This individual is responsible for: 1. Ensuring systemic and individual quality of care. 2. Identifying and implementing process improvements. 3. Integrating quality throughout the organization. 4. Ensuring a network of credentialed providers. 5. Resolving, tracking, and trending quality of care grievances. 6. Serving as a member of the Quality Assurance Performance Improvement Committee and member/ad hoc member of other quality related committees.
Performance and Quality Improvement Coordinator*	The Performance and Quality Improvement Coordinator must, at minimum, be a CPHQ or CHCQM or have comparable experience and education in data and outcomes measurement as described in 42 CFR 438.200 - 438.242. The Performance and Quality Improvement Coordinator serves as MLTC's contact person for quality performance measures. Primary responsibilities include: 1. Focusing organizational efforts on the improvement of clinical quality performance measures. 2. Utilizing data to develop intervention strategies to improve outcomes. 3. Developing and implementing performance improvement projects, both internal and across MCOs. 4. Reporting quality improvement and performance outcomes to MLTC.

Title	Minimum Duties
Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator*	The MCH/EPSDT Coordinator must be a current, Nebraska-licensed registered nurse, physician, or physician's assistant; have a Master's degree in health services, public health, or health care administration, or other related field; or be a CPHQ or CHCQM. Staffing under this position must be sufficient to meet quality and performance measure goals. The coordinator is responsible for: 1. Designing programs to ensure that all member children receive necessary EPSDT services. 2. Promoting family planning services. 3. Promoting preventive health strategies. 4. Designing programs to ensure that all pregnant members receive maternal and postpartum care. 5. Identifying and coordinating assistance for identified member needs, specific to maternal/child health and EPSDT. 6. Interfacing with community partners.
Medical Management Coordinator*	The Medical Management Coordinator must be a State-licensed registered nurse, physician, or physician's assistant if he/she is required to make medical necessity determinations. If the position is not required to make medical necessity determinations, this individual may have a Master's degree in health services, health care administration, or business administration. The Medical Management Coordinator's responsibilities include: 1. Developing, implementing, and monitoring the provision of care coordination, disease management, and case management functions. 2. Ensuring the adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria. 3. Ensuring the completion of appropriate concurrent review and discharge planning of inpatient stays. 4. Monitoring, analyzing, and implementing appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services. 5. Monitoring prior authorization functions and ensuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards.
Provider Services Manager*	The Provider Services Manager is responsible for: 1. Coordinating communications between the MCO and its subcontracted providers. 2. Managing the Provider Services staff. 3. Working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns. 4. Developing provider trainings in response to identified needs or changes in protocols, processes, and forms. 5. Enhancing MCO-provider communication strategies. 6. Notifying MLTC of correspondence sent to providers for informational and training purposes. 7. Participating in the MLTC Administrative Simplification Committee.
Member Services Manager*	The Member Services Manager is responsible for: 1. Coordinating communications between the MCO and its members. 2. Ensuring there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program. 3. Managing the Member Services staff.

Title	Minimum Duties
Claims Administrator	The Claims Administrator is responsible for: 1. Developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with State and Federal requirements and the terms of this contract. 2. Developing cost avoidance processes. 3. Meeting claims processing timelines. 4. Ensuring minimization of claims recoupments. 5. Meeting MLTC encounter reporting requirements.
Provider Claims Educator	This position must be knowledgeable concerning the MCO's Nebraska Medicaid Managed Care grievance, claims processing, and provider services systems and facilitate the exchange of information between these systems and providers. This individual must have a minimum of five (5) years management and supervisory experience in a health care field. The Provider Claims Educator is responsible for: 1. Educating in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available MCO resources, such as provider manuals, websites, provider training materials, and fee schedules. 2. Communicating frequently with providers to ensure the effective exchange of information and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices. 3. Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction. 4. Working with the MCO's call center to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements.
Case Management Administrator*	The Case Management Administrator should have experience as a case manager with a minimum of five (5) years management or supervisory experience in a health care field. The position is responsible for: 1. Overseeing the MCO’s case management functions. 2. Working with other MCO staff to ensure that members’ case management needs are met. 3. Working with the Medical Director and other medical management staff to ensure that the MCO has case management policies/protocols that comply with Federal and State requirements.
Information Management and Systems Director	The Information Management and Systems Director must have relevant training and a minimum of seven (7) years of experience in information systems, data processing, and data reporting to oversee all MCO information systems functions. The position is responsible for: 1. Establishing and maintaining connectivity with MLTC information systems. 2. Providing necessary and timely data and reports to MLTC.
Encounter Data Quality Coordinator	The Encounter Data Quality Coordinator is responsible for: 1. Organizing and coordinating services and communication between MCO administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues. 2. Serving as the MCO's encounter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter data processing and submissions. 3. Analyzing activities related to the processing of encounter data and data validation studies to enhance accuracy and output.
Tribal Network Liaison*	The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members. 2. Serving as the single point of contact with tribal entities and all MCO staff on American Indian issues and concerns. 3. Advocating for American Indian members with case management and

Title	Minimum Duties
	member services staff.
Pharmacist/Pharmacy Director*	The MCO Pharmacist/Pharmacy Director must be a registered pharmacist with a current State license. The incumbent must have a minimum of three (3) years of experience supporting formularies, designing prior authorization requirements, and working with clinical information. The Pharmacist/Pharmacy Director is responsible for: 1. Overseeing the prescription drug and pharmacy benefits. 2. Leading and coordinating formulary and preferred drug list implementation, evaluation, training, reporting, and problem solving. 3. Consulting on and coordinating pharmacy program changes. 4. Understanding clinical pharmacy and drug product information to support plan benefit design in the point of sale system. 5. Overseeing, monitoring, and assisting with the management of pharmacy benefit manager (PBM) activities. 6. Managing the prospective and retrospective drug utilization review (DUR) activities. 7. Supporting call center prior authorization programs and their development/modification. 8. Attending MLTC Pharmacy and Therapeutics Committee and DUR Board meetings. 9. Meeting with MLTC staff and the MCO's PBM, no less than monthly, to discuss operational status updates, including the call center, POS system, grievances, and prior authorizations; and review performance standards and restricted services grievances and appeals.

3. Additional Required Staff

a. Prior authorization staff must include a State-licensed registered nurse or physician's assistant. Staff must work under the direction of the Medical Director or the Medical Management Coordinator (if this person is a State-licensed registered nurse or physician's assistant) to authorize health care services (in compliance with contract requirements), at any time.

b. Concurrent review staff must include a State-licensed registered nurse or physician's assistant. Staff must work under the direction of the Medical Director or the Medical Management Coordinator (if this person is a State-licensed registered nurse or physician's assistant) to conduct inpatient concurrent reviews.

c. Clerical and support staff to ensure the proper functioning of the MCO's operation.

d. Provider services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the MCO program. There must be sufficient staff to maintain/enhance the MCO's provider network to meet MLTC's network standards and work with grievances and appeals staff to resolve provider grievances and disputes on a timely basis. The MCO must designate a local individual to serve as a liaison for behavioral health providers.

e. Member services staff to enable members to receive prompt responses and assistance. There must be sufficient member services staff at all times to provide culturally and linguistically appropriate services.

f. Claims processing staff to ensure the timely and accurate processing/adjudication of original claims and resubmissions. The MCO must have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

g. Encounter processing staff to ensure the timely and accurate processing and submission to MLTC of encounter data and reports.

h. Care management staff to assess, plan, facilitate, and advocate options and services to meet members' health and social needs. The staff must use communication and available resources to promote quality, cost-effective outcomes. The MCO is required to provide and maintain

appropriate levels of care management staff in the State to ensure adequate local geographical coverage for face-to-face contact with physicians and members as appropriate, and may include additional out-of-state staff providing telephone consultation and support.

i. FWA investigative staff to detect and investigate FWA activities. The staff is responsible for preparing and updating the fraud and abuse compliance plan, conducting MCO employee training and monitoring, investigating a sample of paid claim discrepancies, and responding to provider investigation-related inquiries/issues. Each FWA investigator must have a Bachelor's degree; an Associate's degree plus a minimum of two (2) years' experience as a licensed health care provider or auditor; a minimum of four years' experience as a certified coder or billing specialist; or, a minimum of five (5) years law enforcement, health care oversight, compliance, or auditing experience. The MCO must have a minimum of one investigator for every 100,000 members or less.

j. All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff.

4. Care Management and Utilization Management Staff Requirements

a. As part of its care management operations, the MCO must employ a multidisciplinary clinical staff, care coordinators, and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to members. The MCO must ensure an adequate ratio of staff to members to perform all care management functions as described in Section IV.L Care Management of the RFP. Sufficient staff must be available to respond at any time to members, their families/caregivers, or other interested parties calling on behalf of a member.

b. The MCO must ensure that only licensed clinical staff operating within the scope of their training and professional licenses make decisions regarding medical necessity.

5. Written Policies, Procedures, and Position Descriptions

a. The MCO must develop and maintain written policies, procedures, and position descriptions for each functional area, consistent in format and style. The MCO must have written guidelines for developing, reviewing and approving all policies, procedures, and job descriptions. All policies and procedures must be reviewed at a minimum on an annual basis to ensure that they reflect current practices. Once the policies are reviewed, they must be dated and signed by the MCO's appropriate manager, coordinator, director, or administrator. Minutes reflecting the review and approval of the policies by the appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the MCO's Medical Director. Job descriptions must be reviewed a minimum of annually to ensure that they reflect current duties.

b. Based on provider or member feedback, if MLTC determines that a MCO policy or process is inefficient or places an unnecessary burden on the members or providers, the MCO will be required to work with MLTC to change the policy or procedure within a time period specified by MLTC.

6. Staff Training and Meeting Attendance

a. The MCO must ensure that all staff members, including subcontractors, have training, education, experience, and orientation to complete their job responsibilities. MLTC may require additional staffing for a MCO that has substantially failed to maintain compliance with any provision of the contract and/or MLTC policies.

b. The MCO must provide initial and ongoing staff training that includes an overview of MLTC and its policies, the contract, and State and Federal requirements specific to individual job functions. The MCO must ensure that all staff members who have contact with members or providers receive initial and ongoing training with regard to program changes, prior authorization modifications, and the appropriate identification and handling of quality of care/service concerns.

c. The MCO must educate staff concerning their policies and procedures on advance directives in accordance with 42 CFR 422.128.

d. A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained on how social determinants affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, violence, and risk and protective factors for behavioral health concerns. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.

e. The MCO must provide training for staff on the needs of the Long-Term Services and Supports (LTSS) population, including individuals with developmental disabilities and mental health concerns.

f. New and existing prior authorization, provider services, and member services staff must be trained in the geography of the State, as well as the culture and correct pronunciation of cities, towns, and surnames. Appropriate staff must have access to GPS or mapping search engines for the purposes of authorizing services, recommending providers, and transporting members to the most geographically appropriate location.

g. The MCO must provide the appropriate staff representation in meetings or events scheduled by MLTC. All meetings are considered mandatory unless otherwise notified by MLTC.

h. MLTC reserves the right to attend any and all training programs and seminars conducted by the MCO. The MCO must provide MLTC a list of any training dates, times, and locations a minimum of 14 calendar days prior to their occurrence.

E. COVERED SERVICES AND BENEFITS

1. General Provisions

a. The MCO must have available, for members, immediately upon their effective date, at a minimum, those benefits and services specified in the RFP, and as defined in the Nebraska Medicaid State Plan, administrative rules, and MLTC policy and procedures. The MCO must possess the expertise and resources to ensure the delivery of quality health care services to its members in accordance with Nebraska Medicaid program standards and the prevailing local and national medical standards.

b. The MCO must provide a mechanism to reduce inappropriate and duplicative use of health care services, including but not limited to, non-emergent use of hospital emergency rooms.

c. The MCO must ensure the coordination of services it provides with services the member receives from other entities. The MCO must ensure that in the process of coordinating care that each member's privacy is protected in accordance with Federal and State requirements.

d. Services must be rendered by providers that are appropriately licensed or certified, operating within their scopes of practice, and enrolled as a MLTC provider. The MCO must provide the same standard of care for all members, regardless of any member's eligibility category.

e. The MCO must comply with any future legislative and regulatory changes regarding covered services and benefits unless those changes specifically exempt managed care.

2. Amount, Duration and Scope

a. The services offered under the MCO contract must be sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and must be no less than those furnished under FFS Medicaid, as specified in 42 CFR 438.210(a). Upward variances of amount, duration, and scope of these services are allowed.

b. All services covered under this contract must be accessible to MCO members with comparable timeliness, and in a similar amount, duration, and scope as those available to other insured individuals in the same service area.

c. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. However, the MCO may place appropriate limits on a service on the basis of criteria such as medical necessity, or for

utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The MCO must provide its policies regarding this section to MLTC for approval a minimum of 45 calendar days prior to their implementation.

3. Behavioral Health Parity

The MCO must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes, but is not limited to:

a. Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more strictly than the medical management techniques that are applied to medical and surgical benefits.

b. Ensuring compliance with MHPAEA for any benefits offered by the MCO to members beyond those specified in the Medicaid State Plan.

c. Making the criteria for medical-necessity determinations for mental health or substance use disorder benefits available to any current or potential member, or contracted provider, on request.

d. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.

e. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

4. Medically Necessary Services

a. The MCO must specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Medicaid program and addresses the extent to which the MCO is responsible for covering services related to the following:

i. The prevention, diagnosis, and treatment of health impairments.

ii. The ability to achieve age-appropriate growth and development.

iii. The ability to attain, maintain, or regain functional capacity.

b. The MCO may not limit services beyond the limitations in the State's Medicaid program.

5. Second Opinions

When requested by the member, the MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member.

6. Value-Added Services

a. As permitted under 42 CFR 438.6(e), and to the extent consistent with provisions of State law, the MCO may, in its discretion, offer expanded services and benefits to enrollees in addition to those benefits and services specified in this section of the RFP.

b. These expanded services and benefits must, in the judgment of the MCO, be medically appropriate and cost-effective. The expanded services may include health care services that are currently non-covered services by the Medicaid State Plan or which are in excess of the amount, duration, and scope in the Medicaid State Plan.

c. These services/benefits must be specifically defined by the MCO with regard to amount, duration, and scope. MLTC will not provide any additional reimbursement to the MCO for these services or benefits.

d. The MCO must provide to MLTC a description of the expanded services or benefits to be offered by the MCO for approval 45 calendar days prior to implementation. Additions, deletions, or modifications to value-added services made during the contract period must be submitted to MLTC for approval a minimum of 45 calendar days prior to their implementation.

e. The following MLTC priorities may be addressed through value-added services:

i. Reduction in non-emergent use of the emergency department (ED) through increased access to after-hours care, urgent care, same-day appointments, data sharing with physicians and hospitals, member education, and/or other interventions identified by the MCO.

ii. Improved birth outcomes through prenatal, postnatal, and inter-pregnancy care, reduction in early elective deliveries and Cesarean sections, promotion of vaginal birth after Cesarean section, and other interventions identified by the proposer.

iii. Improved outcomes through coordination and integration of prevention-focused physical and behavioral health services delivered in community-based settings.

f. Value-added services are not Medicaid-funded and, as such, are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. The MCO must send the member a notification letter if a value-added service is not approved.

g. Transportation to obtain these services or benefits is the responsibility of the member or the MCO, at the discretion of the MCO.

7. Telehealth and Telemonitoring Services

a. In-person contact between a health care provider and a patient is not required by Title XIX or XXI of the Social Security Act. The MCO must cover medically necessary telehealth services at a rate comparable to an in-person consultation. The MCO may also reimburse the originating site.

b. Health care providers that provide telehealth must follow all applicable State and Federal regulations governing their practice and the services they provide.

c. All telehealth communications must comply with all applicable Federal and State requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

d. The MCO shall, at a minimum, cover telemonitoring services when the following conditions have been met:

i. The member has been hospitalized two or more times in the last twelve (12) months for conditions related to the disease. This provision is not required for infant apnea monitoring.

ii. The member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data.

iii. The originating site has space for all program equipment and full transmission capability.

iv. The provider's record contains data that supports the medical necessity of the service, all transmissions, and subsequent review received from the member, and how the data transmitted from the member is used in the continuous development and implementation of the member's plan of care.

8. Core Benefits and Services

The following services represent a minimum benefit package that must be provided by the MCO to its members:

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.

ii. Outpatient hospital services.

iii. Ambulatory surgical center (ASC) services.

iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.

v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

vi. Services provided in Indian Health Service (IHS) facilities.

vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.

viii. Radiology services.

ix. Health Check (EPSDT) services.

x. Home health services.

xi. Private duty nursing services.

xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).

xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.

xiv. Podiatry services.

xv. Chiropractic services.

xvi. Vision services.

xvii. Free standing birth center services.

xviii. Hospice services, except when provided in a nursing facility.

xix. Skilled/rehabilitative and transitional nursing facility services.

xx. Ambulance services.

xxi. Non-emergency ambulance transportation.

xxii. Transplant services.

xxiii. Pharmacy services.

b. Behavioral Health Services

<u>Services for individuals age 20 and under, unless otherwise indicated:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

a) Partial hospitalization.

b) Day treatment.

c) Intensive outpatient.

d) Medication management.

e) Outpatient therapy (individual, family, or group).

f) Injectable psychotropic medications.

g) Substance use disorder treatment.

h) Psychological evaluation and testing.

i) Initial diagnostic interviews.

j) Sex offender risk assessment.

k) Community treatment aide (CTA) services.

l) Comprehensive child and adolescent assessment (CCAA).

m) CCAA addendum.

n) Hospital observation room services (up to 23 hours and 59 minutes in duration).

o) Parent child interaction therapy.

p) Child-parent psychotherapy.

q) Applied behavioral analysis.

r) Multi-systemic therapy.

s) Functional family therapy.

v. Rehabilitation services

a) Day treatment/intensive outpatient.

b) CTA services.

c) Professional resource family care.

d) Therapeutic group home.

Services for adults age 21 and over:

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital services (acute and sub-acute).

iii. Outpatient assessment and treatment:

a) Partial hospitalization.

b) Social detoxification.

c) Day treatment.

d) Intensive outpatient.

e) Medication management.

f) Outpatient therapy (individual, family, or group).

g) Injectable psychotropic medications.

h) Substance use disorder treatment.

i) Psychological evaluation and testing.

j) Electroconvulsive therapy.

k) Initial diagnostic interviews.

l) Ambulatory detoxification.

m) In-home psychiatric nursing.

iv. Rehabilitation services

a) Dual-disorder residential.

b) Intermediate residential (SUD).

c) Short-term residential.

d) Halfway house.

e) Therapeutic community (SUD only).

f) Community support.

g) Psychiatric residential rehabilitation.

h) Secure residential rehabilitation.

i) Assertive community treatment (ACT) and Alternative (Alt) ACT.

j) Community support.

k) Day rehabilitation.

9. Laboratory and Radiology Services

a. The MCO must provide inpatient and outpatient diagnostic laboratory testing, therapeutic radiology, and radiological services ordered or performed by any network provider.

b. For excluded services, such as dental, the MCO is responsible for laboratory or radiology services that may be required to treat an emergency or provide surgical services.

c. The MCO must provide for clinical lab services and portable (mobile) x-rays for members who are unable to leave their place of residence without special transportation or assistance to obtain PCP-ordered laboratory services and x- rays.

d. The MCO may require service authorization for diagnostic testing and radiological services ordered or performed by any provider for its members.

10. Eye Care and Vision Services

As set forth in the Medicaid State Plan and applicable regulations, the MCO must provide to all members any medically necessary eye care, vision examinations, prescriptive lenses, frames, and treatments. Eye care and vision services are to be performed by a licensed ophthalmologist or optometrist, conforming to accepted methods of screening, and diagnosis and treatment.

11. Pharmacy Services

a. Covered Services

i. The MCO must provide its members with access to outpatient pharmacy services as defined under Section 1927 of the Social Security Act, described in the Medicaid State Plan and further described in this section.

ii. The MCO must provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and must follow the Nebraska Medicaid preferred drug list (PDL).

iii. The MCO must provide coverage for all drugs deemed medically necessary for members under the age of 21 years.

iv. The MCO may manage utilization of drugs through procedures that may include, but are not limited to, prior authorization and utilization and clinical edits.

b. Program Requirements

i. All policies and procedures related to the provision of the pharmacy benefit, including the formulary, UR policies, procedures to ensure compliance with the PDL, clinical and utilization edits, provider requirements, subcontracts, pricing, and reimbursement must be submitted to MLTC for written approval a minimum of 60 calendar days prior to the contract start date.

ii. The MCO must submit any proposed pharmacy program or coverage changes to MLTC for review and approval a minimum of 30 calendar days prior to proposed implementation of the change.

iii. The MCO must have procedures in place to provide a 72-hour supply of medication to a member in the event of an emergency situation on the weekends, holidays, or during off-hours.

iv. The MCO must maintain a website and post current and accurate information and documents regarding its pharmacy program. Such information must be current and searchable including, but not limited to the following:

a) The MCO formulary (list of covered medications) and the NE Medicaid PDL.

b) The MCO pharmacy prior authorization requirements.

c) The MCO maximum allowable cost (MAC) pricing.

d) Instructions on how and whom to contact for questions regarding filling a prescription.

e) A provider manual as a guideline for pharmacy claim submission. The manual must include, but is not limited to:

1) Payer sheet

2) Call center hours

3) Paper claim submission requirements

4) Compound prescriptions requirements

5) Prospective DUR response requirements

6) Toll-free call center numbers

v. The MCO formulary may only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO shall include in its formulary any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition for FDA-approved indications.

vi. The MCO must allow access to all new prescription drugs that are approved by the Food and Drug Administration, distributed by a labeler who participates in the Medicaid Drug Rebate Program, and are medically necessary either by addition of the drugs to the formulary or through prior authorization within ten calendar days from their availability in the marketplace.

vii. The MCO must at a minimum follow MLTC guidelines for off-label drug use.

viii. The MCO must support e-prescribing transactions, including, but not limited to member eligibility, formulary and benefit, and medication history. All transactions and data feeds to support e-prescribing must remain compliant with the National Council for Prescription Drug Programs (NCPDP) and the CMS-defined NCPDP SCRIPT standard version and supporting transactions. The MCO must remain compliant with the most current CMS-defined version of the NCPDP SCRIPT standard. All changes to support updates to the SCRIPT standard are the responsibility of the MCO and must be updated on a timeline to meet CMS-defined implementation dates at no cost to the Nebraska Medicaid program.

ix. The MCO may require prior authorization as a condition of coverage or payment for an outpatient prescription drug or device provided that:

a) The MCO provides a response to the prescriber and pharmacy by telephone, fax, or email indicating approval or denial of the request within one business day of the request; and

b) The MCO complies with the requirements for prior authorization for outpatient prescription drugs in accordance with Section 1927 of the Social Security Act.

x. The MCO must submit its policies and procedures on extemporaneously compounded drugs to MLTC for review and written approval prior to the start date of operations. Any subsequent changes to approved policies must be submitted to MLTC for review and written approval.

xi. The MLTC pharmacy benefit design currently uses the First Data Bank (FDB) drug reference file. MLTC may communicate coverage decisions using the FDB classification system. The MCO must be responsible to determine equivalent benefit designation if the FDB drug reference file is not used by the MCO.

c. Nebraska Medicaid Preferred Drug List

i. The MCO must follow the Nebraska Medicaid PDL. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis. Refer to the following link for additional information:
http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx

ii. The MLTC PDL vendor will provide to the MCO a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC.

iii. The MCO must update the pharmacy claim system within one (1) business day of file receipt of the PDL file.

iv. The MCO must, at the direction of MLTC, perform off-cycle PDL file updates within one (1) business day.

v. The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes.

vi. The MCO is not authorized to and must not negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. MLTC or its designee will negotiate rebate agreements. Regardless if the MCO or its PBM has an existing rebate agreement with a manufacturer, all Nebraska Medicaid outpatient drug claims, including provider-administered drugs, must be rebateable exclusively to Nebraska Medicaid.

vii. The MCO must nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. Written final approval of nominees is made by MLTC.

d. Contractor Formulary

i. The MCO must cover medications that meet the definition of outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927 of the Social Security Act.

ii. The MCO must provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit.

iii. The MCO must submit the formulary for review and approval by MLTC a minimum of 90 calendar days prior to the contract start date.

iv. The MCO must submit all proposed formulary changes, excluding formulary expansion changes, to MLTC for review and written approval prior to the implementation of such changes.

v. The MCO must submit formulary prior authorization and step therapy policies and procedures, and any associated criteria, to MLTC for review and written approval a minimum of 60 calendar days prior to the contract start date. Clinical criteria for prior authorization of drugs require advance written approval of MLTC.

vi. The MCO must update the formulary files at a minimum on a weekly basis.

e. Over-the-Counter (OTC) Coverage

The MCO must, at a minimum, cover the OTC drugs listed in the Medicaid State Plan.

12. EPSDT Services

a. EPSDT is a comprehensive and preventive child health program for members under the age of 21.The EPSDT statute and Federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services not included in a state's Medicaid State Plan, if necessary, to correct or ameliorate a known medical condition (42 U.S.C. 1396d(r)(5) and the CMS Medicaid State Manual). The program consists of two (2) mutually supportive, operational components: (1) ensuring the availability and accessibility of required health care services; and (2) helping Medicaid members and their parents or guardians effectively use these services. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

The MCO must provide:

i. Effective outreach/education that informs parents/guardians of the benefits of having their children receive EPSDT screening, diagnosis, and treatment services.

ii. Education to parents/guardians to assist them in making responsible decisions about preventive health care and appropriate utilization of health care services for their children.

iii. Continuing and comprehensive health care beginning with the screening, and continuing through diagnosis and treatment for any conditions identified during screenings.

iv. Assistance to families in making medical appointments and obtaining needed transportation.

v. The monitoring of provided EPSDT services, to ensure that all services are delivered within established time frames.

b. The MCO must have written procedures for EPSDT services in compliance with 42 CFR Part 441 Subpart B, as well as be in compliance with the CMS State Medicaid Manual, Part 5 – EPSDT. These documents outline the requirements for EPSDT, including assurance that all EPSDT

eligible members are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and that tracking or follow-up occurs to ensure all necessary services are provided to all of the MCO's eligible Medicaid children and young adults.

c. The MCO is required to authorize and provide all medically necessary services (including behavioral health services), whether specified in the Medicaid State Plan or not, except those services that have been identified in this RFP as excluded or prohibited.

d. The MCO is required to ensure the provision of the medical, vision, and hearing screening components and immunizations as specified in the American Academy of Pediatrics periodicity schedule.

e. The MCO must facilitate access to medically necessary behavioral health services recommended during an EPSDT examination when requested by the member or his/her parent/guardian or when the MCO determines that it is necessary or appropriate.

f. The MCO must accurately report, via encounter data submissions, all EPSDT and well-child services, blood lead screening, access to preventive services, and any other services required for MLTC to comply with federally-mandated CMS 416 reporting requirements.

13. Immunizations

a. The MCO must provide to all members under 21 years of age all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices guidelines.

b. The MCO must ensure that all providers use vaccines available without charge under the Vaccine for Children program. This program provides vaccines to Medicaid children 18 years old and younger. Immunizations should be given in conjunction with EPSDT/well child visits or when other appropriate opportunities occur.

c. MCO providers must report required immunization data to the Nebraska State Immunization Information System, administered by DHHS/Division of Public Health. This requirement must be made a part of any contracts the MCO has with its providers.

14. Emergency Medical and Post-Stabilization Services

The MCO is responsible for coverage and payment of emergency services and post-stabilization care services regardless of whether the provider who/that furnishes the services has a contract with the MCO.

a. Emergency Services

i. The MCO must ensure that emergency services be rendered without the requirement of prior authorization of any kind. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.

ii. The MCO must not deny payment for treatment obtained when a representative of the MCO instructs the member to seek emergency services.

iii. The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR 438.114(a).

iv. The MCO must not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

v. The MCO must not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

vi. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

vii. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO.

viii. The MCO must reimburse non-contracted providers for emergency services at no less than the Medicaid FFS rate in effect on the date of service.

b. Post-Stabilization Services

i. As specified in 42 CFR 438.114(e) and 42 CFR 422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:

a) Pre-approved by a network provider or other MCO representative.

b) Not pre-approved by a network provider or other MCO representative, but:

1) Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services, or

2) Administered to maintain, improve, or resolve the member's stabilized condition, and

i) The MCO did not respond to a request for pre-approval within one (1) hour;

ii) The MCO cannot be reached, or

iii) The MCO representative and the treating physician cannot reach agreement regarding the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

ii. The MCO's financial responsibility for post-stabilization care services that have not been pre-approved ends when:

a) A plan physician with privileges at the treating hospital assumes responsibility for the member's care.

b) A plan physician assumes responsibility for the member's care through transfer to another place of service.

c) A MCO representative and the treating physician reach an agreement concerning the member's care.

d) The member is discharged.

15. Emergency Ancillary Services Provided at a Hospital

Emergency ancillary services that are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine, and anesthesiology. Emergency ancillary services rendered by non-network providers in a hospital setting must be reimbursed at the published Medicaid fee schedule in effect on the date of service.

16. Family Planning Services

a. Family planning services are a mandatory Medicaid benefit. The MCO must not restrict the choice of provider from whom/which the member may receive family planning services and supplies. At a minimum, the MCO must provide coverage for the following family planning services:

i. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits. This visit includes anticipatory guidance and education related to members' reproductive health/needs.

ii. Contraceptive counseling to assist members in reaching an informed decision (including natural family planning, education follow-up visits, and referrals).

iii. Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health.

iv. Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs must also be covered.

i. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration.

v. Male and female sterilization procedures provided in accordance with 42 CFR Part 441, Subpart F.

vi. Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage; or, treatment of surgical or anesthesia-related complications during a sterilization procedure.

b. Services must include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection and treatment of sexually transmitted infections (STIs), and age-appropriate vaccination for the prevention of human papillomavirus infection and cervical cancer. Prior authorization must not be required for treatment of STIs.

c. MCO members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR 431.51(b)(2).

d. The MCO must reimburse non-contracted family planning providers at no less than the FFS rate in effect on the date of service for properly billed claims.

e. The MCO may encourage members to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements will be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.

f. The MCO should encourage family planning providers to communicate with the member's PCP once any form of medical treatment in undertaken.

g. The MCO must limit coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem such as thyroid disease, brain tumor, or hormone dysfunction. The MCO must ensure coverage is not available if the sole purpose of the service is attempting to achieve a pregnancy, per 471 NAC 10-005.

17. Prenatal and Maternity Care Services

a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis.

b. The MCO must cover nurse-midwife services that are medically necessary in accordance with their scopes of practice as defined by the applicable statutes and regulations.

c. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both mother and newborn child.

18. Hysterectomies and Sterilizations

a. The MCO must cover the cost of medically necessary hysterectomies as provided in 42 CFR 441.255. Sterilizations must be conducted in accordance with 471 NAC 000-109, 10-005.07, 18-004.06 and Federal regulations at 42 CFR 441.250 – 441.259.

b. A hysterectomy or sterilization will not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing. It will also not be covered if there was more than one purpose for it, but the primary purpose was to render the individual permanently incapable of reproducing.

19. Limitations on Abortions

a. The MCO must ensure that abortion services are approved in writing by both the MCO Medical Director and the MLTC Medical Director before the service is rendered to ensure compliance with Federal and State regulations.

b. The MCO must only provide for abortion services in accordance with 42 CFR 441.202 and the Consolidated Appropriations Act of 2008, which stipulate that abortions are covered only in instances where pregnancy is the result of either:

i. An act of rape or incest; or

ii. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

c. For abortion services performed in accordance with this section, a physician must certify in his/her writing, that, on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider must attach the certification statement to the claim form that must be retained by the MCO. The certification statement must contain the diagnosis or medical condition that makes the pregnancy life endangering.

d. No other abortions, regardless of funding, can be provided as a benefit under this contract. The MCO must not make payment for any core benefit or service under the contract to a network or non-network provider if any abortion performed hereunder violates Federal regulations (e.g., the Hyde Amendment Codification Act).

20. Speech Pathology and Audiology

The MCO must cover, at a minimum, speech pathology and audiology services when the following criteria are met:

a. The services are ordered by a licensed physician.

b. The services are medically necessary.

c. The services or the condition of the member is/are so complex and sophisticated that only a licensed speech pathologist or audiologist could safely and effectively perform the service.

d.

e. The speech pathology or audiology service meets a minimum of one of the conditions listed at 471 NAC 23-003.01 or 23-003-02.

21. Transplants

The MCO must pay for all covered services associated with transplant care for a member. As required by 471 NAC 18-004.40, the MCO must cover transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental. If Medicare policy does not exist for a certain type of transplant, the MLTC Medical Director will determine whether the transplant is medically necessary and non-experimental. The MCO must cover at a minimum the following transplant types:

a. Heart and lung

b. Lung only

c. Heart only

d. Intestinal and/or multi-visceral

e. Kidney only

f. Pancreas only

g. Kidney and pancreas

h. Liver only

i. Bone marrow/stem cell

22. Medical Services for Special Populations

a. The special health care needs (SHCNs) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches.

b. The MCO must assess each member for SHCN within 90 calendar days of enrollment. The assessments must be completed by appropriate health care professionals. Assessments that determine a course of treatment or regular care monitoring, as appropriate, must result in a referral for care management.

c. The MCO must utilize Medicaid historical claims data (if available) to identify members who meet MCO guidelines for SHCN determination. These guidelines must be approved in writing by MLTC a minimum of 45 calendar days prior to their proposed implementation.

d. MCO PCPs must notify the MCO of those members who meet SHCN criteria as soon as possible after identification.

e. Members may self-identify to either the enrollment broker or the MCO that they have SHCNs. The enrollment broker will provide notification to the MCO of these members.

f. Individualized treatment plans resulting from SHCN assessments must be:

vi. Developed by the member's PCP, with member participation, and in consultation with any specialists caring for the member.

vii. Approved by the MCO in a timely manner, as defined and required by the MCO.

viii. Compliant with applicable QA and UM standards.

g. For members determined to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

23. Chiropractic Services

a. Chiropractic services coverage is limited to treatment of the spine by manual manipulation (i.e., by use of hands only) and certain spinal x-rays, per 471 NAC 5-002.

b. Unless provided as a value-added service, the MCO must not cover any other diagnostic or therapeutic service or supply provided by a chiropractor or on his/her order including but not limited to laboratory tests, orthopedic devices, physiotherapy, nutritional supplements, EKGs, and acupuncture, as defined in 471 NAC 5-003.

24. Dialysis Services

The MCO must, per NAC 471 18-004, follow Medicare program guidelines for coverage of dialysis.

25. Durable Medical Equipment

a. The MCO must provide coverage and be financially responsible for medically necessary durable medical equipment (DME), prosthetics, orthotics, medical supplies, and assistive devices including, but not limited to, hearing aids.

b. The MCO must, at minimum, provide coverage for DME-related covered services as listed in Chapters 7 and 8 of Title 471 of the Nebraska Administrative Code.

26. Home Health Services

The MCO must cover the following home health agency services:

a. Skilled nursing services provided by a registered professional nurse or a licensed practical nurse.

b. Home health aide services.

c. Physical therapy provided by a licensed physical therapist.

d. Speech therapy provided by a licensed speech pathologist.

e. Occupational therapy provided by a licensed/certified occupational therapist.

27. Hospice Services

a. The MCO must provide a comprehensive package of hospice services to members, including nursing services, physician services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services, and pastoral care services.

b. These services must be offered based upon individually assessed needs and choices of terminally ill members and their families for palliative care and support.

28. Medical Transportation Services

a. The MCO must provide emergency and non-emergency medical transportation by ambulance for its members.

b. The MCO may establish its own policy for medical transportation services as long as the MCO ensures members' access to care and the MCO's policy is in compliance with current Nebraska Medicaid guidelines for emergency and non-emergency medical transportation.

