LETTER OF UNDERSTANDING

By and Between

UNITEDHEALTHCARE INSURANCE COMPANY

And

MISSISSIPPI DIVISION OF MEDICAID

This Letter of Understanding (Agreement) is made by and between the Mississippi Division of Medicaid (DOM) and UnitedHealthcare Insurance Company (United). United will issue a comprehensive health insurance policy (Policy) to provide coverage to Mississippi children determined to be eligible under the Children's Health Insurance Program (CHIP). This Agreement shall become effective upon its execution by both DOM and United, and shall terminate on December 31, 2013, unless otherwise extended or amended for one (1) additional year. This Agreement, including the attached *Mississippi State and School Employees Health Insurance Management Board Request For Proposal for Health Insurance Coverage under the Children's Health Insurance Program* (RFP), dated February 18, 2009 (except as modified herein), United's response to the RFP, the performance standards and liquidated damages, and the Policy (#POL.I.12.MSCHIP), represents the full and complete understanding of DOM and United, regarding the terms, conditions, and relative responsibilities of each party in the administration and operation of this Agreement.

DOM, an agency of the State of Mississippi, administers the health insurance component of the Mississippi Children's Health Insurance Program. United is an independent legal entity selected to provide comprehensive health insurance coverage to Mississippi children determined to be eligible for CHIP. Nothing in this Agreement shall be construed to create the relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Agreement. No act performed or representation made whether oral or written by United with respect to third parties shall be binding to DOM. It is expressly agreed that this Agreement shall not be construed as a partnership or joint venture between United, or any of United's subcontractors, and DOM.

United will be responsible for providing covered health services under a comprehensive health insurance policy, to include but not limited to inpatient and outpatient hospital services, physician (primary care and specialty) services, family planning services, prescription drugs, laboratory, radiology and other diagnostic services, supportive services, professional ambulance services, routine well baby and well child care visits including administration of immunizations, vision and hearing examinations, eyeglasses, hearing aids, preventive and diagnostic dental care and routine dental fillings. The plan of benefits is to be provided through a comprehensive provider network, and covered health services are to be subject to utilization management requirements.

United will:

- Receive and maintain enrollment data on eligible members as provided by DOM or its designee;
- Develop and provide member handbooks and ID cards;

- Develop and maintain a website to provide general customer service and member education regarding access to services, benefits, provider network, and appeals process.

- Prepare and mail provider directories to new members, and on request, provide members access to a roster of available providers through the member service IVR line, which will transfer them to a live person (additional IVR search functionality to be added upon DOM's request), and internet access to the roster of available network providers;

- Adjudicate claims;

- Communicate claim filing procedures and benefit plan provisions to providers;

- Implement member and provider grievance appeal procedures, which includes expedited review and external independent review features;

- Process payments to providers;

- Respond to inquiries from members, providers, and the general public;

- Implement appropriate utilization management, case management, and disease management;

- Implement the prior-authorization program requirements listed in Attachment E, with any variance to require DOM's approval;

- Produce required and requested reports;

- Establish and maintain a management information system that will submit data to DOM's information management vendor and support all other related electronic data interfaces between the benefit plan and its vendors;

- Change the encounter submission to standard 837-I-D-P and NCPDP file formats. United will use commercially reasonable efforts to implement the change within six (6) months of the date it receives final requirements information from DOM's information management vendor. United and DOM acknowledge that the implementation date may need to be extended, depending upon the complexity of the requirements. United will provide DOM with a regular updates on the progress of the implementation;

- Maintain proper financial controls and reporting;

- Conduct required data matches;

- Comply with the Health Insurance Portability and Accountability Act (HIPAA);

- Cooperate with DOM and with all other vendors of DOM with respect to the ongoing performance under this agreement and in any transition of responsibilities; and

- Exercise reasonable care and due diligence consistent with standards in the industry in the performance of its obligations under this Agreement.

1. Hours of Operation
United agrees to staff a customer service function, claims and medical management operation from its office in Ridgeland, Mississippi. The core times shall be Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m. Central Time. Customer service contact centers shall be staffed from 8:00 a.m. to 6:00 p.m. Central Time. Medical Management core times shall be Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m. Central Time, with Behavioral Health Medical Management available 24 hours, 7 days a week.

2. Account Management
United agrees to provide a contact to DOM who shall be available 24/7 should DOM require immediate access.

3. Insurance
   A. United agrees to furnish DOM evidence of a blanket fidelity bond in an amount no less than Two Million Dollars ($2,000,000), naming DOM as exclusive beneficiary for the duration of the Agreement. Pursuant to such bond, any losses incurred by DOM due to the dishonesty of United's employees or Subcontractors shall be fully payable to DOM. United shall be responsible for procuring any such recovery and reimbursing DOM accordingly.

   B. United, at its own expense, shall be required to maintain throughout the term of this Agreement, professional and comprehensive general liability insurance. Such policy of general liability insurance shall provide a minimum coverage in the amount of One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) annual aggregate; through an insurance company licensed by the Mississippi Insurance Department, or self-insurance approved by DOM, unless such requirement is waived by DOM. Annually, United shall provide DOM a current Certificate of Insurance.

   C. United shall provide a performance bond in the amount of One Million Dollars ($1,000,000), to guarantee timely and complete implementation of the service infrastructure and coverage to be provided under the Policy and referenced herein, including all transition, data and vendor interfaces, and related administrative services. DOM shall be named as exclusive beneficiary. Any failure of United to perform timely and complete establishment of such coverage and service infrastructure shall result in damages recoverable by DOM against United's performance bond. Upon DOM's agreement that United has fulfilled its responsibilities for successfully implementing the Children's Health Insurance Program coverage and service infrastructure, the performance bond, less any amounts previously called by DOM, shall be released.

4. Regulatory Approval
United agrees that the Policy offered and accepted must be approved by the Mississippi Insurance Department prior to the effective date of the Policy.

5. Financial Rating
United agrees to maintain an A.M. Best rating of no less than A-, and promptly (within four (4) business days) notify DOM of any changes in its financial rating by the A.M. Best rating service.

6. Modifications/Amendments/Renegotiation
This Agreement may be modified, altered, or changed only by written agreement signed by United and DOM. The parties agree to renegotiate this Agreement if any revisions to applicable Federal and/or State laws or regulations make significant changes in this Agreement necessary.

7. Agreement Term
A. The effective date of this Agreement will be the latter of the date signed by United or DOM. This Agreement will expire on December 31, 2013, unless otherwise extended for one additional year at DOM's discretion. By June 30, 2013, DOM will notify United, in writing, of DOM's intent as to extend the Agreement for one (1) additional year.

B. This Agreement and/or the Policy may be terminated by either party, with or without cause, upon at least ninety (90) days prior written notice of intent to terminate provided to the other party.

C. Notwithstanding subparagraph B above, United may immediately terminate the Policy for nonpayment of premium after the grace period for which premiums have not been paid.

D. All records and information provided by DOM to United are the sole property of DOM and shall be returned to DOM within thirty (30) days of the termination date of this Agreement, if so requested. United shall be entitled to retain and utilize data that have been captured, computed, or stored in United's databases to the extent that such data cannot be identified or linked to DOM, the Children's Health Insurance Program, or any Member.

E. Upon termination of this Agreement and/or the Policy, United shall fully cooperate with DOM and the new insurer (or third party claims administrator if self-insured) during the transition of the Children's Health Insurance Program to the new insurer/vendor. Upon request of DOM, United shall provide all information maintained by United in relation to the Children's Health Insurance Program in a time frame specified by DOM. Information provided shall be in a format designated by DOM. United shall provide such explanation of the information provided in order to facilitate a smooth transition.

F. In the event United shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets, or shall avail itself of, or become subject to, any proceeding under Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of the rights of creditors, DOM may, at its option, terminate the Agreement in whole or in part. In the event DOM elects to terminate the Agreement under this provision, it shall do so by sending a notice of termination to United by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in the notice of termination. In the event the filing of a petition in bankruptcy by or against a principal Subcontractor, United shall immediately so advise DOM. United shall assure that all tasks related to the Subcontractor are performed in accordance with the terms of the Agreement.

8. Consideration
A. DOM will be responsible for making premium payments to United.

B. Premiums for insurance coverage provided by United must be invoiced in advance on a monthly basis, in sufficient detail and format as determined by DOM. Premium invoices must provide

separate counts and amounts for each enrollment category and premium rate billed, and must agree to the appropriate statistical counts included in United's enrollment report for the period being billed.

C. Premium invoices should be submitted electronically to DOM by the fifth working day of each month for which coverage is to be provided. A monthly payment for all approved invoices shall be made by DOM utilizing electronic fund transfers. Payment for any undisputed amounts should be received by United within thirty (30) days from the date the invoice and supporting documentation was submitted to DOM.

D. Payments shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of United's choice. United understands and agrees that the State is exempt from the payment of sales and use taxes. All payments shall be in United States currency.

E. The payment of an invoice by the DOM shall not prejudice the DOM's right to object or question any invoice or matter in relation thereto. Such payment by the DOM shall neither be construed as an approval of any costs invoiced therein. United's invoice or payment may be subject to further reduction for amounts included in any invoice or payment theretofore made which are determined by the DOM, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the DOM and/or the Children's Health Insurance Program by United, the DOM reserves the right to:

(1) deduct from amounts which are or shall become due and payable to United under Agreement between the parties; or

(2) request and receive payment directly from United within fifteen (15) days of such request, at the DOM's sole discretion.

9. Premiums and Premium Renewals

The initial total monthly per Member premium rate shall be set at $245.01 per full or partial month and shall remain in effect through December 31, 2013. Beginning January 1, 2014, the total monthly per Member premium rate shall be set at $264.83 per full or partial month and shall remain in effect through December 31, 2014. .

10. Reporting Functions

United agrees to provide the reports listed in Sections 11.4.1 through 11.4.8 of the RFP, except the parties agree that United shall not be required to provide the report(s) specified under Section 11.4.1(h) (prescription claims paid by therapeutic categories and listing of the top 25 dispensed drugs). The parties further agree that information relating to inpatient utilization (11.4.1(b)), outpatient utilization (11.4.1(c)), prescription drug utilization (11.4.1(d)), and the utilization management program (11.4.1(j)) will be provided by United in the executive management report (11.4.1(a)), and that United need not submit separate reports relating to inpatient utilization, outpatient utilization, prescription drug utilization, and the utilization management program. Additionally, United agrees to provide certain other standard reports that DOM has determined will be helpful. A complete list of the reports that United will provide is set forth in Attachment G.

11. Performance Standards and Liquidated Damages
United agrees to the performance standards and liquidated damages included in this Agreement as Attachment C.

12. Termination for Non-Availability Of Funds
It is expressly understood and agreed that the obligation of DOM to proceed under this Agreement and/or the Policy is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or federal funds. If the funds anticipated for the continuing fulfillment of this Agreement are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds, or the discontinuance or material alteration of the program under which such funds were provided, or if funds are not otherwise available to the State, DOM shall have the right upon ten (10) days written notice to United, to terminate this Agreement and/or the Policy without damage, penalty, cost, or expenses to DOM of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

13. Release
Upon final payment of the amounts due under this Agreement, United shall release the State from all liabilities and obligations whatsoever under or arising from this Agreement. Payment to United by the State shall not constitute final release of United. Should an audit or inspection of United's records subsequently reveal outstanding liabilities or obligations, United shall remain liable to the State for such liabilities and obligations. Any payment by the State shall be subject to any appropriate recoupment to which the State is lawfully entitled. Any payment under this Agreement shall not foreclose the right of the State to recover excessive illegal payments as well as interest, attorney fees, and costs incurred in such recovery.

14. Access To Records
United agrees that DOM or any of its duly authorized representatives, the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency prior-approved by DOM, at any time during the term of this Agreement, shall, at all reasonable times, have the right to enter onto United's or its subcontractor's premises and shall have access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, and records and/or to otherwise evaluate (including periodic information systems testing) the performance of United and all subcontractors related to United's charges and performance under this Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of United. Refusal by United to allow access to all documents, papers, letters, or other materials shall constitute a breach of this Agreement. Such records shall be kept by United for a period of six (6) years after final payment under this Agreement, unless DOM authorizes in writing their earlier disposition. United is to refund to the DOM any overpayment disclosed by any such audit. However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 6-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it and for one year thereafter. DOM shall also retain the right to perform financial, performance, and other special audits on such records maintained by United during regular business hours throughout the Agreement period. United agrees that confidential information including, but not limited to, medical and other pertinent information relative to Members shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as

otherwise required by law and that all such disclosures fully comply with HIPAA privacy and security standards.

15. Ownership of Information and Data
DOM, Centers for Medicare and Medicaid (CMS), the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by United resulting from this Agreement. United agrees to grant to DOM, the United States Department of Health and Human Services (DHHS), CMS, and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information not covered by copyright of United relating to this Agreement. .

16. Electronic Health Records
DOM is in the process of implementing a Web-based electronic health records (EHR) system. United agrees to work with DOM to develop a means to provide CHIP claims data and other necessary files to the DOM or the EHR Vendor as directed by the DOM.

17. Records Retention and Audit Requirements
United's accounting records and procedures relative to this Agreement are subject to DOM and applicable Federal approval. Accounting procedures, policies, and records shall be completely open to DOM, State, and Federal audit at any time during the Agreement period and for six (6) years thereafter. United shall agree to the following terms for access to records relating to the Agreement:

A. All electronic media claims and related records shall be retained for a period of six (6) years in an electronic format or scanned image;

B. Unless DOM specifies in writing a shorter period of time, United agrees to preserve and make available all other pertinent books, documents, papers, and records of Company involving transactions related to the Agreement for a period of six (6) years from the date of expiration or termination of the Agreement. All aforementioned items involving transactions may be maintained in an electronic format or scanned image.

C. Electronic records of all paper claims and related records shall be retained for a period of six (6) years;

D. All canceled checks and EFT documents shall be retained for a minimum of six (6) years from the date of issuance unless otherwise notified by DOM. Canceled checks may be maintained in an electronic format or CD version.

E. Notwithstanding any other requirements in this Agreement, records and supporting documentation under audit or involved in litigation shall be kept for one (1) year following the conclusion of the litigation or audit;

F. DOM, at its discretion, may use the services of an independent reviewer(s), to perform reviews/audits of United's records. DOM and respective independent reviewers will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. DOM have the right to review/audit records for the entire term of this

Agreement without limitation. Any claimed information, documents, etc. which United may deem as containing "trade secrets" or "confidential" will not preclude an examination of such items through the audit process. United will provide DOM assistance in the audit reviews by providing access to records, copies of claims data tapes, access to reasonable support staff. DOM will bear the cost of any fees charged by their respective independent reviewer. The independent reviewer will sign a confidentiality statement with United insuring that United's financial records, claims data, remittance data, contracts (including the details and terms of the United's Contracts with Participating Providers and pharmaceutical manufacturers and intermediaries) and fees will be treated as confidential to United and will not be revealed in any manner or form by or to any person or entity other than DOM and/or DOM's attorney. Notwithstanding the aforementioned, DOM reserves the right to conduct a review of any and all records deemed necessary to any special investigation by DOM.

G. For the purpose of measuring compliance with Agreement performance standards, the report and determination of DOM's independent reviewer shall be final, binding and conclusive on United and DOM; provided, however, that before a final report and determination is issued, DOM and United shall each have a reasonable opportunity to review the independent reviewer's non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer.

   Nothing in this section shall limit or prevent, in any way, the remedies available to DOM as provided in this Agreement.

H. United shall provide copies of its internal audits and quality assurance reports or a copy of its annual audit conducted on the processing of transactions, pursuant to Statement on Auditing Standards (SAS) #70, upon the request of DOM, which directly affect or relate to the administration of this Agreement. United agrees that authorized Federal, State, and DOM representatives shall, upon 48 hours notice to United, have access to and the right to examine the items listed above during the six-year post-contract period or until resolution. During the Agreement period, the access to these items will be provided at United's office, or if United's office is not located within Hinds, Madison, or Rankin counties of the State of Mississippi, United shall provide any requested documents to DOM at the site designated by DOM in Jackson, Mississippi, at no cost to DOM. DOM and authorized Federal and State representatives shall always have access to and the right to examine items listed above at United's office during the Agreement period and the six-year post-contract period or until resolution. During the 6-year post Agreement period, delivery of and access to the listed items will be at no cost to DOM. United shall provide DOM such data as requested by DOM to transition CHIP to another company. Such data is to include, but not be limited to, co-payment accumulators and out of pocket amounts. This data shall not include the United's proprietary data.

18. Applicable Law/Venue

This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflicts of law's provisions. United shall comply with applicable federal, state, and local laws and regulations. Venue for any action shall be in the First Judicial District, Hinds County, Mississippi.

19. Third Party Action Notification
United shall give DOM immediate notification in writing of any action or suit filed or any claim made by any entity that may result in litigation related to the Policy and/or this Agreement.

20. Assignment/Subcontracting
United shall not assign or subcontract, in whole or in part, its rights or obligations under this Agreement to any other organization without prior written consent of DOM. Any attempted assignment without said consent shall be void and of no effect. Any subcontractors deemed necessary by United shall be subject to prior approval of DOM. Said approval will not unreasonably be withheld and DOM shall respond to any inquiries for approval hereunder in a timely manner. Notwithstanding any subcontract, United shall maintain prime responsibility for all services and any subcontracts hereunder shall include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by United.

21. Employee Status Verification
United represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act codified as Section 71-11-1 et seq., of the Mississippi Code Annotated (1972, as amended), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. United agrees to maintain records of such compliance and, upon request of the State, to provide a copy of each such verification to the State. United further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. United understands and agrees that any breach of these warranties may subject United to the following: (a) termination of this Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to United by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both. In the event of such termination/cancellation, United would also be liable for any additional costs incurred by the State due to Policy cancellation or loss of license or permit.