29. Excluded Services

Excluded services are those services that members may obtain under the Medicaid State Plan, and for which the MCO is not financially responsible. However, the MCO is responsible for informing members about how to access excluded services, providing all required referrals, and assisting in the scheduling of these services. These services will be paid for by MLTC on a FFS basis. Services include:

a. Dental services.

b. Intermediate care facility services for individuals with developmental disabilities.

c. Any institutional LTC/NF services at a custodial level of care.

d. School-based services.

e. All HCBS waiver services.

f. Targeted Case Management services.

g. Medicaid State Plan Personal Assistance Services.

30. Prohibited Services

a. Prohibited services are those required to treat complications or conditions resulting from non-covered services, services not reasonable and necessary, and services that are experimental and investigational unless approved by the MLTC Director.

b. The MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) described in Section 1903(i) of the Social Security Act.

F. MEMBER SERVICES AND EDUCATION

1. Member Rights and Protections

a. Member Rights

i. The MCO must have written policies regarding members' rights that are specified in this section and in compliance with 482 NAC 7-001. At a minimum, each MCO member is guaranteed the right to:

a) Be treated with respect and consideration of his/her dignity and privacy.

b) Receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information.

c) Participate in decisions regarding his/her health care, including the right to refuse treatment. Refusal of treatment is not a reason for which the MCO can request disenrollment of the member from the MCO.

d) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

e) Request and receive a copy of his/her medical records, and request that they be amended or corrected as specified in 42 CFR 438.100.

f) Obtain available and accessible health care services covered under the contract.

g) Request disenrollment per 42 CFR 438.56.

ii. Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those rights will not adversely affect the member's treatment by the MCO, its providers, or MLTC.

b. Indian Health Protections

Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, the MCO must:

i. Permit any American Indian who is enrolled in a MCO and eligible to receive services from a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a PCP, to choose that I/T/U as his/her PCP, as long as that provider has the capacity to provide the service.

ii. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian members who are eligible to receive services from such providers.

iii. In compliance with Section 5006(a) of the American Recovery and Reinvestment Act, (a) exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral, and (b) exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral.

iv. Follow required Indian health protections included in Section IV.Q Provider Reimbursement.

c. Notice to Members of Provider Termination

i. The MCO must make a good faith effort to provide affected members with written notice of a provider's termination from the MCO's network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.

ii. The MCO must provide notice to a member who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice must be provided within ten (10) calendar days from the date the MCO becomes aware of the change, if the notice is provided in advance.

iii. Failure to provide notice prior to the termination date is allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when the provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under any of these circumstances, notice must be issued immediately upon the MCO becoming aware of the circumstances.

2. Member Services Call Center

a. The MCO must:

i. Operate a member call center with a toll-free telephone line to respond to members', their families', and their providers' questions, concerns, inquires, and complaints.

ii. Develop member call center line policies and procedures that address staffing; training; hours of operations; access and response standards; transfers/referrals, including case management referrals from any source; monitoring of calls via recording or other means; and compliance with standards in this RFP.

iii. Ensure the call center staff can handle calls from members with limited English proficiency and members with disabilities, including but not limited to members with hearing or speech disabilities.

iv. Ensure the call center is staffed adequately to respond to members' questions, at a minimum from 8:00 am to 5:00 pm, central time, Monday through Friday.

v. Ensure the member call center provides an option to speak with qualified nurses at any time to triage urgent care and emergency calls from members and to facilitate the transfer of calls to a care manager from or on behalf of a member who requires immediate assistance from a care manager.

vi. Ensure that, during normal business hours, call transfers to case managers be made as warm transfers, i.e. when transferring a call, the call center staff provides the person picking up the call with a brief summary of the member's concern and introduces the member.

If call transfer is not possible, the MCO must ensure that a care manager is notified and returns the member's call within 30 minutes and that the care manager has access to the necessary information to resolve the member's issue. The MCO must implement protocols, approved in advance by MLTC, that describe how member calls to the nurse triage/nurse advice line will be handled.

vii. Ensure the member call center is adequately staffed with individuals trained to accurately respond to member questions regarding managed care, including but not limited to, covered services, the Medicaid program, EPSDT, and the MCO's provider network.

viii. Measure and monitor the accuracy of responses and telephone etiquette and take corrective action as necessary to ensure that members are being given correct information in a helpful and polite manner.

b. The MCO must install, operate, and monitor an automated call distribution system for business and non-business hours, including weekends and holidays. This automated system must:

i. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner.

ii. Transfer calls to other telephone lines, as necessary.

iii. Provide detailed reports in a format approved by MLTC, including the quantity, length, and types of calls received; the number of calls transferred or referred; abandonment rate; wait time; busy signal rate; response time; and call volume.

iv. Provide a message that notifies callers that calls may be monitored for QI purposes.

v.

vi. Provide callers with instructions about what to do in case of an emergency.

vii. Include a voice mailbox with adequate capacity.

viii. Measure the number of calls in the queue.

ix. Measure the length of time callers are on hold.

x. Measure the total number of calls and average calls handled per day, week, and month.

xi.

xii. Measure the average hours of use per day.

xiii. Assess the busiest times and days by number of calls.

xiv. Record calls to assess whether member questions are answered accurately and politely.

xv. Provide a backup telephone system that would operate in the event of line trouble, emergency situations including natural disasters, or other problems, so that access to the call center is not disrupted.

xvi. Provide interactive voice response (IVR) options that are user-friendly for members.

c. The MCO must meet the following call center performance standards:

i. Answer 90% of calls within 30 seconds or direct the call to an automatic call pickup system with IVR options.

ii. Ensure that no more than 1% of incoming calls receive a busy signal.

iii. Maintain an average hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this RFP includes 1) the amount of time a caller waits for a member services representative to assist them after the caller has navigated the IVR system and requested a live person and 2) the amount of time a customer service representative places a caller on hold.

iv. Maintain an abandonment rate of calls of not more than 5%.

v. Return all voice mails no later than the next business day.

d. The MCO must conduct ongoing quality assurance to ensure call center performance standards are met.

e. If MLTC determines that it is necessary to conduct onsite monitoring of the MCO's member call center functions, the MCO is responsible for all reasonable costs incurred by MLTC or its authorized agent(s) related to such monitoring.

3. Oral Interpretation and Written Translation Services

a. In accordance with 42 CFR 438.10(b)(1), MLTC will provide to the MCOs, and on its website, the prevalent non-English languages spoken by members in the State.

b. The MCO must make real-time and culturally and linguistically appropriate oral interpretation services available free of charge to each Medicaid enrollee and member. This applies to all non-English languages, not just those that Nebraska specifically requires. The member must not be charged for interpretation services. The MCO must notify its members that oral interpretation is available for any language, written information is available in Spanish, and how they can access these services. Materials that provide this information must be written in English and Spanish.

c. The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately as specified in 42 CFR 438.10(c)(4) and (5).

4. Requirements for Member Materials

a. The MCO must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).

b. The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.

c. MLTC reserves the right to require the MCO to submit evidence that written member materials were tested against the 6.9 grade reading-level standard.

d. The MCO must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can find on the website and how to obtain written materials if the member does not have access to the website.

e. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual,

speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency.

f. All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member.

g. The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. The MCO must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.

h. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC.

i. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans, if applicable.

j. The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials.

k. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.

l. All written materials related to MCO enrollment and PCP selection must advise members to verify with their usual providers that they are participating providers in the selected MCO and are available to see the member.

m. Marketing materials must be made available by the MCO across the State. Materials may be customized for particular locations or populations within the State.

n. All marketing activities must provide for equitable distribution of materials without bias toward or against any group.

o. Marketing materials must accurately reflect information that is applicable to an average member of the MCO.

p. In all member materials, the MCO must include the date of issue or revision.

q. Copies of all member mailings/materials (print and multimedia) must be provided contemporaneously to MLTC.

5. Member Handbook

a. The MCO must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR 438.10(f)(6).

b. The draft member handbook must be submitted to MLTC for review and approval a minimum of 120 calendar days prior to the contract's start date.

c. The MCO must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it.

d. At a minimum, the MCO must review and update the member handbook annually. The MCO must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the MCO wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation.

e. The MCO's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the MCO

must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.

f. At a minimum, the member handbook must include:

i. A table of contents.

ii. A general description of basic features of how MCOs operate and information about the MCO in particular.

iii. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.

iv. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.

v. Member rights/protections and responsibilities, as specified in 42 CFR 438.100 and this RFP.

vi. Appropriate and inappropriate behavior when seeing a MCO provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action.

vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook.

viii. A description of the PCP selection process and the PCP's role as coordinator of services.

ix. The member's right to select a different MCO or change providers within the MCO.

x. Any restrictions on the member's freedom of choice of MCO providers.

xi. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them.

xii. The amount, duration and scope of benefits available to the member under the contract between the MCO and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.

xiii. Procedures for obtaining benefits, including authorization requirements.

xiv. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.

xv. Information about health education and promotion programs, including chronic care management.

xvi. Appropriate utilization of services including not using the ED for non-emergent conditions.

xvii. How to make, change, and cancel medical appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show".

xviii. Information about a member's right to a free second opinion per 42 CFR 438.206(b)(3) and how to obtain it.

xix. The extent to which, and how, after-hours and emergency coverage are provided, including:

a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c).

b) That prior authorization is not required for emergency services.

c) The process and procedures for obtaining emergency services, including use of the 911-telephone system.

d) That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.

xx. The policy about referrals for specialty care and for other benefits not furnished by the member's PCP.

xxi. How to obtain emergency and non-emergency medical transportation.

xxii. Information about the EPSDT program and the importance of children obtaining these services.

xxiii. Information about notifying the MCO if a female member becomes pregnant or gives birth, the importance of early and regular prenatal care, and obtaining prenatal and post-partum care.

xxiv. Information about member copayments. The charging of a copayment is at the discretion of the MCO. If the MCO chooses to ask its providers to charge copayments, this cost-sharing must be in compliance with 42 CFR 447.50 through 447.57, and cannot exceed the amounts specified at 471 NAC 3-008.

xxv. The importance of notifying the MCO immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.

xxvi. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the MCO's contract with MLTC, either because the service is carved out or the MCO will not provide the service because of a moral or religious objection.

xxvii. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds.

xxviii. Member grievance, appeal, and state fair hearing procedures and timeframes, as described in 42 CFR 438.400-424 and this RFP, as follows:

a) For grievances and appeals:

1) Definitions of a grievance and an appeal.

2) The right to file a grievance or appeal.

3) The requirements and timeframes for filing a grievance or appeal.

4) The availability of assistance in the filing process.

5) The toll-free number(s) the member can use to file a grievance or an appeal by telephone.

6) The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the

cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

b) For state fair hearing:

1) Definition of a state fair hearing.

2) The right to request a hearing.

3) The requirements and timeframes for requesting a hearing.

4) The availability of assistance to request a fair hearing.

5) The rules on representation at a hearing.

6) The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

xxix. As set forth in 42 CFR 438.6(i)(1) and in this section, a description of advance directives that includes:

a) The State's and MCO's policies about advance directives.

b) Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

xxx. Information about how members can file a complaint with MLTC or the Division of Public Health about a provider's failure to comply with advance directive requirements.

xxxi. How a member may report suspected provider fraud and abuse, including but not limited to, the MCO's and MLTC's toll-free telephone number and website links created for this purpose.

xxxii. Any additional information that is available upon request, including but not limited to:

a) The structure and operation of the MCO.

b) The MCO's physician incentive plan (42 CFR 438.6(h)).

c) The MCO's service utilization policies.

d) How to report alleged marketing violations to MLTC.

e) Reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.

xxxiii. A minimum of once a year, the MCO must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.

6. Other Member Notifications

The MCO must also provide the following information to each member:

a. A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.

b. A minimum of annually, the MCO will inform all members of their right to request the following information in compliance with 42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2).

i. An updated member handbook, at no cost to the member.

ii. An updated provider directory, at no cost to the member.

7. Member Newsletter

a. The MCO must develop and distribute, a minimum of twice a year, a member newsletter. This publication must be available on the member portal and mailed to members on request. Topics covered in the newsletter must be timely and relevant to the member population. Suggested topics to discuss include but are not limited to:

i. Educational information on chronic illnesses and ways to self-manage care.

ii. Behavioral health information.

iii. Reminders of flu shots and other prevention measures at appropriate times.

iv. Medicare Part D issues.

v. Cultural competency issues.

vi. Tobacco cessation information and programs.

vii. HIV/AIDS testing for pregnant women.

viii. Other topics as requested by MLTC.

b. The MCO must submit a draft of the member newsletter to MLTC a minimum of 45 calendar days prior to its intended publication for review and approval.

8. Provider Directory for Members

a. The MCO must develop and maintain a provider directory for its members in three (3) formats:

i. A hard copy directory, when requested, for members, potential members, and the enrollment broker.

ii. A web-based, searchable, online directory for members, potential members, and the general public.

iii. An electronic file of the directory to be submitted and updated weekly to MLTC or its designee, and the enrollment broker.

b. The MCO must submit templates of its provider directory to MLTC a minimum of 45 calendar days prior to the contract start date for MLTC's review and approval.

c. The hard copy directory for members must be updated a minimum of monthly. The web-based version must be updated in real time, and no less often than three (3) business days after notification of any change. Daily updates are preferred, if possible.

d. In accordance with 42 CFR 438.10(f)(6), the provider directory must include, but not be limited to:

i. Names, locations, telephone numbers, specialties, and non-English languages spoken of all current contracted providers (including urgent care clinics, FQHCs, RHCs, labs, radiology providers, behavioral health providers, hospitals, and pharmacies) in the MCO's network. Those PCPs, specialists, and other providers who/that are not accepting new patients must be identified.

ii. Hours of operation, including identification of providers with non-traditional hours (before 8 am, after 5 pm, or any weekend hours).

e. To assist Medicaid enrollees in identifying participating providers for each MCO, the enrollment broker will use the MCO's file. This file will be available on the MCO's website, and should be provided to the enrollment broker in a machine readable file and format. As necessary, the enrollment broker will maintain hard copies of the MCO's directory to share with Medicaid enrollees on request.

9. Member ID Cards

MCO members will be issued a minimum of two separate member ID cards related to their Medicaid eligibility and their enrollment in the Nebraska Medicaid managed care delivery system. MLTC issues an ID card to all Medicaid eligible individuals, including MCO members. This card is not proof of eligibility, but can be used by providers to access the State's electronic eligibility verification systems. These systems contain the most current information available on members, including MCO enrollment. No MCO-specific information is printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO benefits and services.

a. The MCO must issue an ID card to each of its members. At a minimum, the card must include:

i. The member's name.

ii. The member's Medicaid ID number.

iii. The enrollment broker's toll-free telephone number.

iv. The MCO's name and address.

v. Instructions on what the member should do in the event of an emergency.

vi. The member's PCP's name and telephone numbers (including the after-hours number, if it is different).

vii. The MCO's toll-free number(s) for Member Services, filing a grievance, and reporting suspected fraud.

c. The MCO may provide the MCO member ID card in a separate mailing from the welcome packet. However, the ID card must be sent no later than ten (10) business days from the date of receipt of the file from MLTC or the enrollment broker that identifies the new member. As part of the welcome packet information, the MCO must explain the purpose of the card and how to use it in tandem with the MLTC-issued card.

d. The card may be issued without the PCP information if no PCP selection has been made as of the date of the card's mailing. Once PCP selection has been made by the member or through auto assignment, the MCO must reissue the card within ten (10) business days of the selection or auto-assignment. As part of the mailing of the reissued card, the MCO must explain the purpose of the new card, the changes between the new and previous card, and that the member should destroy the previous card.

e. The MCO must reissue the MCO ID card to a member within ten calendar days of notice that a member has lost his/her card, had a name or PCP change, or for any other reason that requires a change to the information on the current ID card.

f. If the MCO has knowledge of any MCO member permitting the use of his/her ID card by any other person, the MCO must immediately report this information to the Special Investigation Unit in the Department of Health and Human Services Division of Public Health at (402) 471-9407 (Lincoln and Greater Nebraska) or (402) 595-3789 (Omaha).

g. The MCO must ensure that its subcontractors can identify members in a manner that will not result in discrimination against the members, in order to provide or coordinate the provision of all benefits and services, expanded services, and/or out-of-network services.

h. Pharmacy-Related ID Card Requirements

The MCO must provide, on the member's ID card, prescription billing information that:

vi. Complies with the standards set forth in the National Council for Prescription Drug Programs' Health Care Identification Card Pharmacy and/or Combination ID Card Implementation Guide at the time of issuance of the card.

vii. Includes, at a minimum, the following data elements:

a) The name or identifying trademark of the MCO and the prescription benefit manager.

b) All electronic transaction routing information and any other numbers required by the MCO or its benefit administrator to process a prescription claim electronically.

10. Member Website

a. The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the MCO and receive responses).

b. The MCO website must include general and up-to-date information about the Nebraska Medicaid program and the MCO. All material to be included on the website must be submitted and approved by MLTC in advance of its intended posting. MLTC will review and approve or request changes as quickly as practical but within 30 calendar days of receipt.

c. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website.

d. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.

e. The MCO website must follow all written marketing guidelines included in Section IV G Member marketing..

f. Us of proprietary items that would require use of a specific browser or other interface is not allowed.

g. The MCO must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:

i. The most recent version of the member handbook.

ii. Telephone contact information for the MCO, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number.

iii. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the MCO network.

iv. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment.

v. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility.

vi. Information about how to file grievances and appeals.

11. Medical Records

a. A member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers, as well as but not limited to, those

kept in placement settings such as nursing facilities, assisted living facilities, and other home and community based providers.

b. Each member is entitled to a copy of his or her medical record at no cost.

c. The MCO must have written policies and procedures to maintain the confidentiality of all medical records in compliance with applicable law.

d. he MCO is responsible for ensuring that a medical record (hard copy or electronic) is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

e. The MCO must ensure the medical record includes, at a minimum, the following:

i. Member-identifying information, including name, member ID number, date of birth, gender, and legal guardianship (if applicable).

ii. Primary language spoken by the member and any translation needs.

iii. Services provided through the MCO, date of service, service site, and name of service provider.

iv. Medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO.

v. Referrals including follow-up and outcome of referrals.

vi. Documentation of emergency or after-hours encounters and follow-up.

vii. Signed and dated consent forms (as applicable).

viii. Documentation of immunization status.

ix. Documentation of advance directives, as appropriate.

x. Documentation of each visit must include:

a) Date and begin and end times of service.

b) Chief complaint or purpose of the visit.

c) Diagnoses or medical impression.

d) Objective findings.

e) Patient assessment findings.

f) Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG).

g) Medications prescribed.

h) Health education provided.

xi. Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider. Initials of providers must be identified with correlating signatures.

xii. Documentation of EPSDT requirements including but not limited to:

a) Comprehensive health history.

b) Developmental history.

c) Unclothed physical exam.

d) Vision, hearing and dental screening.

e) Immunizations.

f) Lab testing including mandatory lead screening.

g) Health education and anticipatory guidance.

f. The MCO must have written policies and procedures for the maintenance of medical records to ensure that records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and facilitates an adequate system for follow-up treatment.

g. The MCO must have written standards for documentation on medical records for legibility, accuracy and plan of care that comply with applicable law.

h. When a member changes PCPs, his/her medical records or copies of medical records must be forwarded to the new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

i. MLTC is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. The MCO may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the Nebraska Medicaid program.

j. MLTC must be afforded access to all members' medical records, whether electronic or paper, within 20 business days of receipt of the request or more quickly if necessary in MLTC's sole determination.

k. Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in State statute, and substance use disorder information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR 2.1 et seq.

12. Advance Directives

a. The MCO must maintain written policies and procedures for advance directives, as described in 42 CFR 489.100.

b. The MCO must provide written information to all adult members with respect to:

vi. Their rights under applicable law.

vii. The MCO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

c. The MCO is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive.

d. The MCO must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with MLTC or the DHHS Division of Public Health.

e. Any written information on advance directives must reflect changes in State law as soon as possible, but no later than 90 calendar days after the effective date of a change.

13. Communication with New Members

a. MLTC's enrollment broker is required to send to the MCO a daily electronic transmission file that contains the names, addresses, and telephone numbers of all members newly assigned to the MCO, with an indicator for members who were auto-assigned. The MCO must use this file to identify new members, initiate communication with new members via welcome packet mailings and calls, and assign members to a PCP, if the member has not already chosen one.

b. Welcome Packets

i. The MCO must send a welcome packet to new members within ten business days of receiving the new member file.

ii. The MCO must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two or more new members, the MCO is only required to send one welcome packet.

iii. All contents of the welcome packet are considered member materials and, as such, must be submitted for review and approval by MLTC a minimum of 45 calendar days prior to the contract's start date. The materials must comply with the requirements of this RFP and 42 CFR 438.10 (f)(6). The welcome packet must include, at a minimum:

a) A welcome letter with MCO contact information. If the MCO ID card is mailed separately, the welcome letter must also state that the member will receive his/her member ID card separately.

b) Information on how to request a member handbook.

c) The MCO member ID card (if not mailed separately).

d) Notice that the provider directory and Member Handbook are available on the member portal and that the member may request a hardcopy if he/she wants one. Directions for how to obtain hardcopies must be included in this notice.

e) Other information that the MCO wishes to include, such as an EPSDT program periodicity schedule, prenatal care materials, guidance regarding emergency services, availability of community services/resources, and any other materials that might be appropriate for the member.

c. Welcome Calls

i. The MCO must make welcome calls to new members within 15 business days of the date the MCO sends the welcome packet.

ii. A minimum of 45 calendar days prior to the contract's start date, the MCO must develop and submit to MLTC for approval a script to be used during the welcome call to discuss the following information with the member:

a) A brief explanation of the program.

b) A discussion of member confidentiality requirements.

c) The availability of oral interpretation and written translation services and how to obtain them free of charge.

d) The concept of patient-centeredness, including the importance of the member making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition. If the member did not already select his/her PCP, the member should be advised that s/he may select a PCP and the MCO must assist with this process, if needed.

e) A determination of whether the member is pregnant, has a chronic condition, faces barriers to accessing care (e.g., transportation needs, mobility limitations)

or any special health care needs. Assistance in making an appointment with the PCP must be offered to all members with any of these issues.

f) Assistance with any needed referrals, including but not limited to, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program.

iii. The MCO must make three (3) attempts to contact the member. If the MCO discovers that the member has lost or has never received the welcome packet, the MCO must resend it.

iv. The MCO must report to MLTC, on a monthly basis, the name, telephone number(s), and Medicaid Recipient ID Number of each member it was unable to contact after three (3) attempts.

v. The MCO may propose to MLTC an alternate method and plan for welcoming members per this section, if anticipated to be more effective. MLTC in its sole discretion may approve this alternate method.

14. Member Education

a. In all its written and verbal communications with its members, the MCO must provide ongoing education about how the member can improve his/her health and wellness. This should include, but not be limited to, the member handbook, the new member welcome packet, the member newsletter, other member mailings, and communication with member services representatives, case managers, and other MCO staff.

b. The MCO is responsible for educating members on the appropriate utilization of ER services, including behavioral health emergencies.

c. A minimum of 45 calendar days prior to the contract start date, the MCO must submit to MLTC for review and approval its proposed member education plan. This plan must include, but not be limited to:

i. The MCO's plans for new member outreach, including welcome packets and welcome calls, as well as ongoing member education.

ii. How the MCO plans to reach out to members in need of care management services.

iii. The MCO's plan to incorporate patient engagement tools such as smartphone-based support programs, mobile applications or text messaging innovations. A smartphone-based support program could include the following features:

a) Mobile applications and/or mobile-friendly content that is accessible across a broad range of electronic devices.

b) Consumer-friendly and engaging content that helps keep patients on-track with key health appointments and screenings.

c) Tools to help stratify users by risk profile and direct the higher risk users to State-based or MCO-based resources.

d) Outreach support to educate patients about the mobile tools.

e) Reporting and analytics to help the State measure the effectiveness of the electronically-based support program.

iv. How the MCO plans to meet the informational needs, relative to member education, for the physical and cultural diversity of the State. This may include, but is not limited to, a description of the provisions for non-English speaking members, interpreter services, and alternate communication mechanisms (such as sign language, Braille, or audio tapes).

v. A list of all subcontractors engaged in marketing or member education activities for the MCO.

d. The MCO may not conduct member education or distribute member education materials in provider offices.

G. MEMBER MARKETING

1. General Guidelines for Marketing

a. Marketing, for the purposes of this RFP, is defined in 42 CFR 438.104(a) as any communication from a MCO to a Medicaid enrollee, who is not enrolled in that MCO, that can reasonably be interpreted to try to influence the Medicaid enrollee to 1) enroll in that particular MCO, or 2) either not enroll in, or dis-enroll from, another MCO.

b. Marketing is different than member education. Member education is defined as communication with a MCO member for the purpose of retaining the member as a member and improving his/her health status.

c. Marketing materials include both verbal presentation and written materials, as well as all types of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts, and electronic messages designed to increase awareness and interest in the MCO. This includes any information that references the MCO, is intended for general distribution, and is produced in a variety of print, broadcast, or direct marketing media.

d. All marketing activities must be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of members, Medicaid enrollees, or the general community.

e. All marketing materials and activities must comply with the requirements in 42 CFR 438.10 and the MLTC requirements set forth in this RFP.

f. Under the Nebraska Medicaid managed care program, all direct marketing to Medicaid enrollees or potentially eligible individuals will be performed by MLTC or its designee in accordance with 42 U.S.C. 1396u-2(d)(2)(A) and 42 CFR 438.104.

g. The MCO is responsible for the creation, production, and distribution of its own marketing and member materials. MLTC and its enrollment broker will only be responsible for distributing general material developed and produced by the MCO for inclusion in the enrollment package distributed to Medicaid enrollees. MLTC will determine which materials will be included in the enrollment broker generated packet and which materials will be distributed by the MCO.

h. Activities involving distribution and completion of a MCO enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of MLTC's enrollment broker.

i. The MCO must provide assurances to MLTC that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud members/enrollees or MLTC as specified in 42 U.S.C 1396u-2(d)(2) and 432 CFR 438.104. Marketing materials must not contain any assertion or statement (whether written or verbal) that:

i. The member must enroll in the MCO in order to obtain or not to lose benefits.

ii. That the MCO is endorsed by CMS, the Federal or State government, MLTC, or any similar entity.

j. If a person who provides a testimonial or endorsement for the MCO has a financial interest in the company, this fact must be disclosed in the member/marketing materials.

k. The MCO shall comply with the Office of Minority Health, DHHS' Cultural and Linguistically Appropriate Services Guidelines, which is available at: http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53, and participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Medicaid enrollees.

l. The MCO must ensure that:

i. Marketing materials are distributed statewide.

ii. The MCO does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

iii. The MCO does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

2. Marketing Plan

a. The MCO must develop and implement a plan detailing the marketing activities it will undertake and materials it will create during the contract period, which must incorporate the requirements of this RFP. The detailed, proposed plan must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date.

b. The MCO must not begin member marketing activities associated with this contract prior to approval of the marketing plan by MLTC.

c. The plan must include at a minimum:

i. Stated marketing goals and strategies.

ii. A marketing calendar, which begins with the date of the signed contract between MLTC and the MCO, and runs through the first calendar year of providing services to Medicaid members, that addresses all marketing areas, including advertising plans, website development and launch plans, printed materials, material distribution plans (including specific locations), or outreach activities (health fairs, area events, etc.).

iii. A summary of value-added benefits to be used by MLTC to create a plan comparison chart to assist Medicaid enrollees in selecting the MCO that best meets their needs.

iv. Distribution methods and schedules, including media schedules for electronic or print advertising (including date and station or publication).

v. How the MCO plans to meet the informational needs, relative to marketing (for prospective enrollees), of the physical and cultural diversity within the State. This may include but is not limited to: a description of the provisions for non-English speaking prospective enrollees, interpreter services, or alternate communication mechanisms (such as sign language, Braille, audio tapes, etc.).

vi. A list of all subcontractors engaged in marketing activities for the MCO.

vii. A copy of the training curriculum for marketing representatives (internal staff and subcontractors).

viii. The MCO's procedure for monitoring and enforcing compliance with all marketing guidelines, in particular the monitoring of prohibited marketing methods, among internal staff and subcontractors.

ix. Copies of all marketing materials (print and multimedia) that are directed at Medicaid enrollees planned for distribution by the MCO or any of its subcontractors.

x. Copies of marketing materials that are: (1) currently in concept form, but not yet produced, including a detailed description, or (2) samples from other states that will be duplicated in a similar manner for the Nebraska Medicaid managed care population.

xi. Details of proposed marketing activities and events.

xii. Details regarding the basis it uses for awarding bonuses or increasing the salary of marketing representatives or any other employees involved in marketing activities.

xiii. Details about supplying current materials, as well as plans to remove outdated materials, from public areas.

xiv. The MCO's protocols for responding to unsolicited direct contact (verbal or written) from a Medicaid enrollee or potentially eligible individual. This should include circumstances that will:

a) Initiate referral to the enrollment broker.

b) Initiate referral to the Medicaid Eligibility customer service line.

c) Terminate the conversation.

d. Any changes to the marketing plan, included materials or activities, must be submitted to MLTC for review and approval a minimum of 45 calendar days before intended implementation of the marketing activity.

e. The plan shall be updated quarterly and submitted to MLTC for dissemination to the Medical Assistance Advisory Committee for review, in accordance with 42 CFR 431.12.

3. Allowable Marketing Activities

a. The MCO and its subcontractors are permitted to perform the following activities:

i. Distribute general information through mass media (i.e., newspapers, magazines, and other periodicals; radio; television; the internet; public transportation advertising; billboards; and, any other media outlets), in compliance with prohibitions to placement detailed in this RFP.

ii. Make telephone calls and home visits to members currently enrolled in the MCO (member education and outreach), for the purpose of educating them about services offered by or available through the MCO.

iii. Respond to verbal or written requests for information made by Medicaid enrollees, in compliance with the marketing plan approved by MLTC.

iv. Provide promotional giveaways which do not exceed $15.00 in value, to current members; persons not currently members cannot receive promotional giveaways from the MCO.

v. Attend or organize activities that benefit the entire community, such as health fairs or other health education and promotion activities. MLTC must be notified of the activity and details must be provided about the planned marketing activities using the process described in this RFP.

vi. Attend activities at a business only at the invitation of the entity. MLTC must be notified in advance of the activity and details must be provided.

vii. Attend events at the request of MLTC to disseminate or share information about the MCO, its services and outcomes.

viii. Conduct telephone marketing only during incoming calls from Medicaid enrollees. The MCO may return telephone calls to potential members only when requested to do so by the caller. The MCO must utilize the response plan outlined in the marketing plan during these calls, as approved by MLTC.

ix. Send plan-specific materials to Medicaid enrollees only at their request.

b. If there is any instance in which a MCO-allowable activity conflicts with a prohibited activity, the prohibited activity guidance must be followed.

4. Prohibited Marketing Activities

The MCO and its subcontractors are prohibited from engaging in the following activities:

a. Marketing directly to Medicaid enrollees or potentially Medicaid eligible individuals, including persons currently enrolled in Medicaid or other MCOs. Direct marketing includes direct mail advertising; unsolicited email ("spam"); and, door-to-door, telephonic, or other "cold call" marketing techniques.

b. Asserting that the MCO is endorsed by CMS, the Federal or State government, MLTC, or any similar entity.

c. Distributing plans and materials or making any statement (written or verbal) that MLTC determines to be inaccurate, false, confusing, misleading, or intended to defraud members or MLTC. This includes statements that mislead or falsely describe covered services, membership or availability of providers, or qualifications or skills of providers.

d. Portraying competitors or potential competitors in a negative manner.

e. Assisting with enrollment or improperly influencing MCO selection.

f. Inducing or accepting a member's enrollment or disenrollment from any Medicaid enrollee or member not currently enrolled with the MCO;

g. Using the seal of the State of Nebraska, or MLTC's name, logo, or other identifying marks on any materials produced or issued, without the prior written consent of MLTC.

h. Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage, or that MCOs or a particular MCO is the only provider of Medicaid services and the potential enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits.

i. Comparing itself to another organization/MCO by use of the other's name.

j. Sponsoring or attending any marketing or community health activities or events without notifying MLTC within the timeframes specified in this RFP.

k. Engaging in any marketing activities, including unsolicited personal contact with a Medicaid enrollee or potentially eligible individual, at an employer-sponsored enrollment event when employee participation is mandated by the employer.

l. Marketing or distributing marketing materials, including member handbooks, or soliciting members in any other manner, inside, at the entrance, or within 100 feet of DHHS local offices without prior approval from MLTC. Medicaid eligibility office staff or approved MLTC agents are the only authorized personnel to distribute such materials.

m. Conducting marketing or distributing marketing materials in hospital ERs, including the ER waiting areas, patient rooms, or treatment areas.

n. Registering or asserting any copyright or releasing any report, graph, chart, picture, or other document relating to services provided under this contract, without the prior written consent of MLTC.

o. Purchasing or otherwise acquiring or using mailing lists of Medicaid eligible individuals from third-party vendors, including providers and state offices.

p. Using raffle tickets, event attendance, or sign-in sheets to develop mailing lists of prospective members.

q. Charging members for good or services distributed at events.

r. Charging members a fee for accessing the MCO website.

s. Influencing enrollment in conjunction with the sale or offering of any private insurance.

t. Using terms that would influence, mislead, or cause potential members to contact the MCO, rather than the MLTC-designated enrollment broker, for enrollment.

u. Referencing the private insurance component of the MCO, if any, in any of its Medicaid MCO enrollee marketing materials.

v. Using terms in marketing materials such as “choose,” “pick,” “join,” etc., unless the marketing materials include the enrollment broker’s contact information.

5. Media Contacts

The MCO must not provide information to the media or give media interviews without the prior consent of MLTC. Any contacts by the media or other entity or individual not directly related to the program must be referred to MLTC.

6. Provider Marketing Guidelines

a. When conducting any form of marketing in a provider’s office, the MCO must obtain and keep on file the written consent of the provider.

b. The MCO shall not require its providers to distribute MCO-prepared marketing communications to their patients.

c. The MCO shall not provide incentives or giveaways to providers to distribute them to MCO members or potential MCO members.

d. The MCO shall not allow providers to solicit enrollment or disenrollment in a MCO, or distribute MCO-specific materials at a marketing activity.

e. The MCO shall not provide printed materials to providers with instructions detailing how to change MCOs to members of other MCOs.

f. The MCO must instruct participating providers regarding the following communication requirements:

i. Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they contract.

ii. Participating providers may display and distribute health education materials for all contracted MCOs or they may choose not to display and distribute for any contracted MCOs. Health education materials must adhere to the following guidance:

a) Health education posters cannot be larger than 16 x 24 inches.

b) Children’s books, donated by MCOs, must be in common areas.

c) Materials may include the MCOs name, logo, telephone number and website address.

d) Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.

iii. Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom/which the provider has a contract.

iv. Providers may display MCO participation stickers, but if they do they must display stickers for all contracted MCOs or choose not to display stickers for any contracted MCOs.

v. MCO stickers indicating that the provider participates with a particular MCO cannot be larger than 5 x 7 inches and cannot indicate anything more than “the MCO is accepted or welcomed here”.

vi. Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, providers may not recommend one MCO over another, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone, or a computer in the office.

vii. On actual termination of a contract with the MCO, a provider who/that has contracts with other MCOs may notify their patients of the change and the impact of the change on the patient, including the date of the contract termination. Providers must continue to see current patients enrolled in the MCO through the termination date, according to all terms and conditions specified in the contract between the provider and the MCO.

viii. MCOs must not produce branded materials instructing members about how to change to a different MCO. They must use MLTC-provided or approved materials and refer members directly to the enrollment broker for needed assistance

H. GRIEVANCES AND APPEALS

1. General Requirements

a. The MCO must have a grievance system for members that meet all Federal and State regulatory requirements, including a grievance process, an appeal process, and access to the State’s fair hearing system. The MCO must distinguish between a grievance, grievance system, and grievance process, as defined below:

i. A grievance is a member’s expression of dissatisfaction with any aspect of care other than the appeal of actions.

ii. The grievance system includes a grievance process, an appeal process, and access to the State’s fair hearing system. Any grievance system requirements apply to all three components of the grievance system, not just to the grievance process.

iii. A grievance process is the procedure for addressing members’ grievances.

b. The MCO must:

i. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability.

ii. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.

iii. Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member’s grievance must be a health care professional with clinical expertise in treating the member’s condition or disease if any of the following apply:

a) The denial of service is based on lack of medical necessity.

b) Because of the member’s medical condition, the grievance requires expedited resolution.

c) The grievance or appeal involves clinical issues.

iv. Take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision.

v. Provide access to MLTC and/or its designee for any information related to grievances or appeals filed by its members. MLTC will monitor enrollment and termination practices to ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR 438.226-228.