22. Employment Practices
United shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, age, marital status, political affiliations, or handicap. United must act affirmatively to ensure that employees, as well as applicants for employment, are treated without discrimination because of their race, color, religion, sex, national origin, age, marital status, political affiliation, or handicap. Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. United agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this clause. United shall, in all solicitations or advertisements for employees placed by or on behalf of United, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, age, marital status, political affiliation, or handicap, except where it relates to a bona fide occupational qualification. United shall comply with the non-discrimination clause contained in

Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. United and subcontractors shall comply with related State laws and regulations, if any. United and its subcontractors shall comply with the Civil Rights Act of 1964, any amendments thereto and the rules and regulations thereunder; Section 504 of Title V of the Vocational Rehabilitation Act of 1973 as amended; and the Mississippi Human Rights Act of 1977. If at any time during the term of the Agreement, DOM determines that United is not in compliance with the requirements on employment practices as stated in this Agreement, DOM may terminate the Agreement, but it will have no other rights in this regard relative to employment practices.

23. Prohibited Nondiscriminatory Practices

United shall not discriminate against any Member or provider of service because of race, color, religion, sex national origin, age, marital status, political affiliation, or handicap in the performance of this Agreement.

24. Lobbying

United shall comply with the Anti-Lobbying Act, Title 31 U.S.C., Section 1352 (added under Section 319 of Public Law 101-121) as revised by the Lobbying Disclosure Act of 1995 (P.L. 104-65) and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208). United certifies to the best of its knowledge and belief, that no Federal appropriated funds have been paid or will be paid, by or on behalf of United, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or any employee of a member of Congress in connection with the awarding of any Federal Agreement, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative Agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative Agreement. United shall require that the language of this certification be included in all subcontracts and that all subcontractors shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance is placed when entering into this Agreement. Submission of this certification is a prerequisite for making or entering into this Agreement imposed under Title 31, Section 1352, U.S. Code. Failure to file the required certification shall be subject to civil penalties for such failure. United will likewise abide by the lobbying laws of the State of Mississippi.

25. Bribes, Gratuities, And Kickbacks Prohibited

The receipt or solicitation of bribes, gratuities, and kickbacks is strictly prohibited. No elected or appointed officer or other employee of the Federal Government or of the State of Mississippi shall benefit financially or materially from this Agreement. No individual employed by the State of Mississippi shall be permitted any share or part of this Agreement or any benefit that might arise therefrom.

26. Conflict of Interest

No member or employee of DOM and no other public official of the State of Mississippi or the Federal Government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Agreement shall, prior to the completion of the Agreement, voluntarily acquire any personal interest, direct or indirect, in the Agreement. A violation of this provision shall constitute grounds for termination of this Agreement. In addition, such violation will be reported to the Attorney General and appropriate Federal law enforcement officers for review.

United covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under this Agreement. United further covenants that, in the performance of the Agreement, no person having such known interests shall be employed. This is especially pertinent to subsidiaries or entities housed within the same facility that could be misconstrued as a joint relationship.

27. Compliance with State and Federal Requirements
United shall agree to conform to any requirements or regulations imposed on the State as a condition of continued funding by the Department of Health and Human Services (DHHS) or due to changes in State and/or Federal law. United shall conform to all applicable Federal, State, and local laws, regulations and policies as they exist or as amended. It is expected that United is aware of these and all other federal regulations and requirements governing health care administration and has the necessary components and functionality to maintain the Children's Health Insurance Program's continued compliance with the regulations.

28. Compliance with Mississippi Insurance Department
The Mississippi Insurance Department regulates licensed health plans in Mississippi. United shall agree to comply with all applicable insurance laws of the State of Mississippi and Mississippi Insurance Department rules, regulations, and standards in addition to the specific standards described in the RFP.

29. Oral Statements
No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Agreement. All modifications to this Agreement must be agreed to in writing by DOM and United in order to be effective.

30. Indemnification
To the fullest extent allowed by law, United shall indemnify, defend, save and hold harmless, protect, and exonerate the State of Mississippi, its Commissioners, Board Members, officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by United and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform this Agreement. In the State's sole discretion, United may be allowed to control the defense of any such claim, suit, etc. In the event United defends said claim, suit, etc., United shall use legal counsel acceptable to the State; United shall be solely liable for all reasonable costs and/or expenses associated with such defense and the State shall be entitled to participate in said defense. United shall not settle any claim, suit, etc., without the State's concurrence, which the State shall not unreasonably withhold.

31. Notice
All notices required or permitted to be given under this Agreement must be in writing and personally delivered or sent by certified United States mail postage prepaid, return receipt requested, to the party to whom the notice should be given at the addresses set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address. The addresses to which notices are initially to be sent are as follows:

If to DOM: Executive Director
Division of Medicaid
Walter Sillers Building, Suite 1000
550 High Street
Jackson, Mississippi 39201-1399

If to United: President
UnitedHealthcare Community Plan
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

32. Incorporation of Documents

This Letter of Understanding, along with the following Attachments, represents the full and complete understanding of DOM and United, regarding the terms, conditions, and relative responsibilities of each party in the administration and operation of this Agreement.

Attachment A	State and School Employees Health Insurance Management Board *Request for Proposal for Health Insurance Coverage under the Children's Health Insurance Program*, dated February 18, 2009
Attachment B	United's Response to RFP, Including Best & Final
Attachment C	Performance Standards and Liquidated Damages
Attachment D	Policy (#POL.I.12.MSCHIP)
Attachment E	Prior-Authorization Program Requirements
Attachment F	Business Associate Statement
Attachment G	Reports

IN WITNESS WHEREOF, the parties hereto have caused this Letter of Understanding to be executed on the day and year first above written.

Mississippi Division of Medicaid

Signature

David J. Dzielak
Printed Name

Executive Director
Title

12/28/12
Date

UnitedHealthcare Insurance Company

Signature

Jocelyn Chisholm Carter
Printed Name

President
Title

12/24/12
Date

Exhibit 2

MISSISSIPPI CHILDREN'S HEALTH INSURANCE (CHIP) BENEFIT PLAN

UnitedHealthcare-Mississippi

Effective January 1, 2013

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NOTE: Members with Annual Family Income of less than or equal to 150% of the Federal Poverty Level

SCHEDULE OF BENEFITS
(Coverage Plan # MCHP01)

BENEFIT PERIOD		CALENDAR YEAR BEGINNING JANUARY 1ST
LIFETIME MAXIMUM BENEFITS		No Lifetime Maximum Benefits
DEDUCTIBLE AMOUNTS		No Deductible Amount
OUT-OF-POCKET MAXIMUM (CO-PAY MAXIMUM)		No Out-of Pocket Maximum
COVERED SERVICES	BENEFIT	
	Network Provider	Non-Network Provider
HOSPITAL SERVICES		
Hospital Room and Board (Including Dietary and General Nursing Services)	100%	No Benefits
Other Services	100%	No Benefits
AMBULATORY SURGICAL FACILITY SERVICES SERVICES (ASF)	100%	No Benefits
EMERGENCY ROOM SERVICES	100%	See Below

Emergency Room Services - Benefits for emergency room services will be provided in cases of a Medical Emergency. When emergency room services of a Non-Network Provider are used by a Member for a Medical Emergency, the Network level of Benefits will be provided. However, if a Member uses emergency room services of a Non-Network Provider for a non-emergency situation, no Benefits will be provided to the Member.

	Network Provider	Non-Network Provider
PHYSICIAN SERVICES (M.D. and D.O. only) OR HEALTH CARE PROFESSIONALS		
Office Visits	100%	No Benefits
Other Services Rendered the Physician's Office	100%	No Benefits
Surgery (Hospital/ASF)	100%	No Benefits
Medical (Inpatient)	100%	No Benefits
Diagnostic Services	100%	No Benefits
Other Therapy Services (Includes Drug Therapy for chronic disease or condition)	100%	No Benefits
OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER, FACILITY OR PROFESSIONAL (WHERE APPLICABLE), OR PHYSICIAN (WHERE APPLICABLE)		
Ambulance Services	100%	100%
Durable Medical Equipment (Prior Authorization Required)	100%	No Benefits
Home Infusion Therapy (Prior Authorization Required)	100%	No Benefits
Orthotic/Prosthetic (Prior Authorization Required)	100%	100%
Hospice (Limited to a Lifetime Maximum of $15,000 per Member) (Prior Authorization Required)	100%	100%
Speech Therapy (Prior Authorization Required)	100%	100%
Occupational/Physical Therapy (Prior Authorization Required)	100%	100%
Manipulative Therapy (Limited to $2,000 per Member per Benefit Period)	100%	No Benefits
Private Duty Nursing (Limited to $10,000 per Member per Benefit Period) (Prior Authorization Required)	100%	100%

	Network Provider	Non-Network Provider
Skilled Nursing Services (Limited to 60 Days per Benefit Period)	100%	100%
Free-standing Diagnostic Facility	100%	No Benefits
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	100%	No Benefits
OUTPATIENT PRESCRIPTION DRUGS (Limited to a 30-day supply)		
Generic	100%	No Benefits
Brand	100%	No Benefit
NERVOUS AND MENTAL CARE		
Inpatient Care (Requires Prior Authorization)	100%	No Benefits
Partial Hospitalization	100%	No Benefits
Outpatient Hospital Visits	100%	No Benefits
Outpatient Professional Visits	100%	No Benefits

	Network Provider	Non-Network Provider
SUBSTANCE ABUSE CARE		
Inpatient Care (Prior Authorization Required)	100%	No Benefits
Outpatient Care	100%	No Benefits
Residential Substance Abuse Treatment	100%	100%
TRANSPLANT BENEFITS		
Heart, Lung, Liver, Kidney, Bone Marrow/Stem Cell (Prior Authorization Required)	100%	No Benefits
Transportation/Lodging Expenses (Limited to $10,000 per Member)	100%	Not Applicable
Living Donor Coverage includes searching for matching tissue, donor's transportation charges for removal and preservation and hospitalization. Living donor benefits are only available when the recipient (person receiving the organ) is a Member. See further details.	100%	No Benefits
TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER (TMJ)		
Surgery	100%	No Benefits
Diagnostic	100%	No Benefits
Surgery/Diagnostic Services for TMJ limited to $5,000 Lifetime Maximum Benefits (Prior authorization required)		
NEWBORN WELL BABY CARE	100%	No Benefits

	Network Provider	Non-Network Provider
DIABETES TREATMENT Self-Management Training/ Education and Medical Nutrition Therapy (Limited to $250 per Member per Benefit Period)	100%	No Benefits
WELL CHILD CARE	100%	No Benefits
FAMILY PLANNING SERVICES (Contraceptive Management, Health Screening, Health Education Counseling)	100%	No Benefits
FEMALE HEALTH SERVICES (Routine obstetric/gynecological services)	100%	No Benefits
MATERNITY/PRENATAL SERVICES (Limited to pregnant female members under age 19 who are deemed eligible by DHS) (Limited to four ultrasounds per pregnancy.)	100%	No Benefits
HEARING SERVICES (As limited in this Benefit Plan)	100%	100%
VISION SERVICES (As limited in this Benefit Plan)	100%	No Benefits
DENTAL SERVICES $1500 Calendar Year Max (As limited in this Benefit Plan)	100%	No Benefits
CHILDHOOD ROUTINE IMMUNIZATIONS Benefits will be provided only for the administration of the immunization. The vaccines will be provided by the Mississippi State Department of Health. No Benefits will be provided for the vaccine.	100%	No Benefits

NOTE: Flu Shots and tetanus booster are subject to regular benefits.

PRIOR AUTHORIZATION

Prior Authorization of Elective Inpatient Admissions	Required
Prior Authorization of Durable Medical Equipment (over $500 per item)	Required
Prior Authorization of Home Infusion Therapy	Required
Prior Authorization of Transplant Procedures	Required
Prior Authorization of Private Duty Nursing	Required
Prior Authorization of Inpatient/Residential Substance Abuse Benefits	Required
Prior Authorization of Hospice Care	Required
Prior Authorization of Prosthetics (over $500 per item)	Required
Prior Authorization of Orthotic Devices (over $500 per item)	Required
Prior Authorization of Speech Therapy	Required
Prior Authorization of Occupational Therapy	Required
Prior Authorization of Physical Therapy	Required
Prior Authorization of Inpatient/Partial/ Hospitalization-Nervous/Mental Benefits	Required
Prior Authorization of TMJ Benefits	Required
Prior Authorization of Diabetic Training/Education	Required

NOTE: Members with Annual Family Income of 151% through 175% of the Federal Poverty Level

SCHEDULE OF BENEFITS
(Coverage Plan # MCHP02)

BENEFIT PERIOD	CALENDAR YEAR BEGINNING JANUARY 1ST
LIFETIME MAXIMUM BENEFITS	No Lifetime Maximum Benefits
DEDUCTIBLE AMOUNTS	No Deductible Amount
OUT-OF-POCKET MAXIMUM (CO-PAY MAXIMUM)	$800

COVERED SERVICES	BENEFIT	
	Network Provider	Non-Network Provider
HOSPITAL SERVICES		
Hospital Room and Board (Including Dietary and General Nursing Services)	100%	No Benefits
Other Services	100%	No Benefits
AMBULATORY SURGICAL FACILITY SERVICES (ASF)	100%	No Benefits
EMERGENCY ROOM SERVICES	100% after $15 Co-pay per visit	See Below

Emergency Room Services - Benefits for emergency room services will be provided in cases of a Medical Emergency. When emergency room services of a Non-Network Provider are used by a Member for a Medical Emergency, the Network level of Benefits will be provided. However, if a Member uses emergency room services of a Non-Network Provider for a non-emergency situation, no Benefits will be provided to the Member.

	Network Provider	Non-Network Provider
PHYSICIAN SERVICES (M. D. and D. 0. only) OR HEALTH CARE PROFESSIONAL**		
Office Visits (Note: The Co-pay does not apply to any other services rendered in the physician's office or to office visits for routine well baby and well child care.)	100% after $5 Co-pay	No Benefits
Other Services Rendered in the Physician's Office	100%	No Benefits
Surgery (Hospital/ASF)	100%	No Benefits
Medical (Inpatient)	100%	No Benefits
Diagnostic Services	100%	No Benefits
Other Therapy Services (Includes Drug Therapy for chronic disease or condition)	100%	No Benefits

**The office visit co-payment amount does not apply to Audiologist, Ophthalmologist, Optometrists if the office visit is in connection with Preventive/Wellness Services.

OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER, FACILITY OR PROFESSIONAL (WHERE APPLICABLE), OR PHYSICIAN (WHERE APPLICABLE)		
Ambulance Services	100%	100%
Durable Medical Equipment (Prior Authorization Required)	100%	No Benefits
Home Infusion Therapy (Prior Authorization Required)	100%	No Benefits
Orthotic/Prosthetic (Prior Authorization Required)	100%	100%

	Network Provider	Non-Network Provider
Hospice (Limited to a Lifetime Maximum of $15,000 per Member) (Prior Authorization Required)	100%	100%
Speech Therapy (Prior Authorization Required)	100%	100%
Occupational/Physical Therapy (Prior Authorization Required)	100%	100%
Manipulative Therapy (Limited to $2,000 per Member per Benefit Period)	100%	No Benefits
Private Duty Nursing (Limited to $10,000 per Member per Benefit Period) (Prior Authorization Required)	100%	100%
Skilled Nursing Services (Limited to 60 Days per Benefit Period)	100%	100%
Free-standing Diagnostic Facility	100%	No Benefits
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	100%	No Benefits
OUTPATIENT PRESCRIPTION DRUGS (Limited to a 30-day supply)		
Generic	100%	No Benefits
Brand	100%	No Benefits
NERVOUS AND MENTAL CARE		
Inpatient Care (Prior Authorization Required)	100%	No Benefits
Partial Hospitalization	100%	No Benefits
Outpatient Hospital Visits	100%	No Benefits
Outpatient Professional Visits	100%	No Benefits

	Network Provider	Non-Network Provider
SUBSTANCE ABUSE CARE		
Inpatient Care (Prior Authorization Required)	100%	No Benefits
Outpatient Care	100%	No Benefits
Residential Substance Abuse Treatment	100%	100%
TRANSPLANT BENEFITS		
Heart, Lung, Liver, Kidney, Bone Marrow/Stem Cell (Prior Authorization Required)	100%	No Benefits
Transportation/Lodging Expenses (Limited to $10,000 per Member)	100%	Not applicable
Living Donor Coverage includes searching for matching tissue, donor's transportation charges for removal and preservation and hospitalization. Living donor benefits are only available when recipient (person receiving the organ) is a Member. See further details.	100%	No Benefits
TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER (TMJ)		
Surgery	100%	No Benefits
Diagnostic	100%	No Benefits
Surgery/Diagnostic Services for TMJ limited to $5,000 Lifetime Maximum Benefits (Prior authorization required)		
NEWBORN WELL BABY CARE	100%	No Benefits

	Network Provider	Non-Network Provider
DIABETES TREATMENT Self-Management Training/ Education and Medical Nutrition Therapy (Limited to $250 per Member per Benefit Period)	100%	No Benefits
WELL CHILD CARE	100%	No Benefits
FAMILY PLANNING SERVICES (Contraceptive Management, Health Screening, Health Education Counseling)	100%	No Benefits
FEMALE HEALTH SERVICES (Routine obstetric/gynecological services)	100%	No Benefits
MATERNITY/PRENATAL SERVICES (Limited to pregnant female members under age 19 who are deemed eligible by DHS) (Limited to four ultrasounds per pregnancy.)	100%	No Benefits
HEARING SERVICES (As limited in this Benefit Plan)	100%	100%
VISION SERVICES (As limited in this Benefit Plan)	100%	No Benefits
DENTAL SERVICES $1500 Calendar Year Maximum (As limited in this Benefit Plan)	100%	No Benefits
CHILDHOOD ROUTINE IMMUNIZATIONS Benefits will be provided only for the administration of the immunization. The vaccines will be provided by the Mississippi State Department of Health. No Benefits will be provided for the vaccine.	100%	No Benefits

NOTE: Flu Shots and tetanus booster are subject to regular benefits.

PRIOR AUTHORIZATION

Prior Authorization of Elective Inpatient Admissions	Required
Prior Authorization of Durable Medical Equipment (over $500 per item)	Required
Prior Authorization of Home Infusion Therapy	Required
Prior Authorization of Transplant Procedures	Required
Prior Authorization of Private Duty Nursing	Required
Prior authorization of Inpatient/Residential Substance Abuse Benefits	Required
Prior Authorization of Hospice Care	Required
Prior Authorization of Prosthetics (Over $500 per item)	Required
Prior Authorization of Orthotic Devices (Over $500 per item)	Required
Prior authorization of Speech Therapy	Required
Prior Authorization of Occupational Therapy	Required
Prior Authorization of Physical Therapy	Required
Prior Authorization of Inpatient/Partial Hospitalization Nervous/Mental Benefits	Required
Prior authorization of TMJ Benefits	Required
Prior authorization of Diabetic Training/Education	Required

NOTE: Members with Annual Family Income 176% up through 200% of the Federal Poverty Level

SCHEDULE OF BENEFITS
(Coverage Plan MCHP03)

BENEFIT PERIOD	CALENDAR YEAR BEGINNING JANUARY 1ST
LIFETIME MAXIMUM BENEFITS	No Lifetime Maximum Benefits
DEDUCTIBLE AMOUNTS	No Deductible Amount
OUT-OF-POCKET MAXIMUM (CO-PAY MAXIMUM)	$950

COVERED SERVICES	BENEFIT	
	Network Provider	Non-Network Provider
HOSPITAL SERVICES		
Hospital Room and Board (Including Dietary and General Nursing Services)	100%	No Benefits
Other Services	100%	No Benefits
AMBULATORY SURGICAL FACILITY SERVICES (ASF)	100%	No Benefits
EMERGENCY ROOM SERVICES	100% after $15 Co-pay per visit	See Below

Emergency Room Services - Benefits for emergency room services will be provided in cases of a Medical Emergency. When emergency room services of a Non-Network Provider are used by a Member for a Medical Emergency, the Network level of Benefits will be provided. However, if a Member uses emergency room services of a Non-Network Provider for a non-emergency situation, no Benefits will be provided to the Member.

	Network Provider	Non-Network Provider
PHYSICIAN SERVICES M.D. and D.O.only) OR HEALTH CARE PROFESSIONAL** Office Visits (Note: The Co-pay does not apply to any other Services rendered in the Physician's Office or to office visits for routine well baby and well child care.)	100% after $5 Co-pay	No Benefits

**The office visit co-payment amount does not apply to Audiologist, Ophthalmologist, Optometrists if the office visit is in connection with Preventive/Wellness Services

Other Services Rendered	100%	No Benefits
Surgery (Hospital/ASF)	100%	No Benefits
Medical (Inpatient)	100%	No Benefits
Diagnostic Services	100%	No Benefits
Other Therapy Services (Includes Drug Therapy for chronic disease or condition)	100%	No Benefits
OTHER COVERED SERVICES, OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER, FACILITY OR PROFESSIONAL (WHERE APPLICABLE, OR PHYSICIAN (WHERE APPLICABLE)		
Ambulance Services	100%	100%
Durable Medical Equipment (Prior Authorization Required)	100%	No Benefits
Home Infusion Therapy (Prior Authorization Required)	100%	No Benefits
Orthotic/Prosthetic (Prior Authorization Required)	100%	100%
Hospice (Limited to a Lifetime Maximum of $15,000 per Member) (Prior Authorization Required)	100%	100%

	Network Provider	Non-Network Provider
Speech Therapy (Prior Authorization Required)	100%	100%
Occupational/Physical Therapy (Prior Authorization Required)	100%	100%
Manipulative Therapy (Limited to $2,000 per Member per Benefit Period)	100%	No Benefits
Private Duty Nursing (Limited to $10,000 per Member per Benefit Period) (Prior Authorization Required)	100%	100%
Skilled Nursing Services (Limited to 60 Days per Benefit Period)	100%	100%
Free-standing Diagnostic Facility	100%	No Benefits
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	100%	No Benefits
OUTPATIENT PRESCRIPTION DRUGS (Limited to a 30-day supply)		
Generic	100%	No Benefits
Brand	100%	No Benefits
NERVOUS AND MENTAL CARE		
Inpatient Care	100%	No Benefiits
Partial Hospitalization	100%	No Benefits
Outpatient Hospital Visits	100%	No Benefits

	Network Provider	Non-Network Provider
Outpatient Professional Visits	100%	No Benefits

Note: For the purposes of the office visit co-pay, Licensed Professional Counselors and Licensed Clinical Social Workers are considered Network Providers.

SUBSTANCE ABUSE CARE

Inpatient Care (Prior Authorization Required)	100%	No Benefits
Outpatient Care (Office Visits will be subject to the Physician/Health Care Professional Office Co-pay when provided by the appropriate Provider.)	100%	No Benefits
Residential Substance Abuse Treatment	100%	100%

TRANSPLANT BENEFITS

Heart, Lung, Liver, Renal, Bone Marrow/Stem Cell	100%	No Benefits
Transportation/Lodging Expenses (Limited to $10,000 per Member)	100%	Not Applicable
Living Donor Coverage includes searching for matching tissue, donors transportation charges for removal and preservation and hospitalization. Living donor benefits are only available when the recipient (person receiving the organ) is a Member. See further details.	100%	No Benefits

	Network Provider	Non-Network Provider
TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER (TMJ)		No Benefits
Surgery	100%	
Diagnostic	100%	No Benefits
Surgery/Diagnostic Services for TMJ limited to $5,000 Lifetime Maximum Benefits (Prior authorization required)		
NEWBORN WELL BABY CARE	100%	No Benefits
DIABETES TREATMENT Self-Management Training/ Education and Medical Nutrition Therapy (Limited to $250 per Member per Benefit Period)	100%	No Benefits
WELL CHILD CARE	100%	No Benefits
FAMILY PLANNING SERVICES (Contraceptive Management, Health Screening, Health Education Counseling)	100%	No Benefits
FEMALE HEALTH SERVICE (Routine obstetric/gynecological services)	100%	No Benefits
MATERNITY/PRENATAL SERVICES (Limited to pregnant female members under age 19 who are deemed eligible by DHS) (Limited to four ultrasounds per pregnancy.)	100%	No Benefits
HEARING SERVICES As limited in this Benefit Plan	100%	100%

	Network Provider	Non-Network Provider
VISION SERVICES (As limited in this Benefit Plan)	100%	No Benefits
DENTAL SERVICES $1500 Calendar Year Maximum (As limited in this Benefit Plan)	100%	No Benefits
CHILDHOOD ROUTINE IMMUNIZATIONS Benefits will be provided only for the administration of the immunization. The vaccines will be provided by the Mississippi State Department of Health. No Benefits will be provided for the vaccine.	100%	No Benefits

NOTE: Flu Shots and tetanus booster are subject to regular benefits.

PRIOR AUTHORIZATION

Prior Authorization of Elective Inpatient Admissions	Required
Prior Authorization of Durable Medical Equipment (Over $500 per item)	Required
Prior Authorization of Home Infusion Therapy	Required
Prior Authorization of Transplant Procedures	Required
Prior Authorization of Private Duty Nursing	Required
Prior Authorization of Inpatient/Residential Substance Abuse Benefits	Required
Prior Authorization of Hospice Care	Required
Prior Authorization of Prosthetics (Over $500 per item)	Required
Prior Authorization of Orthotic Devices (Over $500 per item)	Required
Prior Authorization of Speech Therapy	Required
Prior Authorization of Occupational Therapy	Required
Prior Authorization of Physical Therapy	Required
Prior Authorization of Inpatient/Partial Hospitalization Nervous/Mental Benefits	Required
Prior Authorization of TMJ Benefits	Required
Prior Authorization of Diabetic Training/Education	Required

ARTICLE 1
DEFINITIONS

1.1 **Accidental Injury** – traumatic bodily injury sustained solely through accidental means where treatment commences within ten (10) days after the date of such injury. Injury to teeth as a result of chewing or biting will not be considered an Accidental Injury.

1.2 **Acute Care** – short-term diagnostic and therapeutic services rendered in a Hospital for an Enrolled Child who is ill from a disease of an acute nature or an injury of an acute nature. The period of Acute Care continues until the Enrolled Child is stable enough to be transferred to a long-term facility for rehabilitation or maintenance care, or until the Enrolled Child can be discharged to home care.

1.3 **Allowable Charge** – the lesser of the submitted charge or the amount established by the Health Plan, as provided through Provider Network contracts or based on an analysis of provider charges, as the maximum amount for all such provider services covered under the terms of this document.

1.4 **Ambulatory Surgical Facility** – an institution licensed as such by the appropriate state agency whose primary purpose is performing elective surgical procedures on an outpatient basis or an institution certified by Medicare as an Ambulatory Surgical Facility.

1.5 **Benchmark Plan** – The State and School Employees' Health Insurance Plan.

1.6 **Benefit Period** – a period of one calendar year commencing each January 1.

1.7 **Benefit Period Deductible** – the amount of Covered Expense defined by the Board that must be paid by the Enrolled Child before co-insurance is applied.

1.8 **Child** – an individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance.

1.9 **CHIP** – The Children's Health Insurance Program as defined in Title XXI of the Social Security Act. (Refer also to Program.)

1.10 **Co-Payment** – a flat fee that an Enrolled Child may pay for Covered Health Services.

1.11 **Covered Health Care Service** – those health care services to which an Enrolled Child is entitled under the terms of these rules and regulations.

1.12 **Covered Provider** – Health Care Professionals and Facilities providing services within the scope of their licenses under state law and recognized under these rules and regulations to deliver Covered Health Care Services to Enrolled Children.

1.13 **Creditable Coverage** – prior health insurance coverage as defined under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)). Creditable Coverage includes coverage under group or individual health plans or health insurance, Medicare, Medicaid, other governmental plans, and state health benefit risk pools.

1.14 **Division of Medicaid** – the state agency authorized by state law to administer Medicaid.

1.15 **Durable Medical Equipment** – equipment prescribed by the attending physician and determined by the Health Plan to be Medically Necessary for treatment of an illness or injury, or to prevent the Enrolled Child's further deterioration. To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose rather than for comfort or convenience; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the Enrolled Child's home.

1.16 **Eligible Child(ren)** – a low-income child who meets all eligibility criteria for enrollment in the Program.

1.17 **Enrolled Child(ren)** – an eligible child who has been enrolled for coverage with the Health Plan under the Program. Where the parent/guardian is the responsible party for the Enrolled Child, references to the Enrolled Child are intended to include the parent/guardian.

1.18 **Facility** – a hospital or other entity licensed by the state as a specific type of institution to provide a specific level of care. For the purposes of payment as a facility, an entity must be licensed or certified as such by the appropriate state or federal agency, as approved by the Board.

1.19 **Health Care Professional** – a Practitioner or other medical provider who is licensed to perform specified health services consistent with state law. Health Care Professionals include physicians, nurse practitioners, dentists, optometrists, chiropractors, podiatrists, chiropodists, physical therapists, occupational therapists, audiologists, speech pathologists, psychologists, professional counselors, and clinical social workers.

1.20 **Health Plan or Plan** – the entity with whom the Board has contracted to insure, administer, deliver, arrange for, and reimburse the costs of Covered Health Services for Enrolled Children.

1.21 **Home Infusion Therapy** – services and Supplies required for the administration of a Home Infusion Therapy regimen. These services and Supplies must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Practitioner; (3) capable of safe administration in the home, as determined by the Health Plan; (4) provided by a licensed Home Infusion Therapy provider; (5) coordinated and approved by the Health Plan; (6) ordinarily in lieu of inpatient Hospital therapy; and (7) more cost effective than inpatient therapy.

1.22 **Hospital** – an institution which is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice medicine in the state where the institution is located; which continuously provides twenty-four hour a day nursing service by a Registered Nurse (R.N.); and which is duly licensed as a Hospital in such state. The term Hospital may also include an institution that primarily provides psychiatric or chemical dependency care, if licensed as such by the state in which the Hospital is located.

1.23 **Intensified Outpatient Program** – as provided for the treatment of substance abuse, Intensive Outpatient Program refers to a program provided as a continuation of inpatient substance abuse treatment prescribed by a Health Care Professional, under the management of a licensed substance abuse provider.

1.24 **Investigative or Experimental/Investigative** – use of a procedure, facility, equipment, drug, device, or Supply not recognized at the time of treatment as accepted medical practice within the United States for the condition being treated. "Accepted Medical Practice" shall be determined by the advisory/governing bodies of medical practice in the U.S. including, but not limited to, the American Medical Association, the American Dental Association, and the Food and Drug Administration.

1.25 **Low Income Child** – a child whose family income does not exceed two hundred percent (200%) of the federal poverty level.

1.26 **Manipulative Therapy** – all services preparatory to or complimentary to an adjustment of the articulations of the vertebral column and its immediate articulations.

1.27 **Medicaid** – the federal/state program established under Title XIX of the Social Security Act, as amended, which provides federal matching funds for a medical assistance program for eligible recipients.

1.28 **Medical Emergency** – the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in: (1) permanently

placing the patient's health in jeopardy; (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences. Determination of a Medical Emergency shall be based on presenting symptoms rather than final diagnosis.

1.29 **Medically Necessary** – Prescription Drugs, Health Care Services or Supplies required to identify or treat the illness or injury, which a Health Care Professional has diagnosed or reasonably suspects. The Prescription Drugs, Health Care Services or Supplies must be (1) consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (2) in accordance with the standards of good medical practice found in established managed care environments; (3) required for reasons other than the convenience of the patient or his Health Care Professional; (4) the most appropriate Prescription Drug, Supply or level of service which can be safely and efficiently provided to the patient. When applied to the care of an inpatient, it further means that the patient's medical symptoms or condition require that the services cannot safely be provided to the patient as an outpatient. For purposes of coverage under this Plan, the fact that a Health Care Professional has prescribed, ordered, recommended, or approved a Prescription Drug, Health Care Service or Supply does not in itself, make it Medically Necessary. (Refer also to "Investigative" in this Article).

1.30 **Medical Supplies or Supplies** – Supplies provided which are Medically Necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a patient to effectively carry out a Practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use by the patient.

1.31 **Network or Provider Network** – a defined group of Covered Providers recognized by the Health Plan to receive payment for Covered Health Care Services for Enrolled Children.

1.32 **Non-Participating Provider** – a Covered Provider who has not contracted with the Health Plan to deliver Covered Health Care Services to Enrolled Children.

1.33 **Orthotic Device** – an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

1.34 **Out-of-Pocket Maximum** – the aggregate amount of cost sharing (deductibles, co-insurance, and co-payments) incurred by all Enrolled Children in a single family in a Benefit Period. Once the Out-of-Pocket Maximum has been met, Covered Expenses are paid at 100% of the Allowable Charge for the remainder of the Benefit Period.

1.35 **Participating or Network Provider** – a Covered Provider recognized by the Health Plan to receive payment for the delivery of Covered Health Care Services to Enrolled Children.

1.36 **Partial Hospitalization** – inpatient treatment, other than full twenty-four-hour programs, in a treatment facility licensed or certified by the state in which services are rendered. This term includes day, night, and weekend treatment programs.

1.37 **Practitioner** – a physician, dentist, or other Health Care Professional authorized by law to diagnose and prescribe drugs.

1.38 **Pre-Existing Condition** – any condition, as defined by the Health Insurance Portability and Accountability Act, for which an Employer-Sponsored Insurance plan has denied coverage because of its existence prior to coverage under that plan.

1.39 **Prescription Drug** – drugs, including generic drugs and brand name drugs, that under federal law may be dispensed only by written prescription and which are approved for general use by the United States Food and Drug Administration. Prescription Drugs must be dispensed by a licensed pharmacist upon the prescription of a Practitioner as defined by law, must be Medically Necessary, and not Experimental/Investigative in order to be covered under the Program.

1.40 **Program** – Mississippi's Children's Health Insurance Program as authorized by Title XXI of the Social Security Act and Section 41-86-1 et seq. of the Mississippi Code.

1.41 **Prosthetic Device** – an artificial device which replaces all or part of an absent body part, or replaces all or part of the function of a permanently inoperable or malfunctioning body part.

1.42 **Provider** – a Health Care Professional or Facility licensed or certified to provide services within the scope of their license or certification under state law.

1.43 **Rehabilitative Care** – the coordinated use of medical, social, educational, or vocational services, beyond the acute care stage of disease or injury, or the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

1.44 **Skilled Nursing Facility** – a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to patients who require medical or nursing care that rehabilitates injured, disabled or sick patients, and that meets all of the following requirements.

1. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility;

2. Is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Practitioner;

3. Provides services under the supervision of physicians;

4. Provides nursing services by or under the supervision of a licensed registered nurse, with one licensed registered nurse on duty at all times;

5. Maintains a daily medical record of each patient who is under the care of a licensed physician;

6. Is not (other than incidentally) a home maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis facility; and

7. Is not a hotel or motel.

1.45 **Urgent Care** – care necessary for an acute condition, not as serious as an emergency, yet one in which medical necessity dictates early treatment, including that which can be provided in a hospital environment.

1.46 **Utilization Management** – a formal set of techniques designed to assess the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or setting given or proposed for an Enrolled Child, including consultation with the Enrolled Child or his/her family. Utilization management also refers to assisting Enrolled Children in obtaining and utilizing covered medical services where appropriate and when requested. Techniques may include, but are not limited to, pre-certification, concurrent review with discharge planning, case management, or retrospective review.

ARTICLE 2
ELIGIBILITY

2.1 Eligibility Determination

Eligibility for CHIP will be determined by the Division of Medicaid according to rules approved by the Division of Medicaid. Application will be made on the same form as that is used to apply for Medicaid.

2.2 Eligible Child

A. An Eligible Child is defined as a Low-Income Child who meets the following criteria:
   1. Is a Mississippi resident with intent to stay;
   2. Does not have creditable health coverage at the time of application;
   3. Is not eligible for Medicaid;
   4. Is not an inmate of a public institution or a patient in an institution for mental diseases.