2. Complaint and Grievance Processes

a. A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.

b. A member may file a grievance with the MCO or the State at any time.

c. The MCO must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes and not to exceed 90 calendar days from the day on which the MCO receives the grievance.

d. MLTC will establish the method the MCO must use to notify a member of the disposition of a grievance.

3. Service Authorizations and Notices of Action

a. Service Authorization

i. The MCO must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.

ii. The MCO must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

b. Notice of Adverse Action

i. The MCO must notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404.

ii. The MCO must give the member written notice of any action (not just service authorization actions) within the timeframes required for each type of action. The notice must explain:

a) The action the MCO or its subcontractor has taken or intends to take.

b) The reason(s) for the action.

c) The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.

d) The member's or the provider's right to file an appeal.

e) The member's right to request a State fair hearing.

f) Procedures for exercising a member's rights to appeal or grieve a decision.

g) Circumstances under which expedited resolution is available and how to request it.

h) The member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.

iii. The notice must be in writing and must meet the language and format requirements described in Section IV.F Member Services and Education.

c. Timeframes for Notice of Action

i. The MCO must provide notice to the member a minimum of ten (10) days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

ii. The period of advanced notice required is shortened to five (5) days if probable member fraud has been verified.

iii. The MCO must give notice by the date of the action under the following circumstances:

a) The death of a member.

b) A signed written member statement requesting service termination or giving information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services.

c) The member's admission to an institution where he or she is ineligible for further services.

d) The member's address is unknown and mail directed to him/her has no forwarding address.

e) The member has been accepted for Medicaid services by another state.

f) The member's physician prescribes the change in the level of medical care.

g) An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1989.

h) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 calendar days (applies only to adverse actions for nursing facility transfers).

iv. The MCO must provide notice on the date of action when the action is a denial of payment.

v. Standard Service Authorization Denial

vi. The MCO must give notice as expeditiously as the member's health condition requires, and within State-established timeframes, that may not exceed 14 calendar days following receipt of the request for service. The timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCO extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The MCO must issue and carry out its determination as expeditiously as the member's health condition requires and in any event no later than the date the extension expires.

vii. Expedited Service Authorization Denial

For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to

attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCO may extend the time period by up to 14 calendar days if the member requests an extension or if the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest.

viii. Untimely Service Authorization Decisions

The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and, therefore constitutes an adverse action.

4. Appeal Processes

a. A member may file a MCO-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.

b. The member or provider may file an appeal within 90 calendar days from the date on the MCO's Notice of Action.

c. The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.

d. The MCO must:

i. Ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution.

ii. Ensure that there is only one level of appeal for members.

iii. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

iv. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination.

v. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.

e. The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must:

i. Make reasonable efforts to give the member prompt verbal notice of the delay.

ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision.

iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

f. The MCO must provide written notice of disposition, which must include:

i. The results and date of the appeal resolution; and

ii. For decisions not wholly in the member's favor:

a) The right to request a state fair hearing.

b) How to request a state fair hearing.

c) The right to continue to receive benefits pending a hearing.

d) How to request the continuation of benefits.

e) If the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.

5. Expedited Appeals Process

a. The MCO must establish and maintain an expedited review process for appeals that the MCO determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.

b. The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.

c. The MCO must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.

d. The MCO must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than 72 hours after the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest.

e. For any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.

f. In addition to written notice, the MCO must also make reasonable efforts to provide verbal notice of resolution.

g. The MCO must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.

h. If the MCO denies a request for expedited resolution of an appeal, it must:

vi. Transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCO receives the appeal with a possible extension of 14 calendar days.

vii. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.

6. Continuation of Benefits

a. The MCO must continue a member's benefits if any one of the following apply:

i. The appeal is filed timely, meaning on or before the later of the following:

a) Ten (10) calendar days after the MCO mailing the Notice of Action; or

b) The intended effective date of the MCO's proposed action.

ii. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

iii. The services were ordered by an authorized provider.

iv. The authorization period has not expired.

v. The member requests an extension of benefits.

b. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

vi. The member withdraws the appeal.

vii. The member does not request an appeal within ten (10) calendar days from when the MCO mails an adverse MCO decision.

viii. A state fair hearing decision adverse to the member is made.

ix. The authorization expires or authorization service limits are met.

c. The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action.

7. Access to State Fair Hearings

a. A member may request a state fair hearing. The provider may also request a state fair hearing if the provider is acting as the member's authorized representative. A member or his/her representative may request a state fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

b. If the MCO takes action and the member requests a state fair hearing, the State must grant the member a state fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's representative (if any) by the MCO.

c. The member or the member's representative (if any) may request a state fair hearing within 90 calendar days from the date of the MCO Notice of Action.

d. The parties to the State fair hearing include the MCO, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.

e. The State must ensure that any member dissatisfied with a determination denying a member's request to transfer plans/disenroll is given access to a State fair hearing.

8. Reversed Appeals

a. If the MCO or the state fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but in no event later than 72 hours from the date the MCO receives notice reversing the determination.

b. The MCO must pay for disputed services if the MCO or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

9. Grievance and Appeal Recordkeeping Requirements

The MCO must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information:

a. A general description of the reason for the appeal or grievance.

b. The date the grievance or appeal was received.

c. The date of each review or, if applicable, review meeting.

d. Resolution at each level of the appeal or grievance process, as applicable.

e. Date of resolution at each level of the appeal or grievance process, as applicable.

f. Name of the covered person by or for whom the appeal or grievance was filed.

The MCO is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.

10. Information to Providers and Subcontractors

The MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract:

a. The member's right to a State fair hearing, how to obtain a hearing and representation rules at a hearing.

b. The member's right to file grievances and appeals and the requirements and timeframes for filing them.

c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings.

d. The toll-free number(s) to use to file verbal grievances and appeals.

e. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending.

f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

11. Reporting of Complaints, Grievances, and Appeals

The MCO is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals. MLTC reserves the right to extend the monthly reporting requirement at its sole discretion. This information will be used by MLTC to measure the MCO's performance.

I. PROVIDER NETWORK REQUIREMENTS

1. General Provider Network Requirements

a. The network must be supported by written contracts between the MCO and its providers.

b. The MCO must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.

c. There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.

d. The MCO must have available non-emergent after-hours physician or primary care services within its network.

e. Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and

time are fully outlined in Attachment 2 - Access Standards. The MCO must ensure that providers are available within these requirements.

f. The MCO's network providers must comply with all requirements set forth in this RFP.

g. The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements in this section and Attachment 2 – Access Standards.

h. The MCO must make a good faith effort to contract with urgent care centers in the State to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.

i. In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not advertise or otherwise hold itself out as having an exclusive relationship with any provider.

j. In all its contracts with health care professionals, the MCO must comply with the requirements specified in 42 CFR 438.214, 438.610, 455.104, 455.105, 455.106, and 1002.3, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination.

k. The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters in accordance with 42 CFR 438.206(c)(2).

l. The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.

m. The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.

2. Provider Discrimination Prohibition

a. A MCO may not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider who/that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification.

b. MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

c. If a MCO declines to include individual or group providers in its network, it must give the affected providers written notice of the reason for its decision. Federal requirements at 42 CFR 438.12(b) shall not be construed to:

i. Require the MCO to contract with providers beyond the number necessary to meet the needs of its members.

ii. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

iii. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to its members.

3. Mainstreaming of Members

a. To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency),

ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same.

Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f):

i. Denying or not providing a member any covered service or access to an available facility.

ii. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary.

iii. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.

iv. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.

b. If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.

c. If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures shall subject the MCO to intermediate sanction or contract termination.

4. Establishing the Network

a. The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members. The MCO must submit documentation to MLTC, in a format approved by MLTC, to demonstrate it meets this requirement at contract start date and any time there is a significant change (as defined by the State) in the MCO's operations that impacts services.

b. The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, and pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.

c. The MCO must provide an adequate network of (PCPs) to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.

d. The MCO must maintain a network of qualified providers that meets appointment availability and geographic access standards defined in Attachment 2 – Access Standards and all requirements in this section. Attachment 3 – Nebraska Counties Classified by Urban/Rural/Frontier Status provides a map of Nebraska counties classified by urban, rural, and frontier status, as this classification is referenced in the access standards.

e. The MCO's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members. In addition, the MCO must make a good faith effort to include providers currently contracted with behavioral health regions in Nebraska.

f. The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.

g. For members who meet SHCN criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

h. The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions:

i. Co-occurring mental health and substance use disorders.

ii. Co-occurring mental health and substance use disorders and developmental disabilities.

iii. Serious and persistent mental illness.

iv. Severe emotional disturbance among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., Child Welfare, Probation, Developmental Disabilities, etc.).

v. Sex-offending behaviors.

vi. Eating disorders.

vii. Co-occurring serious mental illness (SMI) and common chronic physical illnesses.

i. The MCO must contract with providers who/that demonstrate a commitment to the behavioral health principles of care defined in Section IV.L Care Management of this RFP, including principles of rehabilitation and recovery from mental illness and substance use disorder; a focus on recovery-oriented, trauma-informed services and trauma-specific treatment (e.g., trauma-focused cognitive behavioral therapy); consumer and family involvement in program management and oversight; a family-driven and strengths-based approach to working with children and their families; cultural and linguistic competency; and training for staff about these principles. In addition, the MCO must collaborate with the DHHS Division of Behavioral Health and State behavioral health regions in establishing its network.

j. The MCO's provider network must be submitted to the State, via the provider enrollment file, a minimum of 90 calendar days prior to the contract's start date. A list of Medicaid eligible providers will be provided by MLTC.

k. If any service or provider type is not available to a member within the mileage radius specified in Attachment 2 – Access Standards, the MCO must submit to MLTC, for approval a minimum of 45 calendar days prior to implementation, verification that the covered services are not available within the required distance.

l. The MCO is not precluded from making arrangements with a provider outside the State for members to receive a higher level of skill or specialty than the level that is available within the State.

5. Contracting with FQHCs and RHCs

A MCO must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the MCO and a FQHC or RHC, the MCO must notify MLTC.

6. Adequate Capacity

When establishing and maintaining the network, the MCO must consider:

a. Its anticipated Medicaid enrollment.

b. The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCO.

c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.

d. The numbers of network providers who/that are not accepting new Medicaid patients.

e. The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

f. Members with special health care needs, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.

7. Patient-Centeredness/Patient-Centered Medical Homes

a. The MCO must promote and facilitate the capacity of its providers to provide patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. Patients must be active participants in their own health and well-being; they must be cared for by a physician who leads a medical team that coordinates all aspects of the preventive, acute, and chronic needs of members, using the best available evidence and appropriate technology. The MCO's implementation of PCMHs must be inclusive of pediatric practices. Minimum standards for Patient Centered Medical Homes are listed in Attachment 4 – Patient-Centered Medical Home Standards.

b. Requirements of a PCMH include:

i. Providing comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited to, electronic contacts and ongoing care coordination and health maintenance tracking.

ii. Providing primary health care services for members and appropriate referral to other health care professionals or health professionals with structured follow-up.

iii. Planning and coordinating activities to prevent illness and disease.

iv. Encouraging active participation by a member and his/her family, guardian, or authorized representative, when appropriate, in health care decision-making and care plan development.

v. Facilitating the partnership between members, their PCP, and when appropriate, the member's family.

vi. Encouraging the use of specialty care services and supports.

vii. Providing enhanced access to care outside normal business hours of operation.

viii. Facilitating open scheduling and same-day appointments where possible.

c. The MCO must strive to improve the ability of its behavioral health provider network to meet all the health needs of members through strengthened collaboration with PCPs, service providers, inpatient hospital providers, and consumer/peer providers.

d. The MCO must manage its behavioral health provider network to integrate with other programs and services members receive to promote their recovery, empowerment, and the use of their and their families' strengths, when appropriate, to achieve members' clinical goals and health outcomes. The MCO must work with its providers to coordinate with the following formal and informal resources and programs:

i. Rehabilitation programs that promote and provide skill-building, community support, supported employment and full competitive employment for members.

ii. Recovery support services.

iii. Natural community supports for members and their families.

iv. Anonymous recovery programs (e.g., 12-step programs) for members and their families.

e. The MCO must describe in its response to the RFP, and provide a final PCMH Implementation Plan within 90 calendar days of the date of this contract that also describes, its methodology for promoting patient centeredness/PCMHs within its provider network. The plan should include, but not be limited to:

i. Provision of technology assistance to assist providers in the implementation of patient centeredness, including, but not limited to, electronic health record funding.

ii. Any payment methodology, such as incentive payments, to PCPs to support this transformation.

iii. Provision of technical assistance to assist the PCP's transformation to PCMH recognition (including education, training tools, and data relevant to member clinical care management).

iv. Facilitation of specialty provider network access and coordination to support patient centeredness.

v. Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as coordination of services with specialty behavioral health providers and other community services.

vi. Facilitation of data interchange among PCPs, specialists, laboratories, pharmacies, and other appropriate providers.

vii. A methodology for evaluating the level of provider participation and the health outcomes achieved. MLTC will work with the MCOs to develop a common evaluation methodology. The findings from these evaluations shall be included in the MCO's annual quality evaluation report.

8. Pharmacy Network

a. The MCO must accept into its network any pharmacy or pharmacist participating in the Medicaid program provided the pharmacy or pharmacist is licensed and in good standing with MLTC and accepts the terms and conditions of the contract offered to them by the MCO.

b. The MCO or its contracted PBM must obtain active agreement from a participating pharmacy provider prior to the start of services under this contract for that pharmacist to be considered a network provider, even if that pharmacy has an existing relationship for non-Medicaid services with that MCO or its PBM. The pharmacy provider must agree to the terms of the MCO's PBM contract addendum for the Nebraska Medicaid program.

c. The MCO may contract with specialty pharmacies to the extent the MCO determines is necessary to ensure the adequate availability of specialty drugs. The MCO may limit distribution of specialty drugs to a network of pharmacies that meet reasonable requirements to distribute specialty drugs. The MCO may not exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as the pharmacy is willing to accept the terms of the MCO's agreement with its specialty pharmacies. If the MCO maintains a list of designated specialty drugs, the MCO must submit it to MLTC for review and written approval a minimum of 45

calendar days prior to its intended implementation. Changes to the specialty drug list must also be reviewed and approved by MLTC. Specialty drugs are defined in the Glossary section of this RFP.

d. The MCO may utilize mail-order pharmacies in its network, but must not require or incentivize members to use a mail-order pharmacy, including through different member copays. Members who opt to use this service must not be charged fees, including postage and handling fees.

e. The MCO must not designate preferred pharmacies within its network or offer incentives to members to use a designated pharmacy. The MCO must not incorporate branding of any pharmacy onto member ID cards.

9. Clinical Laboratory Improvement Amendments Requirements

In compliance with the Clinical Laboratory Improvement Amendments (CLIA) and the requirements of 42 CFR 493, Subpart A, MLTC requires all clinical laboratories to provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver during the provider registration process. Failure to do so will result in either a termination of an active provider identification number or denial of initial registration. These requirements apply to all clinical laboratories. Pass-through billing or other activities conducted with the intent of avoiding these requirements is prohibited. The MCO may not reimburse providers who do not comply with the above requirements.

10. Appointment Availability and Referral Access Standards

a. Nebraska's appointment availability standards are included in Attachment 2 – Access Standards. MLTC will monitor each MCO's compliance with these standards through regular reporting per Attachment 6 – Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.

b. Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.

c. Follow-up to emergency room visits must be available in accordance with the attending provider's discharge instructions.

d. Direct contact with a qualified MCO clinical staff person must be available to members through a toll-free telephone number at any time. The MCO may not require a PCP referral for appointments with behavioral health providers when the behavioral health providers are in the MCO's network.

e. The MCO is responsible for monitoring and assuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.

f. The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, MLTC may require that they be implemented by the MCOs.

g. The MCO must monitor the practice of placing members who seek any covered services on waiting lists. If the MCO determines that a network provider has established a waiting list and the service is available through another network provider, the MCO must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider. In circumstances in which the member requires residential behavioral health services and is placed on a waiting list, the MCO must require its providers to offer interim services until residential services are available.

11. Geographic Access Standards

a. The MCO must comply with maximum travel times and/or distance requirements per Attachment 2 – Access Standards. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.

b. If there are gaps in the MCO's provider network, the MCO must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the MCO must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.

c. The MCO must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The MCO must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.

12. Provider Outreach and Application Processing

a. The MCO must develop standardized provider application/credentialing forms and provider contracts for use with all providers, and utilize standardized processes.

b. The MCO is required to submit its provider contract template(s) to MLTC with its proposal.

c. The MCO must notify MLTC, a minimum of 15 calendar days in advance, if it decides no longer to accept provider applications for primary care or a certain specialty because member needs and MLTC access standards are being met otherwise. The MCO must also notify MLTC a minimum of 15 calendar days in advance of resuming acceptance of those provider applications.

13. Provider Enrollment in Medicaid

a. The MCO must require that all of its contracted providers enroll with MLTC as an approved service provider. For specific requirements on provider enrollment, refer to the MLTC website at: http://MLTC.ne.gov/medicaid/Pages/med_providerenrollment.aspx.

b. The MCO must begin its credentialing process concurrently with a provider's Medicaid provider enrollment rather than delaying its credentialing process until MLTC has approved a provider's enrollment in Medicaid.

14. Provider Credentialing and Re-Credentialing

a. The MCO is required to establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.

b. The MCO must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCO must:

i. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or

ii. Deny the application and ensure that the provider is not used by the MCO. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.

c. A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.

d. If the MCO delegates credentialing to a subcontractor, the MCO must obtain MLTC approval of (a) the subcontractor and (b) the credentialing process, including components delegated to the MCO's subcontractor. The MCO must require that all licensed medical professionals are credentialed in accordance with MLTC's credentialing requirements. MLTC retains final approval of the credentialing subcontractor and process.

e. The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCO must also accept any standardized provider credentialing

form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.

f. The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.

g. The MCO must re-credential each provider a minimum of every three (3) years, at a minimum, taking into consideration various forms of data, including but not limited to grievances, results of quality reviews, results of member satisfaction surveys, and utilization management information.

h. The MCO must communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.

i. As part of its credentialing process, the MCO must require each provider entity to disclose the following information in accordance with 42 CFR 455.104:

i. The name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

ii. Whether any of the persons named is related to another as spouse, parent, child, or sibling.

iii. The name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:

a) Keep copies of all requests and responses.

b) Make those requests and responses available to MLTC upon request.

c) Advise MLTC when there is no response to a request.

15. Network Administration

a. The MCO must maintain and continually update its network provider database that contains, at a minimum, the following information for each network provider:

i. Network provider name

ii. Contracted services

iii. Site address(es) (street address, city, zip code, region of the State)

iv. Site telephone numbers

v. Site hours of operation

vi. Emergency/after-hours provisions

vii. Professional qualifications and licensing;

viii. Areas of specialty, including specialties related to behavioral health conditions

ix. Cultural and linguistic capabilities

x. Malpractice insurance coverage and malpractice history

xi. Credentialing status

b. The MCO must have the capability to produce a list of network providers, sorted by type of service and by providers' capability to communicate with members in their primary languages. This list must be available to the MCO's clinical staff at all times, and available to network providers and other interested parties upon their request and at no charge. As described in the Member Services section of this RFP, this list must be available on the MCO's website and updated in real time.

16. Network Development Plan

a. The MCO must submit to MLTC a network development plan with its proposal. This plan should demonstrate the MCO's capability of developing a network within the State. While this RFP does not require or promote the solicitation of letters of intent from potential network providers, the MCO shall demonstrate its track record in building networks in the State or other markets, particularly for Medicaid or other public-payer products. The MCO may also describe its efforts to become more familiar and develop relationships with Nebraska providers.

b. From the date of contract award and then every two weeks until the contract effective date, the MCO shall provide updates about its network development activities. This plan must detail the MCO's network status, including GeoAccess reports, and describe any provider network gaps and the MCO's remediation plans.

c. Future network development plans must be submitted by November 1st of each contract year. This document is an assurance of the adequacy and sufficiency of the MCO's provider network. The MCO must also submit, as needed, an updated plan when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, payments, or eligibility of a new population.

d. The MCO must include in its stated future plans a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis must be derived from:

i. Quantitative data, including performance of appointment standards/appointment availability, eligibility/enrollment data, utilization data, network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case contracts by service type.

ii. Qualitative data (including outcomes data), when available, including grievance information; concerns reported by eligible or enrolled members; grievances, appeals, and requests for hearings data; member satisfaction survey results; and, prevalent diagnoses.

iii. Status of provider network issues within the prior year that were significant or required corrective action by the MCO, including findings from the MCO's annual operational review.

iv. A summary of network development efforts conducted during the prior year.

v. Plans to correct any current material network gaps and barriers to network development.

vi. Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing priorities.

vii. The participation of members, family members/caretakers, providers, including State-operated providers, and other community stakeholders in the annual network planning process.

e. The MCO's network development plan must be submitted to MLTC for approval. The MCO must submit periodic progress reports as requested by MLTC.

17. Provider Network Policies and Procedures

a. The MCO must have policies about how it will:

i. Communicate with the network regarding contractual and/or program changes and requirements.

ii. Monitor network compliance with State rules, MLTC policies, and MCO policies, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring a member's care is not compromised during the grievance/appeal processes.

iii. Evaluate the quality of services delivered by the network.

iv. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.

v. Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.

vi. Process provisional credentials for behavioral health service providers.

vii. Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling.

viii. Provide training for its providers and maintain records of such training.

ix. Educate its provider network regarding appointment time requirements.

x. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

b. All policies and procedures must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to intended implementation.

c. The MCO must notify providers and members of impending policy changes a minimum of 45 calendar days prior to implementation.

J. PROVIDER SERVICES

1. Provider Services

The MCO must have a provider services function to provide support and assistance to all its providers. This function must, at a minimum:

a. Be available Monday through Friday from 7:00 am to 8:00 pm (central time) to address non-emergency provider issues and on an anytime basis for non-routine prior authorization requests and emergent provider and pharmacy issues.

b. Have clinical pharmacists available Monday through Friday, 8:00 am to 8:00 pm (central time), for clinical questions and prior authorization processing.

c. Ensure each MCO provider is provided all rights outlined in the MCO's provider handbook.

d. Provide ongoing provider training, respond to provider inquiries, and provide general assistance to providers regarding program operations and requirements.

e. Make regularly scheduled visits to provider sites, as well as ad-hoc visits as appropriate.

2. Provider Toll-Free Telephone Line

a. The MCO must operate a toll-free telephone line to respond to provider questions, comments, inquiries, and complaints. A separate line or menu option must be dedicated to pharmacy and prescription issues, including member copayments, if applicable.

b. The MCO must ensure that provider calls are acknowledged and resolved within three (3) business days of receipt. If the issue cannot be resolved within three (3) business days, the MCO must notify the provider of the expected resolution timeframe, which shall not exceed 30 business days (including referrals from MLTC).

c. The MCO's call center system must have the capability to track provider call management metrics.

d. After normal business hours, the provider services toll-free telephone line must include recorded information regarding normal business hours and instructions about how to verify enrollment for any MCO member with an emergent or urgent medical condition. However, a provider does not have to obtain verification before providing ED services and care.

e. The MCO must measure and monitor the accuracy of responses provided by call center staff and report this monthly to MLTC. Corrective action must be taken by the MCO as necessary to ensure the accuracy of responses by staff.

f. Call center staff must have access to electronic documentation from previous calls made by or on behalf of the member to the MCO's information line(s).

3. Provider Handbook

a. The MCO must submit a provider handbook to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date. The approved handbook must be available on the MCO website within ten (10) calendar days of its approval by MLTC. The MCO may choose not to distribute the handbook by regular mail as long as it provides written notification to providers that it is available online and includes details about how the provider may request a printed copy at no charge to the provider. The provider handbook must include, but is not limited to, the following:

i. Description of the MCO and its corporate entity.

ii. Services and benefits provided by the MCO, including core services and value-added services.

iii. Emergency service responsibilities.

iv. Confidentiality provisions.

v. Process for verifying a member's enrollment in the MCO.

vi. Medical necessity standards as defined by MLTC and the MCO.

vii. Practice guidelines and protocols.

viii. Network provider credentialing process and criteria.

ix. Medical record standards.

x. MLTC's standards for geographic access and appointment availability.

xi. Mainstreaming requirements.

xii. Utilization management requirements, including procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews for all covered services.

xiii. Clinical criteria for admission, continued stay, and discharge for each covered service.

xiv. Reporting requirements for serious reportable events and reportable adverse incidents.

xv. Use of MLTC preferred drug list.

xvi. Pharmacy payer sheet.

xvii. Compound prescription requirements.
xviii. Prospective DUR response requirements.

xix. Paper and electronic claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim, along with samples of clean and complete claims.

xx. Policies and procedures detailing the provider complaint system including, but not limited to, specific instructions about how to contact the MCO to file a provider complaint, the timelines allowed for resolution, and the procedure for escalation of unresolved disputes.

xxi. Policies and procedures for the MCO's Grievance System, including information about how the provider may file a grievance or appeal on a member's behalf with written permission.

xxii. Process for appealing payment and service denial decisions.

xxiii. Procedures for using web-based provider services.

xxiv. Call center number(s) and hours.

xxv. Names and contact information of provider services staff.

xxvi. MCO prompt pay requirements.

xxvii. Information regarding the MCO's chronic care and disease management programs, including instruction about making referrals.

xxviii. Quality performance standards and requirements.

xxix. Expectations for PCPs.

xxx. Provider rights and responsibilities.

b. The MCO must:

i. Modify or supplement the provider handbook by distributing periodic notices to network providers.

ii. Review the handbook a minimum of bi-annually and amend it, if necessary, in consultation with MLTC and (as appropriate) its members, their families, providers, and other stakeholders.

iii. Redistribute the amended portions of the handbook to network providers through a clear change process.

4. Provider Website

a. The MCO must have a provider website. It may be developed within the MCO's existing website (such as a portal) to meet these requirements. The MCO must post up-to-date and accurate information and documents to its provider website. MLTC may request that any information be added, removed, or altered that it determines is inaccurate, misleading, or is any way contrary to the objectives of this contract.

b. The MCO provider website must include general and up-to-date information about the MCO as it relates to the Nebraska Medicaid program. All information must be searchable, and include, but is not limited to:

i. MCO provider handbook and all MCO policies and procedures.

ii. MCO-relevant MLTC bulletins.

iii. Limitations on provider marketing.

iv. Information on upcoming provider trainings.

v. Provider training manuals.

vi. Information about the provider and member grievance system.

vii. Information about obtaining prior authorizations and referrals.

viii. MCO formulary (list of covered medications) and the Nebraska PDL.

ix. MCO pharmacy prior authorization requirements.

x. Updated MCO MAC pricing.

xi. Instructions regarding how and whom to contact for questions about filling prescriptions.

xii. Information about how to contact the MCO's Provider Services staff.

xiii. A link to the MLTC website and other related websites.

xiv. A link to the MCO's corporate website.

xv. MLTC-approved formulary changes and prior authorization requirements, clinical criteria, and revisions a minimum of 30 calendar days prior to the effective date of the requirement or revision.

c. The MCO must, in collaboration with MLTC, determine which program content shall be published on the website. The MCO's website must provide web-enabled transactional capabilities. These capabilities must include, but are not limited to:

i. Provider/member inquiries.

ii. Submission of initial authorization and other requests.

iii. Web-based referral search system that will allow MCO and MLTC staff, providers, members, and any other interested persons to locate network providers through an online searchable database. The searchable database must include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and demographic information.

d. The MCO provider website is considered marketing material, and must be submitted to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date.

e. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing any member eligibility or identification information on the website.

f. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability an issue.

g. The MCO must ensure that the website is maintained with accurate and current information and is compliant, at all times, with the requirements of this RFP.

5. Provider Outreach, Education, and Training

a. The MCO must provide training to all providers and their staff regarding the requirements of the contract, including limitations on provider marketing, identification of special needs of members (including the LTSS population), and the appropriate utilization of emergency room services, including for behavioral health emergencies. The MCO must make initial training available within 30 calendar days of contracting with a provider.

b. The MCO must also conduct ongoing training throughout the duration of this contract, as deemed necessary by the MCO or MLTC, in order to ensure compliance with program standards and the contract. Training sessions must include, but not be limited to:

vi. Face-to-face and tele- or web-conference training sessions

vii. Recorded provider training sessions on or available from the MCO's website

viii. Training and education for nursing facilities regarding billing procedures for when a member transitions from a skilled to a custodial level of care.

ix. Documentation of training sessions and attendance, available to MLTC on request.

c. The MCO must submit a copy of the provider training handbook and training schedule to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date. Any changes to the handbook must be submitted to MLTC a minimum of 45 calendar days prior to scheduled changes and dissemination of such changes.

d. The MCO must develop and offer specialized initial and ongoing training in billing procedures, service authorization requirements, and other procedures it deems appropriate for network providers who/that have traditionally billed and obtained service authorization primarily from Medicaid or Medicare only or who/that are new to the integrated managed care contracts, including behavioral health providers and pharmacists. MLTC shall be advised of these sessions and appropriate staff shall be allowed to attend at their discretion.

e. The MCO must develop, establish, and maintain a provider advisory committee. The committee must have representation from the major provider organizations in the State, as well as individual providers, including behavioral health and pharmacy providers, as well as providers who primarily serve individuals with disabilities. Whenever feasible, MCO staff shall work collaboratively with the provider advisory committee, as well as established provider organizations, to create network development and management strategies and procedures. In addition, the MCO must establish a behavioral health advisory committee to provide input to the provider advisory committee.

f. The MCO must meet with providers and provider associations on a regular basis and at various locations throughout the State. In addition, the MCO must hold a provider forum no less frequently than quarterly, at various locations across the State. The forums must be facilitated by the MCO's Administrator/CEO or designee. The purpose of the forums is to improve communication between the MCO and its providers. The forums must be open to all providers within the MCO's network. The forums must not be the only venue by which the MCO communicates and participates in a discussion and review of the issues affecting its provider network. Provider forum meeting agendas and minutes must be made available to MLTC on request. The MCO must report information discussed during these meetings and forums to the MCO's executive management and MLTC.

6. Collaboration with Network Providers

a. The MCO must promote ongoing and seamless communication between providers and the MCO. To accomplish this task, the MCO must:

i. In addition to establishing and working collaboratively with the provider advisory committee, include provider representatives in the MCO's committee structure, to give providers a direct voice in developing and monitoring clinical policies and operational issues.

ii. Work with providers to improve administrative efficiencies through the use of the MCO's website, information technology, and other strategies identified through provider meetings and on-site visits.

iii. Provide encryption software on request from a provider to allow the exchange of member data via email.

iv. Provide a monthly newsletter that includes articles covering topics of interest for all provider types. This newsletter must be posted to the MCO's website.

b. The MCO must identify a provider network liaison, who will work collaboratively with the provider advisory committee to establish the process for responding to provider concerns; develop provider trainings in response to identified needs or changes in protocols, processes, and forms; and, enhance MCO-provider communication strategies.

c. Throughout the term of the contract, the MCO must alert providers to modifications in the provider handbook and to changes in provider requirements that are not otherwise communicated by MLTC. To accomplish this task the MCO must:

i. Request and obtain from providers an email address, so they can be alerted to access the MCO's website to download updates to the provider handbook and provider requirements.

ii. Email providers and publish on the MCO's website any policy clarification not otherwise communicated by MLTC.

iii. Post notification of policy and procedural changes on the MCO's website. Advance notification to members and providers of changes that will affect access to or provision of services, or payment of services, is required. The MCO must make a good-faith effort to provide a minimum of 45 calendar days' advance notice of any necessary changes.

7. Provider-Patient Communication/Anti-Gag Clause

a. Subject to the limitations described in 42 CFR 438.102(a)(2), the MCO must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following:

i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

ii. Any information the member needs in order to decide among relevant treatment options.

iii. The risks, benefits, and consequences of treatment or non-treatment.

iv. The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions.

b. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a)(1) will be subject to intermediate sanctions.

c. The MCO must comply with the provisions of 42 CFR 438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members and information disclosure requirements related to physician incentive plans.

8. Provider Complaint System

a. A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by the MCO.

b. The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.

c. This system must be capable of identifying and tracking complaints received by telephone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.

d. As part of the provider complaint system, the MCO must:

i. Have dedicated provider services staff for providers to contact via telephone, electronic mail, regular mail, and in person, to ask questions, file a provider complaint, and resolve problems.

ii. Identify a key staff person specifically designated to receive and process provider complaints.

iii. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual, and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's and MTLC's written policies and procedures.

iv. Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process. The names, telephone numbers, and email addresses of these individuals must be provided to MLTC within 15 calendar days of contract signing, and within two business days of any changes.

e. The MCO must prepare and implement written policies and procedures that describe its provider complaint system. These policies and procedures must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract's start date. The policies and procedures must include, at a minimum:

i. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the resolution timeframes.

ii. A description of how providers may file a complaint with the MCO for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function.

iii. A description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf.

iv. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues.

v. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation.

vi. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary.

vii. A process for giving providers (or their representatives) the opportunity to present their cases in person.

viii. Identification of specific individuals who have authority to administer the provider complaint process.

ix. A description of the system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.

f. The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It must include specific instructions regarding how to contact the MCO's provider services staff and contact information for the MCO staff person who receives and processes provider complaints.

g. The MCO must distribute its policies and procedures to in-network providers at the time of contracting and to out-of-network providers with the remittance advice. The MCO may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the MCO's website. This summary must also detail how the in-network provider can request a hard copy from the MCO at no charge to the provider.

K. SUBCONTRACTING REQUIREMENTS

1. As required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3), the MCO is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

a. The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

b. The MCO must ensure that the prospective subcontractor is financially stable, according to the MCO's standards.

c. The MCO must have a written contract between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

d. The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.

e. If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action.

2. The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 90 calendar days prior to their planned implementation. MLTC must have the right to review and approve or disapprove all subcontracts entered into for the provision of any services under this RFP, including but not limited to, the MCO's PBM contract.