B. Eligibility may not be denied on the basis of health status or medical history.

C. A newborn child for whom an application for CHIP is made within 31 days of birth will not be subject to review of creditable coverage.

2.3 Contributions

There is no enrollment fee or premium required for Eligible Children to be enrolled in the Program.

2.4 Coverage Levels

Eligible Children will have primary coverage under the Program through the Health Plan.

2.5 Enrollment Periods

Application for the Program can be made at any time. There are no special enrollment periods.

2.6 Effective Date of Coverage

For children whose eligibility information is transmitted to the Health Plan on or before the third (3rd) day of the current month, the effective date of coverage under the Benefit Plan will be the first day that month.

After the third day (3rd) day of the current benefit month (or previous business day following a state holiday or weekend), children whose eligibility is transmitted to the Health Plan will have an effective date under the Benefit Plan of the first day of the month following the month in which eligibility was transmitted.

There are two (2) exceptions to the preceding rules. For newborn children applying for coverage within 31 days of the date of birth, the effective date of coverage will be the date of birth. Children whose coverage was denied or terminated due to agency error will be accepted by the Health Plan retroactive to the first (1st) of the appropriate coverage month. Such additions will be limited to incidences of agency error for which there is no other legal means to provide coverage due the child.

2.7 Duration of Eligibility

A. Eligibility is effective for twelve months from the date of coverage or until one of the following events occurs:
   1. the Child becomes eligible for Medicaid;
   2. the Child no longer resides in Mississippi;
   3. the Child dies;
   4. the Child turns nineteen (19) years of age; or
   5. the Child becomes covered under other creditable coverage.

B. The Division of Medicaid shall determine the date of termination of eligibility.

2.8 Duration of Coverage

Coverage under CHIP shall terminate as of the end of the month in which eligibility terminated.

ARTICLE 3
BENEFITS PROVIDED

3.1 Cost Sharing

A. Deductible – No deductible amount is required under this Program.

B. Co-insurance – No co-insurance is required under this Program.

C. Co-payments

1. No co-payments may be charged for immunizations, well baby and well child care, preventive dental services, routine dental fillings, vision screening, hearing screening, eyeglasses, and hearing aids.

2. No co-payments are to be charged to Enrolled Children in families with an annual income up through 150 percent of the Federal Poverty Level.

3. No co-payments are to be charged to Enrolled Children of American Indian/Alaskan Native descent.

4. Enrolled Children in families with an annual income from 151 percent up through 200 percent of the Federal Poverty Level shall be responsible for the following co-payment amounts:

5.

Service	Co-payment
Outpatient Health Care Professional Visit	$5.00
Emergency Room Visit	15.00

D. Out-of-Pocket Maximum

1. The Out-of-Pocket Maximum amounts shall apply to all covered members of a family, as identified by the Division of Medicaid.

2. Families with an annual income from 151 percent up through 175 percent of the Federal Poverty Level shall have an Out-of-Pocket Maximum of $800.

3. Families with an annual income from 176 percent up through 200 percent of the Federal Poverty Level shall have an Out-of-Pocket Maximum of $950.

4. Once the family's co-payment amounts total to the Out-of-Pocket Maximum, the family will no longer be required to pay co-payments for the remainder of the Benefit Period.

3.2 Lifetime Maximum Benefit

There is no limit on the lifetime benefit available to Enrolled Children under the Program.

3.3 Covered Benefits

The following Covered Benefits will be provided subject to the terms and conditions of this Article and the Limitations and Exclusions set forth in this summary.

A. Inpatient Services

Inpatient services must be prior authorized as medically necessary and include the following:

(1) Hospital room and board (including dietary and general nursing services).
(2) Use of operating or treatment rooms.
(3) Anesthetics and their administration.
(4) Intravenous injections and solutions.
(5) Physical therapy.
(6) Radiation therapy.
(7) Oxygen and its administration.
(8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
(10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
(12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
(13) Intensive, Coronary, and Burn Care Unit services.
(14) Occupational therapy.
(15) Speech therapy.

B. **Medical services**

Medical services include the following:

(1) In-hospital medical care.
(2) Medical care in the Practitioner's office, Enrolled Child's home, or elsewhere.
(3) Surgery.
(4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Enrolled Child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an Accidental Injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten days of the accidental injury.
(5) Administration of anesthesia.
(6) Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests.
(7) Radiation therapy.
(8) Consultations.
(9) Psychiatric and psychological service for nervous and mental conditions.
(10) Physicians assisting in surgery, where appropriate.
(11) Emergency care or surgical services rendered in a Practitioner's office including but not limited to surgical and Medical Supplies, dressings, casts, anesthetic, tetanus serum and x-rays.
(12) Well child assessments, vision screening, hearing screening, and laboratory tests according to the American Academy of Pediatrics' recommendations for preventive pediatric health care. Vision and hearing screening are to be included as part of the periodic well child assessments.
(13) Routine Immunizations (according to ACIP guidelines) – Vaccine will be purchased and distributed through the State Department of Health. The Health Plan will reimburse providers for the administration of the vaccine.

C. **Surgical services**

Certain surgeries may be prior authorized as medically necessary. Benefits are provided for the following covered medical expenses furnished to the Enrolled Child by an Ambulatory Surgical Facility:

(1) Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.
(2) Pre-operative preparation.

(3) Use of facility (operating rooms, recovery rooms, and all surgical equipment).
(4) Anesthesia, drugs and surgical Supplies.

D. **Clinic Services**

Clinic services (including health center services) and other ambulatory health care services are covered as medical services.

E. **Prescription drugs**

Health Plan pays for many prescription drugs. These drugs are listed in the preferred drug list (PDL). The Member can call member services for a list of our PDL drugs. This list can change, so it is important that the Members check this list each time the Member needs a prescription.

Generic drugs work the same way as the brand-name versions. If possible, the generic drug will be used. Health Plan will pay for brand name drugs that have a generic available when they are medically necessary and when the Member's doctor requires the prescription be filled as written. Some PDL drugs and all non-PDL drugs need a prior authorization. The Member's doctor will need to tell the Health Plan why the Member needs a specific drug or certain amount of a drug. The Health Plan must approve the request before the Member can get the drug. Health Plan will make a decision within 24 hours once the Health Plan receives all the information. In most cases, the Health Plan will grant a 5-day supply of the medication for the Member until the Health Plan processes the authorization request. If the Health Plan does not approve the request, the Health Plan will tell the Member how to appeal.

(1) The following drugs and medical supplies are covered:

(a) Legend drugs (federal law requires these drugs be dispensed by prescription only)
(b) Compounded medications of which at least one ingredient is a legend drug
(c) Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-tape)
(d) Disposable insulin needles/syringes
(e) Growth hormones
(f) Insulin
(g) Lancets
(h) Legend contraceptives
(i) Retin-A (tretinoin topical)
(j) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)

(k) Vitamin and mineral supplements, when prescribed as replacement therapy
(l) Legend pre-natal vitamins

(2) The following are excluded:

(a) Anabolic steroids (e.g., Winstrol, Durabolin)
(b) Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder
(c) Anti-wrinkle agents (e.g., Renova)
(d) Charges for the administration or injection of any drug
(e) Dietary supplements
(f) Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi)
(g) Minerals (e.g., Phoslo, Potaba)
(h) Medications for the treatment of alopecia, e.g. Minoxidil (Rogaine)
(i) Non-legend drugs other than those listed as covered
(j) Pigmenting/depigmenting agents
(k) Drugs used for cosmetic purposes
(l) Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorrette, Nicoderm, etc.)
(m) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes
(n) Any medication not proven effective in general medical practice
(o) Investigative drugs and drugs used other than for the FDA approved diagnosis
(p) Drugs that do not require a written prescription
(q) Prescription Drugs if an equivalent product is available over the counter
(r) Refills in excess of the number specified by the Practitioner or any refills dispensed more than one year after the date of Practitioner's original prescription

F. **Over-the-counter medications**

Benefits will be provided for select over-the-counter medications purchased with a prescription, including analgesics, vitamins, nicotine replacement, topical formulations, gastrointestinal agents, and cough/cold medications such as pseudoephedrine.

G. **Laboratory and radiological services**

Medically Necessary laboratory and radiological services are covered, but certain diagnostic tests must be pre-certified, as determined by the Board or the Health Plan.

H. **Prenatal care and pre-pregnancy family planning services and Supplies**

Infertility services are excluded.

I. **Mental Health Services**

(1) Inpatient mental health services, other than services described under substance abuse services, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services.

(a) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an Enrolled Child.
(b) Benefits for covered medical expenses are provided for Partial Hospitalization.
(c) Certification of medical necessity by the Utilization Management Program is required for admissions to a hospital.
(d) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.

(2) Outpatient mental health services, other than services described under substance abuse services.

(a) Benefits for Covered Medical Expenses for treatment of nervous and mental conditions on an outpatient basis.
(b) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.

J. **Durable medical equipment and other medically-related or remedial devices** (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)

(1) Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, at the Health Plan's discretion, the purchase price of such equipment may be allowed.
(2) To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of

illness, injury or disease; and (4) appropriate for use in the Enrolled Child's home.

(3) Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when Medically Necessary. Shoes are not covered except for the following: (1) a surgical boot which is part of an upright brace; (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes; and (3) a custom fabricated shoe in the case of a significant foot deformity.

(4) Eyeglasses are limited to one per year.

(5) Hearing aids are limited to one per ear, as indicated, every three years.

K. **Disposable medical supplies**

Supplies provided which are Medically Necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an Enrolled Child to effectively carry out a Practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the Enrolled Child's home.

L. **Home and community-based health care services**

(1) Services and supplies required for the administration of Home Infusion Therapy regimen must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Practitioner; (3) as determined by the Utilization Management Program capable of safe administration in the home; (4) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the Utilization Management Program; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.

(2) Benefits for home health nursing services must be approved by the Utilization Management Program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually. (Refer to Nursing care services in following section.)

M. **Nursing care services**

(1) Benefits are provided for Covered Expenses when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered. Nurse practitioner services are covered as Medical Services.

(2) Benefits for nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) are

covered only when ordered and supervised by a Practitioner and when the services rendered require the technical skills of a RN or LPN.

(3) Benefits for private duty nursing services are provided for an illness or injury that the Utilization Management Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services.

(4) Benefits are provided for nursing services in the home for illness or injury that the Utilization Management Program determines to require the skills of a RN or LPN. Benefits for nursing services provided in an Enrolled Child's home must be approved by the Utilization Management Program in lieu of hospitalization.

(5) Benefits for nursing services are limited to $10,000 annually. This limit does not apply to nurse practitioner services.

(6) No nursing benefits are provided for the following:
   (a) Services of a nurse who ordinarily lives in the Enrolled Child's home or is a member of the Enrolled Child's family;
   (b) Services of an aide, orderly or sitter; or
   (c) Nursing services provided in a Personal Care Facility.

(7) Benefits are provided for confinement in a skilled nursing facility for up to 60 days per benefit period, subject to utilization management requirements.

N. Abortion

Elective abortions are covered only when documented to be medically necessary in order to preserve the life or physical health of the mother.

O. Dental Services

(1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). The following Covered Dental Services are limited to $1500 each calendar year:
   (a) Bitewing X-Rays-as needed, but no more frequently than once every six months;
   (b) Complete Mouth X-Ray and Panoramic X-Ray- as needed, but no more frequently than once every twenty (24) months;
   (c) Prophylaxis- one every six (6) months; must be separated by six full months;
   (d) Fluoride Treatment – limited to one each six (6) month period;
   (e) Space maintainers – limited to permanent teeth through age 15;

(f) Sealants – covered up to age 14, every 36 months.

(2) Benefits are provided for restorative, endodontic, periodontic and surgical dental services as indicated below and are limited to $1500 each calendar year:

(a) Amalgam, Silicate, Sedative, and Composite Resin Fillings including the replacement of an existing restoration;
(b) Stainless steel crowns to posterior and anterior teeth;
(c) Porcelain crowns to anterior teeth only;
(d) Simple extraction;
(e) Extraction of an impacted tooth;
(f) Pulpotomy, pulpectomy and root canal;
(g) Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services (The Calendar Year Maximum does not apply to these services.)

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Enrolled Child is covered under the Plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury.

(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Enrolled Child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office.

(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions.

(4) Benefits are provided for diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a Practitioner or dentist, subject to a lifetime maximum benefit of $5,000 per member. This lifetime maximum will apply regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

P. **Substance abuse treatment services**

1. Inpatient substance abuse treatment services and residential substance abuse treatment services:

(a) Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol

abuse, drug abuse, or a combination of alcohol and drug abuse.

(b) Benefits for covered medical expenses are provided for Medically Necessary inpatient stabilization and residential substance abuse treatment.

(c) Certification of Medical Necessity by the Health Plan's Utilization Management Program is required for admissions to a hospital or residential treatment center.

(d) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

2. Outpatient substance abuse treatment services:

(a) Benefits are provided for covered medical expenses for Medically Necessary Intensified Outpatient Programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility.

(b) Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient.

(c) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

Q. **Case management services**

Medical Case Management may be performed by the Utilization Management Program of the Health Plan for those Enrolled Children who have a catastrophic or chronic condition. Through medical case management, the Utilization Management Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and Supplies which are not otherwise covered. The decision to provide extended or alternative benefits is made on a case-by-case basis to Enrolled Children who meet the Utilization Management Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the Utilization Management Program.

R. **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders**

(1) Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the Enrolled Child's Practitioner and provided by a licensed physical therapist.

(2) Benefits are provided for Medically Necessary occupational therapy services prescribed by the Enrolled Child's Practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist.

(3) Benefits are provided for Medically Necessary speech therapy services prescribed by the Enrolled Child's Practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.

(4) Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

S. **Hospice care**

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of $15,000.

T. **Anesthesia**

Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

U. **Transplants**

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

(a) the Enrolled Child obtains prior authorization from the Utilization Management Program; and

(b) the condition is life-threatening; and

(c) such transplant for that condition is the subject of an ongoing phase III clinical trial; and

(d) such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and

(e) the Enrolled Child is a suitable candidate for the transplant under the medical protocols used by the Utilization Management Program.

(2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.

(3) Benefits are provided for transportation costs of recipient and one other individual to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of one individual at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two (2) other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses

incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to $10,000.

(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient, the following applies:

(a) The following expenses are covered:

- A search for matching tissue, bone marrow or organ;
- Donor's transportation;
- Charges for removal, withdrawal and preservation;
- Donor's hospitalization.

(b) When only the recipient is an Enrolled Child, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the Enrolled Child's contract.

(c) When both the recipient and the donor are Enrolled Children, the donor is entitled to benefits under the donor's contract.

(d) When only the donor is an Enrolled Child, the donor is not entitled to donor coverage benefits.

(e) If any organ or tissue is sold rather than donated to the Enrolled Child, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered under the Enrolled Child's contract.

V. Manipulative therapy

Manipulative therapy is a covered medical expense, but benefits are limited to $2,000 per benefit period.

W. Optometric services

Benefits are provided for Medically Necessary services and Supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for an annual routine eye examination, if indicated by the results of a vision screening, and the fitting of eyeglasses.

X. **Medical transportation**

Professional ambulance services to the nearest hospital which is equipped to handle the Enrolled Child's condition in connection with covered hospital inpatient care, or when related to and within 72 hours after accidental bodily injury or medical emergency whether or not inpatient care is required, are covered expenses.

Y. **Surgery for mastectomy and reconstruction of the breast**

When the Health Plan determines the Medically Necessity of medical and surgical benefits with respect to a Member's mastectomy, Benefits will be provided for breast reconstruction when such Covered Services is elected by the Member. In accordance with the terms and provisions of this Benefit Plan, the following benefits will be provided:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications in connection with all stages of mastectomy, including lymphedemas.

Z. **Bariatric Surgery**

Benefits will be provided for bariatric surgery procedures for an Enrolled Child age 18 or older (children turning 19 years of age are not eligible) subject to certification by the Health Plan's medical management/utilization review program. The criteria to qualify for bariatric include, but are not limited to, the following:

1. Body Mass Index (BMI) exceeding 40; or BMI greater than 35 in conjunction with one or more severe co-morbidities (e.g., clinically significant obstructive sleep apnea; coronary heart disease; medically refractory hypertension (blood pressure greater than 140 mmHG systolic and/or r90 mmHg diastolic despite concurrent use of 3 anti-hypertension agents of different classes); Type 2 diabetes mellitus).
2. Documentation of a motivated attempt of weight loss through a structured diet program prior to bariatric surgery, which includes physician or other health care provider's notes and/or weight loss logs from a structured weight loss program for a minimum of six (6) months.
3. Psychological assessment to determine psychological readiness for the procedure and for enhancing success during post-surgery adjustment.

Approved bariatric surgery procedures include Roux-en-Y Gastric bypass (RYGB); Laparoscopic Adjustable Silicone Gastric Banding(LASGB); Sleeve Gastrectomy; Biliopancreatic Diversion (BPD); Duodenal Switch (DS) Procedure.

AA. **Preventive Services for Women**

1. All preconception and prenatal care visits.
2. Contraceptive methods and counseling, including FDA-approved contraceptive methods, sterilization procedures, and patient education/counseling for all women with reproduction capacity.
3. Breastfeeding support, supplies and counseling in conjunction with each childbirth, including comprehensive lactation support and counseling by a trained provider using pregnancy and/or postpartum, and coverage of the costs of renting breastfeeding equipment.
4. Annual screening and counseling for interpersonal and domestic violence.

3.4 Covered Providers

A. Benefits shall be allowed for Covered Health Services provided by Network Providers.

B. No Provider paid under the Program may charge an Enrolled Child or the family of an Enrolled Child any amount in excess of the amount paid by the Health Plan for Covered Health Care Services.

ARTICLE 4
LIMITATIONS AND EXCLUSIONS

Notwithstanding any other provisions of these rules and regulations, benefits will be limited, excluded, and conditioned as follows:

4.1 No benefits shall be provided for services or Supplies which are provided for the following:

A. Convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Practitioner for an Enrolled Child who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the Enrolled Child was admitted to a hospital for his or her own convenience or the convenience of his or her Practitioner, or that the care or treatment provided did not relate to the condition for which the Enrolled Child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the Enrolled Child was hospitalized and then only during such time as such services are medically necessary.

B. Cosmetic purposes, except for correction of defects incurred by the Enrolled Child while covered under the Program through traumatic injuries or disease requiring surgery.

C. Sex therapy or marriage or family counseling.

D. Custodial care, including sitters and companions.

E. Elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother.

F. Equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, and so forth).

G. Procedures which are Experimental/Investigative in nature.

H. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

I. Services and Supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be Medically Necessary.

J. Services which the Health Plan determines are not medically necessary for treatment of injury or illness.

K. Services provided under any federal, state, or governmental plan or law including but not limited to Medicare except when so required by federal law.

L. Nursing or personal care facility services, e.g. extended care facility, nursing home, or personal care home, except as specifically provided otherwise.

M. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

N. Inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable Enrolled Children disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Utilization Management Program.

O. Outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable Enrolled Children disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the Enrolled Child's Practitioner and provided by a licensed therapist.

P. Care rendered by a Provider, who is related to the Enrolled Child by blood or marriage or who regularly resides in the Enrolled Child's household.

Q. Services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.

R. Treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.

S. Reversal of sterilization regardless of claim of medical necessity.

T. Charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.

U. Travel, whether or not recommended by a Practitioner, except as provided for under Transplant Benefits.

V. Services related to diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.

W. Treatment of any injury arising out of or in the course of employment or any sickness entitling the Enrolled Child to benefits under any Workers' Compensation or Employer Liability Law.

X. Any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the Enrolled Child is unable to recover from the responsible party, benefits of the Program shall be provided.

ARTICLE 5
APPEALS AND GRIEVANCES

5.1 Health Plan shall provide a 3 (three) level review process for appeals. This process is as follows:

A. First Level Review

1. The Member, his or her representative or a Provider may initiate the appeal process by filing a verbal or written appeal within forty-five calendar days of the incident, or at which time the Member has knowledge of the circumstances which would give rise to the appeal, whichever comes first.

2. Health Plan's Appeals Coordinator will investigate the appeal Using applicable statutory, regulatory and contractural provisions, as well as the Health Plan's written policies.

3. Within fifteen (15) calendar days after receipt of the appeal, the Appeals Coordinator or Medical Director when necessary, will prepare and send a notice, outlining the Health Plan's determination, to the Member and/or Provider.

4. The notice, which will be sent first class mail, will contain the following information:

   a. The title(s) and qualifying credentials(s) of the person(s) participating in the appeal review process:

   b. A statement of the reviewer's understanding of the appeal;

   c. The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail; and

   d. A reference to the evidence or documentation used as the basis for the decision.

   e. If the decision is a denial, a clear description of the individual's right to and the process required for further review.

5. Upon Members request, and for both a legitimate reason and a reasonable period, the fifteen (15) calendar day time frame referenced in this section for step one may be extended. The Member must be informed that an extension of the time frame for this step could also extend the total grievance appeal process time frame to more than 90 days.

B. Second Level Review

1. If the Member, his or her representative or the Provider is dissatisfied with Health Plan's decision on an appeal, the Member, his or her representative or the Provider may send to the Health Plan a written statement containing an explanation of the appeal and reason(s) for dissatisfaction with Health Plan's decision. This written request must be received by Health Plan within fifteen (15) calendar days of the member's and/or Provider's receipt of Health Plan's decision. This written request must be received by Health Plan's decision.

2. Health Plan will investigate each appeal using applicable statutory, regulatory, and contractual provisions, as well as the Health Plan's written policies. As part of the investigation, Health Plan:

   a. May contact the Member and/or the appropriate provider by phone or in person:

   b. Will consult with its management, and /or Medical Director, as necessary, and, if the appeal involves an adverse medical determination, Health Plan's Consulting providers who have appropriate expertise in the area which is the subject of the appeal;

   c. Health Plan will render a decision on the appeal within fifteen (15) calendar days of the receipt of the appeal. Health Plan will send a written decision to the Member and Provider within the fifteen (15) calendar days of the receipt of the appeal;

   d. The written decision shall be in the form of a Notice. The Notice, which will be sent first class mail, shall contain the following information:

      i. The names(s), title(s) and qualifying credentials(s) of the person(s) participating in the appeal review process;

      ii. A statement of the reviewer's understanding of the appeal;

      iii. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

      iv. A reference to the evidence or documentation used as the basis for the decision; and

      v. If the decision is a denial, a clear description of the individual's right to and the process required for further review.

e. If the Member is dissatisfied with the result of the Health Plan's appeal decision, he or she may continue the appeal process by filing a written request along with additional information that may be available for reconsideration of the appeal with Health Plan, within fifteen (15) calendar days of receipt of Health Plan's notice regarding the appeal.

C. Third Level of Review

1. If the Member, his or her representatives or the Provider remains dissatisfied with the Health Plan's decision on the appeal, he or she must send to the Health Plan a written statement restating the appeal and the reason(s) for the dissatisfaction within Health Plan's decision, along with any additional information pertinent to the appeal. Health Plan must receive the written statement within 15 days of the Member's and/or Provider's receipt of Health Plan's decision on the appeal.

2. The Health Plan will review the request for reconsideration and any new information that may have become available since the time the appeal was first considered.

3. The individuals reviewing the reconsideration shall not be the same individuals that Health Plan utilized in the initial determination when the appeal was denied. In the event the third level appeal review involves a final adverse determination being made by Health Plan about the denial, reduction, suspension or termination of health care services or treatment, other than for timeliness, the Appeals Coordinator, within ten (10) calendar days of the Health Plan's receipt of the individuals third request, will refer all pertinent documentation relating to the request to the Health Plan's legal department for final determination. The Health Plan will refer the medical determinations to an external independent review organization for a final determination of the appeal. Such documentation shall include:

   a. All files associated with the step one, step two and step three appeals by Health Plan's staff, including all documentation assembled during the reviews;

   b. The Member's pertinent medical records;

   c. The attending physician's recommendations;

   d. Consulting reports from appropriate health care professions;

   e. Other documents submitted by the Member, his/her representative, or a provider;

f. Any applicable generally accepted practice guidelines, including those developed by the federal government, national or professional medical societies, boards or associations; and

g. Any applicable clinical review criteria developed and/or used by the Health Plan.

The independent external review organization must thoroughly review all documentation provided by the Health Plan and make a final determination regarding the Appeal. Such review and written notice to the Health Plan shall be completed within fifteen (15) calendar days of receipt. The notice to the Health Plan shall identify the qualifying credentials of the person(s) participating in the review and thoroughly explain the basis for the final determination.

4. Once the third level appeal review is complete. Health Plan shall send a notice, by first class mail outlining the determination, to the Member and Provider. The notice shall contain:

   a. The title(s) and qualifying credential(s) of the person(s) participating in the reconsideration process, if applicable;

   b. A statement of the reviewer's understanding of the appeal.

   c. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

   d. A reference to the evidence or documentation used as the basis for the decision.

   e. If the decision is a denial, a clear description of the individual's right to the process required for further review.

2. Expedited Appeal Procedures

   A. The Health Plan shall provide an expedient review of an appeal involving an urgent or emergency medical situation. This process is as follows:

      1. This process shall include all requests by Members concerning admissions, availability of care, continued stay or health care services being received by a Member in an emergency situation where he or she has not been discharged from a facility (hospital). The request for an expedited review may be submitted by the Member, his or her representative or a Provider verbally to a designated representative of the Health Plan.

2. In the expedited review process, all necessary information, including Health Plan's decision, shall be transmitted between Health Plan, the independent review organization (where applicable), the Member, his or her representative or the Provider by telephone, facsimile or the most expeditious method.

3. The Health Plan shall make a decision and notify the Member and his or her representative as expeditiously as the member's medical condition requires, but in no event more than seventy-two (72) hours after the review is requested. Health Plan shall provide written confirmation of its decision concerning an expedite review within two (2) working days of providing notification of that decision if the initial notification was not in writing.

B. The written decision shall be in the form of a Notice. The Notice, which will be sent first class mail, shall contain the following information:

1. The title(s) and qualifying credential(s) of the person(s) participating in the appeal review process;

2. The qualifying credentials of any independent external review organization staff participating in the review;

3. A statement of the reviewer's understanding of the appeal;

3. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

4. A reference to the evidence or documentation used as the basis for the decision; and

5. An explanation of how to request a reconsideration of an appeal decision.

6. If the decision is a denial, a clear description of the individuals right to pursue the matter in a court of appropriate jurisdiction.

Exception: Upon member request, and for both a legitimate reason and a reasonable period, the seventy-two hour (72) hour timeframe referenced in this section may be extended by up to fourteen (14) calendar days.

3. Grievance Process

a. The Member, his or her representative or a Provider may initiate a grievance either verbally or in writing. By initiating a grievance, one is expressing dissatisfaction with the benefit plan, services rendered, benefit plan policies and/or claims processing timeliness.

b. The Health Plan's Appeals Coordinator will investigate the grievance using applicable statutory, regulatory and contractual provisions, as well as Health Plan's written policies. As necessary, the Appeals Coordinator will confer with individuals responsible for operational activities directly related to the grievance.

c. Within thirty (30) calendar days after receipt of the grievance, the Appeals Coordinator will prepare and send a notice, outlining Health Plan's responses to the Member and/or Provider.

ARTICLE 6
UTILIZATION MANAGEMENT

6.1 The Health Plan may conduct such utilization management activities as are necessary to ensure that Covered Health Care Services provided Enrolled Children are Medically Necessary.

6.2 Utilization management activities conducted by the Health Plan may cause undue hardship on Enrolled Children or their families in accessing Covered Health Care Services.

6.3 The Health Plan must allow for retrospective review for Medical Necessity after medical services have been provided in the event of failure to pre-certify or notify the Utilization Management Program.

6.4 Medical Case Management may be performed by the Utilization Management Program for those Enrolled Children who have a catastrophic or chronic condition. Through medical case management, the Utilization Management Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and Supplies which are not otherwise covered under the Program. The decision to provide extended or alternative benefits shall be made on a case-by-case basis to Enrolled Children who meet the Utilization Management Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits shall be made by the Health Plan.

6.5 As set forth in Article 3, certain services may be subject to review of Medical Necessity and require pre-approval.

6.6 The Health Plan shall provide a means by which the parent/guardian of the Enrolled Child may receive approval to access out of network services if the needed medical service is not available in the Health Plan's network.

ARTICLE 7
GENERAL CONDITIONS

7.1 Neither the Board nor Department of Finance and Administration shall be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance, or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Health Care Professional or other person participating in or having to do with the care or treatment of the Enrolled Child.

7.2 The benefits for Covered Health Care Services shall be provided only to the extent that the Provider can provide such service, and payment therefore to the Provider by the Health Plan as herein provided shall constitute a complete discharge of the obligation of the Program hereunder with respect thereto.

7.3 Any notice required to be given by Health Plan to Enrolled Child hereunder shall be deemed to be given and delivered when deposited in the United States mail, postage prepaid, addressed to the Enrolled Child or parent/guardian at the address that appears in the records of the Health Plan.

7.4 Persons claiming benefits under the Program must furnish the State or the Health Plan such information as may be necessary to administer benefits under the program.

7.5 Each Enrolled Child receiving care under the Program authorizes and directs any Provider to furnish to the Health Plan at any time upon request all information, records, copies of records, or testimony relating to attendance, diagnosis, examination, or treatment, and by such authorization, expressly waives any and all laws providing for privileged communications between Health Care Professional and patient. Such authorization and waiver, and compliance therewith by each Provider affected, shall be a condition precedent to rights to benefits to each Enrolled Child covered under the Program, and no benefits shall be provided in any case where such authorization and waiver is not given full effect.

7.6 The Health Plan will hold information, records, or copies of records concerning Enrolled Children as confidential. The Health Plan will restrict the use or disclosure of information concerning Enrolled Children to purposes directly connected with the administration of the Program. Information considered confidential is to include, but not be limited to, the following:

A. Names and addresses;
B. Medical services provided;
C. Social and economic conditions or circumstances;
D. Medical history, including diagnoses and treatments; and
E. Information related to the liability of third parties.

7.7 Any materials distributed to Enrolled Children or their families must directly relate to the administration of the Program.

7.8 Proof of Loss

A. Written proof of loss for which claim is made should be furnished to Health Plan as soon as possible after the covered service is rendered. The deadline for filing claims for covered services rendered by network providers is subject to the provisions set forth in the Health Plan's network provider contracts. Claims for covered services rendered by non-network providers, and approved by the Health Plan, must be filed within the timeframe agreed to by the Health Plan, but in no case later than the end of the calendar year following the year in which the services were provided.

B. Upon failure of an Enrolled Child or Provider to so notify the Health Plan or furnish proof of loss, payment may be refused or a percentage of the regular payment provided may be paid at the option of the Health Plan; provided, however, failure to give notice of proof of loss within the time provided shall not invalidate a claim if it can be shown that compliance with this provision was not reasonably possible and that notice of claim was given as soon as reasonably possible.

7.9 The Health Plan may enforce reimbursement or subrogation rights by requiring the Enrolled Child or parent/guardian to assert a claim to any of the foregoing coverages to which he/she may be entitled.

7.10 If the Health Plan is notified that an Enrolled Child may have other creditable health coverage, the Health Plan will notify the Division of Medicaid for further investigation.

7.11 The Health Plan is authorized to make payment directly to Health Care Professionals, Hospitals, or other Covered Providers furnishing services for which benefits are provided under the Program.

7.12 Whenever any condition or requirement of the Program has been breached by an Enrolled child or he/she shall be in default as to any term or condition hereof, failure of the Board, the Department of Finance and Administration or the Health Plan to avail of any right stemming from such breach or default, or indulgences granted, shall not be construed as a

waiver of the right of the Board, Department of Finance and Administration or the Health Plan on account of existing or subsequent such breach or default.

7.13 In the event the Program is terminated, such termination alone shall operate to terminate all rights of the Enrolled Child to benefits under the Program, as of the effective date of termination.

7.14 In the event any Enrolled Child's coverage is terminated under the Program, such termination shall operate to terminate all rights of the Enrolled Child to benefits under the Program, as of the effective date of termination.

ARTICLE 8
CONTINUATION COVERAGE

8.1 There are no continuation of coverage options under the Program for children whose eligibility has terminated.

8.2 The Health Plan will issue a Certificate of Creditable Coverage to children whose coverage has terminated.

Attachment A

Mississippi State and School Employees Health Insurance Management Board Request For Proposal for

Health Insurance Coverage under the Children's Health Insurance Program,

dated February 18, 2009

STATE OF MISSISSIPPI

Request for Proposal
for
Health Insurance Coverage
under the
Children's Health Insurance Program (CHIP)
February 18, 2009

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Appendices

1. Introduction and General Information

1.1 *Introduction*

The Mississippi State and School Employees Health Insurance Management Board ("Board"), acting administratively through the Department of Finance and Administration ("DFA"), is seeking to enter into a contract with a qualified Contractor to provide comprehensive health insurance coverage for Mississippi children determined to be eligible for the Children's Health Insurance Program ("CHIP"). The DFA is coordinating this Request for Proposal ("RFP") with assistance from PricewaterhouseCoopers, LLP.

The current five-year policy with Blue Cross & Blue Shield of Mississippi (BCBSMS) to provide health insurance coverage to children covered under the Mississippi Children's Health Insurance Program will end on December 31, 2009. BCBSMS currently provides all services under the policy, with the exception of the vision provider network, which is subcontracted through Vision Services Provider and nurse triage services, which are subcontracted through McKesson Health Solutions.

The purpose of this RFP is to obtain proposals from qualified Contractors for a contract effective date of January 1, 2010. The term of the initial contract will be four years, with an option to renew for one additional year, at the Board's discretion. Proposers are asked to provide proposals on a non-participating (no dividend or deficit accounting) insured and/or self-insured basis.

For the insured proposal, the proposed per Member premium rate is to have the following three separately identifiable components: (1) a paid claim estimate; (2) an incurred but unpaid (IBU) claim reserve estimate; and (3) an administrative fee, which may vary in total based on the monthly enrollment in CHIP. The sum of the three components equals the total monthly billable premium rate. The total billable premium rate must be guaranteed at least one year. While the one year proposal option is required, as an additional option, you can also provide a rate proposal for a longer period (e.g., 2 years). It is required that you provide and guarantee the administrative fee component to be used in future renewals for the five year period. Thus at the end of 2010, you will develop insured rates for 2011 based on the administrative fee you have proposed added to updated estimated 2011 incurred claims. All premiums for coverage of children under CHIP will be paid to the Contractor by the Division of Medicaid (DOM). For further details on the fee quotation requirements, refer to **Section 14** of this RFP.

For the self-insured proposal, the proposed Administrative rate is the billed rate. The proposed per Member per month administrative fee must be guaranteed for five years. For your medical provider network fee schedule, you must be willing to establish a separate network contractual arrangement whereby you will jointly work with the Board at the end of each year to determine the appropriate provider fee schedule increase for the following year. All administrative fees under CHIP will be paid to the Contractor by the (DOM). For further details on the fee quotation requirements, refer to **Section 14** of this RFP.

The paid claim estimate and the IBU claim reserve estimate components requested in **Section 14** are illustrative only and are based on your estimated projections.

Note: For self-insured proposals, the IBU reserve will be held by the Board during the contract period. For further details on the fee quotation requirements, refer to Section 14 of this RFP.

If a self-insured arrangement is selected, this contract shall be governed by the applicable provisions of the Mississippi Personal Service Contract Review Board Regulations, a copy of which is available from the Mississippi State Personnel Board located in the Robert G. Clark Jr. Building at 301 North Lamar Street, Suite 100, Jackson, Mississippi 39201 or by accessing their website at www.spb.state.ms.us.

1.2 General Information about CHIP

The Children's Health Insurance Program (CHIP) was established under Title XXI of the Social Security Act as amended.