3. The MCO must not execute a subcontract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or who/which is otherwise barred from participation in the Medicaid or Medicare programs. The MCO must not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

L. CARE MANAGEMENT

1. General Requirements

a. The MCO must develop a care management program that focuses on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators.

b. The MCO must work with its providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem. Principles that guide this care integration include:

i. The system of care must be accessible and comprehensive, and fully integrate an array of prevention and treatment services for all age groups. It must be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement.

ii. Mental illness and substance use disorder are health care issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings.

iii. Many people suffer from both mental illness and substance use disorder. As care is provided, both illnesses must be understood, identified, and treated as primary conditions.

iv. Relevant clinical information must be accessible to both the primary care and behavioral health providers consistent with Federal and State laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

c. The MCO must assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition.

d. The MCO must incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. CM must engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate.

e. The MCO must identify members who require medium/intensive CM based on their chronic conditions. The MCO must identify and track members whose clinical conditions or social circumstances place them at a higher risk of eventually needing intensive CM services. The proactive engagement of and early intervention with at-risk members may prevent or minimize their eventual need for more intensive CM services.

f. The MCO's CM program must address the social determinants of health and how they may affect members' health and wellness. This requirement includes:

- **i.** Ensuring that all covered services, including mental health or substance use disorder treatment services, appropriate to a member's level of need, are available when and where the member needs them.
- **ii.** Ensuring that all care management staff are familiar with available community resources and will refer members to these resources, such as, but not limited to, housing assistance programs and shelters, food banks/pantries, educational opportunities, and organizations which can assist with and address physical and/or sexual abuse.
- **iii.** Developing, subscribing to, or acquiring a tool accessible to its care management staff that maintains updated information regarding these resources in Nebraska communities within 90 calendar days of the contract start date. The MCO shall make access to this information available to MLTC staff on request.

g. A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained about how social determinates affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, and violence. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.

h. The MCO is required to provide CM separate from, but integrated with, utilization management (UM) and quality improvement (QI) activities. The major components of CM include advocacy, communication, problem-solving, collaboration, and empowerment.

i. As part of the CM system, the MCO must employ care coordinators and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to a member. See staffing requirements in Section IV.D Staffing Requirements.

j. A minimum of 60 calendar days prior to the contract start date, the MCO must provide to MLTC for review and approval a CM program description, policies and procedures, a description of services available at each CM level, member outreach procedures, and flow diagrams.

k. The MCOs must submit policies and procedures specific to care management for individuals who are dually eligible, have adult-onset disabilities, developmental disabilities and/or otherwise receive institutional or community-based long-term supports and services that address the unique needs of these populations.

l. In addition, the MCO must annually review, and update as necessary, with the input, review, and approval of the Clinical Advisory Committee (CAC), the CM policies and procedures. Once they are approved by the CAC, any proposed changes must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to intended implementation. All appropriate staff must be trained about the CM policies and procedures; they must also be shared with providers to promote consistency of care.

2. Health-Risk Screening/Assessment

a. The MCO must provide a health-risk screening to all members on enrollment to identify members in need of CM services.

b. As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members potentially in need of CM services, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, evaluation of claims data, member self-referral, and physician referral. The MCO must submit the algorithms and methodologies it proposes to use to identify potential CM members to MLTC for review and approval a minimum of 60 calendar days prior to their intended implementation.

c. Health-risk assessments must be developed to collect information such as, but not limited to:

i. Severity of the member's conditions/disease state.

ii. Co-morbidities, or multiple complex health care conditions.

iii. Recent treatment history and current medications.

iv. Long-term services and supports the member currently receives.

v. Demographic and social information (including ethnicity, education, living situation/housing, legal status, employment status, food security).

vi. Activities of daily living (including bathing, dressing, toileting, mobility, and eating).

vii. Instrumental activities of daily living (including medication management, money management, meal preparation, shopping, telephone use, and transportation).

viii. Communication and cognition.

ix. Indirect supports.

x. General health and life goals.

xi. Safety (need for welfare/protection to eliminate harm to self or others).

xii. The member's current treatment providers and care plan, if applicable.

xiii. Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma.

xiv. Substance use, including alcohol.

xv. Interest in receiving CM services.

d. The MCO must assign members to risk stratification levels (low, medium, high), which determines the intensity of intervention levels and follow-up care required for each member. These member assignment levels and their criteria must also be provided to MLTC for review and approval a minimum of 60 calendar days prior to their intended implementation.

e. The MCO must ensure that members who have high costs or potentially high costs, or otherwise qualify, be assigned to the medium or high risk level and receive more intensive CM services.

f. The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.

g. The MCO must conduct ongoing predictive modeling to identify members who may need CM evaluation.

3. Behavioral Health Principles of Care

a. The following behavioral health principles of care must guide the MCO's integrated service delivery system:

i. Services will be part of an overall coordinated system of care that ensures access to mental health (MH) and substance use disorder (SUD) treatment services to improve the overall health of every person served. To the fullest extent possible, services should be provided in the community where the member lives.

ii. Services will provide recovery-based care.

iii. Services will be trauma informed.

iv. Services will be person-centered, consumer and family driven, and age and developmentally appropriate.

v. Medicaid SUD services will be delivered in accordance with the principles of recovery-oriented systems of care.

vi. Members will be able to choose their own provider to the fullest extent possible at all levels of treatment.

vii. Services will provide a resiliency-based system of care for children and their families.

b. The MCO must ensure that "active treatment" is being provided to each member. Active treatment includes implementation of a professionally-developed and supervised individual plan of care, in which the member participates and shows progress.

4. Basic CM Services

a. The MCO must develop and adopt a CM program consistent with existing State policies and procedures to ensure all members who are eligible for CM have access to basic CM services.

b. The MCO's basic CM program must promote empowerment of the person and shared decision making. Examples of basic level CM services the MCO may provide include:

i. Assistance with appointment scheduling and identifying participating providers, when necessary.

ii. Assistance with CM and accessing primary care, behavioral health, preventive and specialty care, as needed.

iii. Coordination of discharge planning with a focus on the seriously mentally ill population.

iv. Coordination that links a member to providers, medical services, or residential, social, community, and other support services, when needed.

v. Continuity of care that includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. Continuity of care activities must ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress, or problems. Continuity of care activities must provide processes by which MCO members and network/non-network provider interactions are effective and must identify and address those that are not.

vi. Assistance with identifying and referral to the social supports and community resources that may improve the health and living circumstances of a member, including but not limited to, nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse.

vii. Following up with members and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.

c. The MCO must develop and adopt policies and procedures annually (that have been approved in advance by MLTC) to address the following:

i. A strategy to ensure that all members and/or authorized family members or guardians are involved in care planning, as appropriate.

ii. A method to actively engage members in need of CM who are unresponsive to contact attempts or disengaged from CM.

iii. An approach that uses pharmacy utilization data to tailor CM services.

iv. An approach to encourage participation in CM activities by, and collaboration among, the following providers:

a) PCPs and behavioral health providers. This includes policies that ensure that PCPs refer members to behavioral health specialists when SMI is present or the member identifies as having a SMI.

b) HCBS service coordinators.

c) Community support providers.

v. Procedures and criteria for making referrals to specialists and sub-specialists to ensure that services can be furnished to members promptly and without compromising care. The MCO must (a) provide the coordination necessary for referral of MCO members to specialty providers to determine the need for services outside the MCO network and (b) refer a member to the appropriate service providers.

vi. Results of the identification and assessment of any member with SHCNs to ensure that services and activities are not duplicated and to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

vii. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.

viii. Documentation of referral services and medically indicated follow-up care in each member's medical record.

ix. Documentation in the member's medical record of all urgent care, emergency encounters, and any medically indicated follow-up care.

x. A process that ensures that when a provider is no longer available through the MCO, the MCO allows members, who are undergoing an active course of treatment, to access services from non-contracted providers for an additional 90 calendar days to ensure continuity of care.

xi. A process that ensures continuity of care for members with SHCNs who are in CM.

d. For members assigned to medium risk care management, the MCO must meet basic care management requirement and:

i. Facilitate relapse prevention plans for members with depression and other high-risk behavioral health conditions and their PCPs (e.g., patient education, extra clinic visits, or follow-up telephone calls).

ii. Partner with provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.

iii. Educate provider office staff about symptoms of exacerbation(s) and how to communicate with patients.

iv. Develop speaking points and triggers for making emergency appointments.

v. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors, or unmet needs.

e. For members assigned to high risk care management, the MCO must meet requirements for members assigned to low and medium risk care management and the MCO must develop and adopt policies and procedures (that have been approved in advance by MLTC) for the following:

i. As appropriate, organize the care using a person-centered, inter-disciplinary primary care and specialty treatment team to assist with development and implementation of individual medical care plans, that are in accordance with State QI and UM standards.

ii. Provide list of community resources (for referral).

iii. Plan for coordination and communication with State staff who are responsible for management of HCBS waivers.

iv. Develop a process to engage non-compliant members.

v. Develop a strategy for communication with members and their families, as well as key service and support providers and local social and community service agencies.

vi. Identify providers with special accommodations (e.g., sedation dentistry).

vii. Educate staff about barriers members may experience in making and keeping appointments.

viii. Facilitate group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes, or tobacco use.

ix. Communicate on a member-by-member basis on gaps/needs to ensure that a member obtains baseline and periodic medical evaluations from his/her PCP.

f. The MCO must develop, implement, and evaluate written policies and procedures consistent with existing State policies and procedures, regarding continuity of care. These written protocols must be reviewed on an annual basis by the MCO, be updated as needed, and provided to MLTC a minimum of 60 calendar days in advance of intended implementation for review and approval. In particular, the policies and procedures must address the following situations:

i. Members whose treating providers become unable to continue service delivery for any reason.

ii. Member transitions from the children's system to the adult system.

iii. Member transitions to/from IHS or other tribal agencies.

iv. Member discharges from inpatient and residential treatment levels of care, including State psychiatric hospitals.

5. Coordination with Providers and Other CM Programs

a. Members who are aged, blind, or disabled; dual eligible; or who are enrolled in HCBS waiver programs or other State programs are likely to have one or more case or care managers.

b. The MCO must demonstrate an understanding of health care and social service programs and initiatives offered by MLTC and other State agencies, and leverage those programs when appropriate for members receiving medium and intensive CM. Leveraging of existing programs may take the form of subcontracting or highly collaborative partnering, for example, and is intended to take advantage of existing resources and infrastructures to reduce or eliminate duplication of effort. Highly collaborative partnering must include, but is not limited to, crisis response services in coordination with behavioral health system entities.

c. The MCO must attempt to ascertain whether a member has any other case or care managers, and, if so, to engage with them. The MCO must also attempt to ascertain whether a member has

any other identified caregivers in the member's care planning and CM, and, if so, to engage with them.

d. The MCO is responsible for ensuring coordination between its providers and the WIC program. Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.

e. While the MCO must collaborate with other caregivers for overall planning and management, it retains responsibility for ensuring that the member continues to receive appropriate medical services in the most cost-effective manner.

f. The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.

6. Special Considerations for Pregnant Members

a. The MCO must ensure that Medicaid members under its care who are pregnant begin receiving care within the first trimester, or within seven (7) days after enrolling in the MCO or notification of the member's pregnancy.

b. The MCO must provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services to its female members. A pregnant member must be assured direct access within the MCO's provider network to routine OB/GYN services, and the OB/GYN is required to notify the PCP of his/her provision of such care and coordinate that care with the PCP.

c. The MCO must develop an outreach program to encourage women to seek prenatal services during their first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include distribution of brochures and/or periodic articles that emphasize the importance of this care to all members.

d. The MCO must perform or require health providers to perform a risk assessment of all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO must provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth.

e. The MCO must screen members for the DHHS Division of Behavioral Health Women's Set Aside program and make referrals to the Division of Behavioral Health (DBH) as appropriate. MLTC will provide screening criteria for the program.

f. The MCO must ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO must ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child when the child is added to the MCO.

g. Appropriate referrals must also be made to the WIC program for nutritional assistance and other needed community resources. The MCO is responsible for ensuring that coordination occurs between the WIC program and MCO providers. Coordination includes referral of potentially eligible women, infants, and children and reporting appropriate medical information to the WIC program.

h. The MCO must develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. The MCO is required to provide details of its plan in the MCO Marketing Plan submitted to DHHS for approval. Some goals of this program are to:

i. Improve overall engagement in the maternity population and assist women with keeping appointments and educating them about needed health screenings throughout their pregnancy.

ii. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection with maternity case managers or other public health resources.

i. Improve health decisions across the pregnant population based on available State-based and MCO-based programs and services.

j. The MCO must provide care management services to women postpartum who were identified as high risk during their pregnancy or who had an adverse pregnancy outcome, including preterm delivery within 37 weeks. Care management services shall include referral to safety net services for baby care and breastfeeding support.

7. Coordination with HCBS Service Coordinators

a. The MCO must collaborate and coordinate with HCBS case managers in a manner that complements, but does not duplicate, the member's plan of services and supports.

b. The MCO must develop and submit to MLTC for approval (a minimum of 60 calendar days in advance of intended implementation) a policy and procedures for coordination with HCBS case managers. This policy and these procedures must address methods the MCO will use to ensure that coordination services are not duplicated.

8. Coordination with Tribal Organizations

a. The MCO must develop policies for care coordination/collaboration for members who are Tribal members or are eligible for care through IHS or other Tribally-funded health and human services program, including:

i. Identification and appointment of a Tribal Liaison, to work with IHS and the Tribes.

ii. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the MCO's network.

iii. Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally-operated facility/ program, and urban Indian clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638.

iv. Development of methods for regular planning to coordinate on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate health service delivery.

b. All policies and procedures must be submitted to MLTC for review and approvals a minimum of 60 calendar days prior to the contract start date and before new policies are to be implemented.

9. Coordination with the Division of Children and Family Services

The MCO must develop processes and procedures for collaboration with the Division of Children and Family Services for children who are in foster care placement. CM must include collaborating with the child's Children and Family Services Specialist and identifying and responding to a child's health care needs including behavioral health. Policies and procedures must include:

a. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.

b. How health needs identified through screenings will be monitored and treated.

c. How medical information will be updated and appropriately shared, which may include the development and implementation of an electronic health record.

d. Steps to ensure continuity of health care services.

e. The oversight of prescription medications.

M. QUALITY MANAGEMENT

1. The MCO must include QM processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members.

a. The MCO's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract.

b. The MCO must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system as a result of this RFP. The MCO will be provided with the final Quality Strategy when it is approved by CMS.

c. The MCO must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities.

d. The MCO's QM program must include:

i. A quality assurance and performance improvement (QAPI) program.

ii. Performance improvement projects (PIPs).

iii. Quality performance measurement and evaluation.

iv. Member and provider surveys.

v. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program, as described in Sections IV.C Business Requirements and IV.I Provider Network Requirements of this RFP.

e. The MCO must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as UM and CM. The MCO is expected to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.

2. Quality Management Deliverables

The MCO must submit the following QM deliverables to MLTC as described in Attachment 5 – Policies, Procedures and Plans, and Attachment 6 – Reporting Requirements. Any subsequently revised documents must also be submitted to MLTC for review and approval a minimum of 60 calendar days prior to their planned implementation.

a. Description and composition of the QAPI Committee (QAPIC).

b. A written description of the MCO's QM program, including detailed QM goals and objectives, a definition of the scope of the program, accountabilities, and timeframes.

c. A QM work plan and timeline for the coming year that clearly identifies target dates for implementation and completion of all phases of the MCO's QM activities, consistent with the clinical quality performance measures and targets set by MLTC, including, but not limited to:

i. Data collection and analysis.

ii. Evaluation and reporting of findings.

iii. Implementation of improvement actions, where applicable.

iv. Individual accountability for each activity.

d. Procedures for remedial action for deficiencies that are identified.

e. Specific types of problems requiring corrective action.

f. Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.

g. Procedures for provider review and feedback about results.

h. Annual QM evaluation that includes:

i. Description of completed and ongoing QM activities.

ii. Identified issues, including tracking of issues over time.

iii. Analysis of and tracking progress about implementation of QM goals and the principles of care, as appropriate, and as defined in this RFP. Measurement of and compliance with these principles must be promoted and enforced through the following strategies, at a minimum:

a) Use of QM findings to improve practices at the MCO and subcontractor levels.

b) Timely reporting of findings and improvement actions taken and their relative effectiveness.

c) Dissemination of findings and improvement actions taken and their relative effectiveness to key stakeholders, committees, members, families/caregivers (as appropriate), and posting on the MCO's website.

d) Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. The MCO must use an industry-recognized methodology, such as SIX SIGMA or other appropriate method(s), for analyzing data. The MCO must demonstrate inter-rater reliability testing of evaluation, assessment, and UM decisions.

e) An analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of service to members, and overall effectiveness of the QM program.

i. Procedures assessing the quality and appropriateness of care furnished to members with SHCNs. The assessment mechanism must use appropriate health care professionals to determine the quality and appropriateness of care.

3. QAPI Program

The MCO's QAPI program, at a minimum, must comply with State and Federal requirements (including 42 CRF 438.204) and UM program requirements described in 42 CFR 456. The QAPI program must:

a. Ensure continuous evaluation of the MCO's operations. The MCO must be able to incorporate relevant variables as defined by MLTC.

b. At a minimum, assess the quality and appropriateness of care furnished to members.

c. Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician.

d. Maintain a health information system that can support the QAPI program. The MCO's information system must support the QAPI process by collecting, analyzing, integrating, and reporting data required by the State's Quality Strategy. All collected data must be available to the MCO and MLTC.

e. Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually. This information must be submitted for review and approval by MLTC prior to distribution.

f. Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance. The MCO must further develop, operationalize, and implement the outcome and quality performance measures with the QAPIC, with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders.

g. Require that the MCO make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-site operational review of the MCO and any additional QM reviews. This may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.

4. QAPIC

a. The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

b. The MCO must form a QAPIC no later than one month following the contract's start date. The MCO's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC.

c. The MCO must include, at a minimum, the following as members of the committee:

i. The MCO's QM Coordinator.

ii. The MCO's Performance and Quality Improvement Coordinator.

iii. The MCO's Medical Management Coordinator.

iv. The MCO's Member Services Manager.

v. The MCO's Provider Services Manager.

vi. Family members/guardians of children or youth who are Medicaid members.

vii. Adult Medicaid members.

viii. Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.

d. The MCO's QAPIC must:

i. Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC.

ii. Review the Cultural Competency Plan.

iii. Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify.

iv. Establish annual performance targets.

v. Review and approve all member and provider surveys prior to their submission to MLTC.

vi. Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries.

vii. Provide training; participation stipends; and reimbursement for travel, child care, or other reasonable participation costs for members or their family members. Participation stipends should only be provided if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization.

viii. Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.

e. Additional required committees must include:

i. Clinical Advisory Committee.

ii. Corporate Compliance Committee.

iii. Provider Advisory Committee.

iv. Utilization Management Committee.

v. The additional required committees must report, on a minimum of a quarterly basis, to the QAPIC. The QAPIC must monitor performance as part of its annual QAPI Work Plan and Program Evaluation.

5. Data Collection

a. The MCO must collect performance data and conduct data analysis with the goal of improving members' quality of care. The MCO must document and report to the State its results on performance measures chosen by MLTC to improve quality of care and members' health outcomes.

b. Data analysis must consider the MCO's previous year's performance, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. Data must be collected from administrative systems, medical records, and member and provider surveys. The MCO must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCO's encounter data system. The MCO must ensure that data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data.

ii. Screening the data for completeness, logicalness, and consistency.

iii. Collecting service information using MLTC-developed templates.

c. The MCO's data analysis process must be able to identify and resolve system issues consistent with a continuous quality improvement approach.

d. The MCO is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for performance measures and PIPs must be returned by the MCO in a format specified by MLTC, and by the due date specified. Any extension to collect and report data must be made in writing in advance of the initial due date and is subject to approval by MLTC. Failure to follow the data collection and reporting instructions that accompany the data request may result in a penalty being imposed on the MCO per Section IV, V Contract Non-compliance.

6. Quality Performance Measurement and Evaluation

a. The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period. Performance measures include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required

by CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC.

b. MLTC may utilize a hybrid or other methodology for collecting and reporting performance measure rates, as allowed by NCQA for HEDIS measures or as allowed by other entities for nationally recognized measures. The MCO must collect data from medical records, electronic records, or through approved processes, such as those utilizing a health information exchange. The number of records that the MCO collects will be based on HEDIS, external quality review (EQR), or other sampling guidelines. It may also be affected by the MCO's previous performance rate for the measure being collected. The MCO must provide MLTC on request with its methodology for calculating performance measures.

c. The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that does not show statistically significant improvement in a measure rate. MLTC may require the MCO to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.

d. The MCO must report results of measuring or assessing outcomes and quality, and must incorporate these performance indicators into its PIPs. To the extent possible, results should be posted publicly on the MCO's website immediately after being accepted by the QAPI Committee and approved by MLTC.

e. Any outcomes and performance measure results that are based on a sample of member, family, or provider populations must demonstrate that the samples are representative and statistically valid. Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks.

f. The MCO must report to MLTC on a quarterly basis the minutes and disposition of quality program initiatives that were presented to the QAPIC to ensure that all quality initiatives are reviewed at the frequencies outlined in the Quality Management Program Description. The reporting requirements are described in Attachment 6 – Reporting Requirements.

7. Performance Improvement Projects

a. The MCO must conduct a minimum of two clinical and one non-clinical PIPs. A minimum of one (1) clinical issue must address an issue of concern to the MCO's population, which is expected to have a favorable effect on health outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.

b. The MCO must participate in a minimum of one (1) joint PIP with the other MCOs; the topic will be identified by MLTC.

c. PIPs must be addressed in the MCO's annual QM Program Description, Work Plan, and Program Evaluation. The MCO must report the status and results of each project to MLTC as outlined in the Quality Strategy. PIPs must comply with CMS requirements, including:

i. A clear study topic and question as determined or approved by MLTC.

ii. Clear, defined, and measurable goals and objectives that the MCO can achieve in each year of the project.

iii. A study population.

iv. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The MCO must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

v. The methodology for evaluation of findings from data collection.

vi. Implementation of system interventions to achieve quality improvement.

vii. A methodology for the evaluation of the effectiveness of the chosen interventions.

viii. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable.

ix. Planning and initiation of activities for increasing and sustaining improvement.

d. The MCO must submit to MLTC the status or results of its PIPs in its annual QM Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.

e. The MCO must implement the PIP recommendations on approval by MLTC and the QAPIC.

f. Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCO's quality assessment and performance improvement program [42 CFR 438.240(d)(2)].

g. CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.

h. MLTC reserves the right to request additional reports from the MCO. The MCO will be notified of additional reporting requirements no less than 30 calendar days prior to the due date of a report.

8. Member Satisfaction Surveys

a. The MCO must contract with a vendor that is certified by NCQA to perform CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions (CCC) supplemental items.

b. The MCO must use the most current version of CAHPS for Medicaid enrollees. For the CAHPS Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and separate data and results when submitting reports to MLTC to fulfill the CHIPRA requirement.

c. Samples of members 18 years of age and older and caregivers/family members of children and youth should be included in all member surveys. Samples should be representative of members and caregivers/family members based on the type of question asked.

d. Each survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and State benchmark standards. Survey results and action plans derived from these results are due 45 calendar days after the end of each contract year. MLTC reserves the right to make CAHPS member survey results public.

e. Survey results and descriptions of the survey process must be reported to MLTC separately for each required CAHPS survey. Upon administration of the CAHPS Child surveys, results for Medicaid children and CHIP children must be reported separately.

9. Provider Satisfaction Surveys

a. The MCO must conduct an annual provider survey to assess providers' satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes, including medical reviews and support for PCMH implementation.

b. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval a minimum of 90 calendar days prior to its intended administration. The methodology used by the

MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.

c. The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results. This report is due 45 calendar days after the end of the each contract year.

10. MLTC Quality Management Committee

The MCO must attend annual meetings of MLTC's QM Committee. The QM Committee meets to review data and information used to develop the Quality Strategy; recommend actions to improve members' quality of care, access, utilization, and satisfaction; and, to review the PIP results and recommend future PIP topics. The QM Committee also reviews MLTC's Quality Strategy and makes recommendations for its improvement.

11. Member Advisory Committee

a. To promote a collaborative effort to enhance the MCO's patient-centered service delivery system, the MCO must establish a Member Advisory Committee that is accountable to the MCO's governing body. Its purpose is to provide input and advice regarding the MCO's program and policies.

b. The MCO's Member Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO's membership.

c. At a minimum, the MCO's Member Advisory Committee must provide input into the MCO's planning and delivery of services; QM/quality improvement activities; program monitoring and evaluation; and, member, family, and provider education.

d. The MCO must provide an orientation and ongoing training for Member Advisory Committee members so that they have sufficient information and understanding of the managed care program to fulfill their responsibilities.

e. The MCO must develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the Committee that must include, but is not limited to, members' perspectives about improving quality of care. This Plan must be submitted to MLTC for approval a minimum of 60 calendar days before the contract start date and annually thereafter.

f. The MCO's Member Advisory Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings. The MCO must pay travel costs for committee members who are members or their representatives.

g. MLTC must be copied on all correspondence to the committee, including agendas and committee minutes.

h. The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually. This report must include the membership of the committee (name, address, and organization represented), a description of any orientation and/or ongoing training activities for committee members, and information about Committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports must be submitted to MLTC according to the schedule described in Attachment 6 – Reporting Requirements.

12. Clinical Advisory Committee

a. The MCO must develop, establish, and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment, including diseases/chronic conditions common in the Medicaid population, disabilities, and mental health and/or substance use disorder treatment for adults, children, and adolescents in the State.

b. The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with CM and utilization management functions, including clinical and practice guidelines, and utilization management criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State.

c. The committee must include members who care for children, adolescents and adults in the State across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations and represent pharmacists, physical health providers, and behavioral health providers.

d. The committee must review and approve initial practice guidelines. Any significant changes in guidelines must also be reviewed/approved by the Committee prior to adoption by the MCO.

e. The committee must meet on an as-needed basis, but a minimum of twice a year and preferably quarterly.

f. The MCO must submit to MLTC for approval its plan for development of the committee a minimum of 60 calendar days in advance of its establishment. The MCO must also provide copies of the committee's minutes to MLTC.

13. External Quality Review

a. The MCO is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, services covered under the contract, per 42 CFR 438.350. The EQR is conducted by MLTC's contracted external quality review organization (EQRO) or other designee. The EQR will include, but is not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.

b. The MCO must provide the necessary information required for these reviews, provide working space and internet access for EQRO staff, and make its staff available for interviews.

N. UTILIZATION MANAGEMENT

1. General Requirements

a. The MCO's UM activities must include the evaluation of medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided to members when they need them. The MCO's UM program must also focus on individual and system outliers to assess if individual members are meeting their health care goals and if service utilization across the system is meeting the goals for delivery of community-based services.

b. The MCO's UM program must comply with Federal utilization control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR 438.

c. The MCO must require inpatient hospital providers to comply with Federal requirements regarding UM plans, UM committees, plans of care, and medical care evaluation studies, as described in 42 CFR 44, 455 and 456.

d. The MCO must not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member, as described in 42 CFR 210(e).

e. The MCO must actively monitor Federal and State Medicaid regulations for updates and changes and must monitor all UM activities for compliance with Federal and State Medicaid regulations.

2. UM Program Description

The MCO must have a written UM Program description that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually and include, at a minimum:

a. Criteria and procedures for the evaluation of medical necessity of medical services for members.

b. Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.

c. Mechanisms to detect and document over- and under-utilization of medical services.

d. Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.

e. Availability of UM criteria to providers.

f. Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.

g. Availability of physician reviewers to discuss determinations by telephone with physicians who request them.

h. Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.

i. A process and procedures to address disparities in health care.

j. A process for identifying and analyzing clinical issues by appropriate clinicians and, when necessary, developing corrective actions to improve services.

k. A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR. The MCO must submit this description to MLTC for approval no later than 60 calendar days prior to the contract start date, annually thereafter, and prior to any intended revisions. MLTC's approval must be obtained prior to implementation of these policies.

l. Reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the MLTC's Preferred Drug List and other State publications.

m. A process for providing prescribers with members' drug utilization data obtained from MLTC and the Nebraska DUR board to inform prescribing activity. As part of this effort, the MCO must:

i. Work to improve collaboration across prescribers, to reduce conflicting or duplicate prescribing.

ii. Provide reports to PCPs and other network providers about the patterns of prescription utilization by members, in an effort to increase collaboration and reduce inappropriate prescribing patterns.

n. A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 30 calendar days after its completion.

3. Practice Guidelines

a. The MCO must develop practice guidelines, in accordance with 42 CFR 438.236(b), that:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

ii. Consider the needs of the MCO's members, including children with serious emotional disorders and adults with serious and persistent mental illness.

iii. Are adopted in consultation with participating health care professionals.

iv. Comply with State and Federal requirements.

v. Are approved in advance by the Clinical Advisory Committee and MLTC.

vi. Are reviewed and updated a minimum of annually, as appropriate.

vii. Are disseminated, by the MCO, to all affected providers and, on request, to members and enrollees (42 CFR 438.236(c).

viii. Are posted to the MCO's website.

ix. Provide a basis for consistent decisions for utilization management, member education, service coverage, and any other areas to which the guidelines apply (42 CFR 438.236(d).

b. The MCO must provide affected network providers with technical assistance and other resources to implement the practice guidelines.

c. The MCO must coordinate the development of clinical practice guidelines with other MLTC MCOs to avoid providers receiving conflicting guidelines from different MCOs.

d. The MCO must monitor the application of practice guidelines annually through peer review processes and collection of performance measures for review by the MCO's QAPIC.

e. Using information acquired through its QM and UM activities, the MCO must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into care management and UR activities.

4. Service Authorization Procedures

a. The MCO and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. The MCO must have processes to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider, when appropriate.

b. The MCO must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a practitioner with the necessary credentials and experience, and who has appropriate clinical expertise in treating the member's condition or disease.

c. The MCO must develop service authorization procedures with the input, review, and approval of the Quality of Care Clinical Advisory Committee. These procedures must be submitted to MLTC, for review and approval, a minimum of 60 calendar days prior to the contract's start date.

d. The MCO must:

i. Incorporate the definition of medical necessity for covered services, inclusive of service definitions and levels of care, into MCO documents, where applicable.

ii. Not require service authorization for emergency services.

iii. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose.

iv. Not arbitrarily deny a required service solely because of the member's diagnosis, type of illness, or condition. This also applies to the MCO's subcontractors.

v. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

vi. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization requirements.

vii. Use a licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section IV.D Staffing Requirements of this RFP.

viii. Have written policies and procedures for prescribers to request peer review and peer-to-peer consultations on prior authorizations. Peer-to-peer review or peer consultation must be conducted by a State-licensed prescriber.

ix. Consult with the requesting network provider, when appropriate.

x. Notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404.

xi. For standard authorizations, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the member's health condition requires and within the timeframes included in Section IV.H Grievances and Appeals of this RFP.

xii. For expedited service authorizations, make a decision within the timeframes identified in Section IV.H Grievances and Appeals of this RFP, including when the network provider indicates, and the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, or would cause a prudent layperson, possessing an average knowledge of medicine and health, reason to believe that his/her condition is of such a nature that failure to obtain immediate medical care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

5. Service Authorizations for Pharmacy Services

a. The MCO must submit to MLTC, for review and written approval a minimum of 60 calendar days prior to the contract's start date, clinical criteria for all drugs requiring clinical prior authorization, including:

i. Clinical criteria.

ii. Evaluation flow charts.

iii. Process supporting tables.

b. Prior authorization may be used for drugs under the following conditions:

i. When prescribing medically necessary non-formulary or non-preferred (non-PDL) drugs.

ii. When prescribing drugs inconsistent with approved FDA labeling, including behavioral health drugs; or when prescribing is inconsistent with nationally accepted guidelines.

iii. When prescribing brand name medications that have A-rated generic equivalents.

iv. To minimize potential drug over-utilization.

v. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

c. MLTC may, at its discretion, prohibit prior authorization for selected drug products or devices.

d. The MCO must maintain a toll-free telephone number and fax line for providers to submit requests for prior authorization of drugs that are non-preferred or subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone or fax, and through an automated process. If the MCO or its pharmacy benefits manager operates a separate call center for prior authorization requests, it will be subject to the same provider call center standards set forth in Section IV.J Provider Services of this RFP.

e. The MCO may not penalize or charge the prescriber, pharmacy or enrollee in any way for authorization requests and approvals.

f. The MCO must allow submission of pharmacy prior authorization requests through a common written form within 30 calendar days of it being developed and approved by the Administrative Simplification Committee and MLTC.

g. A member receiving a prescription drug that is subject to new or different prior authorization requirements (e.g., new clinical edits, removal from formulary or PDL) shall be permitted to continue to receive that prescription drug if determined to be medically necessary for a minimum of another 60 calendar days. The MCO must determine whether this medical necessity is present in consultation with the prescriber.

h. The MCO is allowed to implement step therapy or fail first protocols to promote utilization of the most cost-effective and clinically appropriate drug therapy. However, if so implemented, the MCO must provide a clear process in writing for a provider to request an override of these restrictions. At a minimum, the MCO must grant the override when the prescriber provides evidence that the preferred treatment method has been or is likely to be ineffective in the treatment of the patient's medical condition or will cause or will likely cause an adverse reaction or other physical harm to the patient.

6. Concurrent Review

a. The MCO must develop a system of concurrent review for inpatient services to monitor the medical necessity of the need for a continued stay. The concurrent review system must include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one (1) day, based on the medical necessity determination.

b. An important feature of concurrent review is the evaluation of each hospital case against established criteria, including national clinical guidelines. The MCO must use published and commercially available criteria for hospital case reviews to facilitate evaluation by UR nurses.

7. Retrospective Utilization Review of Network Providers

a. The MCO must develop and implement retrospective UR functions for examining trends, issues, and problems in utilization, particularly over- and under-utilization that may need to be addressed including:

i. A system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services.

ii. A reasonable appeal process that includes: standard communication with reasonable timelines, UR criteria that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims.

iii. Written policies and procedures through which the prescriber of pharmacy services is able to submit additional information for special consideration and additional review of denied prior authorization requests that do not meet criteria.

iv. Retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to members, were appropriate and medically necessary, and were authorized and billed in accordance with the MCO's requirements.

v. Provider reviews related to Medicaid compliance issues.

vi. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.

vii. Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) for each provider that monitor and report under-and over-utilization of services at all levels of care, including monitoring providers' utilization of services by race, ethnicity, gender, and age.

viii. Processes for claims denied payment through retrospective review that ensure that claims are denied individually (i.e., that each claim denied must be specifically reviewed) and any denials (both those resulting in repayment and those withheld from a future payment) must be subjected to due process before payment is withheld or repaid. In the absence of a fully denied claim, the provider must be paid in good faith.

b. The MCO must monitor for potential off-label drug usage.

c. The MCO must monitor emergency services utilization by provider and member and have routine methods for addressing inappropriate utilization. For UR, the test for appropriateness of the request for emergency services must be whether a prudent layperson would have requested such services. For the purposes of this RFP, a prudent layperson is one who possesses an average knowledge of health and medicine.

d. These policies must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to the contract start date or the policies' intended implementation. The policies must be reviewed by the MCO annually and updated as necessary.

8. Medication Therapy Management

a. The MCO must develop a medication therapy management (MTM) program specific to the needs of its members.

b. The MTM program shall include coordination among the MCO, the member, the pharmacist, and the prescriber using various means of communication and education. It must assist members in understanding their prescriptions and engage them in education about their medication and efforts to improve their compliance with prescribed medication regimens. It must also educate members about how to effectively communicate about their preferences and needs with their prescribers to promote shared decision-making.

c. At a minimum, the MTM program must assess prescribing patterns and treatment plans for psychotropic medications, medications at risk of abuse, and other medications identified by MLTC or the MCO.

d. The MCO must submit an annual report to MLTC that describes its MTM program activities, the relative effectiveness of its efforts over the reporting period, and the MCO's activities planned for the next reporting period.