In 1998, the Mississippi Legislature established the Mississippi Children's Health Insurance Program Commission ("Commission"). The Commission was charged with developing a plan setting forth the manner and means by which Mississippi would further utilize funds to provide assistance to uninsured children under CHIP.

The Commission determined that the Board should be given the authority to implement CHIP as a fully insured statewide program. The Contract for the CHIP health insurance policy was awarded as a result of a competitive bidding process to Blue Cross & Blue Shield of Mississippi and the program commenced providing health insurance coverage on January 1, 2000. A copy of the 1998 Children's Health Insurance Commission's Final Report is available upon request.

Note: The benefit and eligibility structure of the program has essentially remained the same since 2000. The passage of the Children's Health Insurance Program Reauthorization Act 2009 (H.R. 2) in February allows states to modify benefit and eligibility; however Mississippi has made no changes as of the date of the release of this RFP.

1.3 CHIP Funding

CHIP is funded with a combination of federal and State matching funds.

1.4 CHIP Eligibility

Children qualify for CHIP coverage based on annual family income and age, provided such children are not eligible for Medicaid and do not have any creditable health coverage as of the date of their application. The age and income levels for CHIP eligibility are as follows:

Ages of Children Eligible for Coverage	Annual Family Income
Birth to 12 months	185% to 200% of the Federal Poverty Level (FPL)
Ages 1 to 5	133% to 200% of FPL
Ages 6 through 18	100% to 200% of FPL

Currently, approximately 65,000 children are covered by the CHIP. Most current estimates are that CHIP has reached a significant number of the State's eligible children. State law provides if there are any funding shortfalls the DOM may limit enrollment.

The DOM determines eligibility for CHIP. Once a child is determined to be eligible by DOM for CHIP, coverage is effective for a twelve-month period or until a child attains age 19, moves out of state, becomes eligible for Medicaid or acquires other creditable coverage. Coverage is made available to eligible children on a "guaranteed issue" basis. There are no exclusions for pre-existing conditions, and coverage is granted on a guaranteed renewal basis, subject to recertification of the Member's continued eligibility by DOM.

1.5 Plan of Benefits

The plan of benefits to be provided by the Contractor is included in the Rules and Regulations for CHIP, which is **Appendix A** of this RFP. In general, covered health services include inpatient and outpatient hospital services, physician (primary care and specialty) services, family planning services, prescription drugs, laboratory, radiology and other diagnostic services, supportive services, professional ambulance services, routine well baby and well child care visits including administration of immunizations, vision and hearing examinations, eyeglasses, hearing aids, preventive and diagnostic dental care and routine dental fillings. The plan of benefits is to be provided through a comprehensive provider network, pursuant to **Section 8** of this RFP, and covered health services are to be subject to utilization management requirements, set forth in **Section 4.15** of this RFP.

The plan of benefits is based on the benefits offered under the Mississippi State and School Employees' Health Insurance Plan. As benefits change under the State and School Employees' Health Insurance Plan, the plan of benefits offered under CHIP may change accordingly. If significant changes are made to the plan of benefits or significant changes occur in enrollment to the extent that such changes materially impact the Contractor's performance under this Contract, the Board and the Contractor agree to renegotiate the premium rate (fully-insured) or administrative rates (self-insured).

1.6 Cost Sharing

No premiums are charged to Members for coverage under CHIP. For children in families with annual income at or below 150% of the FPL, there are no cost sharing requirements in the plan of benefits. Likewise, there are no cost sharing requirements in the plan of benefits for children of Native Alaskan or Native American descent, regardless of the poverty level. All covered expenses are 100% paid by the Contractor in an insured contract or by the DOM in a self-insured contract.

For Members in families with annual income greater than 150% up to 200% of the FPL, cost sharing requirements are imposed in the form of copayments up to an out-of-pocket maximum, as specified in Appendix A of this RFP. There are no cost sharing requirements for routine well baby and well child care visits, including administration of immunizations, vision and hearing examinations, eyeglasses, hearing aids and preventive and diagnostic dental care and routine dental fillings. Also, under federal law, the total amount of copayments for all covered Members cannot exceed 5% of the family income in any benefit period. The out-of-pocket maximums set forth in **Appendix A** have been designed to comply with the federal limits on cost sharing.

1.7 Employer-Sponsored Health Insurance

There is a provision in the CHIP legislation that allows the use of available funds to subsidize insurance premiums for children in families with access to employer-sponsored health insurance, but whose parents cannot afford to pay the premiums to cover their dependent children. However, this arrangement is not currently in place in Mississippi.

Should such an arrangement be implemented in the future, it is understood that the then incumbent Contractor would be given an opportunity to renegotiate the terms of its Contract with the Board so that it more properly reflects the requirements of such an arrangement.

1.8 Scope of Services Requested in RFP (for both Fully-insured and Self-insured)

One primary Contractor will be selected (Subcontractor arrangements by the primary Contractor are permissible) to provide the coverage and related administrative services for the specified plan of benefits to enrolled Members on a statewide basis. Services will include, but not be limited to, the following:

a) Receiving and maintaining enrollment data on eligible Members as provided by DOM;

b) Developing and providing Member handbooks and ID cards;

c) Developing and maintaining a website to provide general customer service and Member education regarding access to services, benefits, provider network, and appeals process.

d) Preparing and mailing provider directories to new members, and on request, providing inter-active voice response (IVR) access to the roster of available network providers (IVR must also include an easily accessible option allowing transfer to a live person), and internet access to the roster of available network providers;

e) Adjudicating claims; (in accordance with Mississippi Department of Insurance Code § 83-9-5, which outlines the required time periods for processing claims);

f) Communicating claim filing procedures and Benefit Plan provisions to providers;

g) Implementing Member and provider Grievance Appeal Procedures, which includes expedited review and external independent review features;

h) Processing payments to providers;

i) Responding to inquiries from Members, providers, and the general public; (such responses could, in appropriate circumstances, be limited to referring the inquirer to the appropriate State agency or other third party);

j) Implementing appropriate utilization management, case management, and disease management;

k) Mirroring the current prior-authorization program requirements as shown in **Appendix A1**. Any variance from the current program will require Board approval for both self-insured and fully-insured.

l) Producing required and requested reports;

m) Establishing and maintaining a management information system (MIS) that will submit data to the Board's Information Management Vendor (IMV) and support all other related electronic data interfaces between the Benefit Plan and its vendors;

n) Maintaining proper financial controls and reporting;

o) Conducting required data matches; and

p) Complying with the Health Insurance Portability and Accountability Act (HIPAA).

A high level overview of the interaction between the entities involved with the Children's Health Insurance Program is provided in Appendix B of this RFP.

1.9 Definitions

Refer to **Appendix A** for a set of definitions that apply to this RFP. Additional definitions that are relevant are as follows:

1.9.1 Access

A Member's ability to obtain covered services within reasonable time limits

1.9.2 Adequate Network

A network of health care providers that is sufficient in numbers and types of providers and facilities to ensure that all services to Members will be accessible without unreasonable delay. Adequacy will be determined by a number of factors, including the types of providers available by discipline, geographic accessibility, and travel distance.

1.9.3 Adverse Determination

A determination by the Contractor that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Contractor's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, or terminated. Adverse determination must be made in accordance with Mississippi Code § 41-23-1 (4).

1.9.4 Appeals

An Appeal is an oral or written statement of a Member or provider's belief that a delay, denial, reduction, suspension, or termination of health services, in whole or in part, or a failure to approve, furnish or provide payment for same, has occurred.

1.9.5 Appropriate

The selections among available health care alternatives, which are determined to be the most effective for the Member's individual situation.

1.9.6 Benefit Plan

The benefits and the provisions for the Mississippi Children's Health Insurance Program described in the ***Rules and Regulations***, as set forth in **Appendix A** of this RFP.

1.9.7 Calendar Year Quarter

The three-month period beginning on the first day of the following months: January, April, July, and October.

1.9.8 Case Management

A process whereby medical professionals work with the patient, family, caregivers, health care providers, and the Contractor to coordinate a timely and cost-effective treatment program. Case management services

are typically used when a patient needs complex, costly, and/or high technology services, and when assistance is needed to guide the patient through a continuum of health care providers from whom services may be received.

1.9.9 Centers for Medicare and Medicaid Services (CMS)

An organization within the U.S. Department of Health and Human Services responsible for the Children's Health Insurance Program and Medicaid programs. Prior to July 1, 2001, this agency was known as the Health Care Financing Administration (HCFA).

1.9.10 Claim

A request for payment for health care related services rendered.

1.9.11 Clinical Peer Reviewer

A physician or other health care professional who holds a non-restricted license in the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

1.9.12 Continued Stay Review or Concurrent Review

An element of utilization management involving the ongoing assessment of health care as it is being provided, especially referring to, but not limited to, an inpatient confinement in a hospital.

1.9.13 Contract

As it relates to a third party administrator, the contract shall mean the agreement executed between the Board and the Contractor and shall include the Request for Proposal, any and all such addenda thereto, the Contractor's written proposal, and subsequent written clarification(s) when such formally become part of the agreement.. As it relates to a health insurance company, contract shall mean the policy approved by the State of Mississippi Department of Insurance, and the letter of understanding executed between the Board and the Contractor that shall include the Request for Proposal, any and all such addenda thereto, the Contractor's written proposal, and subsequent written clarification(s) when such formally become part of the letter of understanding.

1.9.14 Contractor

For purpose of this RFP only, a health insurance company or third party administrator (TPA) licensed by the Mississippi Department of Insurance. The term Contractor as used in this RFP shall refer to the primary Contractor, unless otherwise specified; however, the primary Contractor may subcontract certain services in accordance with the terms specified in this RFP.

1.9.15 Disease Management or Disease Management Programs

Disease management is a system of coordinated health care interventions and communication for populations with conditions in which patient self-care efforts are significant. Disease management:

a. Supports the physician or practitioner/patient relationship and plan of care;

b. Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and

c. Evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health

Disease management programs target patient populations with specific high cost conditions for which there is a substantial gap between the minimum standard of care and actual care.

1.9.16 Discharge Planning

Discharge planning is defined as the process of preparing a patient to leave a hospital. The discharge planning process is an element of utilization management and includes the gathering of pertinent information upon the Member's admission which will be needed to coordinate a timely discharge.

Discharge planning also involves the coordination of providers, patient education, Home Health Care, outpatient equipment/supplies, etc. necessary to facilitate a timely and safe transition to a non-acute hospital setting or to the patient's home.

1.9.17 Eligibility Determination

The process conducted by the Division of Medicaid by which children are determined to be eligible for CHIP.

1.9.18 Emergency Services

Services and supplies furnished or required to screen, evaluate, and/or stabilize a medical emergency. Services defined as such are listed under Section 1867 (e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical condition exists, the Contractor is obligated to pay for the covered emergency services. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-network and out–of–network coverage.

1.9.19 Enrollment

The process conducted by the Contractor by which children who have been determined eligible by the Division of Medicaid become covered under the Benefit Plan.

1.9.20 Fiscal Year (FY)

The State of Mississippi's fiscal year is July 1 through June 30. The federal fiscal year is October 1 through September 30.

1.9.21 Grievance

A Grievance is an oral or written statement of a Member or provider's belief that a delay, denial, reduction, suspension, or termination of health services, in whole or in part, or a failure to approve, furnish, or provide payment for same, has occurred.

1.9.22 HIPAA

Health Insurance Portability and Accountability Act of 1996

1.9.23 Healthcare Effectiveness Data and Information Set (HEDIS)

A set of performance measures designed by the National Committee for Quality Assurance (NCQA) to help health care purchasers understand the value of health care purchases and measure health plan performance.

1.9.24 Hospice Care

The provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members during the final stage of terminal illness. Full scope health services are centrally coordinated through an interdisciplinary team directed by a physician.

1.9.25 Independent Reviewer

Entity under contract with the Board to performs reviews/audits of the Contractor's records and performance on behalf of the Board.

1.9.26 Member

A child who is eligible and enrolled to receive health care services for which payment may be provided under the terms of the Benefit Plan. When the parent/guardian is the responsible party for the Member, references to the Member in this RFP are intended to include the parent/guardian.

1.9.27 Out-of-Network Review

The process of determining if the Contractor will allow in-network level benefits for services provided by an out-of-network provider

1.9.28 PBM

Pharmacy Benefit Manager

1.9.29 Pre-certification or Prior Authorization

An element of utilization management, the purpose of which is to determine if an admission or health care service is medically necessary. It occurs prior to an admission or prior to the commencement of services.

1.9.30 Preventive Care

Care provided to prevent disease/illness and/or its consequences. The term as used herein is to designate prevention and early detection programs, rather than restorative or treatment programs.

1.9.31 Retrospective Review

An element of utilization management, using medical records after an admission or after a course of treatment has commenced.

1.9.32 State

The State of Mississippi and its authorized agents.

1.9.33 Subcontract

An agreement between the Contractor and a provider of health care services to furnish covered medical services to Members or with any other organization or person that agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations under the terms of this Contract.

1.9.34 Subcontractor

A provider of health care services, administrative services or any other organization with which the Contractor has contracted or delegated some of the functions, services or responsibilities which the Contractor is obligated to provide under the terms of the Contract.

1.9.35 Tertiary Care

Care administered at a highly specialized medical center. It is generally associated with the utilization of high-cost technology resources.

1.10 Mississippi CHIP Census, Enrollment and Historical Claims Information

1.10.1 Census

In order to receive a copy of the census data for the Members currently enrolled in the CHIP Benefit Plan, proposers must execute and return a signed copy of the Confidentiality Agreement enclosed in Appendix C of this RFP. The census information includes gender, date of birth, and the five-digit zip code of the Member's home residence. The Confidentiality Agreement should be returned via overnight mail or facsimile to:

Cheryl Turner
Director, Special Programs
DFA - Office of Insurance
501 North West Street
901 Woolfolk Building, Suite B
Jackson, MS 39201
Fax - (601) 359-6568

1.10.2 Enrollment

The following enrollment information is provided in Appendix D to this RFP:

a) Monthly enrollment in the Children's Health Insurance Program from inception through December, 2008

b) CHIP Household language report as of December, 2008

c) Enrollment by age group 2006 through June 2008

d) Enrollment by FPL for 2006 through June 2008

1.10.3 Historical Claims Information

The following historical claims information is provided in Appendix E to this RFP:

a) Type of claims by volume for 2006 through June 2008

b) Paid claims by claim type 2006 through September 2008

c) Incurred claims by claim type 2006 through June 2008

d) Paid claims by age group 2006 through September 2008

e) Incurred claims by age group 2006 through June 2008

f) Paid claims by FPL 2006 through September 2008

g) Incurred claims by FPL 2006 through June 2008

h) Claims exceeding $75,000

i) CHIP copayment report calendar year 2007 and out-of-pocket information

j) CHIP immunization rates

k) Top 15 inpatient claims by diagnoses

l) Prescription drug claim utilization information

2. Proposal Submission and Evaluation Information

2.1 Calendar of Events

The following calendar of events has been established:

Activity	Date
RFP issued	February 18, 2009
Notice of Intent to Propose due	March 4, 2009
Written questions due	March 4, 2009
Response to questions released	March 10, 2009
Proposals due	March 30, 2009
Finalists Presentation	May 18 - 22, 2009
Site visits to finalists	June 8, 2009
Vendor Selected	June 24, 2009
Contract/Policy effective date	January 1, 2010

The Board reserves the right to adjust the calendar of events as it deems necessary.

2.2 Questions and Correspondence Regarding RFP

All questions regarding this RFP must be submitted **in writing** on or before 5:00 p.m. CT on March 4, 2009 to the attention of:

Cheryl Turner
Director Special Programs
DFA - Office of Insurance
501 North West Street
901 Woolfolk Building, Suite B
Jackson, MS 39201
Fax - (601) 359-6568
turnerc@dfa.state.ms.us

Questions may be submitted by email or facsimile, as well as by regular mail. Use of email is strongly encouraged. The proposer shall reference all inquiries by the RFP section and page number. No proposer shall seek or respond to non-written instructions.

2.3 Notice of Intent to Propose

Any interested proposers are requested to indicate, **by returning the enclosed Notice of Intent to Propose Form included in Appendix F to this RFP,** its intention to propose as a primary Contractor on or before 5:00 p.m. CDT on March 4, 2009.

Only those vendors that submit an "Intent to Propose" on March 4, 2009 will be allowed to submit questions. The Notice of Intent to Propose may be submitted via regular mail, email, or fax, with questions, or separately at the vendor's discretion. Use of e-mail is strongly encouraged. The Notice of Intent to Propose must indicate the name, title, address, direct telephone number, fax number, and email address of the person serving as your company's contact. Responses to questions will be posted on the DFA website, www.dfa.state.ms.us under "Bid and RFP Notices", and it is the Proposer's responsibility to monitor the website for such postings. The submission of a Notice of Intent to Propose does not obligate the vendor to submit a proposal. Likewise, vendors are encouraged, but not required, to submit a Notice of Intent to Propose. Also, if there are no questions concerning the RFP, the proposer should so state this in the Notice of Intent to Propose. The Notice of Intent to Propose must be addressed to the attention of:

Cheryl Turner
Director Special Programs
DFA - Office of Insurance
501 North West Street
901 Woolfolk Building, Suite B
Jackson, MS 39201
Fax – (601) 359-6568
turnerc@dfa.state.ms.us

2.4 Submission of Proposals

All proposals are due at the following location by 2:00 p.m. CDT, March 30, 2009. **Any proposals received after the deadline will not be considered.** Proposers should submit nine (9) hardcopies and two (2) copies on CD-ROM of their proposal to the following:

Nine (9) Hardcopies and
Two (2) Copies on CD ROM
Cheryl Turner
Director Special Programs
DFA - Office of Insurance
501 North West Street
901 Woolfolk Building, Suite B
Jackson, MS 39201
Fax – (601) 359-6568
turnerc@dfa.state.ms.us

The electronic copies of the proposal response are to be submitted on CD-ROM using Microsoft Word, with any Exhibits provided to vendors in this RFP in Microsoft Excel, submitted via the CD-ROM using Microsoft Excel.

2.5. Proposal Format

This section outlines the requirements that govern determination of compliance of a proposer's response to the RFP. Proposals not containing the information required in this section may be considered unacceptable by the Board.

a) Each copy of the proposal should be numbered and placed in a three-ring binder.

b) Tabs should be used to divide all sections and each attachment. Tabs must extend beyond the right margin of the paper so that it can be read from the side and is not buried within the document.

c) Order of presentation:

Section 1) Cover letter – Note: Proposers are to indicate in the cover letter to the proposal response how each of the minimum requirements set forth in **Section 2.14** are met.

Section 2) Statement of Compliance (see Appendix G)

Section 3) DHHS Certification Regarding Debarment, Suspension, and other Responsibility Matters (see Appendix U)

Section 4) Answers to the questionnaire in **Section 16** of this RFP

Section 5) Completed Fee Quotation and Administrative Expense Illustration Forms (see Appendices H and I).

Section 6) Required Exhibits A through R to supplement questionnaire response – Note: Exhibits should be set forth in the proposal response in the same order as requested in **Section 16** of this RFP.

Section 7) Appendix of other materials included in proposal response

d) A proposer's response to this RFP must be submitted in writing. In preparing your response to any RFP question or request for information, you should repeat each question or requirement and then state your response. Provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g. your company does not collect or furnish certain information), indicate the reason rather than providing general information that fails to answer the question. All information requested is considered important. If you have additional information you would like to provide, include it as an attachment. The information contained in your response to this RFP will be used by the Board in determining whether or not you will be selected. The proposal the Board selects will be a working document. As such, the Board will consider the proposal an integral part of any final contract and will expect that all representations made in the proposal will be honored. It is the proposer's sole responsibility to submit information relative to the evaluation of his proposal and the Board is under no obligation to solicit such information if it is not included with the proposer's proposal. Failure of the proposer to submit such information may cause an adverse impact on the evaluation of the proposer's proposal. All documentation submitted in response to this RFP and any subsequent requests for information pertaining to this RFP shall become the property of the Board and will not be returned to the proposer.

FAILURE TO PROVIDE ALL OF THE REQUESTED INFORMATION MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

2.6 Acknowledgment of Amendments

Should an amendment to the RFP be issued, it will be posted on DFA's website at www.dfa.state.ms.us under "Bid and RFP Notices". Further, proposers must acknowledge receipt of any amendment to the RFP by signing and returning the amendment form with the proposal, by identifying the amendment number and date in the space provided for this purpose on the amendment form, or by letter. The acknowledgment must be received by DFA by the time and at the place specified for receipt of proposals. It is the proposer's sole responsibility to monitor the website for amendments to the RFP.

2.7 Representation Regarding Contingent Fees

By submission of a proposal, the proposer represents that it has not retained any person or agency to solicit or secure a State contract upon an agreement or understanding for a commission or a percentage, brokerage, or contingent fee. The State will not pay any brokerage fees for securing or executing any of the services outlined in the RFP. Therefore, all proposed fees must be the net of commissions and percentage, contingent, brokerage, service fees, or finders' fees.

2.8 Representation Regarding Gratuities

By a submission of a proposal, the proposer represents that it has not violated, is not violating, and promises that it will not violate any prohibition against gratuities as set forth in Section 7-204 (Gratuities) of the Mississippi Personal Services Contract Procurement Regulations, a copy of which may be obtained by contacting the Mississippi State Personnel Board located at 301 North Lamar Street, Suite 100, Jackson, Mississippi or by accessing the website at www.spb.state.ms.us.

2.9 Certification of Independent Price Determination

By submission of a proposal, the proposer certifies that the prices submitted in response to the RFP have been arrived at independently and without – for purposes of restricting competition – any consultation, communication, or agreement with any other proposer or competitor relating to those prices, the intention to submit a proposal, or the methods or factors used to calculate the fees proposed.

2.10 Corrections and Clarifications

The Board reserves the right to request clarifications or corrections to proposals. Any proposal received which does not meet the "Minimum Vendor Requirements", Proposal Format requirements in **Section 2.5** of this RFP, or does not comply with other proposal requirements may be considered to be "non-responsive" and may be rejected.

2.11 Right of Negotiation

Discussions and negotiations regarding pricing and other matters may be conducted with proposer(s) who submit proposals determined to be reasonably susceptible of being selected for award, but proposal(s) may be accepted without such discussions. The Board reserves the right to further clarify and/or negotiate with the "proposer evaluated best" following completion of the evaluation of proposals but prior to Contract execution, if deemed necessary by the Board. The Board also reserves the right to move to the next best proposer(s) if negotiations do not lead to a final Contract with the best proposer(s).

2.12 Withdrawal of a Proposal

A proposer may withdraw a submitted proposal by submitting a written notification for its withdrawal to the Board, signed by the proposer, and mailed to the contact listed in **Section 2.4** of this RFP. The Board shall not accept any amendments, revisions, or alterations to proposals after the due date unless requested by the Board. **The Board reserves the right to further clarify and/or negotiate with the proposer(s) on any matter submitted.**

2.13 Cost of Proposal Preparation

All costs incurred by the proposer in preparing and delivering its proposal and any subsequent time and travel to meet with the Board regarding the proposal, shall be at the proposer's expense.

2.14 Minimum Vendor Requirements

The following proposal requirements are mandatory. Failure to meet any of these proposal criteria as of the proposal due date will result in the disqualification of a proposal.

2.14.1 Primary Contractor Minimum Requirements

a) Has a minimum of five years of experience in providing similar services to those requested in this RFP.

b) Currently provides similar services to those requested in this RFP to at least one group, with at least 50,000 covered lives (includes active employees, retirees, COBRA, and dependents). This requirement can be met if the proposer currently services a federal or state medical assistance program, i.e., Medicare, Medicaid, or SCHIP with at least 50,000 covered lives.

c) Provides similar services to those requested in this RFP to a total covered population of at least 300,000 covered lives (includes active employees, retirees, COBRA, Medicare, Medicaid, SCHIP, and dependents).

d) Is currently licensed as required by the State of Mississippi, or agrees to become licensed at least 60 days prior to the effective date of the Contract resulting from this RFP.

e) Agrees to secure a blanket fidelity bond, effective January 1, 2010, in the amount of two million dollars ($2,000,000) naming the Board as exclusive beneficiary for the duration of the Contract. Pursuant to such bond, any losses incurred by the Board due to the dishonesty of the Contractor's employees or Subcontractors shall be fully payable to the Board. The Contractor shall be responsible for procuring any such recovery and reimbursing the Board accordingly.

f) Agrees to secure a performance bond, within 60 days after selection of the Contractor by the Board, in the amount of one million dollars ($1,000,000) naming the Board as exclusive beneficiary. Pursuant to such bond, any failure of the Contractor to perform timely and complete implementation of the services as described in a mutually agreed upon implementation plan shall be recoverable to the Board.

g) To the extent any services are to be Subcontracted, has executed contracts (i.e. family planning, vision, hearing, nurse triage), or letters of commitments that demonstrates each Subcontractor's willingness to undertake their portion of the

proposed project. Preference in the evaluation process shall be given in the following order: executed contracts, letters of commitments.

h) Currently holds SAS70 Type II certification detailing description of controls, as well as testing of controls over a minimum six month period

i) Agrees to establish a satellite office within the State of Mississippi providing the functions as described in **Sections 9** and **10**, at least 30 days prior to the effective date of the Contract.

2.14.2 Subcontractor Minimum Requirements

a) Has been providing the services they will be performing under this contract on an ongoing basis for at least five years.

b) Currently provides similar services to those requested in this RFP to at least one group, with at least 50,000 covered lives (includes active employees, retirees, COBRA, and dependents). This requirement can be met if the proposer currently services a federal or state medical assistance program, i.e., Medicare, Medicaid, or SCHIP with at least 50,000 covered lives. Note: This requirement only applies to the Medical Provider Network, the Pharmacy Benefit Manager, and the Utilization Management Vendor, to the extent it is appropriate for the services being subcontracted.

c) Has provided the services they will be performing under this contract to a total covered population of at least 300,000 covered lives (includes active employees, retirees, COBRA, Medicare, Medicaid, SCHIP, and dependents). Note: This requirement only applies to the Medical Provider Network, the Pharmacy Benefit Manager, Utilization Management Vendor, to the extent it is appropriate for the services being subcontracted.

d) Is currently licensed as required by the State of Mississippi or agrees to become licensed at least 60 days prior to the effective date of the Contract resulting from this RFP.

2.15 Mississippi Public Records Act/Statement of Confidentiality

Any proposal, including accompanying attachments, will be available for review by the State and School Employees Health Insurance Management Board, members and staff of the legislature, or oversight boards appointed by the legislature, the Mississippi Division of Medicaid and the State's consultants.

The proposal is further subject to the "Mississippi Public Records Act of 1983," codified as Section 25-61-1 et seq., Mississippi Code Annotated (1983) and exceptions found in Section 79-23-1 of the Mississippi Code. The Board understands that you may consider some of the information required to be provided in this RFP to be proprietary. The statute listed above provides that you can request, prior to the release of any information, to be notified by the Board of the request for the information and given sufficient time to seek protection from the appropriate court. If you do not seek and obtain protection from the appropriate court, all information supplied, whether marked confidential or not, may be released. The Board requests that each page of your proposal that you consider to be confidential be on a different color paper than non-confidential pages and be marked in the upper right hand corner with the word "CONFIDENTIAL." No additional restrictions on the release of information contained in your proposal will be accepted by the Board.

2.16 Transparency, Full Disclosure and Independent Review

While this section is more closely aligned with self-insured proposals, the same guidelines and processes are also to be applied for the Contractor's insured proposal. Thus, complete transparency as stated in **Sections 2.16.1** and **2.16.2** must be provided which will result in the Contractor offering the lowest net insured premiums paid by the Board. The provisions for Contractor disclosure as stated in **Section 2.16.3** (a) must be provided by the Contractor to confirm the transparency provisions of **Sections 2.16.1** and **2.16.2** in the development of the insured premium rates. The provisions of Independent Review as stated in **Section 2.16.3** (b) must also be provided for the Contractor's insured proposal.

2.16.1 All Services

The Contractor shall provide a transparent financial pricing arrangement to the Board relative to the services under this contract. The parties agree that "transparency" shall refer to financial arrangements which represent a direct and complete pass-through of all elements of negotiated provider pricing (e.g. discounts & dispensing fees, etc.). The Board must receive the full and complete amount of any discounts received by the Contractor from any and all service areas. The Contractor will not retain a differential (i.e. spread) between the amount reimbursed to the Contractor by the Board for each transaction and the payments made to the service providers by the Contractor.

2.16.2 PBM Services Only

a) The Board will not apply the above standard to specialty pharmaceutical transactions when owned by the Contractor. For these specialty pharmaceuticals the Board will accept the best possible discount arrangements from the Contractor as it relates to a discount from Average Wholesale Price (AWP). Rebates generated through specialty pharmaceuticals will be subject to the transparency requirement described below.

b) The Contractor shall remit to the Board all rebates received by the Contractor attributable to the Board's utilization that the Contractor receives from any and all service areas. A "rebate" will include any amounts received directly or indirectly by the Contractor, regardless of title or description, whether by cash, credit or other in kind methodologies attributable to the Board's utilization. Reimbursement for research projects based on data analysis not specifically attributable to the Board's utilization data is not included in this requirement and may be retained by the Contractor.

c) The only compensation the Contractor will receive from or on behalf of the Board, for the Pharmacy Benefit Management services described in this proposal or any subsequent contract, shall be the Contractor's quoted self-insured administrative fees listed in the Contractor's proposal.

2.16.3 All Services

a) The Board must have access to all of the Contractor's and Subcontractors' financial records, claims data, remittance data, contracts (e.g. provider network, etc.), reports and other information, related to this Contract, and required by the Board to verify that the Transparency requirement is being met by the Contractor during the period covered by the contract.

Full disclosure as used herein would include, but not be limited to, auditing the following types of financial arrangements:

1) Any amount paid for the Benefit Plan by the Contractor for services under contract with the Contractor is subject to audit even though the Contractor may deem said contracts proprietary and confidential;

2) Fees, which include administrative fees, paid to the Contractor are subject to review for audit purposes;

3) Discounts negotiated directly by the selected Contractor with medical providers shall be subject to audit;

4) Any amount paid for the Benefit Plan by the selected Contractor to specialty pharmacy, when <u>not</u> owned by the selected Contractor, will be subject to audit, whether or not the contract is considered proprietary and confidential by the selected Contractor;

5) Discounts negotiated directly by the selected Contractor with manufacturers and/or pharmacy providers shall be subject to audit; and

6) Aggregate rebate reporting

b) The Board and/or DOM, at their discretion may, use the services of an Independent Reviewer(s), to perform reviews/audits of the Contractor's records on. The Board and/or DOM and respective independent reviewers will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. The Board and/or DOM have the right to review/audit records for the entire term of this contract without limitation Any claimed information, documents, etc. which the Contractor may deem as containing "trade secrets" or "confidential" will not preclude an examination of such items through the audit process. The Contractor will provide the Board and/or DOM assistance in the audit reviews by providing access to records, copies of claims data tapes, access to reasonable support staff. The Board and/or DOM will bear the cost of any fees charged by their respective independent reviewer. The Independent Reviewer will sign a confidentiality statement with the Contractor insuring that the Contractor's financial records, claims data, remittance data, contracts (including the details and terms of the Contractor's contracts with Participating Providers and pharmaceutical manufacturers and intermediaries) and fees outlined in **Section 2.16.1** of this Contract will be treated as confidential to the Contractor and will not be revealed in any manner or form by or to any person or entity other than the Board and/or DOM and the Board's and/or DOM's attorney. Notwithstanding the aforementioned, the Board and/or DOM reserve the right to conduct a review of any and all records deemed necessary to any special investigation by the Board and/or DOM.

c) For the purpose of measuring compliance with Contract performance standards, the report and determination of the Board's independent reviewer shall be final, binding and conclusive on the Contractor and the Board; provided, however, that before a final report and determination is issued, the Board and the Contractor shall each have a reasonable opportunity to review the independent reviewer's non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer. Nothing in this section shall limit or prevent, in any way, the remedies available to the Board as provided in **Section 3.20** of this Contract.

2.17 Contract Conditions

Section 3 contains standard statutory and Contract provisions and Appendix G contains the Statement of Compliance. Please review **Section 3** of the RFP carefully and include a signed Statement of Compliance as **Section 2** of your completed proposal. FAILURE TO SUBMIT A SIGNED STATEMENT OF COMPLIANCE WILL RESULT IN YOUR PROPOSAL BEING ELIMINATED FROM FURTHER CONSIDERATION.

2.18 DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

By submission of a proposal, the proposer certifies that it is not currently debarred from submitting bids for contracts issued by any political subdivision or agency of the State of Mississippi and is not an agent of a person or entity that is currently debarred from submitting bids for contracts issued by any political subdivision or agency of the State of Mississippi. In addition, Appendix U contains a DHHS Certificate Regarding Debarment.

Each proposer submitting a proposal must complete this certificate and submit with its proposal. FAILURE TO SUBMIT A SIGNED CERTIFICATE WILL RESULT IN YOUR PROPOSAL BEING ELIMINATED FROM FURTHER CONSIDERATION.

2.19 Duration of Proposal

Within the proposal, you must state that your proposal is valid for a period of at least 270 days following the date of submission. The proposal shall become part of the Contract in the event the Contract is awarded to your organization.

2.20 Proposal Evaluation Criteria and Process

A comprehensive, fair and impartial evaluation of proposals received in response to this Request for Proposal will be conducted. An evaluation committee will evaluate the proposals in the following three-phase process:

2.20.1 Phase One

In Phase One of the evaluation process, all proposals received will be reviewed to determine if the following mandatory requirements of this RFP have been satisfied:

a) Proposal submission deadline met

b) Minimum vendor requirements in **Section 2.14** are met

c) Required format followed

d) Original and requested number of copies of proposal have been provided

e) Signed Statement of Compliance provided and degree of acceptance of Contract terms

f) Narrative questionnaire answered

g) Duration of proposal requirements in **Section 2.19** are met

h) Required exhibits to RFP provided

Failure to comply with the mandatory requirements may result in rejection of a proposal. This is a pass/fail evaluation. The Board reserves the right to waive minor informalities in a proposal in this phase of the evaluation.

2.20.2 Phase Two

In Phase Two of the evaluation process, the evaluation committee will judge responses received relative to the cost and technical merits of each proposal. Areas are listed in order of their relative importance:

a) Experience/Qualification

b) Cost (i.e. provider discounts, administrative fees, total premium)

c) Member Access, Provider Match, Provider Network and Services

d) Medical Management, Pharmacy Benefit Management, Vision, Dental, Nurse Triage and Disease Management Programs

e) Member Services

f) Organizational Stability, Administrative and Management Information Systems, Administrative Staff and Procedures, and Quality Assurance Programs

Only those proposers selected as finalists, as a result of this process, will proceed to the third phase of the evaluation process.

2.20.3 Phase Three

In Phase Three of the evaluation process, references will be contacted and service provision verified.

a) Finalists presentations will consist of technical "question and answer" interviews to be conducted in the offices of the Mississippi Department of Finance and Administration to allow finalist the opportunity to showcase their service area. Likewise, Board members, consultants and staff may use this opportunity to verify information provided by the vendor in the submitted proposal.

b) On-site reviews will be conducted to clarify or verify the proposer's proposal and to develop a comprehensive assessment of the proposal. During this Phase of the evaluation, each finalist will be required to provide additional information, including but not limited to more detailed information regarding the proposed provider network and negotiated discount arrangements with network providers including access to all

provider contracts and proposed pharmacy pricing information. A disruption analysis may be conducted during this phase of the evaluation and each finalist may be required to provide detailed information regarding their proposed provider network, including provider tax ID numbers, in a specified electronic format.

2.21 Right to Consider Historic Information

The Board reserves the right to consider historical information regarding the proposer, whether gained from the proposer's proposal, question and answer conferences, references, site visits, or any other source during the evaluation process.