9. Drug Utilization Review Program

a. The MCO must develop and maintain DUR programs, including prospective and retrospective DUR programs. The guidelines for these programs must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to the contract's start date or intended implementation of any changes. The MCO must:

i. Establish and maintain retrospective DUR exception criteria.

ii. Conduct drug criteria analysis and generate and review member and provider profiles.

iii. Develop a case tracking system and project reports.

iv. Implement prescriber and pharmacy educational intervention program.

v. Conduct prescriber and pharmacy assessment/evaluation of educational intervention program.

vi. Submit an analysis of cost outcomes and an evaluation of the effectiveness of the prescriber and pharmacy educational interventions to members, prescribers, and pharmacies.

vii. Use results of reviews to inform MTM education and outreach needs.

viii. Perform, at a minimum, one (1) retrospective DUR intervention each quarter of the contract year.

ix. Submit quarterly to MLTC the documentation needed to support preparation of MLTC's annual CMS DUR report.

b. The MCO shall nominate a non-voting staff member to attend the Nebraska Drug Utilization Review Board meetings, which occur six (6) times a year, for the term of this contract. The MCO shall obtain MLTC's written approval of the nominee.

10. Psychotropic Drug Oversight

The MCO must:

a. Utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative. If appropriate, the MCO must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist.

b. Manage the prescribing of psychoactive medications to members age 20 and under by:

i. Measuring psychopharmacology usage and prescribing patterns.

ii. Monitoring the use of, and the claims related to, psychopharmacology to identify target populations (e.g., age subsets) for proposed interventions.

iii. Preparing member-specific profiles of medication use based on pharmacy data to inform MCO interventions with prescribers.

iv. Developing prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member. The MCO must:

a) Implement these interventions on the approval of MLTC.

b) Report to MLTC the results of the intervention.

c) Support MLTC pharmacy initiatives by promoting and communicating the adoption of clinical policy recommendations to PCPs, and other network providers, including behavioral health providers.

d) In consultation with the DUR board, propose to MLTC additional pharmacy interventions focused on members.

v. Submit reports to MLTC detailing approvals and denials of psychotropic medication requests for youth. The report must utilize the eligibility categories provided to the MCO via the enrollment files for each youth for whom a drug request is made by a prescriber. These reports must be submitted as specified in Attachment 6 – Reporting Requirements.

vi. If requested by MLTC, participate and collaborate with inter-agency workgroups and initiatives.

11. Restricted Services

a. The MCO is required, at a minimum, to implement a restriction program consistent with the provisions of 471 NAC 2 concerning restricted services, also known as restricted services procedures.

b. Restricted services are a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The restricted services mechanism cannot prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

c. MLTC may request that a member be placed in a restricted services status when it determines that over-utilization, duplication of services, non-compliance, or drug-seeking behavior is suspected of the member.

d. The MCO, through retrospective UR or through the recommendation of a network provider, may also determine that the services available to a member be restricted and communicate these restrictions to MLTC.

e. The MCO must:

i. Be able to implement in its claims system a restricted services status for a member and have the ability to communicate this status to MLTC and other MCOs.

ii. Provide enrollees and providers with advance written notification of the decision to restrict services provided to a member.

iii. Allow members in the restricted services program to change providers for cause.

iv. Conduct the following activities and have in place written policies and procedures, approved by MLTC, for such activities that fall under the care coordination and daily operational aspects of restricted services, including but not limited to:

a) Assigning a care manager to review, document, and manage the clinical or organizational needs of a member enrolled in restricted services.

b) Assigning staff member(s) to communicate and collaborate with MLTC's enrollment broker and Pharmacy Unit on an ongoing basis concerning the coordination and processes for restricted services.

c) Conducting retrospective UR to identify the potential need for restricted services for a member, in addition to requests by network providers for a review of utilization patterns by a member.

d) Maintaining sufficient documentation for all member restricted service recommendations, including but not limited to documentation of over-utilization or duplication of services and documentation from network providers who requested a review by the MCO of a member because of suspected over-utilization of services or duplication of services.

f. The continued need for restricted services for a member must be evaluated by the MCO a minimum of every two years.

g. If a member has a restricted services status and is unable to obtain care or services from his/her restricted services provider(s) due to extenuating services, the MCO must have policies and procedures in place to authorize necessary exceptions.

h. The MCO must submit a monthly report, in a manner and format to be specified by MLTC, of the status of all members participating in a restriction program.

12. Utilization Management Committee

a. The MCO must establish an internal UM Committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The UM Committee must be chaired or co-chaired by the Medical Director and must report its findings to the QAPIC. The UM Committee must review, at a minimum:

i. The need for and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan.

ii. Grievances and appeals (including expedited appeals and state fair hearings) related to UM activities to determine any needed policy changes.

iii. Information from UM operations relevant to system gaps are identified and shared with provider network staff through this committee.

iv. Results from internal audits of UM (e.g., live call monitoring and documentation reviews), to effect changes in policies and procedures and plan training activities.

O. PROGRAM INTEGRITY

1. General Requirements

a. The MCO must comply with all State and Federal laws and regulations relating to FWA in the Medicaid program, including but not limited to 42 CFR 438.1 – 438.812.

b. The Nebraska Medicaid Program Integrity Unit (NMPI) is the entity within MLTC charged with identifying and investigating allegations of FWA and erroneous payments.

c. The Medicaid Fraud and Patient Abuse Unit (MFPAU), of the Nebraska Attorney General's office, has primary responsibility to investigate and prosecute provider fraud for the Nebraska Medicaid program.

d. The MCO must certify that all statements, reports, and claims, financial and otherwise, are true, accurate, and complete. The MCO must not submit for payment purposes those claims, statements, or reports that it knows, or has reason to know, are not properly prepared or payable pursuant to Federal and State law, applicable regulations, its contract with MLTC, and MLTC policy.

e. The MCO must immediately report to NMPI any suspicion or knowledge of fraud including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent.

f. The MCO must pursue all recovery of payments identified as FWA or erroneous and reflect the recovery on the claim record. In the event that the MCO does not pursue all recoveries, including third-party liability (TPL), MLTC will pursue them and recoup the money.

g. In accordance with 42 CFR 433 and MLTC policies and procedures, the MCO must report overpayments made by MLTC to the MCO as well as overpayments made by the MCO to a provider or subcontractor.

h. The MCO, as well as its subcontractors and providers, whether contracted or non-contracted, must comply with all Federal requirements (42 CFR 455) about disclosure reporting. All tax-reporting provider entities that bill or receive Nebraska Medicaid funds as a result of this contract must submit routine disclosures in accordance with timeframes specified in 42 CFR 455(B), including at the time of initial contracting, contract renewal, within 45 calendar days of any change to the information on the disclosure form, a minimum of annually, and at any time on request.

i. The MCO must require that all its providers and subcontractors take all the necessary actions to permit the MCO to comply with the FWA and erroneous payments requirements included in this RFP, its contract with MLTC, and State and Federal regulations. To the extent that the MCO delegates oversight responsibilities to a third party, the MCO must require that the third party complies with all provisions of the contract relating to FWA and erroneous payments. Although all providers with whom the MCO contracts are enrolled in the Medicaid program and subject to its regulations, the MCO agrees to require, via contract, that those providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

j. The MCO must have a FWA and erroneous payments unit within the organization comprised of experienced staff members. As described in Section IV.D Staffing Requirements, this unit must include a State-based Program Integrity Officer and a minimum of one (1) investigator for every 50,000 or fewer members. The unit's primary purpose is to prevent, detect, investigate, and report suspected FWA and erroneous payments that may be committed by network providers, members, employees, or other third parties with whom/which the MCO contracts.

k. The MCO and its employees must cooperate fully with centralized oversight agencies responsible for FWA and erroneous payments detection and prosecution activities. This cooperation must

include providing access to all necessary case information, computer files, and appropriate staff. In addition, this cooperation may include participating in periodic FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members. The MCO must participate in the quarterly Nebraska Health Care Fraud Task force meeting by sending one of its dedicated FWA staff.

l. The MCO must cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. This cooperation must include providing, on request, information, access to records, and access to interview the MCO's employees and consultants, including but not limited to those with expertise in program administration, medical or pharmaceutical issues, or any other matter related to the investigation.

m. MLTC will not transfer its law enforcement functions to the MCO.

n. When NMPI requests access to or copies of any records or data maintained by the MCO or its providers, the response must be in the form and manner and by the due date requested by NMPI.

o. The MCO must confirm in writing, by completing a form that MLTC will provide during the readiness review and on an annual basis during the duration of the contract that the MCO's Compliance Officer(s) understand all requirements related to the MCO's receipt of State and Federal funds. The MCO must confirm that its officers understand that they are subject to criminal prosecution, civil action, or administration actions for any intentional false statements or other fraudulent conduct related to their contractual obligations.

p. NMPI will seek all appropriate remedies for fraud, abuse and violation of law if it determines that the MCO, a provider, employee, or subcontractor has committed fraud or abuse as defined in this contract, or has otherwise violated applicable law.

2. Policies and Procedures

a. The MCO must have policies and procedures that are designed to prevent, reduce, detect, correct, and report known or suspected FWA and erroneous payments in accordance with State and Federal requirements and its contract with the State. Requirements for these policies and procedures are described in this section.

b. All FWA and erroneous payment policies, and the designation of the compliance officer and committee must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date and a minimum of 30 calendar days prior to the intended implementation of any material changes. The MCO's submission of new or revised policies and procedures for review and approval by MLTC will not void any existing policies and procedures that have been approved by MLTC previously. Unless otherwise required by law, the MCO may continue to operate under existing policies and procedures until MLTC approves the new or revised policies for prospective application. The MCO must develop and use a certification process that demonstrates the policies and procedures were reviewed and approved by the MCO's senior management.

c. To remain in compliance with its contract with MLTC, the MCO must comply with current FWA and erroneous payments policies and procedures.

3. Prohibited Affiliations

a. In accordance with 42 CFR 438.610, a MCO may not knowingly have a relationship with and must have a proactive method to prevent the following relationship(s):

i. An individual or entity who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of:

a) A director, officer, or partner of the MCO.

b) A person with beneficial ownership of 5% or more of MCO equity.

c) A person or entity with an employment, consulting, or other arrangement with the MCO under its contract with the State.

iii. Any individual or entity excluded for cause from participation in any state Medicaid program or the Medicare program.

iv. Any individual or entity listed on the Federal System for Award Management, the Office of Inspector General's List of Excluded Individuals and Entities database, or the Nebraska Medicaid Excluded Providers list.

b. The MCO must conduct a search of the then-current version of these lists monthly to capture exclusions and reinstatements that have occurred since the previous search.

c. When the MCO identifies a relationship with a debarred or excluded individual or entity, it must report it to NMPI within three (3) business days. The MCO must initiate efforts to sever the relationship with the debarred or excluded individual or entity immediately. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription.

d. If MLTC finds the MCO is not in compliance with these requirements, NMPI will notify the Federal DHHS Secretary of noncompliance and may not renew or otherwise extend the duration of the existing contract with the MCO unless the Secretary provides to the State and to the Congress a written statement describing the compelling reasons that support renewing the contract.

4. Excluded Providers

The MCO may not contract with or reimburse providers that are excluded by the Medicare, Medicaid, or Children's Health Insurance Programs (CHIP).

5. Federal Financial Participation

Federal financial participation (FFP) is not available for:

a. Funds paid to providers excluded by the Medicare, Medicaid, or CHIP. The MCO is responsible for the return of any money paid for services provided by an excluded provider.

b. Payments made to a provider or fiscal agent that fails to disclose ownership or control information.

c. Expenditures for services furnished by providers who/that fail to comply with a request made by the Federal DHHS Secretary or MLTC. As applicable, FFP will be denied for expenditures for services furnished beginning the day following the date the information was due to the Federal DHHS Secretary or MLTC and ending on the day before the date the information was supplied.

6. The MCO and MFPAU

a. The MCO and the MCO's subcontractors or providers, whether contracted or non-contracted, must make available to MFPAU, on request or as required by this contract, State or Federal law, any and all administrative, financial, or medical records relating to the delivery of services for which Nebraska Medicaid funds are expended.

b. The MCO must comply promptly with the MFPAU requests for data stored or formulated by the MCO or its subcontractors, including but not limited to, claims data, encounter data, eligibility information, and enrollment data, if MFPAU determines it is necessary to carry out its responsibilities.

c. When responding to a request for data, the MCO must certify that the data supplied to MFPAU is true, accurate, and complete. This data must be supplied without charge and in the form and time frames requested by MFPAU.

d. The MCO must allow MFPAU staff access to its location(s) of business, whether within or outside of the State. Access to the MCO's places of business must be allowed during normal business hours, and also at other times under special circumstances when after-hour admission is required. Special circumstances are at the sole discretion of MFPAU.

e. MFPAU has the right to recover inappropriately expended Medicaid funds directly from participating and non-participating providers, the MCO, its subcontractors, and any third party in the MCO network in criminally and civilly prosecuted cases or settlements. The MCO is not entitled to any part of recovered funds.

f. The MCO must subrogate to MFPAU any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products.

g. In the event that the MCO conducts a hearing or review of its decision to institute interventions or sanctions against a provider, MFPAU must be provided adequate notice of the hearing, and furnished copies, at that time, of any and all pleadings and evidence. MFPAU has the right to intervene in these proceedings. If necessary for MFPAU's investigative purposes, MFPAU may suspend these proceedings until MFPAU's investigation is complete.

h. Regardless of any monetary settlement, payment, intervention, sanction, or other agreement between the MCO and any provider suspected of fraud, MFPAU retains the right to pursue any and all appropriate civil or criminal actions against the provider.

7. National Provider Identifier

The MCO must require each of its contracted physicians to have a national provider identifier. This identifier must be included on the provider file submitted to the State.

8. Compliance Plan

a. The MCO must submit a written FWA and erroneous payments compliance plan to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date, and annually thereafter by December 31st of each year. The initial compliance plan must be approved by MLTC before it can be implemented. Requests for revision(s) to the plan must be submitted in writing to MLTC a minimum of 30 calendar days prior to the requested implementation date of the revision(s). MLTC will respond in writing with approval or questions within 15 calendar days. Revisions must be approved by MLTC prior to their implementation.

b. The FWA and erroneous payments compliance plan must include the following components:

i. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable State and Federal requirements.

ii. Agreement to report all allegations of fraud to the NMPI. The policies and procedures must designate those staff members responsible for reporting fraud.

iii. The designation of a Program Integrity Officer and compliance committee that is accountable to senior management and must ensure an adequately staffed compliance office.

iv. Discussion of the compensation and qualifications of the staff, who must be adequate in number and training, to effectively monitor the Nebraska Medicaid contract.

v. Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers, and subcontractors, enforced through well-publicized disciplinary guidelines.

vi. Effective training and education for the Program Integrity Officer, MCO employees, and subcontractors.

vii. Detailed information about the False Claims Act and the other provisions described in Section 1902(a)(68)(A) of the Social Security Act. A description of the methodology and standard operating procedures used to prevent, identify, intervene, and investigate FWA and erroneous payments, and to recover overpayments or otherwise sanction providers.

viii. Enforcement of standards through well-publicized guidelines included in member and provider handbooks, trainings, and member and provider newsletters.

ix. A description of the proactive specific controls in place to detect FWA and erroneous payments, including an explanation of the technology used to identify aberrant billing patterns, claims edits, post-processing review of claims, and record reviews.

x. Provision that the MCO's FWA and erroneous payments unit has access to provider records.

xi. Procedures for ongoing monitoring and auditing of MCO systems, including but not limited to, claims processing, billing and financial operations, enrollment functions, member services, provider services, and continuous quality improvement; and the MCO's providers, subcontractors, employees, and any others, as appropriate.

xii. Procedures for timely, complete, and consistent exchange of information and collaboration with NMPI, MFPAU, and MLTC's contracted external quality review organization regarding suspected fraud and abuse.

xiii. Provisions for the confidential reporting of plan violations, such as a hotline to report violations, and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths must be created for the reporting of fraud so that such reports cannot be diverted by any supervisors or other personnel.

xiv. Protections to ensure that no individual who reports program integrity-related violations or suspected FWA is retaliated against by anyone who is employed by or contracts with the MCO. The MCO must ensure that the identity of individuals reporting violations or suspected violations of the compliance plan must be kept confidential to the extent possible. Anyone who thinks that s/he has been retaliated against may report this violation to MLTC or the Federal DHHS Office of Inspector General.

xv. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the contract in accordance with 42 CFR 438.608(b)(7).

xvi. Agreement to and the method the MCO will use to suspend all provider payments when notified by MLTC to suspend payments because of a credible allegation of fraud.

xvii. The method the MCO will use to comply with requests from NMPI or the MFPAU for access to and copies of any records kept by the MCO, computerized data stored by the MCO, or information maintained by MCO providers to which MLTC is authorized to have access.

xviii. The method the MCO will use to prevent payments to international accounts.

9. Employee Education

a. The MCO must comply with Federal law to educate employees about FWA, the compliance plan, and false claims recoveries (Deficit Reduction Act of 2005 – Section 6032). This includes:

i. Evidence of completed, effective education for the Program Integrity Officer and the organization's employees, MCO providers, and members about the compliance plan, FWA, and erroneous payments and how to report any allegations regarding any of them.

ii. Effective lines of communication between the compliance officer and the MCO employees, MCOs, providers, and MLTC and its designee(s).

iii. Established written policies for all employees (including management), and any subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A) of the Social Security Act. The MCO must include detailed information about the MCO's policies and procedures for detecting and preventing FWA. The MCO must also include in any employee handbook a specific discussion of the laws described in the written policies, and the whistleblower rights and protections of and for employees.

b. This training must be conducted annually for all employees and within 30 calendar days of employment for new hires.

c. The MCO must require new employees to complete and attest to training within 30 calendar days of hire related to the following in accordance with State and Federal laws:

i. MCO code of conduct training.

ii. Privacy and security (including but not limited to HIPAA).

iii. FWA and erroneous payments.

iv. Procedures for the timely, consistent exchange of information and collaboration with MLTC.

v. Organizational chart, including the Program Integrity Officer and program integrity investigator(s).

vi. Provisions of 42 CFR 438.610 and all relevant State and Federal laws, regulations, policies, procedures and guidance (including CMS' *Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks*) issued by MLTC, DHHS, CMS, the Office of Inspector General, including updates and amendments to these documents or any such standards established by the State.

d. The MCO must maintain a toll-free provider compliance hotline number and ensure that the number and an accompanying explanatory statement are distributed to its members and providers through its member and provider handbooks.

e. The MCO must create and disseminate written materials for educating employees, managers, providers, and subcontractors about health care fraud laws, the MCO's policies and procedures for preventing and detecting FWA and the rights of employees to act as whistleblowers. The MCO's education must comply with all requirements of Section 1902(a) (68) of the Social Security Act.

10. Service Verification

a. The MCO must have a method and regularly verify that services have been actually provided. This verification may be conducted by mail, electronic correspondence, or telephone. Sampling criteria may include a representative sample or a targeted sample. The MCO must report the results of this monitoring to NMPI quarterly.

b. The MCO must immediately notify NMPI of any providers who/that are excluded from the MCO network or that leave the network to avoid a for-cause termination.

11. Audit Requirements

a. Twice each year, the MCO must complete an error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.

b. The MCO must also complete quarterly audits to identify:

i. Services paid after the recipient's death or incarceration.

ii. Home-based services, such as prescription drugs, therapies, or medical supplies, received by the patient while that patient is hospitalized, or living in or treated in a setting reimbursed at an all-inclusive rate.

12. Nebraska Medicaid Program Integrity Oversight

a. The MCO must notify NMPI if it identifies patterns of data mining outliers, audit concerns, critical incidences, hotline calls, or other internal and external tips with potential implications about provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15). This notification must be made on a minimum of a quarterly basis, unless circumstances warrant earlier notification. Along with such notification, the MCO must take steps to triage or substantiate these tips and provide timely updates to NMPI.

b. The MCO must report all tips and make all referrals to MLTC, in writing, a minimum of every two (2) weeks. The MCO must include all relevant documentation within this notification.

13. Monthly Reporting to MLTC

a. The MCO must submit the following reports to NMPI in the format, reporting period, and timeframe specified below. The MCO must also have documented policies and processes to collect the information necessary for the following reports:

i. A monthly cumulative report of all new referrals of potential FWA and erroneous payments received by the MCO. The report must be submitted electronically in an Excel spreadsheet that includes the following details: provider name, provider national provider identifier (NPI), Nebraska Medicaid Provider ID number, provider type, provider address, date the referral was received, a summary of the allegations, the previous calendar year's net payments to the provider, the current calendar years to-date net payments to the provider, the MCO staff person assigned to the referral, the source of the referral, the potential amount at risk, and a summary of investigative activities completed since receipt of the referral. The report is due by the second Friday of each month to report the previous month's information, if any.

ii. A monthly update of all previously reported referrals of provider FWA and erroneous payments under review by the MCO. The report must be sent electronically in an Excel spreadsheet and include the details from the new referrals report (described in the previous section) with updates to all investigative activities that have been completed since the receipt of the referral. This report is due by the second Friday of each month to report the previous month's information, if any.

iii.

iv. Monthly reports of claims adjudicated to finalization by the MCO in the previous calendar month. The report must include the number and dollar amount of claims submitted, the amount disallowed and reduced, the amount of payments by other sources, and net payments. This information must be reported by claim type, provider type, and the disallowed or reduced reason. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

v. A monthly report of all overpayments identified and collected. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

vi. A monthly report of all providers that have left the MCO provider network, including the provider's name, NPI, Medicaid Provider ID number, provider type, address, and reason. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

vii. A monthly report of the MCO's efforts to detect and prevent FWA. The report is due by the second Friday of each month to report the previous month's information, if any. The content of the report shall include, but is not limited to:

a) Utilization review activities.

b) Member and provider hotline complaints.

c) MCO QA/QI meeting minutes and reports.

d) All site-visit reports.

14. Collaboration with NMPI and Other MCOs

NMPI will hold regular meetings with all MCOs to review and discuss investigations, compliance, prevention, and other Program Integrity-related activities. These meetings will be attended by the MCO's Program Integrity Officer and CEO or COO. The MCO's Program Integrity Officer will serve as the primary point of contact for all issues related to FWA and erroneous payments.

15. Investigative Collaboration

a. The MCO must cooperate with all appropriate State and Federal agencies, including the MFPAU and the federal DHHS Office of Inspector General, in investigating fraud.

b. Once the MCO discovers potential fraud, it must promptly perform an investigation of all incidents of suspected or confirmed fraud that occurred in the ten years preceding the precipitating event. The MCO must promptly provide the results of any preliminary investigations to NMPI.

c. The MCO must not notify the provider of an investigation when there is a potential credible allegation of fraud.

d. The MCO must cooperate and assist MLTC and any State or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected FWA or erroneous payments. At any time during normal business hours, MLTC, MFPAU, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, federal DHHS, or any of their designees, and as often as they deem necessary during the contract period and for a period of six (6) years from the expiration date of the contract (including any contract extensions/renewals), have the right, power, and authority to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract or any other applicable laws.

e. The MCO and its subcontractors must make all program and financial records and service delivery sites open to the representative or any designees listed immediately above. MLTC, MFPAU, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above must have timely and reasonable access and have the right, power, and authority to examine and make copies, excerpts, or transcripts from any books, documents, papers, or records that are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcripts; contact and conduct private interviews with MCO clients, employees, and contractors; and complete on-site reviews of all matters relating to service delivery as specified by the contract. The rights of access in this subsection are not limited to the required retention period, but will last as long as records are retained. The MCO must provide originals or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form and language requested.

f. The MCO's employees and its contractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

g. The MCO must notify NMPI when it denies a provider credentialing application, disenrolls a provider for program integrity-related reasons, or otherwise limits the ability of a provider to participate in the program, for program integrity reasons.

16. Payment Suspension Due to Credible Allegations of Fraud

a. The MCO must comply with federal laws and regulations (such as 42 CFR 455.23) that require the suspension of Medicaid payments when there is a credible allegation of fraud. NMPI will determine whether payments should be suspended or if an exception is appropriate. NMPI will notify the MCO of payment suspensions and the MCO must then suspend payments. The MCO must ensure that no Nebraska Medicaid dollars are received by a provider whose payments have been suspended or who/that has been terminated by MLTC.

b. In cases involving potential or confirmed risk to patients, NMPI and the MFPAU may allow the MCO to engage in actions that would otherwise be prohibited. Any prior approval will be provided to the MCO in writing, from NMPI and the MFPAU, and will detail the action or actions the MCO may take. The MCO may not take any action against the provider at issue that is not specified by NMPI and the MFPAU.

c. After a credible allegation of fraud, unless prior written approval is obtained from NMPI in coordination with the MFPAU, the MCO must not take any of the following actions:

i. Contact the subject of the investigation concerning any matter related to the investigation.

ii. Institute any interventions, sanctions, or remedial procedures towards the subject of the investigation, including but not limited to hearings, suspension, or termination.

iii. Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the provider.

iv. File any civil action based upon the suspected fraud against the subject of the investigation.

v. Enter into or attempt to negotiate any settlement or agreement regarding the suspected fraud.

vi. Accept any money or other thing of value offered by the subject of the investigation in connection with suspected fraud.

17. Recoupments

If the MCO thinks that it is appropriate to initiate a recoupment or withholding action against a provider under these circumstances, the MCO must consult with both NMPI and the MFPAU to ensure that such action is permissible. In the event that the MCO obtains funds from an action when recoupment or withholding is prohibited, the MCO must return the funds to the provider.

P. MCO REIMBURSEMENT

1. General Requirements

a. MLTC's contracts with MCOs for the HERITAGE HEALTH are full-risk arrangements, with the exception of a risk corridor as required and discussed in this section.

b. The State will make monthly capitation payments to the MCO to cover all services in the contract, except for any mother's costs of obstetrical deliveries, for which MLTC will pay the MCO a supplemental payment, in addition to the monthly capitation payment. Capitation payments will be made prospectively for prospective enrollment and retrospectively to the first day of the member's enrollment, and based on the MCO's electronic enrollment file.

c. The MCO must agree to accept, as payment in full, the capitation rate and supplemental payments established by MLTC pursuant to the contract, and must not seek additional payment from a member or MLTC for any unpaid cost.

d. The MCO must assume 100% liability for any expenditures above the monthly capitation rate.

e. Payment for items or services provided under this contract may not be made to any entity located outside of the United States. The term "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

f. The MCO must have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions must be borne by the MCO.

2. Capitation Rate Determination Process

a. MLTC will develop cost-effective and actuarially sound rates in accordance with generally accepted actuarial principles and CMS rules and regulations, appropriate for the populations covered and the services provided, as described in this RFP.

b. MLTC will not use a competitive bidding process to determine the MCO capitation rates.

c. Capitation rates will be in effect for the initial six (6) month contract period beginning with the program start date.

d. Monthly capitation rates have been established separately for two (2) regions, shown in the map in Attachment 9 – Rating Regions:

i. Rating Region One (1) consists of 41 counties: Antelope, Boone, Burt, Butler, Cass, Cedar, Clay, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Gage, Hamilton, Jefferson, Johnson, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Pierce, Platte, Polk, Richardson, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Thurston, Washington, Wayne, and York.

ii. Rating Region Two (2) consists of 52 counties: Adams, Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Phelps, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Thomas, Valley, Webster, and Wheeler.

e. The categories of aid (COA) are:

i. Aged, Blind, and Disabled, ages birth to 20 years, males and females (ABD 00-20 M&F)

ii. Aged, Blind, and Disabled, ages 21 years and older, males and females (ABD 21+ M&F)

iii. Aged, Blind, and Disabled Duals, ages 21 and older, males and females (ABD 21+ Duals M&F)

iv. Aged, Blind, and Disabled, ages 21 years and older, women with cancer (ABD 21+ F-WWC)

v. Children's Health Insurance Program, males and females (CHIP M&F)

vi. Family under 1 year, M&F*

vii. Family 01-05 years, M&F

viii. Family 06-20 years, F

ix. Family 06-20 years, M

x. Family 21 years+, M&F

xi. Foster Care, M&F

xii. Katie Beckett 00-18 years, M&F

xiii. LTSS (Institutional) – Duals

xiv. LTSS (Institutional) – Non-Duals

xv. LTSS (Home and Community Based) – Duals

xvi. LTSS (Home and Community Based) – Non-Duals

*Family Category of Aid - Section 1931 Children and related and Section 1931 Adults and related populations.

Capitation rates are developed using encounter data, fee-for-service data, and supplementary financial information, from each MCO under contract at the time of this RFP's release, for the eligible populations from State fiscal years 2013, 2014, and 2015. Following is a list of adjustments considered in the rate development:

xvii. Utilization trend

xviii. Unit cost trend

xix. Medicaid program changes

xx. Coordinated care savings

xxi. MCO administrative allowance

f. Attachments 10-A – Physical and Behavioral, 10-B – Physical and Behavioral Health Databook, Rating Region 2, 10-C – Dual Databook and 10-D – Long Term Services and Supports Databook include databooks, provided by MLTC's actuary.

g. The MCO must provide any information requested by MLTC to assist in the determination of MCO rates. MLTC will give the MCO reasonable time to respond to the request, and the MCO must fully cooperate. MLTC will make the final determination as to what is considered reasonable.

h. A minimum of annually, MLTC and its actuary will jointly review the information necessary to develop actuarially-sound capitation rates. This review will include an analysis of any anticipated fee schedule changes or other programmatic changes to the HERITAGE HEALTH, claims experience cost reporting information collected from the MCO, Department of Insurance annual statements, various trend data sources, and administrative experience.

i. Any adjusted rates will be actuarially sound and consistent with requirements set forth in 42 CFR 438.6(c). Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

j. MLTC reserves the right to adjust the capitation rate more frequently than annually as program changes dictate. Circumstances precipitating a rate change include and are not limited to:

i. Changes to benefits and services included in the monthly capitation rates.

ii. Changes in Federal law, Federal regulations, State law, State regulations, State policies, or the Medicaid State Plan.

iii. Changes to Medicaid population groups eligible to enroll in HERITAGE HEALTH.

iv. Legislative appropriations and budgetary constraints.

k. MLTC's actuary will provide, as part of its certification of capitation rates, a narrative that identifies the specific data, assumptions, and methodologies behind the specific payment rates for each rating region. This narrative will address any MCO-specific factors that influence provision of

services to Medicaid members, including but not limited to, reserve contributions and capital costs.

3. Capitation Rates and Payment

a. MLTC will pay the MCO in accordance with the monthly capitation rates specified in Attachment 11 - Rates.

b. The monthly capitation payment is based on member enrollment for the month. This is determined by the total number of Medicaid members assigned to the MCO as of the last working day of the previous month. For age group assignment purposes, age is determined at the beginning of the month for which the payment is intended. The MCO will receive additional payments to cover the cost of services retroactive to the first day of the month of the member's enrollment.

c. The entire monthly capitation payment will be paid during the month of birth, the month of death, and the first month of any incarceration.

4. Transplant Services

The historical cost for transplant services is shown in Attachment 12 – Historical Transplant Cost Distribution Data. The cost for these historical transplants has been added to the base data so that the resulting capitation rates include the costs for these services. The MCO is encouraged to review the information in Attachment 12 – Historical Transplant Cost Distribution Data to assist in making a decision surrounding the appropriate level of reinsurance.

5. Supplemental Delivery Payments

a. In addition to the monthly capitation rate, MLTC will pay MCOs a one-time supplemental lump-sum payment for deliveries.

b. The MCO must pay for all covered services associated with maternity care of a pregnant member.

c. The supplemental delivery payment is intended to cover the care of the pregnant member, not the newborn.

d. When a member is enrolled in the MCO on her date of delivery and the delivery results in a live birth, MLTC will pay the MCO one supplemental maternity payment. The payment will not be prorated.

e. When a member is enrolled in the MCO for part of the pregnancy, but was not enrolled on the date of the delivery, the MCO will not receive the supplemental maternity payment, or any portion thereof.

f. For maternity cases that result in termination of the pregnancy or miscarriage, the MCO is reimbursed through the monthly capitation rate for the member. The MCO will not receive the supplemental delivery payment.

g. The supplemental payment for deliveries is intended to reimburse the MCO for five (5) months of prenatal care, the delivery, and two (2) months of post-partum care.

h. The supplemental payment is generated after documentation of a live birth. A live birth is defined as any birth not resulting in miscarriage, still birth, or any other birth not resulting in life.

i. The MCO must not bill for a supplemental maternity payment until the hospital inpatient delivery is paid by the MCO. The MCO must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.

j. The MCO must request payment for the supplemental delivery payment no later than twelve months following the date of service for the delivery. Failure to have supporting records, when audited, may result in recoupment of the supplemental delivery payment.

6. Payment Adjustments

a. In the event an erroneous payment is made to the MCO, MLTC will reconcile the error by adjusting the MCO's next monthly capitation payment or future capitation payments on a schedule determined by MLTC.

b. Adjustments to prior capitation payments may occur if it is determined that a member's aid category or eligibility has changed.

c. In cases of a retroactive effective date for Medicare enrollment of a member, the MCO must recoup payments made to its providers. The MCO must initiate recoupments within 60 calendar days of the date the MCO becomes aware of Medicare enrollment. The MCO must instruct the provider to resubmit the claim(s) to Medicare.

d. The MCO must refund payments received from MLTC for a deceased member after the month of death and an incarcerated member the month after entering involuntary custody. MLTC will recoup the payment within 30 calendar days of the date MLTC notifies the MCO of death or incarceration. The MCO must notify MLTC should the MCO become aware of a member's death or incarceration.

7. Health Insurance Providers Fee

a. Pursuant to Section 26 CFR Part 47 (the applicable regulations providing guidance about section 9010 of the Affordable Care Act), the MCO must pay the Health Insurance Providers Fee (HIPF) annually. The full cost of the HIPF includes both the HIPF and the allowance for the federal income tax liability related to the HIPF.

b. MLTC will pay the portion of the HIPF specifically related to the MCO's performance of this contract, with an adjustment for federal and state income tax, as described below:

i. The MCO is required to submit Internal Revenue Service Form 8963, pursuant to the federal regulations referenced immediately above, to MLTC by September 5th of each year.

ii. All documents listed above and any additional data or information requested by MLTC must be submitted with an attestation by the reporting MCO in accordance with the certification requirements specified in Section IV.T Reporting and Deliverables.

iii. Following the determination of the amount to be reimbursed and the federal and state income tax impact related to the HIPF fee, the capitation rate per member per month for each aid category will be reprocessed. The capitation payment will include the prorated HIPF payment through December 31st. After January 1st, MLTC will determine a settlement, approved by MLTC's actuary, showing the amount already paid by the State for its portion of the HIPF tax. If the settlement calculation indicates MLTC owes the MCO, the amount due will be paid in a retroactive capitation payment.

iv. The MCO and MLTC's actuary will each calculate the HIPF, and compare the results. The MCO must provide MLTC with verification of payment to the IRS.

8. Risk Adjustment

a. Risk-adjusted rates will not be considered in the first year of this contract. For subsequent years of the contract, each MCO's proposed base capitation rates will be risk-adjusted based on the MCO's risk score, reflecting the expected health care expenditures associated with its enrolled members relative to the applicable total Medicaid population.

b. To establish risk-adjusted rates, MLTC's actuary will analyze the risk profile of members enrolled in each MCO using a national risk-adjustment model specified by MLTC.

i. Each member will be assigned to risk categories based on his/her age, gender, and disease conditions. This information and the relative cost associated with each risk

category will reflect the anticipated utilization of health care services relative to the overall population.

ii. The relative costs will be developed using State historical data from Medicaid FFS claims and MCO encounter data, as determined appropriate by MLTC's actuary.

c. Risk adjustment will be completed 60 calendar days after the end of each contract year and reviewed semi-annually. Risk adjustment may be completed more than semi-annually if MLTC determines it is warranted.

d. MLTC will provide the MCO with three months advance notice of any major revision to the risk-adjustment methodology. The MCO must provide any input regarding the proposed changes, if at all, within 14 days. MLTC will consider the feedback from the MCOs when making changes to the risk adjustment methodology.

9. Risk Corridor

a. Annual MCO profits or losses must not exceed 3% per year.

b. Profits and losses are calculated by MLTC's actuary as a percentage of the aggregate of all qualifying revenue by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract.

c. The risk corridor calculation must be completed within nine months of the end of the contract year based on the formula below. These calculations ignore revenue taxes, non-operating income, and any forfeited hold-back. The earned hold-back from the prior year is not treated as income in the risk corridor calculation.

Risk corridor profit/loss = qualifying revenue
- MLR rebate
- Net qualified medical expenses calculated for the MLR
- Total allowed administration calculated for the administrative cap.

d. If the risk corridor calculation referenced immediately above produces a profit above 3%, the MCO must ensure that the amount over 3% is deposited in the reinvestment account, as described in this section, within nine months of the end of each contract year.

e. The MCO must provide a full financial statement and additional data as requested to MLTC and its actuary to support the risk corridor calculation. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited funds will be returned to the MCO for deposit back into the reinvestment distribution account.

f. If the risk corridor calculation produces a loss of more than 3%, MLTC will pay the MCO an amount equal to the loss above that amount.

g. There will be no risk corridor payment by either party if the risk corridor calculation produces an amount between a three percent gain and a three percent loss.

h. Regardless of the risk corridor calculation, the MCO is eligible to receive its earned hold-back.

10. MLTC Quality Performance Program

a. The MCO must participate in the MLTC quality performance program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes. Neb. Rev. Stat. 71-831 is provided as Attachment 13 – Neb. Rev. Stat. 71-831.

b. Pursuant to Neb. Rev. Stat. §71-831, the MCO must hold back 1.5% of the aggregate of all income and revenue earned by the MCO and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the MCO to earn via the quality performance program.

c. QPP measures for which the MCO is eligible to earn hold-back funds are included in Attachment 14 – Quality Performance Program Measures – Contract Year One.

d. The MCO must report its performance measures that affect the MCO's eligibility to earn hold-back funds monthly, quarterly, and annually.

e. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess the MCO's performance based on the measures annually and notify the MCO of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC will make this determination within six (6) months after the end of each contract year.

f. All earned hold-back funds become the property of the MCO.

g. The MCO must deposit unearned (forfeited) hold-back funds into the reinvestment account to be forfeited to MLTC. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited hold-back funds will be retained by MLTC.

h. No interest will be due to either party on hold-back funds retained by the MCO or returned to MLTC.

i. MLTC reserves the right to modify annually the measures and criteria for earning the hold-back funds. In the event MLTC modifies the measures or criteria, MLTC will provide the MCO 60 calendar days advance written notice. These measures will include operational or administrative measures that reflect MCO business processes and may lead to improved access to and quality of care, CMS Medicaid Adult and Child Core Measure sets, HEDIS measures, and MLTC-identified measures that represent opportunities for improvement as indicated by HERITAGE HEALTH historical performance.

j. Any earned hold-back will not be included in the MCO's income for the year nor considered part of the medical loss ratio (MLR) calculation.

11. State Performance Penalties

a. Pursuant to Neb. Rev. Stat. §71-831, 0.25% of the aggregate of all income and revenue earned by the MCO and related parties under the contract must be at risk as a penalty if the MCO fails to meet minimum performance metrics. MLTC will provide minimum performance metrics to the MCO prior to year two (2) of the contract.

b. The MCO must report its performance on the minimum performance metrics monthly, quarterly, and annually.

c. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess annually the MCO's performance compared with the minimum performance metrics and notify the MCO of the amount of liquidated damages due to MLTC. MLTC will make this determination within six (6) months after the end of each contract year.

d. MLTC reserves the right to modify the minimum performance metrics and criteria for assessing liquidated damages annually. In the event MLTC modifies the metrics or criteria, MLTC will provide the MCO 60 calendar days advance written notice.

12. Administrative Cap

a. Per Neb. Rev. Stat. §71-831, 68-908, and 71-801 (2012), the MCO's administrative spending must not exceed 7%, except up to an additional 3% is allowed, if the additional amount is for the purpose of quality improvement and approved by MLTC.

b. The MCO's total administrative spending must not under any circumstance exceed 10%. The total allowable administrative expense rate is the lesser of 10% and the total of allowable QI and non-QI administrative expenses, less any related-party administrative margin.

c. With its quarterly financial report, the MCO must provide to MLTC a detailed accounting of administrative expenses, including allowable QI expense.

d. To ensure compliance with the State law, MLTC will calculate the administrative expense rate within nine months of the end of each contract year.

e. Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation.

13. Medical Loss Ratio

The MCO must provide an annual Medical Loss Ratio (MLR) report to MLTC, in a form, manner, and pursuant to a timeline prescribed by MLTC. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than 85%, the MCO must refund MLTC the difference. (See Attachment 15 – Medical Loss Ratio Requirements for the MLR calculation methodology and classification of costs.)

14. Reinvestment Accounts

a. Pursuant to Neb. Rev. Stat. §71-831, the MCO must provide for the reinvestment of profits in excess of the contracted amount, performance contingencies imposed by the department, and any unearned (forfeited) hold-back funds. To this end, the MCO must establish and manage two accounts:

i. A hold-back account, for the purpose of holding funds listed in the QPP. Funds in this account include both the Federal and State share of cost in the State's Medicaid program.

ii. A reinvestment account, for the purpose of holding funds pursuant to Neb. Rev. Stat. §71-831 after the federal share of cost has been returned to MLTC.

b. Both the holding and reinvestment distribution accounts must:

i. Be separate from other accounts required by the contract, or that may be required by State or Federal law.

ii. Have no risk-bearing investments.

iii. Be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. §30-3801 to 30-38110).

c. The MCO must use funds in the reinvestment distribution account in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

d. The MCO must develop, with input from MLTC and its stakeholders, a plan for expenditure of funds in the reinvestment distribution account, for approval by MLTC. The MCO must submit a report to MLTC describing implementation of the plan and evaluating the impact of an approved plan within 90 calendar days of the end of each contract year.

e. The MCO must ensure that:

i. The annual financial reporting package as describe in this section is submitted by the MCO within six (6) months of the end of each contract year.

ii. Upon written approval of the annual financial reporting package by MLTC, the MCO must transfer to the State all funds held in the reinvestment holding account.

iii. Once the State has reimbursed the federal share, the MCO must accept the remaining State share for re-deposit into the reinvestment distribution account.

f. MLTC will ensure that:

i. The annual financial reporting package, including the MLR rebate calculation, risk corridor calculation, and earned/unearned hold-back calculation is reviewed, and written approval is provided, within 45 calendar days after receipt from the MCO.

ii. All funds deposited into the reinvestment holding account are transferred to the State by the MCO for reconciliation and reimbursement of the Federal share via reporting on CMS Form 64.

iii. The federal share of such dollars is determined and reimbursed to the federal government.

iv. The remaining State share is returned to the MCO for deposit into the reinvestment distribution account, which is managed by the MCO, subject to contractual requirements.

g. The MCO will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the reinvestment holding and reinvestment distribution accounts. Oversight of the financial accounting will be in accordance with the financial management reporting requirements outlined in Section IV.T Reporting and Deliverables of this RFP.

15. Return of Funds

a. All amounts owed by the MCO to MLTC, as identified through routine or investigative reviews of records or audits conducted by MLTC or other State or Federal agencies, are due no later than 30 calendar days following MCO notification, unless otherwise authorized in writing by MLTC. MLTC reserves the right to collect amounts due by withholding and applying all balances due to MLTC from future payments. MLTC reserves the right to collect interest on unpaid balances beginning 30 calendar days from the date of initial notification. Any unpaid balances after the refund is due are subject to interest at the current Federal Reserve Board lending rate or an annualized rate of 10%, whichever is higher.

b. The MCO must reimburse MLTC for any federal disallowances or sanctions imposed on the State as a result of any failure by the MCO to abide by the terms of the contract. The MCO is subject to any additional conditions or restrictions placed on MLTC by the federal DHHS as a result of the disallowance. Instructions for the return of funds would be provided by written notice.

Q. PROVIDER REIMBURSEMENT

1. Reimbursement to In-Network Providers

The MCO must reimburse in-network providers for covered services provided to its members.

2. Provider Rate Increases

The MCO must ensure that any rate increases for providers of services under the State Medical Assistance Act required by legislative appropriation are passed on in their entirety to participating providers.

3. Enhanced Payments for Primary Care Services

In accordance with Section 1202 of the Affordable Care Act, the MCO must have mechanisms in place to reimburse providers for certain evaluation and management services and immunization administration services furnished by a physician with a specialty in family medicine, general internal medicine, or pediatric medicine. These services must be reimbursed at a rate not less than 100% of the Medicare payment rate for these services. The MCO must establish payment rates for these primary care services that are, at a minimum, consistent with the equivalent FFS Medicare rate.

4. Indian Health Protections

a. Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the MCO must:

i. Provide I/T/U providers, whether participating in the network or not, payment for covered services provided to Indian members who are eligible to receive services from these providers either:

a) At a rate negotiated between the MCO and the I/T/U provider, or

b) If there is not a negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

ii. Make prompt payment to all I/T/U providers in its network in compliance with Federal regulations regarding payments to practitioners in individual or group practices, per 42 CFR 447.45 and 447.46.

b. Additional required Indian health protections are included in Section IV.F Member Services and Education.

5. Psychiatric Residential Treatment Facilities

The MCO's rate of reimbursement for psychiatric residential treatment facilities must be no less than the published Medicaid FFS rate on the date of service.

6. Value-Based Contracting

a. It is the policy of MLTC that HERITAGE HEALTH should promote added value for members and providers. Value is captured through programs that improve outcomes and lower costs. Contracted providers shall be engaged in the pursuit of improved value. A key mechanism to achieve this is through value-based contracting arrangements. For purposes of this contract, value-based contracts are defined as payment and contractual arrangements with providers that include two components:

i. Provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics, and

ii. Payment methodologies that align their financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

b. The MCO must enter into value-based purchasing agreements with 30% of its provider network by the third year of the contract, and 50% of its provider network by the fifth year of the contract.. By the end of the first year of the contract, the MCO must submit to MLTC for its review and approval its plan for implementing value-based purchasing agreements. In its response to this RFP, the MCO shall describe its philosophy regarding value-based purchasing agreements and provide evidence of its effective use in the State or other markets.

c. The MCO must notify MLTC of any risk-sharing agreements it has negotiated with a provider within 15 calendar days of any contract signing with the provider containing this provision. Any provider contract that includes capitation payments must require the submission of encounter data within 90 calendar days of the date of service. As applicable, the provider contracts must comply with the requirements set forth in Section IV.I Provider Network Requirements of this RFP and in compliance with 42 CFR 434.6. The MCO must maintain all provider contracts in compliance with the provisions specified in 42 CFR 438.12 and 42 CFR 438.214, as well as this RFP. MLTC reserves the right to direct the MCO to terminate or modify any provider contract if MLTC determines that the modification or termination is in the best interest of the State.

7. Physician Incentive Plans

a. The MCO's physician incentive plans must meet the requirements of 42 CFR 422.208 and 422.210.

b. A physician incentive plan cannot make a payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member.

c. The MCO must submit any contract templates that include an incentive plan to MLTC for review and approval a minimum of 60 calendar days prior to their intended use. Any provider incentive plan must receive prior MLTC approval. The MCO must disclose the following information in advance to MLTC:

i. Services furnished by physician/groups that are covered by any incentive plan.

ii. Type of incentive arrangement (e.g., withhold, bonus, or capitation).

iii. Percent of withhold or bonus (if applicable).

iv. Panel size, and if patients are pooled, the method used.

v. If the physician/group is at substantial financial risk, documentation that the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss.

d. If the physician/group is put at substantial financial risk for services not provided by the physician/group, the MCO must ensure adequate stop-loss protection for individual physicians and conduct annual member and provider satisfaction surveys.

e. The MCO must provide the information specified in 42 CFR 422.210(b) regarding its physician incentive plan to any Medicaid member on request.

f. If required to conduct member and provider satisfaction surveys (as described in Sections IV.F Member Services and Education and IV.J Provider Services), survey results must be disclosed to MLTC and, on request, to members.

8. Payments to Out-of-Network Providers

a. If the MCO is unable to provide necessary services to a member within its network, the MCO must adequately and timely arrange for the provision of these services out-of-network. In these circumstances, the MCO must ensure that any prior authorization and payment issues are resolved expeditiously.

b. The MCO must ensure that, if applicable, the cost to the member is no greater than it would have been if the services were furnished within the network.

c. For services that do not meet the definition of emergency services, the MCO is not required, unless otherwise provided for in this contract, to reimburse out-of-network providers at more than 90% of the Medicaid rate in effect on the date of service to providers with whom/which it has made a minimum of three (3) documented attempts to contract.

d. The MCO must pay for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of these services. The MCO must reimburse emergency service providers 100% of the Medicaid rate in effect on the date of service. In compliance with Section 6085 of the Deficit Reduction Act of 2005, this requirement also applies to out-of-network providers.

e. During the initial 90 calendar days of the contract, the MCO must pay out-of-network providers at 100% of the Medicaid FFS rate, to support member continuity of care.

f. The MCO may require prior authorization for out-of network services, unless those services are required to treat an emergency medical condition.

g. MCO members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions. The out-of-network provider must bill the MCO and be reimbursed at no less than the Medicaid rate in effect on the date of service.

h. MCO members shall be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No

additional reimbursements will be made to the MCO by MLTC for MCO members who elect to receive family planning services outside the MCO's provider network.

9. Reimbursement to FQHCs and RHCs

a. The MCO must reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34.

b. The MCO must not enter into alternative reimbursement arrangements with FQHCs or RHCs, if initiated by the FQHC or RHC, without prior approval from MLTC.

c. If a MCO is unable to contract with an FQHC or RHC within PCP access distance standards provided in Attachment 2 – Access Standards, the MCO is not required to reimburse that FQHC or RHC for out-of-network services without prior approval unless:

i. The medically necessary services are required to treat an emergency medical condition.

ii. FQHC/RHC services are not available through a minimum of one (1) MCO within MLTC's established travel standards.

d. The MCO may stipulate that reimbursement is contingent on receiving a clean claim and all medical information required to update the member's medical record.

e. The MCO must inform members of these rights in its member handbook.

10. Critical Access Hospital Contracting and Reimbursement

Per 471 NAC 10-010.03F and 10.010.06A, the MCO must make all critical access hospital (CAH) inpatient payments utilizing interim per-diem rates calculated by MLTC with an annual year-end cost settlement. The annual year-end cost settlement occurs at the end of each CAH's fiscal year. Outpatient rates are calculated by MLTC on a cost-to-charge basis with an annual year-end settlement. Critical access hospitals are listed in Attachment 16 – Critical Access Hospitals.

11. University of Nebraska Medical Center (UNMC) Physician/Practitioner Payments

In compliance with 471 NAC 18.006.02, the MCO must pass on supplemental payments for services provided by practitioners acting in the capacity of an employee or contractor of the University of Nebraska Medical Center or its affiliated medical practices, UNMC Physicians, and Nebraska Pediatric Practice, Inc. These payments are calculated into the capitation rate on a quarterly basis.

12. Provider-Preventable Conditions, Including Health Care Acquired Conditions

In accordance with Section 2702 of the Affordable Care Act, the MCO must have mechanisms in place to preclude payment to providers for provider-preventable conditions (PPCs) in compliance with 42 CFR 447.26(b). PPCs, including health care acquired conditions (HACs), are those conditions that occur in inpatient hospital settings. MLTC uses the full list of Medicare's HACs, with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients. To ensure member access to care, any reductions in payment to providers must be limited to the added cost resulting from the PPC. The MCO must require provider self-reporting through its claims systems, and track the PPC data and report it to the State via the encounter file. See Attachment 17 – 2015 Health Care Acquired Conditions for a listing of HACs that apply to this provision.

13. Effective Date of Payment for New Members

The MCO is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility. The MCO must reimburse a member, for payments already made by the member, for Medicaid covered services during the retroactive eligibility period. The date of enrollment in a MCO will match the Medicaid eligibility date.

14. Inappropriate Payment Denials

If the MCO demonstrates a pattern of inappropriately denying or delaying provider payments for covered services, the MCO may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations in which MLTC has ordered payment after appeal but also to situations in which no appeal has been made (i.e., MLTC learns of the documented abuse from other sources.)

15. Payment for Emergency Services

In the event of a medical emergency, the MCO may pay a provider that is not enrolled with MLTC for medically necessary care provided to a member.

16. Pharmacy Reimbursement

a. The MCO's dispensing fee reimbursement must be, at a minimum, the current Medicaid FFS rate for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider.

b. The MCO and the PBM may not charge pharmacy providers transaction-based or claims-processing fees. The MCO may be subject to sanctions in the event it charges these fees. This applies not only to situations in which MLTC has investigated an appeal, but also to situations in which no appeal has been made (i.e., MLTC learns of the fee from other sources).

c. The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

17. Maximum Allowable Cost Program

a. The MCO must establish an extensive MAC program in order to promote cost containment when generics are utilized.

b. The MCO must provide a description of its MAC program for review and written approval by MLTC a minimum of 90 calendar days prior to the contract start date.

c. The MCO must establish a process for timely notification of the MAC pricing updates to network pharmacies. It must also provide this information on the MCO's website. The information must be reviewed and updated weekly.

d. Policies and procedures about MAC pricing must be submitted to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date.

e. The MCO must eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace. MAC pricing must be reviewed and updated based on market changes a minimum of weekly for both price increases and decreases.

f. The MCO must have a process in place to ensure that MAC pricing is appropriate and not routinely below the wholesale price available to State pharmacists. The MCO must provide a reasonable administrative appeals process to allow a dispensing provider to contest a listed MAC rate, which includes the following requirements:

i. The MCO or its PBM must respond to a provider who has contested a MAC rate through this procedure within seven calendar days.

ii. The MCO or its PBM must take steps to determine if the MAC price is appropriate given current State market conditions.

iii. If an update is warranted, the MCO must make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network.

g. The MCO must provide a MAC file to the MLTC PDL contractor a minimum of quarterly. The file format will be defined by MLTC before the contract start date.

h. The MCO must override the MAC on PDL products when the name-brand product is preferred over the generic product.

i. The MCO must have a written policy and procedure that meets State and Federal requirements for providing brand-name products when the prescriber appropriately determines and documents that the brand-name product is medically necessary.

R. SYSTEMS AND TECHNICAL REQUIREMENTS

1. General Requirements

a. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, enrollment, care management, utilization, claims adjudication and payment, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. Reporting formats and other requirements will be determined by MLTC after contract award.

b. The MCO must provide documentation about its health information system that ensures data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data.

ii. Screening the data for completeness, logicalness, and consistency.

iii. Collecting service information in standardized formats to the extent feasible and appropriate.

c. The MCO must provide MLTC with live access to all its systems at any time.

2. HIPAA Standards and Code Sets

The MCO must be able to perform the following functions electronically including electronic claims management capabilities:

a. Receive enrollment verification via a HIPAA-compliant 834 format.

b. Receive electronic premium payments remittance advices via a HIPAA-compliant 820 format.

c. Provide enrollment verification in a HIPAA-compliant 270/271 format.

d. Accept prior authorization requests in a HIPAA-compliant 278 format.

e. Allow claims inquiry and response in a HIPAA-compliant 276/277 format.

f. Accept electronic claims transactions in a HIPAA-compliant 837 format.

g. Generate HIPAA-compliant electronic remittance advices in the 835 format.

h. Submit encounter data via the HIPAA-compliant 837 formats.

i. Make claims payments via EFT.

j. Transmit and receive the NCPDP transaction in the current HIPPA compliant format.

3. Resource Availability and Systems Changes

a. Resource Availability

i. The MCO must provide systems help desk (SHD) services for all MCO, MLTC and other State agency staff who may have direct access to MCO systems.

ii. The MCO's SHD must be available via local and toll-free telephone service and via e-mail from 7:00 am to 7:00 pm, central time, Monday through Friday. If requested by MLTC, the MCO must staff the SHD on a Saturday or Sunday.

iii. The MCO's SHD staff must be able to answer user questions regarding MCO system functions and capabilities; report any recurring programmatic and operational problems to appropriate MCO or MLTC staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate MLTC login account administrator.

iv. The MCO must ensure that individuals who place calls to the SHD between the hours of 7:00 pm to 7:00 am, central time, Monday through Friday, are able to leave a message. The SHD must respond to messages by noon of the following business day.

v. The MCO must ensure that recurring problems, not specific to system unavailability, identified by the SHD are documented and reported to MCO management within one business day of recognition so that deficiencies are promptly corrected.

vi. The MCO must have information systems (IS) service management system that provides an automated method to record, track, and report all questions or problems reported to the SHD.

b. Systems Policies and Procedures

i. The MCO must have in place written systems policies and procedures that document all manual and automated processes for its IS, including the safeguarding of all its information.

ii. The MCO must maintain and distribute to all users (including MLTC) distinct systems design and management manuals, user manuals, and quick reference guides.

iii. The MCO must ensure that the systems user manuals contain information about, and instructions for, using applicable systems functions and accessing applicable system data.

iv. The MCO must ensure that all manuals and reference guides are available in printed form and on the MCO's website.

v. The MCO must update the electronic version of these manuals immediately on taking effect, and make printed versions available within ten (10) business days of the update taking effect.

c. System Changes

i. The MCO's systems must conform to future federal and/or MLTC-specific standards for encounter data exchange a minimum of 90 calendar days prior to the standard's effective date, as directed by CMS or MLTC.

ii. If a system update or changes are necessary, the MCO must draft the appropriate revisions to the documentation, and forward them to MLTC for review and approval a minimum of 45 calendar days prior to intended implementation. Upon MLTC approval, the MCO must prepare revisions to the appropriate manuals before implementing the system changes, and must have printed manual revisions made within ten (10) business days of the system revision.

The MCO must notify MLTC of changes to its system a minimum of 90 calendar days prior to the projected date of the change. These changes include major upgrades, modifications, or updates to application or operating software associated with the following core production systems:

a) Claims processing.

b) Eligibility and enrollment processing.

c) Service authorization management.

d) Provider enrollment and data management.

e) Conversions of core transaction management systems.

iii. The MCO must respond to notification from MLTC of IS problems, excluding IS unavailability, in the following timeframes:

a) Within five (5) calendar days of notification from MLTC, the MCO must respond in writing regarding system problems.

b) Within 15 calendar days, the correction must be made or a requirements analysis and specifications document must be provided to MLTC.

c) The MCO must correct the deficiency by an effective date to be determined by MLTC.

d) The MCO's systems must have a system-inherent mechanism for recording any change to a software module or subsystem.

iv. Unless otherwise agreed to in advance by MLTC, the MCO must not schedule systems unavailability to perform system maintenance, repair, or upgrade activities to take place during hours that could compromise or prevent critical business operations.

v. The MCO must work with MLTC on any testing initiative required by MLTC and must provide sufficient system access to allow MLTC staff to participate in the testing activities.

4. Systems Refresh Plan

The MCO must provide to MLTC an annual systems refresh plan. This plan must outline how ISs within the MCO's span of control will be systematically assessed to determine the need to modify, upgrade, or replace application software, operating hardware and software, telecommunications capabilities, or information management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, or any other relevant issues. The systems refresh plan must also indicate how the MCO will ensure that the version and/or release level of all IS components (application software, operating hardware, and operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF to support the IS component.

5. Eligibility and Enrollment Data Exchange

The MCO must:

a. Receive, process, and update enrollment files sent daily by MLTC or the enrollment broker.

b. Update its eligibility and enrollment databases within 24 hours of receipt of these files.

c. Transmit to MLTC, in the formats and methods specified by MLTC, member address and telephone number changes.

d. Use the member's Medicaid ID number to identify each member across multiple populations and systems within its span of control.

e. Be able to identify potential duplicate records for a single member and, upon confirmation of this duplicate record by MLTC, resolve the duplication so that the enrollment, service utilization, and member interaction histories of the duplicate records are linked or merged.

6. Other Electronic Data Exchange

a. The MCO's system must scan, house, and retain indexed electronic images of documents used by members and providers to interact with the MCO. These documents must be housed in appropriate database(s) and document management systems to maintain the logical relationships to certain key data such as member identification numbers, provider identification numbers, and claim identification numbers. The MCO must ensure that records associated with a common event, transaction, or member service issue have a common index that will facilitate the search, retrieval, and analysis of related activities, such as interactions with a particular member about a reported problem.

b. The MCO must implement optical character recognition technology that minimizes manual indexing and automates the retrieval of scanned documents.

7. Electronic Messaging

a. The MCO must provide a continuously available electronic mail communication link (email system) to facilitate communication with MLTC. This email system must be capable of attaching and sending documents created using software compatible with MLTC's installed version of Microsoft Office and any subsequent upgrades as adopted.

b. As needed, the MCO must be able to communicate with MLTC over a secure virtual private network (VPN).

c. The MCO must comply with national standards for submitting protected health information (PHI) electronically and must set up a secure email system that is password protected for both sending and receiving any PHI.

8. Provider Enrollment

On the effective date of the MCO contract and weekly thereafter, MLTC will furnish to the MCO a list of Nebraska Medicaid provider types and specialty codes. In order to coordinate provider enrollment records, the MCO must utilize these codes in all provider data communications with MLTC and the enrollment broker. The MCO will provide the following:

a. A weekly provider file to include provider name, address, licensing information, Tax ID, NPI, taxonomy, contract information, and any other data as required by MLTC and in a format specified by MLTC.

b. All relevant provider ownership information as prescribed by MLTC, Federal, or State laws.

c. Performance of all Federal- or State-mandated exclusion background checks on providers (owners and managers). The providers must perform the same checks on all of their employees a minimum of annually.

d. Provider enrollment systems must include, at a minimum, the following functionality:

i. Audit trail and history of changes made to the provider file.

ii. Automated interfaces with all licensing and medical boards.

iii. Automated alerts when provider licenses are nearing expiration.

iv. Retention of NPI requirements.

v. System-generated letters to providers when their licenses are nearing expiration.

vi. Linkages of individual providers to groups.

vii. Credentialing information.

viii. Provider office hours.

ix. Provider languages spoken.

x. Provider disability accommodations.

9. Information Security and Access Management

a. The MCO's systems must utilize an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function must:

i. Restrict access to information on a "least privilege basis (e.g., users who are permitted inquiry privileges only will not be permitted to modify information).

ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities. Global access to all functions must be restricted to specified staff, with approval of MLTC.

iii. Restrict unsuccessful attempts to access system functions to three attempts, with a system function that automatically prevents further access attempts and records those occurrences.

b. The MCO must make system information available to duly authorized representatives of MLTC and other State or Federal agencies to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed.

c. The MCO's systems must contain controls to maintain information integrity. These controls must be in place at all appropriate points of processing. The controls must be tested in periodic and spot audits using a methodology to be developed jointly by MLTC and the MCO.

d. Audit trails must be incorporated into all systems to allow information about source data files and documents to be traced through the processing stages to the point at which the information is finally recorded. The audit trails must:

i. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action.

ii. Have the date and identification "stamp" displayed on any online inquiry.

iii. Have the ability to trace data from the final place of recording back to its source data file or document.

iv. Be supported by listings, transaction reports, update reports, transaction logs, or error logs.

v. Facilitate auditing of individual records as well as batch audits.

vi. Be maintained online for no less than two (2) years and be retrievable within 48 hours.

e. The MCO's systems must have inherent functionality that prevents the alteration of finalized records.

f. The MCO must provide for the physical safeguarding of its data processing facilities and the systems and information housed within those facilities. The MCO must provide MLTC with access to data facilities on request. The physical security provisions must be in effect for the duration of this contract.

g. The MCO must restrict perimeter access to equipment sites, processing areas, and storage areas through a key card or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

h. The MCO must include physical security features designed to safeguard processor site(s) including fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

i. The MCO must put in place procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network inside the MCO's span of control. This includes but is not limited to ensuring that no provider or member services applications can be directly accessible over the internet and must be appropriately isolated to ensure appropriate access.

j. The MCO must ensure that remote access users of its ISs can only access these systems through two-factor user authentication and by methods including VPN, which must be approved in writing and in advance by the State.

k. The MCO must comply with recognized industry standards governing security of State and Federal automated data processing systems and information processing. At a minimum, the MCO must conduct a security risk assessment and communicate the results in an IS security plan provided prior to the start date of operations. This risk assessment must also be made available to appropriate Federal agencies.

10. Systems Availability, Performance, and Problem Management Requirements

a. The MCO must ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to confirmation of MCO enrollment (CME), electronic claims management (ECM), and self-service member and provider services functions are available to the applicable IS users at any time, except during periods of scheduled system unavailability agreed to by the State and the MCO. Unavailability caused by events outside of a MCO's control is outside the scope of this requirement.

b. The MCO must ensure that, at a minimum, all other system functions and information are available to the appropriate system users between the hours of 7:00 am and 7:00 pm, central time, Monday through Friday.

c. The MCO must ensure that the systems and processes within its span of control associated with its data exchanges with the State are available and operational according to specifications and the data exchange schedule.

d. In the event of a declared major failure or disaster, the MCO's eligibility/enrollment and claims processing systems must be back online within 72 hours of the failure or disaster.

e. On discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and information, as defined in this section of the contract, including any problems affecting scheduled exchanges of data between the MCO and the State, the MCO must notify MLTC within 60 minutes of such discovery. In its notification the MCO must explain in detail the impact to critical path processes, such as enrollment management and encounter submission processes.

f. When the problem results in delays in report distribution or problems with online access to critical systems functions and information during a business day, the MCO must notify MLTC within 15 minutes of discovery of the problem. This notification will allow the applicable work activities to be rescheduled or handled based on IS unavailability protocols.

g. The MCO must provide a minimum of hourly updates to MLTC on IS unavailability events, including problem resolution. At a minimum these updates must be provided via email or telephone.

h. The MCO must resolve unscheduled IS unavailability and restore services of CME and ECM functions, caused by a failure of systems and telecommunications technologies within the MCO's span of control, within 60 minutes of the official declaration of system unavailability. Unscheduled system unavailability to any other MCO IS functions caused by system and telecommunications technologies within the MCO's span of control must be resolved, and the restoration of services implemented, within eight hours of the official declaration of IS unavailability.

i. Cumulative system unavailability caused by systems or infrastructure technologies within the MCO's span of control must not exceed 12 hours during any continuous 20 business day period.

j. The MCO is not responsible for the availability and performance of systems and infrastructure technologies outside of its span of control.

k. Within five (5) business days of the occurrence of a system availability problem, the MCO must provide MLTC with full written documentation that includes a corrective action plan describing how the MCO will prevent the problem from occurring again.

11. Contingency Plan

a. The MCO, regardless of the architecture of its systems, must develop and be continually ready to implement, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made), to continue essential application or IS functions during or immediately following the failure or disaster.

b. Contingency plans must include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP must focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items, such as employee notification processes and the procurement of office space, equipment, and supplies needed to do business in emergency mode.

c. The MCO must submit a final contingency plan to MLTC for review and approval no later than 45 calendar days before the contract start date.

d. At a minimum, the contingency plan must address the following scenarios:

vi. The central computer installation and resident software are destroyed or damaged.

vii. System interruption or failures that result from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage.

viii. System interruption or failure that result from network, operating hardware, software, or operations errors that compromise the integrity of data maintained in a live or archival system.

ix. System interruption or failure that result from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but prevents access to the system, such as causing unscheduled system unavailability.

x. The plan must specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

xi. The MCO must annually test its plan through simulated disasters and lower level failures in order to demonstrate to MLTC that it can restore systems functions on a timely basis. In the event the MCO fails to demonstrate through these tests that it can restore systems functions, the MCO must submit a corrective action plan to MLTC describing how the failure will be resolved within ten business days of the conclusion of the test.

12. Off-site Storage and Remote Back-up

a. The MCO must provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

b. The data back-up policy and procedures must include, but not be limited to:

vi. Descriptions of the controls for back-up processing, including how frequently back-ups occur.

vii. Documented back-up procedures.

viii. The location of data that has been backed up (off-site or on-site, as applicable).

ix. Identification and description of what is being backed up as part of the back-up plan.

x. Any change in back-up procedures in relation to the MCO's technology changes.

c. MLTC must be provided with a list of all back-up files to be stored at remote locations and the frequency by which these files are updated.

13. Records Retention

a. The MCO must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged. Online access to claims processing data must be possible by Medicaid ID number, provider ID number, and/or internal control number). The MCO must provide 48-hour turnaround or shorter for requests for access to information that is six (6) years old, and 72-hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed.

b. The historical encounter data submission must be retained for a period not less than six (6) years, following generally accepted retention guidelines.

S. CLAIMS MANAGEMENT

1. General Requirements

The MCO must develop and maintain claims processes that ensure the correct collection and processing of claims, as well as analyzes, integrates, and reports data. These processes must result in information about service utilization, claims disputes, and appeals that can be used for process and program improvement.

2. Functionality

a. The MCO must maintain an electronic claims management (ECM) system that will:

i. Uniquely identify the attending and billing provider of each service.

ii. Identify the date of receipt of the claim (the date the MCO receives the claim as indicated by the date stamp on the claim).

iii. Identify real-time accurate history with dates of adjudication, results of each claim, such as paid, denied, pended, adjusted, voided, appealed, etc., and follow-up information about disputed claims.

iv. Identify the date of payment, (the date of the check or other form of payment), and the number of the check or EFT.

v. Identify all data elements as required by MLTC for encounter data submission, as described in this RFP.

vi. Have the ability to integrate member claim and diagnosis history for use when adjudicating claims to override edit checks (such as prior authorization), based on the existence of a diagnosis or prior claim history.

vii. Accept submission of paper-based claims and electronic claims by participating providers, and non-participating providers according to the MCO policies as approved by MLTC.

viii. Accept submission of electronic and paper adjustment and void transactions.

ix. Have the capability to pay claims at $0.00.

x. For the purpose of this section, identify means to capture, edit and retain.

b. The ECM capability must function in compliance with the systems and data management requirements specified in Section IV.R Systems and Technical Requirements of this RFP.

c. The MCO must have ECM capability that can handle online submission of individual claims as well as accept and process batches of claims submitted electronically, with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, etc.).

d. The MCO must support an automated clearinghouse mechanism that allows providers to request and receive EFTs for claims payment.

e. The MCO must support a CAQH/Committee on Operating Rules for Information Exchange compliant interface to the automated clearinghouse that allows providers to request and receive EFTs of claims payments.

f. The MCO's claims processing system must be available at any time, except for scheduled downtime as agreed to by MLTC.

g. The MCO must adhere to national standards and standardized instructions and definitions that are consistent with industry norms. These must include, but are not limited to, HIPAA-based standards and federally-required safeguards, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19.

h. The MCO must include nationally-recognized methodologies to correctly pay claims, including but not limited to:

i. Medicaid Correct Coding Initiative for professional, ambulatory surgical center, and outpatient services.

ii. Multiple procedure/surgical reductions.

iii. Global day evaluation and management bundling standards.

i. The MCO must provide online and telephone-based capabilities to obtain claim processing status information.

j. The MCO must comply at all times with standardized paper billing forms/formats and all future updates.

k. The MCO must not employ off-system or gross adjustments when processing corrections for payment errors, unless the MCO requests and receives prior written approval from MLTC.

l. The MCO agrees that if MLTC presents recommendations concerning claims billing and processing that are consistent with industry norms, the MCO must comply with these recommendations within 90 calendar days.

m. The MCO must not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the MCO or a third party.

n. The MCO must assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by the MCO, or due to systems within the MCO's span of control.

3. Claims Processing

a. Except for claims from pharmacy providers, the MCO must ensure that all provider claims are processed according to the following timeframes:

i. Within five (5) business days of receipt of a claim, the MCO must provide an initial screening and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

ii. Process and pay or deny, as appropriate, a minimum of 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the claim.

iii. Process and pay or deny, as appropriate, a minimum of 99% of all clean claims for medical services provided to members within 60 calendar days of the date of receipt.

iv. Fully adjudicate (pay or deny) all other claims within six (6) months of the date of receipt.

b. For pharmacy providers, the MCO must establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all clean claims from pharmacy providers for covered services are paid within seven calendar days of receipt and 99% of all clean claims are paid within 14 calendar days of receipt, except to the extent providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC within three business days of their implementation.

c. Rejected Claims

i. The MCO may reject claims because of missing or incomplete information. In those circumstances, the original claim must be returned to the provider accompanied by a rejection letter.

ii. A rejected claim should not appear on a remittance advice because it will not have been entered into the MCO's claims processing system.

iii. The rejection letter must indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. The letter must contain, at a minimum, the following information:

a) Member name and Medicaid ID number.

b) Provider ID number.

c) Date of service.

d) Total billed charges.

e) A list of known defects or reasons for rejection.

f) MCO's name.

g) The date the letter was generated.

d. Pended Claims

If a clean claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

e. Adjustments and Voids

i. Incorrect claims payments must be adjusted or voided electronically.

ii. Only a paid claim may be adjusted or voided.

iii. Incorrect provider numbers or member Medicaid ID numbers cannot be adjusted. The claim must be voided and then resubmitted.

f. Timely Filing Guidelines

i. The MCO must not deny provider claims on the basis of untimely filing for claims that involve coordination of services or subrogation (when the provider is pursuing payment from a third party). In situations of third party benefits, the timeframes for filing a claim must begin on the date that the third party completes resolution of the claim.

ii. The MCO must not deny claims solely for failure to meet timely filing guidelines due to an error by MLTC or its subcontractors. If a provider files erroneously with another MCO but produces documentation verifying that the initial filing of the claim occurred timely, the MCO must process the provider's claim and not deny for failure to meet timely filing guidelines.

iii. For purposes of MCO reporting on payments to providers, an adjustment to a paid claim must not be counted as a claim and electronic claims must be treated as identical to paper claims.

g. Claim System Edits

i. The MCO must perform system edits, including but not limited to:

a) Confirming eligibility and MCO enrollment for each member.

b) Validating member name.

c) Validating unique member identification number.

d) Confirming benefit package variations.

e) Identifying invalid, missing, and/or mismatched NPIs and/or tax identification numbers that could result in improper payments.

f) Performing system edits for valid dates of service, including ensuring that the dates of services are not in the future or outside the member's Medicaid eligibility span.

g) Ensuring that timeliness standards are met.

h) Ensuring data accuracy.

i) Determining medical necessity, as defined by qualified, medically trained, and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

j) Determining whether a covered service requires prior authorization and if so, whether the MCO gave its approval.

k) Flagging, in an automated manner, a claim as being an actual or possible duplicate and either denying or pending the claim as necessary.

l) Ensuring that the service is covered and eligible for payment.

m) Ensuring that the system approves only those claims received from providers eligible to render services for which the claims were submitted and that the provider has not been excluded from receiving Medicaid payments.

n) Ensuring that the system evaluates claims for services provided to members to ensure that any applicable benefit limits are applied and that over-utilization standards are considered.

ii. The MCO must have the ability to update current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, Tenth Revision (ICD-10-CM), and other codes based on HIPAA standards and move to future versions as required.

iii. In addition to CPT, ICD-10-CM, ICD-10-PCS, and any other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the MCO's and MLTC's evaluation of performance measures.

iv. The MCO must perform post-payment review on a sample of claims to ensure services provided were medically necessary and were provided in accordance with State and Federal requirements. This must include, as applicable, a review of provider documentation.

4. Drug Claims Processing

a. Use of a Pharmacy Benefits Manager

i. The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with the requirements of this RFP.

ii. The MCO must identify the proposed PBM and the ownership of the proposed PBM in its proposal. Before entering into a subcontract with a PBM, the MCO must obtain MLTC approval. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO must submit a written description of the assurances it would require and procedures it would put in place contractually, such as an independent audit, to prevent patient steering, ensure no conflicts of interest exist, and ensure the confidentiality of proprietary information. These assurances and procedures must be provided to MLTC for review and approval a minimum of 60 calendar days prior to the date pharmacy services begin under the contract.

iii. The MCO must submit a plan for oversight of the PBM's performance prior to the start of the MCO's PBM. The plan must be submitted a minimum of 60 calendar days prior to the PBM's intended contract start date for review and approval by MLTC. The PBM, if approved, must comply with this RFP and all MLTC requirements.

iv. The MCO must not allow its owned or contracted PBM to charge transaction fees to pharmacy network providers.

v. The MCO must oversee, monitor, and assist with the management of PBM activities, related to the use of mental health drugs for children, including the establishment of prior authorization criteria, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18. This includes ensuring the implementation of point of service (POS) system edits defined in the DHHS Psychotropic Drugs and Youth Initiative as outlined in Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative.

b. The MCO must develop and implement a master set of pricing rules and algorithms that will be applied to all pharmacy claims based on business area, and State and Federal requirements and policies. These policies and procedures must be submitted to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date.

c. The MCO must allow pharmacies to fill prescriptions for covered drugs ordered by any Nebraska Medicaid provider regardless of the prescriber's managed care network participation.

d. The claims processing system must edit and validate claim transaction submissions for completeness and accuracy in accordance with National Council for Prescription Drug Programs (NCPDP) standards. The system must have the ability to accommodate existing and future NCPDP standards, including, but not limited to, electronic and paper submission of multiple ingredient compound prescriptions, and partial fills.

e. The MCO claims processing system must, at a minimum, update its NDC file weekly, including all product, packaging, prescription, and pricing information and provide online access to reference file information.

f. The MCO's claims processing system must maintain a history of the pricing schedules and other significant reference data.

g. The MCO's drug claims processing system must be available at any time, except for scheduled downtime as agreed to by MLTC.

h. Provider Identifier

i. The MCO's claims processing system must use prescriber and pharmacy NPIs for claims processing. All prescribing participating providers must have an individual NPI number. This/these must be the same NPI number(s) used for enrollment in the Nebraska Medicaid program.

ii. The MCO must deny prescriptions written by prescribers who are not enrolled with Nebraska Medicaid.

i. Prospective Drug Utilization Review

i. The claims processing system must, at a minimum, establish a central electronic repository for capturing, storing, and updating prospective DUR data.

ii. The claims processing system must assess each active drug regimen of members in terms of ingredient duplication, therapeutic duplication, drug/drug interactions, drug/age contraindications, drug/gender limitations, drug/pregnancy contraindications, drug/disease contraindications, over- and under-utilization, incorrect dosage or duration of drug treatment, clinical abuse or misuse, and other clinically appropriate evaluations.

5. Payments to Providers

a. The MCO must have procedures, approved by MLTC, available to providers in written and electronic form for the acceptance of claim submissions that include:

i. The process for documenting the date of actual receipt of non-electronic claims and the date and time of electronic claims.

ii. The process for reviewing claims for accuracy and acceptability.

iii. The process for preventing the loss of claims.

iv. The process for reviewing claims to determine if they are complete, correct, and payable.

b. At a minimum, the MCO must run one (1) provider payment cycle weekly.

c. The MCO must encourage its providers, as an alternative to the filing of paper claims, to submit and receive claims information through electronic data interchange.

d. The MCO must notify all contracted providers to file claims associated with covered services directly to the MCO or its subcontractors (as applicable), on behalf of Nebraska Medicaid members.

e. The MCO must pay providers interest at an annualized rate of 12%, calculated daily for the full period in which a payable clean claim remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

6. Remittance Advice

a. The MCO must produce a remittance advice that reflects the MCO's payments or denials to providers. Each remittance advice generated by the MCO to a provider must clearly identify for each claim:

i. Name of the member.

ii. Unique member Medicaid identification number.

iii. Patient claim number or patient account number.

iv. Date of service.

v. Total provider charges.

vi. Member liability, specifying any coinsurance, deductible, copayment, or non-covered amount.

vii. Amount paid by the MCO and/or the amount denied and the HIPAA-compliant reasons for denial.

viii. An attachment to the RA if the claim was denied due to a TPL, including but not be limited to, TPL carrier information such as carrier code, policy number, and mailing address.

ix. A description of provider rights for claims disputes.

b. Adjustments and voids must appear on the RA under "Adjusted or Voided Claims" as either approved or denied.

c. The related remittance advice must be sent with the payment, unless the payment is made by EFT. Any remittance advice related to an EFT must be sent to the provider no later than the date of the EFT.

d. If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice must specifically identify all the required information and documentation not submitted. Resubmission of a claim with the necessary information/documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

e. In compliance with 42 CFR 455.18 and 455.19, the following statement must be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable Federal and/or State laws."

7. Paid Claims Sampling

a. On a monthly basis, the MCO must conduct service verification surveys including providing members' own individual EOB notices or information to a sample group of members in a manner that complies with 42 CFR 455.20 and 433.116(e). In easily understood language, the required notice must specify:

i. The description of the service furnished.

ii. The name of the provider furnishing the service.

iii. The date on which the service was furnished.

iv. The amount of payment made for the service.

b. The MCO must stratify the sample group to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that the MCO or MLTC considers a particular specialty

(or provider) to warrant closer scrutiny, the MCO may oversample this group. The paid claims sample should be a minimum of 2% of claims per month. The results must be reported to MLTC on a quarterly basis, per the requirements in Attachment 6 – Reporting Requirements.

c. The service verification surveys may be conducted at any point after a claim has been paid, but no more than 45 calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

d. The MCO must track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to MLTC. The MCO must use the feedback received through this process to modify or enhance the verification of receipt of paid services sampling methodology.

e. Within three business days, results indicating that paid services may not have been received by the member, must be referred to MLTC and the MCO's fraud and abuse department for review.

f. The MCO must report the total number of service verification surveys sent out to members, the total number of surveys completed, the total number of services requested for validation, the number of services validated, and an analysis of interventions related to complaints or other issues, all according to the interval listed in Attachment 6 – Reporting Requirements.

8. Claims Dispute Management

a. The MCO must develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to MLTC for approval a minimum of 60 calendar days prior to the contract start date.

b. The claims dispute process must give providers the option to request binding arbitration for claims that have been denied, underpaid, or bundled, by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution. If the MCO and the provider are unable to agree on an association, the rules of the American Arbitration Association apply. The arbitrator must have experience and expertise in the health care field and must be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator must conduct a hearing and issue a final ruling within 90 calendar days of being selected, unless the MCO and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorneys' fees, must be shared equally by the parties. Each party shall bear its own attorneys' fees, if any.

c. The MCO must systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

d. The MCO must adjudicate each disputed claim to a paid or denied status within 30 business days of receipt.

9. Claims Payment Accuracy

a. On a monthly basis, the MCO must submit claims payment accuracy percentage reports to MLTC, in a format determined by MLTC.

b. The report must be based on an audit conducted by the MCO. The audit must be conducted by an entity or staff independent of claims management. Responsibilities and job requirements for the internal audit staff are outlined in Section IV.D Staffing Requirements of this RFP.

c. The audit must utilize a random sample of all processed or paid claims on initial submission in each month. A statistically-valid sample, with provider and financial stratification, must be selected from the entire population of electronic and paper claims processed or paid on initial submission.

d. The minimum attributes to be tested for each claim selected must include:

i. Claim data is correctly entered into the claims processing system.

ii. The claim is associated with the correct provider.

iii. Proper authorization was obtained for the service.

iv. Member eligibility on the processing date was correctly applied.

v. The allowed payment amount agrees with the contracted rate and the terms of the provider agreement between the MCO and the provider.

vi. Duplicate payment of the same claim did not occur.

vii. The denial reason, if applicable, was applied appropriately.

viii. Copayments were considered and applied if applicable.

ix. Patient liability was correctly identified and applied.

x. Modifier codes were correctly applied.

xi. Other insurance was properly considered and applied if present.

xii. Proper benefit limits were applied.

xiii. Proper coding including bundling and unbundling was applied.

e. The results of testing should be documented, at a minimum, to include:

i. Results of each attribute tested for each claim selected.

ii. The amount of any overpayment or underpayment for claims processed or paid in error.

iii. An explanation of the erroneous processing for each claim processed or paid in error.

iv. A determination of whether any error is the result of keying errors or errors in the configuration or table maintenance of the claims processing system.

v. Documentation that any claims processed or paid in error have been corrected.

f. If the MCO subcontracts for the provision of any covered services and the subcontractor is responsible for processing claims, the MCO must submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report must be based on an audit conducted in compliance with the requirements of this section of the RFP.

10. Encounter Data

a. The MCO must submit encounter data that meets established MLTC data quality standards. These standards are defined by MLTC to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. MLTC will revise and amend these standards as necessary to ensure continuous quality improvement.

b. The MCO must submit encounter data accurately, meeting the standard of 95% correct encounters. The MCO must make an adjustment to encounter claims when the MCO discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed.

c. The MCO must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MLTC data quality standards as originally defined or subsequently amended. The MCO must comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

d. In the event that the MCO denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO must submit all available claims data to MLTC without alteration or omission.

e. When the MCO has entered into capitated reimbursement arrangements with providers, the MCO must require submission of all utilization or encounter data to the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of FFS claims. The MCO must require this submission from providers as a condition of the capitation payment and must make every effort to enforce this contractual provision to ensure timely receipt of complete and accurate data.

f. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by MLTC, in order to support comprehensive financial reporting and utilization analysis.

g. The MCO must submit encounter data according to standards and formats as defined by MLTC, complying with standard code sets and maintaining integrity with all reference data sources, including provider and member data.

h. All encounter data submissions are subject to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted, must be completed within one business day of receipt.

i. MLTC will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by MLTC, to ensure accurate processing or encounter data quality, and will return these transactions to the MCO for research and resolution. MLTC will require expeditious action on the part of the MCO to resolve errors or problems associated with these claims or the adjudication of these claims, including any necessary changes or corrections to any systems, processes, or data transmission formats. Generally the MCO must, unless otherwise directed by MLTC, address 90% of reported errors within 30 calendar days and address 99% of reported errors within 60 calendar days. These errors will be considered acceptably addressed when the MCO has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute.

j. MLTC may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section IV.V Contract Non-Compliance.

k. The MCO must collect and submit to MLTC complete and accurate data on member characteristics, provider characteristics, and services furnished to members through an encounter data system, per the State's specifications.

l. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by the State, to support comprehensive financial reporting and utilization analysis.

m. The MCO must adhere to applicable Federal and MLTC payment rules in the definition and treatment of certain data elements, such as units of service.

n. The NPI is required on all claims and encounter submissions from providers who are eligible for an NPI. The MCO must assist providers to obtain an NPI, if necessary.

o. The MCO must ensure that encounter files contain settled claims, adjustments, denials, and voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom/which the MCO has a capitation arrangement. The MCO must ensure that the level of detail associated with encounters from providers with whom/which the MCO has a capitation arrangement must be equivalent to the level of detail associated with encounters for which the MCO receives and settles as a FFS claim.

p. The MCO CEO, CFO, or their designee must attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

q. All institutional and professional encounters must be submitted electronically in the standard HIPAA transaction formats, specifically the American National Standards Institute X12N 837. Compliance with all applicable Federal (including but not limited to HIPAA) and State requirements, as amended, is required. MLTC and the MCOs will coordinate the timing of the transition to future HIPAA standard transaction formats, as appropriate.

r. Initially, pharmacy encounter claims must be submitted in the State's current proprietary format. In the future, the MCOs are expected to move to the standard NCPDP transaction format. MLTC and the MCOs will coordinate the timing of the transition to the NCPDP transaction format. Compliance with Federal and State requirements, as amended, is required.

s. The MCO must have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, for submission into the appropriate HIPAA compliant formats.

t. Encounter records must be submitted so that payment for discrete services that may have been submitted in a single claim can be ascertained.

u. Encounter data must be submitted a minimum of monthly on a date designated by MLTC and include all clean claims adjudicated and/or adjusted by the MCO.

v. Within two (2) business days of the end of a payment cycle, the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

w. The MCO must submit a weekly claim-level detail file of pharmacy encounters to MLTC that includes individual claim level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to, the total number of metric units; dosage form, strength, and package size; and NDC for each covered outpatient drug dispensed to Medicaid enrollees.

x. The MCO must institute processes to ensure the validity and completeness of the data it submits to MLTC. At its sole discretion, the State will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid ID number), category and sub-category (if applicable) of service, diagnoses codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals will also be reviewed and verified. Additionally, the MCO must reconcile all encounter data submitted to the State to control totals and to the MCO's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 6 – Reporting Requirements.

11. Drug Rebates

a. Nebraska Medicaid is required to and submits the following claims for rebate per Section 1927 of the Social Security Act:

i. Outpatient pharmacy drugs.

ii. Outpatient hospital drugs.

iii. Provider-administered drugs.

b. Section 1903(m)(2)(A) of the Social Security Act states that any outpatient drugs provided by MCOs are eligible for the rebates authorized under Section 1927 of the Act.

c. The MCO must incorporate the following requirements into its appropriate day-to-day systems and business activities:

i. Include the NDC and the date of payment for all encounter data for provider-administered drugs.

ii. Ensure that the NDC is appropriate for the HCPCS/CPT code based on the drug description, strength, and date of service.

iii. Ensure that the HCPCS/CPT and NDC units reported represent a medically appropriate dosing.

iv. Ensure that the date of service of the claim is not past the CMS-determined termination date of the drug.

v. Ensure the NDC is from a rebate-eligible manufacturer on the date of service of the claim.

d. The MCO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies at the claims level for products purchased through the 340B discount drug program, and must have a system in place to transmit these files to MLTC's proprietary system. The MCO must utilize the NCPDP field designated for this purpose, or may include the 340B instructions in its Provider Handbook.

e. The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply to the MCO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. MLTC has the right to audit this information at any time. MLTC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that the information is confidential under applicable law.

f. The MCO is not authorized to negotiate rebates with drug companies for PDL products. MLTC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including drugs administered by medical professionals, must be exempt from these agreements.

g. The MCO must implement a process to timely support MLTC's Medicaid rebate dispute resolution processes. The MCO must assign a single point of contact to research any encounters that are denied on submission to MLTC or identified as a dispute by the manufacturer within 30 calendar days. The MCO must provide an explanation of these disputes to MLTC at the encounter level in a spreadsheet. If claim information is found to be in error, the encounter must be voided within five (5) business days of the determination.

h. The MCO must submit all drug encounters, including retail pharmacy prescription encounters and medical claim encounters for drugs administered by medical professionals, with the exception of inpatient hospital drug encounters, to MLTC. MLTC or its vendor will submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the MLTC Director pursuant to Section 2501 of the ACA.

12. Disputed Drug Encounter Submissions

a. At a minimum, on quarterly basis, MLTC will review the MCO's drug encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process, if any.

b. Within 60 calendar days of receipt of a disputed encounter file from MLTC, the MCO must, if needed, correct and resubmit any disputed encounters and send a response file that includes (1) corrected and resubmitted encounters, or (2) a detailed explanation of why the disputed encounters could not be corrected, including documentation of all attempts to correct the disputed encounters at an encounter claim level.

c. In addition to the administrative sanctions in Section IV.V Contract Non-Compliance, failure by the MCO to submit weekly drug encounter claims files and/or a response file to the disputed encounters file within 60 calendar days as detailed immediately above may result in a quarterly offset to the MCO's capitation payment. This offset will equal the value of the rebate assessed for the disputed encounters.

13. Audit Requirements

a. The MCO must ensure that its systems facilitate the auditing of individual claims. Adequate audit trails must be provided throughout the systems. To facilitate claims auditing, the MCO must ensure that the systems follow, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

b. State Audits

i. The MCO must provide to any State auditor (including the Auditor of Public Accounts), or his/her designee, on written request, files for any specified accounting period for which a valid contract exists, in a file format or audit-defined media required by the auditor. The MCO must provide information necessary to assist the auditor in processing or using the files.

ii. If the auditor's findings point to discrepancies or errors, the MCO must provide a written corrective action plan to MLTC within ten (10) business days of receipt of the audit report.

c. Audit Coordination and Claims Reviews

i. The MCO must coordinate audits with MLTC or its designee and respond within 30 calendar days of a request by MLTC regarding the MCO's review of a specific provider and/or claim(s), and the issue reviewed.

ii. In the event MLTC or its designee identifies a mispayment, the MCO has 30 calendar days from the date of notification of the mispayment to determine if the claim(s) were corrected or adjusted prior to the date of MLTC notification. On receipt of this notification, the MCO must not correct the claims, unless directed to do so by MLTC.

iii. MLTC reserves the right to review any claim paid by the MCO or its designee. The MCO has the right to collect or recoup any overpayments identified by the MCO from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the MCO will collect and remit the overpayment to MLTC. In the event the MCO does not collect mispayments from the provider within 30 calendar days of notification of the overpayment, the MCO must refund the overpayment to MLTC. Failure by the MCO to collect an overpayment from a provider does not relieve the MCO from remitting the identified overpayment to MLTC.

d. If the MCO performs pharmacy services audits, it must submit to MLTC the policies and procedures of this process for review and written approval. The MCO must not utilize contingency-fee-based pharmacy audits.

14. Claims Processing Reports

a. The MCO will report to MLTC, on a monthly basis, summary data on claims payment activity and reasons for claims denials. The reporting requirements will be provided by MLTC.

b. In concert with its claims payment cycle, the MCO must provide an electronic status report indicating the disposition of every adjudicated and adjusted claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the MCO. The status report must contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to, TPL data.

15. Third-Party Liability

a. General TPL Information

i. Pursuant to applicable law, the Medicaid program is the payer of last resort. All other available TPL resources must meet their legal obligation to pay claims before the MCO pays for the care of a Medicaid member.

ii. The MCO must exercise full assignment rights as applicable; must make every reasonable effort to determine any TPL to pay for services rendered to members under this contract; and, cost avoid or recover this liability from the third party(ies).

iii. At the request of MLTC, the MCO must demonstrate that reasonable effort has been made to seek, collect, and report TPL, and the MCO's cost avoidance and recovery efforts.

iv. MLTC has the sole responsibility for determining whether or not reasonable efforts have been demonstrated. This determination will consider reasonable industry standards and practices.

v. The MCO must coordinate benefits in accordance with 42 CFR 433.135, et seq., and 471 NAC 3-004 in order to avoid costs and recover payments from liable parties as appropriate. The term "state" means "MCO" for purposes of complying with the Federal regulations referenced in the immediately preceding sentence. However, the MCO must pay and chase claims for which third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the DHHS Division of Children and Family Services.

vi. The MCO may utilize subcontractors to comply with coordination-of-benefit efforts for services provided under this contract. The two methods for coordinating benefits are cost avoidance and post-payment recovery.

vii. TPL is established when the MCO receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a member.

viii. If the probable existence of TPL cannot be established, the MCO must adjudicate the claim. The MCO must recover payments if TPL is later determined to exist.

ix. The MCO must identify the existence of potential TPL to pay for covered services through the use of diagnosis and trauma code editing in accordance with 42 CFR 433.138(e).

x. If a TPL insurer requires the member to pay any co-payments, coinsurance, or deductibles, the MCO is responsible for making these payments even if the services are provided outside of the MCO network.

xi. The MCO, or its subcontractors or providers, must not pursue collection from the member, but directly from the liable third party(ies), except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004.

xii. MLTC may require a MLTC-contracted TPL vendor to review paid claims that are over 90 calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the MCO's encounter data.

xiii. MLTC is solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

b. Cost Avoidance

i. The MCO must cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed.

ii. The MCO may "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement for any liable TPL if:

a) The claim is for labor and delivery and postpartum care; however, any cost associated with the inpatient hospital stay for labor and delivery and post-partum care must be cost-avoided.

b) The claim is for prenatal care for pregnant women, or preventive pediatric services (including EPSDT).

c) The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D child support agency. The MCO must seek recovery of reimbursement within 60 calendar days after the end of the month in which the payment was made.

c. Post-Payment Recovery

i. Post-payment recovery is necessary in cases in which the MCO has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid.

ii. The MCO must seek recovery within 60 calendar days after the end of the month it learns of the existence of a liable third party after a claim is paid.

iii. The MCO must have established procedures for recovering post-payments for MLTC's review and approval during the readiness review.

iv. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters.

v. The MCO must seek reimbursement in accident/trauma-related cases when claims in the aggregate equal or exceed $250, as required by the Medicaid State Plan.

vi. The amount of any recoveries collected by the MCO outside of the claims processing system must be treated by the MCO as offsets to medical expenses for the purposes of reporting.

d. Distribution of TPL Recoveries

i. The MCO may retain up to 100% of its TPL collections if all of the following conditions exist:

a) Total collections received do not exceed the total amount of the MCO financial liability for the member.

b) There are no payments made by MLTC related to FFS claims, reinsurance, or administrative costs (i.e., lien filing, etc.).

c) Such recovery is not prohibited by applicable law.

ii. MLTC will utilize TPL data in calculating future capitation rates.

e. TPL Reporting Requirements

i. The MCO must provide TPL information to MLTC weekly in a format required by MLTC and must cooperate in any manner necessary with MLTC or its cost recovery vendor.

ii. Any money recovered from third parties will be retained by the MCO and reported monthly to MLTC.

iii. The MCO must post all third-party payments to claim level detail by member. The MCO must include the collections and claims information in the encounter data submitted to MLTC, including any retrospective findings via encounter adjustments.

iv. At the request of MLTC, the MCO must provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. This information must be provided within 30 calendar days of MLTC's request. This information may include, but is not limited to, individual medical records to determine liability for the services rendered.

v. The MCO must report members with third party coverage to MLTC on a monthly basis, reporting additions and updates of TPL information in a format and medium specified by MLTC.

vi. The MCO must submit an annual report of all health insurance collections for its members plus copies of any Form 1099s received from insurance companies for that period of time.

f. Right to Conduct Identification and Pursuit of TPL

i. MLTC may pursue recovery if the MCO fails to recover reimbursement from the third party, to the limit of legal liability, 365 days from the date of service of the claim(s).

ii. The MCO must seek subrogation amounts regardless of the amount believed to be available as required by Federal law. The amount of any subrogation recoveries collected by the MCO outside of the claims processing system must be treated by the MCO as offsets to medical expenses for the purposes of reporting.

16. Coordination of Benefits Data

a. MLTC or its designee will provide the MCO with a list of known third party resources for its members via the enrollment file, based on information made available to MLTC at the time of eligibility determination or re-determination. If the MCO operates or administers any non-Medicaid HMO, health plan, or other lines of business, the MCO must assist MLTC with the identification of members with access to other insurance.

b. The MCO must provide, to MLTC, any third party resource information, in a format requested by MLTC, and must cooperate with MLTC or its cost-recovery vendor.

17. Coordination of Benefits for Dual Eligible Members

a. The MCO is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. The MCO must ensure that services covered and provided under this contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. The MCO must coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. The MCO must propose strategies, in its RFP response, to coordinate care for dually-eligible members.

b. The MCO must sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare. Under this crossover process, a Medicare provider, who may or may not be part of the MCO's network, must submit a claim to Medicare and there is an automatic crossover to MLTC for whatever Medicaid payment is due.

c. The MCO must include in all of its provider agreements provisions to ensure continuation of benefits. In addition, the provider agreement must specify the provider's responsibility regarding TPL, including:

i. Identifying TPL coverage, including Medicare and long-term care insurance as applicable.

ii. Seeking TPL payments before submitting claims to the MCO.

T. REPORTING AND DELIVERABLES

1. General Requirements

a. This section of the RFP describes in general terms the requirements placed on the MCO regarding State and Federal reporting. Program and financial reporting requirements are discussed throughout the RFP and summarized in Attachment 6 – Reporting Requirements. The MCO must comply with all reporting requirements, or to the extent it does not it may be subject to penalties, sanctions, or contract termination.

b. All deliverables are subject to review by the State and will not be considered complete until deemed complete by MLTC. The format and content of each deliverable must be defined and

agreed upon prior to the onset of work. The State will not review a deliverable unless the format and content has been approved in advance.

c. MLTC may grant approval, reject all or some part of the deliverable, or request that revisions be made by the MCO. Additional review periods are required whenever revisions are requested or a deliverable is rejected. Each deliverable must be consistent with previously approved deliverables. The State reserves the right to require the MCO to revise deliverables previously approved or to reject current deliverables based on inconsistencies with previously approved deliverables.

d. MCO policies are subject to approval by MLTC, and will be monitored through operational reviews.

2. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.106). The MCO must disclose this information to MLTC with its proposal. This information must be provided during the readiness review, annually thereafter for each contract year, and within 30 calendar days of any change in the MCO's management, ownership or control.

3. Information Related to Business Transactions

a. The MCO must furnish, to MLTC and the federal DHHS, information related to significant business transactions as set forth in 42 CFR 455.105. Failure to comply with this requirement may result in termination of this contract.

b. The MCO must submit, within 30 calendar days of a request made by MLTC, full and complete information regarding:

i. The ownership of any subcontractor with whom/which the MCO has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

ii. Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of the request.

c. For the purpose of this contract, "significant business transactions" means any business transaction or series of transactions during any State fiscal year that exceed(s) $25,000 or 5% of the MCO's total operating expenses, whichever is greater.

4. Encounter Data

a. The MCO must comply with the required format and timelines provided by MLTC for the submission of encounter data. Encounter data includes claims paid or denied by the MCO or the MCO's subcontractors for services delivered to members through the MCO during a specified reporting period. MLTC collects and uses this data for many purposes such as federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement, utilization patterns, access to care determinations, and various research studies.

b. MLTC may change the encounter data transaction requirements with 90 calendar days advance written notice to the MCO. The MCO must, on notice from MLTC, make the necessary changes to its systems to comply with MLTC requirements and provide notice of the changes to its contractors. It is the MCO's responsibility to ensure that its contractors comply with MLTC requirements within the specified timeframes.

5. Financial Reporting

a. The MCO must submit quarterly and annual financial reporting to MLTC. The details and timing of the reports will be developed with MCO input. Examples of expected reports include, but are not limited to:

i. Certification statement.

ii. Balance sheet.

iii. Income statement.

iv. Lag (incurred but not reported) report.

v. Medical loss ratio calculation.

vi. Profit/risk corridor calculation report.

vii. Related-party statements.

viii. Run rate income statement.

ix. Auditor's report and report on internal controls.

x. Performance measure calculation reports.

xi. Annual disclosure report.

xii. Enrollment/revenue reconciliation.

b. MLTC also requires the MCO to electronically provide detailed claims and membership data that tie to the run rate income statement. The MCO's response to a MLTC data request shall include, at a minimum, the following data fields:

i. Rating category.

ii. Category of service.

iii. Utilizers.

iv. Paid dollars.

v. Paid units.

vi. Units measure.

vii. Paid days.

viii. Cost per unit.

ix. Cost per day.

x. Per member per month (PMPM) cost.

xi. Member months.

xii. Month of service.

xiii. Month of payment.

c. The MCO must obtain an annual financial audit acceptable to MLTC for any expenditure of State-awarded funds made by the MCO. The audit must include management letters and audit recommendations.

d. State auditors must have access to all records and accounts for the contract year(s) in which the award was made. The MCO must comply with Federal and State single audit standards, as applicable. MLTC reserves the right to audit or request an audit (at the MCO's expense) of any data or report required under the contract.

e. Risk contracts must provide that MLTC and CMS may inspect and audit any financial records of the MCO or its contractors. There must be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits either of them deem necessary to assure quality, appropriateness, or timeliness of services and reasonableness of their costs.

6. Information on Persons Convicted of Crimes

The MCO must furnish to MLTC information about any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106. Failure to comply with this requirement may lead to termination of this contract.

7. Submission Process and Timeframes

a. The MCO must ensure that all required deliverables, which may include documents, manuals, files, plans, or reports, as stated in this RFP or required at a future date, are submitted to MLTC in a timely manner for review and approval. The MCO's failure to submit the deliverables as specified may result in the assessment of liquidated damages, as stated in Section IV.V Contract Non-Compliance of this RFP.

b. MLTC may, at its discretion, require the MCO to submit additional deliverables both ad hoc and recurring. If MLTC requests any revisions to the deliverables already submitted, the MCO must make the changes and re-submit the deliverables, according to the time period and format required by MLTC. A 60 calendar day notice will be given on changes to any ongoing reports.

c. Unless otherwise specified in Attachment 6 – Reporting Requirements, deadlines for submitting deliverables are:

i. Monthly deliverables must be submitted no later than the 15th calendar day of the following month.

ii. Quarterly deliverables must be submitted within 45 calendar days of the last day of the calendar quarter immediately preceding the due date.

iii. Annual reports and files, and other deliverables due annually, must be submitted within 30 calendar days following the 12th month of the contract year; except, those annual reports that are specifically exempted from this 30 calendar day deadline by this RFP or by written agreement between MLTC and the MCO.

iv. If a due date falls on a weekend or State-recognized holiday, deliverables are due the next business day.

8. Ad Hoc Reports

a. The MCO must prepare and submit any other reports required and requested by MLTC, any of MLTC's designees, the State Legislature, or CMS that are related to the MCO's duties and obligations under this contract. Information considered to be proprietary must be clearly identified by the MCO at the time of submission.

b. Ad-hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

9. Errors

a. The MCO must prepare complete and accurate reports for submission to MLTC. If after preparation and submission, a MCO error is discovered, either by the MCO or MLTC, the MCO must correct the error(s) and resubmit the report within the following timeframes:

i. For encounters, in accordance with the timeframes specified in the Section IV.S Claims Management of this RFP.

ii. For all reports, 15 calendar days from the date of discovery by the MCO or date of written notification by MLTC (whichever is earlier). MLTC may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can

demonstrate to MLTC's satisfaction that the problem cannot be corrected in 15 calendar days.

b. Failure of the MCO to respond within these timeframes may result in penalties per Section IV V Contract Non-Compliance..

10. Reporting Dashboard

a. The MCO must work with MLTC to develop a reporting dashboard. The purpose of this dashboard is to provide MCO and MLTC leadership with easily accessible MCO results related to access to and quality of care, as well as program cost-effectiveness. Access to this dashboard will be determined in consultation with MLTC. The dashboard must be operational within six months after the contract start date. The dashboard will augment, but not replace, other reporting templates required by MLTC. At its sole discretion, MLTC may determine that reports generated by this dashboard are sufficient and may no longer require the MCO to complete similar or other reports. Dashboards must be updated within the timelines specified by MLTC. The reporting dashboard must include, at a minimum, statistics related to:

i. Member enrollment.

ii. Call center statistics.

iii. Status of credentialing applications.

iv. Performance measures.

v. Care management.

vi. Pending grievances and appeals.

vii. Pending claims.

viii. Financial status.

ix. Any other issues as identified by MLTC.

b. MLTC reserves the right to require MCO participation in an alternative reporting and dashboard system at its discretion.

U. CONTRACT MONITORING

1. MCO Policies and Procedures

MLTC will provide the MCO with updates to attachments; other information; interpretation of all pertinent State and/or Federal Medicaid regulations; and, MCO policies, procedures, and guidelines affecting the provision of services under this contract. The MCO will submit written requests to MLTC for additional clarification, interpretation, or other information, as appropriate. Provision of this information does not relieve the MCO of its obligation to keep informed of applicable State and Federal laws related to its obligations under this contract.

2. Operational Reviews

a. In accordance with CMS requirements (42 CFR 438.204), MLTC, or its designee, will conduct periodic operational reviews to ensure program compliance and identify best practices. The reviews will identify and make recommendations for areas of improvement, monitor the MCO's progress towards implementing mandated programs or operational enhancements, and provide the MCO with technical assistance when necessary. The type and duration of the review will be solely at MLTC's discretion.

b. This monitoring by MLTC does not relieve the MCO of its responsibility to continuously monitor its providers' and subcontractors' performance to ensure compliance with contract provisions.

c. Except in cases in which advance notice is not possible or advance notice may render the review less useful, MLTC will give the MCO a minimum of three (3) weeks advance notice of the date of

a review. MLTC reserves the right to conduct reviews without notice to monitor contractual requirements and performance.

d. MLTC, or its designee, will coordinate with the MCO to establish the scope of any review, the review site (if on-site), relevant time frames for obtaining information, and the review criteria.

e. MLTC may request, at the expense of the MCO, to conduct on-site reviews of functions performed at out-of-State locations and will coordinate travel arrangements and accommodations with the MCO.

f. The review may include an inspection of the MCO's facilities, as well as auditing or review of any records including, but not limited to, medical records, grievances, enrollments, disenrollments, utilization and medical management, finance, management systems, policies and procedures, or any other areas or materials relevant to this contract.

g. In preparation for a review, the MCO must cooperate with MLTC, by forwarding, in advance, policies, procedures, job descriptions, contracts, records, logs, and any other materials upon request. Documents not requested in advance must be made available during the course of a review. MCO staff must be available at all times during a review. The MCO must provide an appropriate private workspace and internet access to the review team.

h. The MCO will be provided a copy of the draft review report and given the opportunity to comment on any review finding prior to MLTC issuing the final report, unless the review concerns potential fraudulent or criminal action. The MCO must develop corrective action plans based on the recommendations, if necessary. However, once MLTC finalizes the findings, the MCO must comply with all recommendations that result from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions, and/or enrollment restrictions.

i. Corrective action plans and any modifications must meet the approval of MLTC. Unannounced follow-up reviews may be conducted at any time after the initial operational review, to determine the MCO’s progress in implementing the recommendations and achieving compliance.

j. The MCO may not distribute, or otherwise make available, the operational review tool, draft operational review report, or final report to other MCOs.

3. Business Reviews

a. MLTC will schedule business reviews with each MCO, which will be held on a quarterly basis or frequency as determined by MLTC. Business reviews are regular meetings with MLTC staff and MLTC leadership to review ongoing business operations of the MCO, performance metrics, quality outcomes, and other topics as determined by MLTC.

b. The MCO shall participate in MLTC-organized business reviews.

c. The MCO CEO will participate in, and ensure other key staff members as requested by MLTC to participate in the business reviews. The CEO must ensure the MCO is prepared to participate pursuant to an MLTC-developed agenda and/or presentation template.

V. CONTRACT NON-COMPLIANCE

1. Administrative Actions

a. In the event the MCO fails to perform any obligation under the contract, at the discretion of MLTC, the MCO may be subject to the administrative actions detailed below. , MLTC will provide written notice to the MCO of non-compliance or deficiency. Administrative actions exclude liquidated damages, intermediate sanctions, and termination, and include:

i. A warning through written notice (may include consultation).

ii. Education about program policies and billing procedures. The MCO may be required to participate in a provider education program as a condition of continued participation.

MCO education programs may include attendance at quarterly meetings, at which issues and topics may include, but not be limited to:

a) The use of procedure codes.

b) The review of key provisions of the Medicaid program.

c) Instruction about reimbursement rates.

d) Instruction about how to inquire about coding problems.

e) Quality/medical issues.

iii. Submission of a Corrective Action Plan (CAP). MLTC will approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, and required status reports.. The CAP must address:

a) The steps to be taken by the MCO to comply with the terms of the contract.

b) A timeframe for anticipated compliance and a date certain for correction of the issue.

2. Liquidated Damages

MLTC may impose liquidated damages if the terms of the CAP are not met. Liquidated damages will continue until satisfactory correction of the issue has occurred, as determined by MLTC.

In the event the MCO fails to comply with any term or condition of the RFP or specifically subparagraphs a – h as listed below, the damages detailed in this section and Attachment 18 – Liquidated Damages may be assessed in the sole discretion of MLTC. If assessed, the damages will be used to reduce MLTC's payments to the MCO. If the damages exceed amounts due from MLTC, the MCO will be required to make cash payment to MLTC for the amount in excess.

a. Readiness Review

MLTC will conduct a formal review of the MCO's readiness to implement all required services described in this RFP. Should the MCO fail the review, MLTC may assess damages of $5,000 for each calendar day until such time as MLTC certifies that the MCO has met all readiness requirements.

b. Date of Implementation

Should the MCO fail to begin full operations on the contract start date, and should MLTC determine that the MCO is responsible for the delay, MLTC may assess damages of $10,000 per calendar day for each day beyond the contract start date that the MCO fails to begin full operations.

c. Timely Reports and Data Delivery Requirements

All reports and data (including encounters) required by the contract must be produced in the format and media approved by MLTC and submitted by the due dates required by MLTC. If the data is incomplete, incorrect, or untimely, MLTC may assess a penalty of $1,000 for each calendar day that a report or data delivery is late, includes less than the required copies, or is not in the approved format.

d. Network Performance Requirement

Between the contract award date and the contract start date, the MCO must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of 90 calendar days prior to the contract start date. MLTC may assess a penalty of $1,000, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.

e. Employment of Key Personnel

The MCO must meet all key personnel requirements specified in Section IV.D Staffing Requirements of this RFP. MLTC may assess a penalty of $1,000 per day, per position, for each day after the 30 allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.

f. Excessive Reversals on State Fair Hearings

If more than 10% of the MCO decisions on member appeal are overturned by the State Fair Hearing process the MCO may be assessed a penalty of $25,000 per reversal exceeding 10% in a contract year.

g. Marketing and Member Education Violations

i. Whenever MLTC in its discretion determines the MCO or any of its agents, subcontractors, volunteers, or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, or providing any health care services, in the discretion of MLTC one or more of the remedial actions specified in Section IV.V Contract Non-Compliance shall apply.

ii. Unfair, deceptive, or prohibited marketing practices shall include, but are not limited to:

a) Failing to secure written approval before distributing marketing or member materials.

b) Engaging in, encouraging, or facilitating prohibited marketing by a provider.

c) Directly marketing to members or potential members.

d) Failing to meet time requirements for communication with new members (e.g., distribution of welcome packets or welcome calls).

e) Failing to provide interpretation services or make materials available in required languages.

f) Engaging in any of the prohibited marketing or member education practices detailed in this RFP.

g) Making false or misleading verbal or written statements, visual descriptions, advertisements, or other representations of any kind that have the capacity, tendency, or effect of deceiving or misleading MCO members or potential members about any health care services, the MCO, any health care provider, or the HERITAGE HEALTH.

h) Representing that a MCO or network provider offers any service, benefit, access to care, or choice that it does not offer.

i) Representing that a MCO or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure that it does not possess.

j) Failing to state a material fact, if the failure deceives or tends to deceive.

k) Offering any kickback, bribe, award, or benefit to any Medicaid enrollee as an inducement to select, or to refrain from selecting, any health care service, MCO, or health care provider.

l) Using the Medicaid member's or another person's information that is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a State or Federal confidentiality law, including:

1) Medical records information.

2) Information that identifies the member as a recipient of any government-sponsored or mandated health coverage program.

m) Using any device or artifice in advertising a MCO or soliciting Medicaid enrollees that misrepresents the solicitor's profession, status, affiliation, or mission.

iii. If MLTC determines that the MCO or its subcontractor(s) has marketed to and the member has enrolled in the MCO, MLTC may impose the following sanctions:

a) The MCO will be required to send a letter to each member, notifying the member of the violation and of his/her right to select another MCO. The members disenrollment will be on the earliest effective date allowed.

b) Any payments made to the MCO on behalf of the member(s) will be recouped if the member disenrolls.

c) The MCO will be assessed an additional $5,000 monetary sanction per member.

iv. If MLTC determines that the MCO has violated any of the marketing and/or outreach requirements outlined in the contract, the MCO may be subject to damages up to $10,000 per violation. The amount of damages is at the discretion of MLTC.

h. Other Liquidated Damages may be assessed as otherwise permitted in the RFP.

i. MLTC will provide written notice and factual basis for the assessment of liquidated damages to the MCO. Within ten (10) business days of receipt of the written notice, the MCO may appeal the assessment of liquidated damages in writing to the Deputy Director of the Delivery Systems Section of MLTC. A written decision will be issues within ten (10) business days. Within five (5) business days of receipt of the written decision, the MCO may request reconsideration of the decision in writing to the Director of MLTC. The Director shall issue a written opinion within 30 calendar days. No further appeals shall be allowed.

3. Failure to Provide Benefits and Services

If MLTC determines that the MCO has failed to provide one or more benefits or services, MLTC will direct the MCO to provide the benefit(s) or service(s). If the MCO continues to refuse to provide the benefit(s) or service(s), MLTC will authorize the member(s) to obtain the services from another source and will notify the MCO in writing that the MCO will be charged the actual cost of the services. In this event, funds equivalent to the expense(s) will be deducted from the next monthly capitation payment or a future payment as determined by MLTC. With the deductions, when made, MLTC will provide a list of the affected member(s) concerning which payments to the MCO have been deducted, the nature of the benefit(s) or service(s) denied, and payments MLTC made or will make to provide the medically necessary covered benefit(s) or service(s).

W. INTERMEDIATE SANCTIONS

1. Acts or Failures to Act Subject to Intermediate Sanctions

The following violations are grounds for intermediate sanctions that may be imposed in the sole discretion of MLTC when the MCO act or fails to act:

a. The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with MLTC, to a member covered under the contract.

b. The MCO imposes on members premiums or charges that are in excess of allowable charges permitted under the Medicaid program.

c. The MCO discriminates against members on the basis of their health status or need for health care services.

d. The MCO misrepresents or falsifies information that it furnishes to CMS or to the State.

e. The MCO misrepresents or falsifies information that it furnishes to a member, enrollee, or health care provider.

f. The MCO fails to comply with the requirements for physician incentive plans, if applicable.

g. The MCO distributes, directly or indirectly through any agent, marketing materials that were not approved in advance by MLTC or that contain false or materially misleading information.

h. The MCO violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

i. Any other action or inaction that the State deems a violation and that merits a sanction consistent with this section.

2. Other Misconduct Subject to Intermediate Sanctions

MLTC in its sole discretion also may impose sanctions against a MCO if it finds any of the following non-exclusive actions or occurrences:

a. The MCO failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from MLTC.

b. The MCO was excluded from participation in Medicare because of fraudulent or abusive practices, pursuant to Public Law 95-142.

c. The MCO or any of its owners, officers, or directors was convicted of a criminal offense relating to performance of the contract with MLTC, of fraudulent billing practices, or of any negligent practice resulting in death or injury to a MCO member.

d. The MCO presented, or caused to be presented, any false or fraudulent claim for services, or submitted or caused to be submitted false information to the State or CMS.

e. The MCO engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made to the MCO by MLTC.

f. The MCO rebated or accepted a fee or portion of a fee or charge for a member referral.

g. The MCO failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

h. The MCO failed to keep, or make available for inspection, audit, or copying, the records regarding payments claimed for providing services.

i. The MCO failed to furnish any information requested by MLTC regarding payments for providing goods or services.

j. The MCO furnished goods or services to a member, which at the sole discretion of MLTC, and based on competent medical judgment and evaluation, are determined to be insufficient for his/her needs, harmful to the member, or of grossly inferior quality.

3. Sanction Types

a. MLTC may impose the following intermediate sanctions at its sole discretion:

i. Civil monetary penalties as specified in Attachment 18 – Liquidated Damages.

ii. Appointment of temporary management as described in this section.

iii. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.

iv. Suspension of all new enrollments into the MCO, including auto-assignments, as of the effective date of the sanction.

v. Suspension of payment for members enrolled after the effective date of the sanction, unless and until CMS or MLTC is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

vi. Any other remedy, right, or sanction allowed under the contract or applicable law.

b. Payments under the contract will be denied for new members when, and for as long as, payment for those members is denied by CMS in accordance with the requirements of 42 CFR 438.730.

4. Notice of Sanction to MCO and CMS

a. Prior to imposing any intermediate sanction, the State will give the MCO timely written notice that explains the following:

i. The basis and nature of the sanction.

ii. The MCO's right to an administrative hearing.

b. MLTC will give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 CFR 438.700, specifying the affected MCO, the kind of sanction, and the reason for MLTC's decision to lift a sanction (if applicable). Notice will be given no later than 30 calendar days after MLTC imposes or lifts the sanction.

5. Payment of Liquidated Damages and Sanctions

a. The purpose of establishing and imposing liquidated damages is to provide a means for MLTC to obtain the services and level of performance required for successful operation of the contract. MLTC's failure to assess liquidated damages in one or more of the particular instances described herein will in no event waive the right, power, or authority of MLTC to assess additional liquidated damages or actual damages at that time or in the future.

b. The decision to impose liquidated damages (including intermediate sanctions) will include consideration of some or all of the following factors:

i. The duration of the violation.

ii. Whether the violation (or one that is substantially similar) has previously occurred.

ii. The MCO's compliance history.

iii. The severity of the violation and whether it imposes an immediate threat to the health or safety of the MCO's members.

iv. The good faith exercised by the MCO in attempting to achieve or remain in compliance.

c. The violations described in Attachment 18 – Liquidated Damages are examples of the grounds, but not an exclusive list of grounds, on which MLTC may impose liquidated damages.

d. Any liquidated damages assessed by MLTC that cannot be collected through withholding from future capitation payments will be due and payable to MLTC within 30 calendar days after the MCO's receipt of the notice of liquidated damages. However, in the event an appeal by the MCO results in a decision in favor of the MCO, any funds withheld by MLTC will be returned to the MCO as consistent with the appeal decision.

6. Special Rules for Temporary Management

a. MLTC may install temporary management if it finds that there is continued egregious behavior by the MCO, including, but not limited to, behavior that is described in 42 CFR 438.706, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act.

b. MLTC will impose temporary management if it finds that a MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In this circumstance, MLTC must also notify members of the MCO of their right to select another MCO, and allow them to do so. The State may not delay imposition of temporary management to

provide a hearing regarding the sanction. In addition, MLTC will not terminate temporary management until it determines that the sanctioned behavior will not recur.

7. Payment of Outstanding Monies or Collections from MCO

The MCO will be paid for any outstanding monies due less any assessed liquidated damages or sanctions. If liquidated damages exceed monies due, collection will be made from the MCO performance bond or any insurance policy or policies required under this contract, as appropriate. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

8. Provider Sanctions

Nothing contained in this RFP shall prohibit MLTC, pursuant to applicable law, from imposing sanctions, including civil liquidated damages, license revocation, and Medicaid termination, on a health care provider for its violations of applicable law.

X. TRANSITION AND IMPLEMENTATION

1. Preliminary Implementation Plan

a. The MCO is responsible for submitting a preliminary implementation plan with its proposal. This plan must describe the MCO's plan to comply with all the major areas of the contract including:

i. Member services.

ii. Network development and management.

iii. Quality management, including credentialing.

iv. Care management.

v. Utilization management.

vi. Transition and care coordination.

vii. Information systems management.

viii. Claims management.

ix. Grievances and appeals.

b. The preliminary implementation plan must also address staffing, facilities, and other operational issues as identified in this RFP and the MCO's proposal. The plan must include tasks, deliverables, and milestones necessary to implement the program.

2. Transition Period

a. The transition period for the contract begins on contract award and ends 90 calendar days after the contract start date. During the transition period the MCO must implement the requirements of the contract and this RFP and collaborate with MLTC to facilitate a seamless transition between MCOs, providers, and programs in order to prevent an interruption of services and to ensure continuity of care for members.

b. On contract award, the MCO must immediately begin collaborating with MLTC to review the contract, its proposal, and preliminary implementation plan. The MCO must provide to MLTC implementation plan updates, weekly, and collaborate with MLTC to address the following:

i. Defining project management and reporting standards.

ii. Establishing communication protocols between the MCO, MLTC, and existing providers.

iii. Defining expectations for the content and format of contract deliverables.

iv. Resolving transition and implementation issues to MLTC's satisfaction.

c. At minimum, the MCO must have the following key staff in place to participate in the transition coordination/collaboration process:

i. Chief Executive Officer.

ii. Chief Operating Officer.

iii. Medical Director/Chief Medical Officer.

iv. Behavioral Health Clinical Director.

v. Member Services Manager.

vi. Provider Services Manager.

vii. Information Management and Systems Director.

viii. Quality Management Coordinator.

ix. Case Management Administrator.

3. Comprehensive Implementation Plan

a. After contract award and before contract start date, the MCO must develop a detailed and comprehensive implementation plan to monitor progress throughout the transition/implementation period.

b. The MCO must include in its implementation plan a detailed description of its implementation tasks, methods, staff accountable for completing tasks, and timelines, at a minimum for the following areas/issues:

i. Staffing.

ii. Data systems including system readiness testing, acceptance testing, transfer of electronic data and records, and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data.

iii. Network development.

iv. Clinical transition.

v. Utilization management.

vi. Care management.

vii. Quality management.

viii. Member services.

ix. Member outreach/communications.

x. Security, business continuity, disaster recovery, and contingency planning.

xi. Member Handbook and Provider Manual completion.

xii. Claims and eligibility interface development.

xiii. Compliance plan.

xiv. Financial reporting plan.

xv. Member and staff orientation and training plans.

xvi. Post-implementation deliverables.

4. Network Adequacy Requirement

The MCO must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population 90 calendar days prior to the contract's start date. The MCO must submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract effective date. The plan must detail the MCO's network, including GeoAccess reports, and describe any provider network gaps and the MCO's remediation plans. Additional requirements regarding network adequacy are included in Section IV. I Provider Network Requirements of this RFP.

5. Personnel

The MCO must submit key staff resumes with its proposal, as possible. All key staff, as detailed in Section IV.D Staffing Requirements must be hired prior to the Readiness Review. A minimum of two (2) weeks prior to the readiness review, the MCO must submit to MLTC the resumes of any key staff member (that was not submitted with the MCO's proposal) for MLTC review and approval. At that time, the MCO must submit updated organizational charts. The MCO must have sufficient personnel working and operating in the State during the transition and implementation period in order to be fully compliant with the terms of the contract.

6. Transitioning of Managed Care Members and Operations

a. When applicable, the MCO must transition members receiving services so care is not disrupted.

b. The MCO must collaborate with the current MCOs, the behavioral health MCO, the Pharmacy Benefits Manager, and providers to develop and implement care plans for members who require them during the transition and deliver all services contained in the plans.

c. At a minimum, the MCO must provide service information, emergency telephone numbers, and instructions about how to obtain additional services to each member affected by the transition.

d. If applicable and as necessary, the MCO must transition from the current MCO to the new MCO, pending grievances, appeals, and member/provider service issues to ensure their timely resolution.

e. The MCO must have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings.

7. Transitioning from the MLTC FFS Pharmacy Program to the MCO Pharmacy Program

a. The MCO must submit a transition plan to MLTC for review and approval prior to the start date of operations that includes, at a minimum, procedures for continuity of care of prior authorized pharmacy services when an individual transfers from the MLTC FFS pharmacy benefit to the MCO pharmacy plan. This transition plan must ensure that members can continue treatment with any prescribed medications for a period of a minimum of 90 calendar days.

b. The MCO must load to its pharmacy claims processing system the current prior authorization records from MLTC or its designee prior to the contract start date. The MCO is responsible for creating drug reference file conversion tables if needed. The MCO must also load the current restricted services designation(s) by the MLTC FFS pharmacy program to its system prior to the contract start date.

8. Readiness Review

a. Prior to the contract start date, MLTC will conduct an operational and financial readiness review of the MCO, and will provide needed technical assistance. The MCO must cooperate with MLTC's review process to assess the MCO's operational readiness and ability to provide covered services to members as of the contract start date. The MCO will be permitted to commence operations, and Medicaid enrollees will be enrolled with the MCO, only if the readiness review factors are met to MLTC's satisfaction.

b. Based on the results of the review, MLTC will issue a letter of findings and, if necessary, request a corrective action plan from the MCO.

c. The readiness review will cover all provisions of the contract with a particular focus on assessing the following areas:

i. Network adequacy.

ii. Staffing adequacy.

iii. Subcontracts.

iv. Provider services.

v. Member services.

vi. Quality management.

vii. Care management.

viii. Utilization management.

ix. Financial management.

x. Information processing and system testing.

xi. Transition of behavioral health recipients.

xii. Continuity of care.

xiii. Grievance and appeal process.

d. During the readiness review, the MCO must provide to MLTC staff access to MCO staff, operational documentation (including a demonstration of computer systems), private workspace, and the internet.

e. If the MCO is unable to demonstrate its ability to meet the requirements of this contract, as determined by MLTC, within the time frames specified by MLTC, MLTC may terminate this contract and have no liability for payment to the MCO.

Y. Termination of MCO Contract

a. In the event a MCO is terminated or its contract expires, the MCO must provide services through the end of the contract term and pay for all covered services for all members prior to the date of contract termination.

b. The MCO must submit, for approval by MLTC, a detailed plan for the transition of its members to another MCO that includes the schedule for key activities and milestones. The MCO must:

i. Make provisions for continuing all management and administrative services and the delivery of direct services to members until the transition of all members is completed and all other requirements of the current contract are satisfied.

ii. Designate a person with the appropriate training to act as the transition coordinator. The transition coordinator must interact closely with MLTC and staff from the other MCO to ensure a safe and orderly transition.

iii. Provide all reports set forth in this contract necessary for the transition process. This includes providing MLTC, until MLTC is satisfied that the MCO has completed all outstanding obligations, the following additional reports. These reports are due on the fifth day of each succeeding month for the prior month:

iv. Monthly claims aging report by provider/creditor including incurred-but-not-reported amounts.

v. Monthly summary of cash disbursements.

vi. List of all outstanding obligations necessary to complete the contract.

vii. Notify subcontractors of contract termination or expiration, as directed by MLTC.

viii. Notify all its members that the MCO will no longer serve as their MCO a minimum of 45 calendar days in advance of the termination. The MCO shall be financially responsible for all costs associated with this notification. The notification must be approved in advance by MLTC.

ix. Notify each participating provider in writing that the MCO's contract with MLTC is ending a minimum of 45 calendar days in advance of the termination. The written notice must include the contract end date and must explain to the participating provider how the provider can continue participating in the Medicaid program. The MCO shall be financially responsible for all costs associated with this notification. The notification must be approved in advance by MLTC.

x. Pay all outstanding obligations for covered services provided to members. The MCO must cover continuation of services for members for the period for which payment is made, as well as for inpatient admissions up until the member's discharge.

xi. Cooperate with other MCOs during the transition period including, at a minimum, sharing and transferring member information and records. MLTC will notify the MCO with specific instructions and about required actions at the time of transfer.

xii. Return any funds advanced to the MCO for coverage of members for periods after the contract end date to MLTC within 30 calendar days of the contract end date.

xiii. Supply all information necessary for reimbursement of outstanding claims.

xiv. Provide MLTC, in a format approved by MLTC:

a) A list of all network providers.

b) A list of members who are receiving care management services.

c) A list of all services requiring MCO prior authorization.

d) A list of all members receiving prior authorized services with an approved duration that extends beyond the contract termination date.

Z. FFS CLAIMS MANAGEMENT AND PROCESSING

The State of Nebraska intends to award a minimum of two (2) and a maximum of three (3) MCO contracts for the scope of work as described in Section IV. A. Program Description through Y. Termination of MCO Contract. One of the awarded contracts will also include the scope of work as described in Section IV. Z. FFS Claims Management and Processing.

1. Claims Broker Services

The State is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, the State is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, the State will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, the State intends to enter into a services agreement with a MCO.

In addition to the MCO responsibilities outlined in this RFP, MLTC will award the processing of the remaining Nebraska Medicaid FFS claims, hereafter referred to as "claims broker services," to a single MCO. Any reference to claims in this section is also inclusive of FFS adjustments, recoupments, voids, and financial transactions. Payment for claims broker services will be paid separately from managed care capitation payments. MLTC will pay the claims broker an administrative processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate.

MLTC will reimburse the MCO for claims broker services based on a per claim administrative fee. The fee will be adjusted yearly based on administrative expense for the FFS claims processing. Each year, the CBS will report the PMPM costs for FFS claims by the following categories:

1. Provider Services
2. Care Coordination / Service Authorizations
3. Member Customer Services
4. Data Capture
5. Claim / Adjustment Processing and Adjudication
6. TPL/COB
7. Grievance and Appeals

All values in red below indicate a value that must be submitted by the CBS.

Category	**Populations not covered by Managed Care 2.0 - All Services**
Provider Services	(1)
Care Coordination / Service Authorizations	(2)
Member Customer Services	(3)
Data Capture	(4)
Claim / Adjustment Processing and Adjudication	(5)
TPL/COB	(6)
Grievance/Appeals	(7)
Total	**(1)+(2)+(3)+(4)+(5)+(6)+(7) = (8)**
MMs	**(9)**
Annual Dollar Est.	**(8) * (9) = (10)**

The State will use the reported values to calculate an updated total dollar estimate by taking the total PMPM for each population and multiplying it by the corresponding MMs (as illustrated by (10), in the above table). This annual dollar estimate will be divided by the fee-for-service claim volume for each year to determine the administrative price per claim for the next year.

MLTC will pay for a claim to be processed multiple times if the resubmission is due to provider error. If a claim is denied multiple times due to a claims broker error, MLTC will only pay to process the claim once.

The claims broker must provide detailed reports to the State for validation of FFS payments and recoveries. The claims broker is responsible for all servicing aspects of FFS claims unless otherwise expressly identified as an exception by MLTC. MLTC will award the claims broker services portion of this contract to the winning MCO with the highest score for Section IV. R. Systems and Technical Requirements, S. Claims Management and Z. FFS Claims management and Processing.

The MCO chosen as the claims broker must develop and maintain claims handling and payment policies and procedures in accordance with Nebraska Medicaid policy, CMS's National Correct Coding Initiative (NCCI) guidelines and Medicaid service limits. The claims broker must ensure accurate collection, processing, payment, and reporting of all FFS claims.

2. Reimbursement for Claims Broker FFS Payments

The claims broker must make payments for all FFS claims to providers. The claims broker must submit to MLTC a reconciliation report of all funds expended and received with remaining balance to be reimbursed for FFS payments. The claims broker may submit a funding request on a weekly basis to MLTC to cover the cost of FFS claims payments. The report must be submitted with each funding request to justify the request.

3. Implementation Timeframe

MLTC anticipates that the implementation of the claims broker functionality will occur during the second year of the contract. MLTC will identify the date for claims broker services to begin and MLTC will coordinate with the MCO providing the claims broker services throughout years one (1) and two (2) of the contract.. The claims broker must submit to MLTC with its proposal the number of months that it will take to be ready to pay FFS claims. MLTC will give the claims broker sufficient time to ensure a smooth implementation process.

4. Functionality

The claims broker must maintain the same functionality for FFS claims that is required for managed care claims as described in Section IV.S Claims Management of this RFP. FFS claims must be processed even if the billing provider is not contracted with the MCO who is performing claims broker services. The claims broker processing system must handle retroactive member eligibility and process claims accordingly.

The MCO must make system or operational changes for FFS claims processing within 60 calendar days of notification by MLTC. The claims broker must correct all processing errors identified by MLTC immediately on notification. Recoupment of erroneous payments made to providers is the sole responsibility of the claims broker. MLTC will not reimburse the claims broker for uncollected recoupments for claims paid in error.

The claims broker processing system must maintain functionality to process claims for services that require unique provider and member reimbursement methodologies that differ from standard processing protocol.

The claims broker must give MLTC inquiry access to its FFS claims processing system to view claims and all information related to FFS claims processing. The claims broker must provide system user training to MLTC staff who support this scope of work.

5. Claims Processing

The claims broker must maintain the same claims processing standards for all non-drug FFS claims that is required for managed care claims, as described in Section IV.S Claims Management of this RFP. Requirements for rejected claims, pended claims, adjustments, voids, and timely filing guidelines must mirror managed care requirements. Claim system edits for FFS claims must be maintained in the same manner as required for managed care claims. The claims broker should expect that FFS claims will have different editing and payment methodologies than managed care claims, and must maintain these edits and payment processes separately. The claims broker claims processing system must post all applicable edits to denied FFS claims during a single processing cycle.

6. Drug Claims Processing

The claims broker must use a PBM to process all FFS drug claims. The PBM must pay FFS claims in accordance with the same requirements for managed care pharmacy claims in this RFP.

7. Service Authorization Procedures

The claims broker must develop and administer prior authorization procedures for services paid as FFS in accordance with Nebraska Medicaid policy and the requirements of Section IV.N Utilization Management of this RFP. FFS claims must be paid or denied in accordance with FFS authorization policies.

8. Payments to Providers

The claims broker must pay FFS claims at a fee schedule rates set by MLTC.

9. Remittance Advice

The claims broker must adhere to the same remittance requirements for FFS claims as required for managed care claims as outlined in Section IV.S Claims Management of this RFP.

10. Third Party Liability

The claims broker must develop and maintain a process to identify and capture information regarding other insurance sources (TPL) for FFS members. Information regarding TPL must be maintained on the member file and utilized during claims payment to ensure that Medicaid is the payer of last resort. The claims broker will also perform recovery activities for claims that have been paid by Medicaid where third-party coverage was applicable. These payment recoveries will be returned to the State in full immediately upon receipt. The claims broker must expend the same level of effort on the recovery and cost avoidance of casualty claims for FFS claims as is expended on managed care claims. Denial of FFS claims for TPL coverage must comply with all MLTC policies and applicable law. MLTC will retain responsibility for all estate recovery activities.

11. Member Services

The claims broker must provide member services call center activities to all eligible FFS members in the same manner as required for managed care members as outlined in Section IV.F Member Services and Education of this RFP. MLTC will provide the claims broker with an interface that provides FFS member eligibility.

12. Provider Services

The claims broker must provide a provider toll-free telephone line to all providers who render services to FFS members, according to the requirements of Section IV.J Provider Services of this RFP. These services must be available to providers even if they are not contracted with the MCO providing claims broker services. These activities include the management of electronic data interchange and trading partner agreements, as well as call center support for provider inquiries such as member eligibility and benefit limits, claims processing issues, or other program clarifications. The claims broker must make provider notifications, bulletins, newsletters, FAQs and other pertinent information available on its website to providers participating in the FFS programs.

13. Paid Claims Sampling

The claims broker must adhere to the same paid claims sampling requirements for FFS claims as required for managed care claims outlined in Section IV.S Claims Management of this RFP.

14. Claims Dispute Management

The claims broker must adhere to the same claims dispute management requirements for FFS claims as required for managed care claims outlined in Section IV.S Claims Management of this RFP. FFS claims must be disputed through the State fair hearing process. The claims broker must support MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC.

15. Claims Payment Accuracy

The claims broker must adhere to the same claims payment accuracy requirements for FFS claims as required for managed care claims as outlined in Section IV.S Claims Management of this RFP.

16. Claims Data

The claims broker must submit all data relevant to the adjudication and payment of FFS claims to MLTC as required by the State. All claims data must be submitted to MLTC in standard HIPAA formats, as applicable. FFS claims data (including adjustments and recoupments) must be submitted a minimum of monthly on a date designated by MLTC. Claim data must be identified as FFS and must have the appropriate account code on the claim.

17. Drug Rebates

The claims broker must provide pharmacy claims information to MLTC so the State may perform all drug rebate activities (including disputed drug rebates) for FFS drug claims.

18. Audit Requirements

The claims broker must adhere to all audit requirements for managing FFS claims as required for managed care claims, as outlined in Section IV.S Claims Management of this RFP. The claims broker must support MLTC by providing claims payment explanations, as requested.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

Further, Section III. Terms and Conditions must be returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal must consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder must provide three years of independently audited financial statements, prepared under U.S. generally accepted accounting principles, and associated enrollment figures applicable to the firm. The bidder must also provide the last three years rating from AM Best Company; verification of any contributions made to the bidder to improve its financial position after its most recent audit (e.g. copies of bank statements and deposit slips), if applicable; and, a statement of whether the bidder or predecessor company has filed or had filed against it any bankruptcy or insolvency proceeding, and if so, relevant details. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization in the form of a letter, indicating that the bidder's business relationship with the financial institution is in positive standing.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Sub-Contractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Sub-Contractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Sub-Contractor(s) experience must be listed separately. Narrative descriptions submitted for Sub-Contractors must be specifically identified as Sub-Contractor projects.

iii. If the work was performed as a Sub-Contractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Sub-Contractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Sub-Contractor.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and a minimum of three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUB-CONTRACTORS

If the bidder intends to Sub-Contract any part of its performance hereunder, the bidder must provide:

vi. name, address, and telephone number of the Subcontractor(s);
vii. specific tasks for each Subcontractor(s);
viii. percentage of performance hours intended for each Subcontract; and
ix. total percentage of Subcontractor(s) performance hours.

3. TECHNICAL APPROACH

The technical approach section of the Technical Proposal must consist of the following subsections:

a. Understanding of the project requirements (limited to three pages);
b. Response to proposal statements and questions in Attachment 19 – Proposal Statements and Questions; and
c. Proposal deliverables as listed in Attachment 5 – Policies, Procedures, and Plans.

Form A
Bidder Contact Sheet
Request for Proposal Number 5151 Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Form B

Notification of Intent to Attend First Pre-Proposal Conference

Request for Proposal Number 5151 Z1

Bidder Name:	
Bidder Address:	
Contact Person:	
E-mail Address:	
Telephone Number:	
Fax Number:	
Number of Attendees:	

The "Notification of Intent to Attend Pre-Proposal Conference" form should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivered or US Mail by the date shown in the Schedule of Events.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

Pre-Solicitation Notice and Schedule of Events for Medicaid Integrated Managed Care Procurement

TO: All Prospective Bidders

FROM: Michelle Thompson / Teresa Fleming

DATE: October 19, 2015

SUBJECT: RFP Number 5151Z1 for Statewide Medicaid Integrated Managed Care Contracts

The State of Nebraska, Department of Health and Human Services (DHHS), is issuing notice of its intent to release a Request for Proposal, RFP Number 5151Z1, for the purpose of selecting qualified contractors to provide statewide integrated medical, behavioral health, and pharmacy services for approximately 230,000 Medicaid and Children's Health Insurance Program (CHIP) enrollees through the Medicaid managed care delivery system. DHHS expects to award a minimum of two or a maximum of three contracts for the program in March 2016 and the program to begin operations on January 1, 2017.

A planned schedule of events for this procurement is included below in this notice. The RFP will be available and posted to the Internet prior to the date of the first pre-proposal conference (October 26, 2015). At the pre-proposal conference, leadership from the Division of Medicaid and Long-Term Care will present an overview of the scope of the RFP and planned changes to the managed care program. The state will also have its contracted actuarial firm Optumas available to provide an overview of the capitation rate assumptions and methodologies.

Notification of release of the RFP will be sent to those included in the contact list for this notice. To be added to this list, interested parties should notify Michelle Thompson / Teresa Fleming at as.materielpurchasing@nebraska.gov.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	TBD
2.	Last day to submit "Notification of Intent to Attend Pre-Proposal Conference"	October 23, 2015
3.	First Pre-Proposal Conference Location: Nebraska State Office Building 301 Centennial Mall South Lower Level, Conference Room A Lincoln, NE 68508 Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 8559164#	October 26, 2015 1:00 – 5:00 PM Central Time
4.	Last day to submit First Round of written questions	November 2, 2015
5.	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 16, 2015
6.	Second Pre-Proposal Conference (if needed) Location: Lincoln, NE *Room and specific time to be announced at a later date. This will be held at the option of the state.*	November 19, 2015
7.	Last day to submit Second Round written questions	November 23, 2015
8.	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
9.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time

A more complete schedule of events, including planned activities after proposal opening, will be included in the RFP at its release