2.22 Provider Network – Letters of Commitments/Contracts

In the evaluation process, the Contractor's provider network will only be evaluated to the extent that the Contractor has executed contracts and letter of commitments with providers.

2.23 Proposer is Solely Responsible to Submit all Relative Information

The proposer is cautioned that it is the proposer's sole responsibility to submit information related to the evaluation categories and that the evaluation committee and/or Board is under no obligation to solicit such information if it is not included with the proposer's proposal. Failure of the proposer to submit such information may cause an adverse impact on the evaluation of the proposer's proposal.

2.24 Site Visits After Award of Contract

After award of the Contract, representatives from the Board or its designees may conduct on-site reviews of the organization (including any Subcontractors) awarded the Contract. The purpose of these on-site reviews is to assess the capability of the organization to meet program standards and implementation standards as described in this RFP. By submission of a proposal, the Contractor agrees to an on-site review.

2.25 Right to Reject, Cancel, and/or Issue another RFP

Issuance of this RFP does not constitute a commitment by the Board to award a Contract. The Board specifically reserves the right to reject any or all proposals received in response to this RFP, cancel the RFP in its entirety, or to issue another RFP.

2.26 Primary Contractor Responsibility

The selected Contractor is required to assume responsibility for all required services described in this RFP. Further, the Board will consider the selected Contractor to be the sole point of contact with regard to contractual matters. The Board will not execute a contract with more than one vendor, although subcontracting arrangements are permissible. If the primary Contractor subcontracts the responsibilities of this Contract, the primary Contractor must cause the Subcontractor to meet the terms and requirements of this Contract including all rights to audit terms.

2.27 Contract Transition Requirements

Upon termination or expiration of the Contract resulting from this RFP, the Contractor must agree to perform each of the following activities in order to transition Contract operations to a subsequent Contractor.

a) Upon termination of this Contract, the Contractor shall fully cooperate with the Board and the successor during the transition of the Children's Health Insurance Program to the new Contractor. Upon request of the Board, the Contractor shall provide all information maintained by the Contractor in relation to the Children's Health Insurance Program in a time frame specified by the Board. Information provided shall be in a format designated by the Board. The Contractor shall provide such explanation of the information provided as to facilitate a smooth transition. Explanations of the information shall include, but not be limited to, file layouts, data dictionary, and legends.

b) Arrange for the timely and orderly transfer of records to the new Contractor for cases being handled through case management or identified as potential candidates for case management activities and for any Members who are confined as an in-patient at a Hospital as of the date of Contract termination.

c) Be financially responsible for (insured product), or adjudicate claims (self-insured product) with dates of service through 11:59 p.m. on the day of Contract termination, including those claims for which payment is denied by the Contractor and subsequently approved upon appeal.

d) Be financially responsible (insured product) for Member Grievances or handle all Appeals (self-insured product) of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination, which are subsequently overturned at a Grievance or Appeal proceeding.

e) Promptly handle all complaints, Grievances, and Appeals for claims incurred prior to the Contract termination.

f) Pursuant to HIPAA, issue certificates of creditable coverage to all Members covered under the Benefit Plan as of the Contract termination date.

g) Any costs associated with providing the above services will be the responsibility of the Contractor selected through this RFP.

2.28 Change in the Children's Health Insurance Program Administration

In the event the Mississippi State and School Employees Health Insurance Management Board's administrative responsibilities relative to the Children's Health Insurance Program are transferred to the Mississippi Division of Medicaid (DOM) prior to an award being made from this RFP, DOM may elect to consider your proposal for possible award, or reject all submitted proposals and conduct a new RFP process. By submission of a proposal in response to this RFP, you agree that all terms, conditions, offers and representations contained in your proposal are valid regardless as to which entity (the Board or DOM) awards the Contract.

3. Statutory Requirements and Draft Contract Clauses

3.1 Contract Clauses In General

The following contract clauses will be included in the Contract along with the Sample Business Associate Statement (Appendix X) and such other clauses as are needed to delineate the Contractor's responsibilities to provide health insurance coverage and related administrative services. The Contract is subject to approval by the Board, and if awarded to a Third Party Administrator, to the approval of the Mississippi State Personal Services Contract Review Board.

3.2 Contract Term

a) The effective date of this Contract will be January 1, 2010. The Contract's term will be for four (4) years with a one year option to renew, based solely at the Board's discretion. By September 1, 2013, the Board will notify the Contractor, in writing, of the Board's intent as to renewal of the Contract for one additional year. The effective date of the Services administered by the Contractor shall be January 1, 2010. The Contractor shall fully implement the program by January 1, 2010.

b) This Contract may be terminated by either party, with or without cause, upon at least ninety (90) days prior written notice of intent to terminate provided to the other party.

c) All records and information provided by the Board to the Contractor are the sole property of the Board and shall be returned to the Board within thirty (30) days of the termination date of this Contract. The Contractor shall be entitled to retain and utilize data that have been captured, computed, or stored in the Contractor's databases to the extent that such data cannot be identified or linked to the Board, Children's Health Insurance Program or member.

d) Upon termination of this Contract, the Contractor shall fully cooperate with the Board and the successor during the transition of the Children's Health Insurance Program to the new Contractor. Upon request of the Board, the Contractor shall provide all information maintained by the Contractor in relation to the Children's Health Insurance Program in a time frame specified by the Board. Information provided shall be in a format designated by the Board. The Contractor shall provide such explanation of the information provided as to facilitate a smooth transition. Explanations of the information shall include, but not be limited to, file layouts, data dictionary, and legends.

3.3 Consideration

a) The Division of Medicaid (DOM) shall not provide any prepayments or initial deposits in advance of services being rendered. Only those services agreed to by Contract shall be considered for reimbursement/compensation by the DOM. Payment for any and all services provided by the Contractor to the Board and/or the Children's Health Insurance Program shall be made only after said services have been duly performed and properly invoiced.

b) In consideration for the services provided by the Contractor under this Contract, the DOM shall compensate the Contractor, proposing as a Self-Insured Vendor, through administrative fees illustrated in Appendix H-II "Self-Insured Fee Quotation Form" of this Contract. In consideration for the services provided by the Contractor, proposing as a Fully-Insured Vendor, the DOM shall compensate the Contractor the total monthly billable premium rate as illustrated in Appendix H-I "Insured Fee Quotation Form". All invoices for health insurance premiums, self-insured administrative fees and any authorized pass-through payments rendered by the Contractor must be submitted, to the Board and DOM on a monthly basis, in sufficient detail and format as determined by the Board and/or DOM

Such invoices must include, at a minimum, a description of the service(s) provided, the quantity or number of units billed, the compensation rate, the time period in which the services were provided, total compensation requested for each individual service being billed and the total amount due the Contractor for the period invoiced.

Premiums for insurance coverage provided by the Contractor must be invoiced in advance on a monthly basis, in sufficient detail and format as determined by the Board and/or DOM. Premium invoices must provide separate counts and amounts for each enrollment category and rate/fee billed, and must agree to the appropriate statistical counts included in the Contractor's enrollment report for the period being billed. Premium invoices should be submitted to the Board and DOM at the first of each month for which coverage is to be provided. Self-insured administrative fee invoices will be paid in arrears, and must provide clear definition of the rate/fee billed. All invoices shall be submitted to the Board and DOM at the first of each month for review and approval. Upon advice from the Board, a monthly payment for all approved invoices shall be made by the DOM utilizing electronic fund transfers. Payment for any undisputed amounts should be received by the Contractor within ten (10) days from the date the invoice and supporting documentation was submitted to the Board and DOM.

For self-insured administrative fees, the DOM agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies", Section 31-7-301, et seq. of the 1972 Mississippi Code Annotated, as amended, which generally provides for payment of undisputed amounts within forty-five (45) days of receipt of the invoice.

Payments shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the Contractor's choice. The State may, at its sole discretion, require the Contractor to submit invoices and supporting documentation electronically at any time during the term of this Contract. The Contractor understands and agrees that the State is exempt from the payment of sales and use taxes. All payments shall be in United States currency.

c) The payment of an invoice by the DOM shall not prejudice the DOM's right to object or question any invoice or matter in relation thereto. Such payment by the DOM shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. The Contractor's invoice or payment may be subject to further reduction for amounts included in any invoice or payment theretofore made which are determined by the DOM, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment or increased for underpayment on subsequent invoices.

For any amounts which are or shall become due and payable to the DOM and/or the Children's Health Insurance Program by the Contractor, the DOM reserves the right to:

(1) deduct from amounts which are or shall become due and payable to the Contractor under Contract between the parties; or

(2) request and receive payment directly from the Contractor within fifteen (15) days such request, at the DOM's sole discretion.

d) The Contractor agrees to the performance standards and liquidated damages relative to such services as outlined in **Section 13** "Performance Standards and Liquidated Damages" of this Contract.

3.4 Identity of and Relationship Between the Parties

The Mississippi State and School Employees Health Insurance Management Board ("Board") acting administratively through the Department of Finance and Administration ("DFA"), an agency of the State of Mississippi, administers the health insurance component of the Mississippi Children's Health Insurance Program ("CHIP"). DFA acts on behalf of the Board in executing the Board's day-to-day operational responsibilities concerning CHIP.

The Contractor is an independent legal entity contracted by the Board to provide health insurance coverage and administrative services relative to CHIP.

The Contractor and the Board are independent legal entities. Nothing in this Contract shall be construed to create the relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Contract. It is expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any Subcontractor and the Board.

Neither the Contractor nor the Board nor any of their respective agents or employees shall control or have any right to control the activities of the other party in carrying out the terms of this Contract, nor shall either party, its respective agents or employees, be liable to third parties for any act or omission of the other party.

Nothing in this Contract is intended to be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.5 Status of the Contractor

It is expressly agreed that the Contractor or any Subcontractor is an independent Contractor performing services for the Board and is not an officer or employee of the State of Mississippi or the Board. The Contractor shall not act as an agent for the State. No act performed or representation made, whether oral or written, by the Contractor with respect to third parties shall be binding to the Board.

The Contractor shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should the Contractor default in these or other responsibilities, jeopardizing the Contractor's ability to perform services effectively, at the Board's sole discretion, this Contract may be terminated for default.

The Contractor shall give the Board immediate notice in writing of any action or suit filed or of any claim made by any approved Subcontractor, vendor, or other party which might reasonably be expected to result in litigation related in any manner to this Contract or which may impact the Contractor's ability to perform.

The Contractor shall not use the Board's name or refer to this Contract directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from the Board.

3.6 Compliance with State and Federal Requirements

The Contractor shall agree to conform to any requirements or regulations imposed on the State as a condition of continued funding by the Department of Health and Human Services (DHHS) or due to changes in State and/or Federal law. The Contractor shall conform to all applicable Federal, State, and local laws, regulations and policies as they exist or as amended.

The Contractor agrees that all work performed as part of this Contract will comply fully with administrative and other requirements established by the Federal and State of Mississippi laws, regulations, and guidelines and agrees to fully reimburse the State for any loss of funds, overpayments, duplicate payments, or incorrect payments resulting from noncompliance by the Contractor, its staff, agents, or Subcontractors as revealed in any subsequent audits.

It is expected that each proposer is aware of these and all other federal regulations and requirements governing health care administration and has, as part of their proposal, the necessary components and functionality to maintain the Children's Health Insurance Program's continued compliance with the regulations.

3.7 Compliance with Mississippi Department of Insurance

The Mississippi Department of Insurance regulates licensed health plans and third party administrators in Mississippi. The Contractor shall agree to comply with all applicable insurance laws of the State of Mississippi and Department of Insurance rules, regulations, and standards in addition to the specific standards described in the RFP.

3.8 Applicable Law/Venue

This Contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflicts of laws provisions. The Contractor shall comply with applicable federal, state, and local laws and regulations. Venue for any action shall be in the First Judicial District, Hinds County, Mississippi.

3.9 Employee Status Verification

The Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act (Senate Bill 2988 from the 2008 Regular Legislative Session) and will register and participate in the status verification system for all newly hired employees. The term employee as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, status verification system means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. The Contractor agrees to maintain records of such compliance and, upon request of the State, to provide a copy of each such verification to the State. The Contractor further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration

laws of the State of Mississippi. The Contractor understands and agrees that any breach of these warranties may subject the Contractor to the following: (a) termination of this Contract and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to the Contractor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both. In the event of such termination/cancellation, The Contractor would also be liable for any additional costs incurred by the State due to contract cancellation or loss of license or permit.

3.10 Cooperation with Board

The Contractor shall cooperate with the Board and with all other Contractors of the Board with respect to the ongoing performance under this Contract and in any transition of responsibilities.

3.11 Ownership of Information and Data

The Board, Centers for Medicare and Medicaid (CMS), the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor resulting from this Contract.

The Contractor agrees to grant to the Board, the United States Department of Health and Human Services (DHHS), Mississippi Division of Medicaid, CMS, and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information not covered by copyright of the Contractor relating to this Contract.

3.12 Access to Records/Right of Inspection

The Contractor agrees that data contained on tapes, discs, files, batch files, and other records pertinent to the Children's Health Insurance Program and the Health Care Services received by Members, unless prohibited by law, are the property of the Board and must be made capable of separate retrieval and distribution.

The Contractor shall provide to the Board written procedures documenting the security and offsite storage of all such records. The Contractor shall provide to the Board, upon request, a copy of the procedures throughout the term of the Contract.

No other agreements of any kind may be made by the Contractor with any other party for furnishing any information or data accumulated by the Contractor under this Contract, contained in the subsystems, or used in the operation of the Children's Health Insurance Program without the written approval of the Board. Specifically, the Board reserves the right to review any data released from the reference files, subsystems, reports, histories, or data files created pursuant to this Contract.

The Contractor agrees that the Board or any of its duly authorized representatives, the Mississippi Division of Medicaid, the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency prior-approved by the Board, at any time during the term of this Contract, shall, at all reasonable times, have the right to enter onto the Contractor's or Subcontractor's premises and shall have access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, and records and/or to otherwise evaluate (including periodic information systems testing) the performance of the Contractor and all Subcontractors related to the Contractor's charges and performance under this Contract. All reviews and audits shall be performed in such a manner as will not unduly delay the work of the Contractor.

Refusal by the Contractor to allow access to all documents, papers, letters, or other materials shall constitute a breach of this Contract.

Such records shall be kept by the Contractor for a period of six (6) years after final payment under this Contract, unless the Board authorizes in writing their earlier disposition. The Contractor is to refund to the Board any overpayment disclosed by any such audit. However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 6-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it and for one year thereafter. The Board shall also retain the right to perform financial, performance, and other special audits on such records maintained by the Contractor during regular business hours throughout the Contract period. The Contractor agrees that confidential information including, but not limited to, medical and other pertinent information relative to Members shall not be disclosed to any person or organization for any purpose without the expressed, written authority of the Board or as otherwise required by law and that all such disclosures fully comply with HIPAA privacy and security standards.

3.13 Records Retention and Audit Requirements

The Contractor's accounting records and procedures relative to this Contract are subject to the Board and applicable Federal approval. Accounting procedures, policies, and records shall be completely open to the Board, State, and Federal audit at any time during the Contract period and for six (6) years thereafter. The Contractor agrees that the Board, Division of Medicaid, State of Mississippi, and federal funding and oversight agencies of CHIP have the right to audit all records maintained by the Contractor relative to this Contract. The Board shall also maintain the right to perform financial, claim and performance reviews, and other special audits on such records.

The Contractor shall agree to the following terms for access to records relating to the Contract:

a) All original paper claims adjudicated under the Contract shall be imaged when received and retained for a minimum of thirty (30) days. Copies of all claims shall be stored on microfilm or electronic media. Storage shall be at a site mutually agreed upon by the Board and the Contractor. Microfilm or CD copies of all paper claims and related records shall be retained for the duration of the Contract and turned over to the Board or its designated agent, if so requested by the Board, at the conclusion of this Contract;

b) All electronic media claims and related records shall be retained for a period of six (6) years;

c) Unless the Board specifies in writing a shorter period of time, the Contractor agrees to preserve and make available all other pertinent books, documents, papers, and records of the Contractor involving transactions related to the Contract for a period of six (6) years from the date of expiration or termination of the Contract;

d) All original canceled checks and EFT documents shall be retained for a minimum of six (6) years from the date of issuance unless otherwise agreed by the Board; storage shall be at a site mutually agreed upon by the Board and the Contractor. All requests for information and/or copies of documents from the Board must be provided by the Contractor to the Board at the site designated by the Board in Jackson, Mississippi at no cost to the Board;

e) Records and supporting documentation under audit or involved in litigation shall be kept for one (1) year following the conclusion of the litigation or audit;

f) The Contractor shall agree that authorized Federal, State, Board's and/or DOM's representatives shall have access to and the right to examine the items listed above during

the 6-year-post-contract period or until resolution. During the Contract period, the access to these items will be provided at the Contractor's office, or if the Contractor's office is not located within Hinds, Madison, or Rankin counties of the State of Mississippi, the Contractor shall provide any requested documents at a site designated by the Board and/or DOM, at no cost. The Board and/or DOM and authorized Federal and State representatives shall always have access to and the right to examine items listed above at the Contractor's office during the 6-year-post-contract period or until resolution. During the 6-year-post-contract period, delivery of and access to the listed items will be at no cost;

g) The Contractor shall provide copies of its internal audits and quality assurance reports or a copy of its annual audit conducted on the processing of transactions, pursuant to Statement on Auditing Standards (SAS) #70, upon the request of the Board and/or DOM.

h) The Board and/or DOM, at their discretion may, use the services of an independent reviewer(s), to perform reviews/audits of the Contractor's records on. The Board and/or DOM and respective independent reviewers will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. The Board and/or DOM has the right to review/audit records for the entire term of this Contract without limitation Any claimed information, documents, etc. which the Contractor may deem as containing "trade secrets" or "confidential" will not preclude an examination of such items through the audit process. The Contractor will provide the Board and/or DOM assistance in the audit reviews by providing access to records, copies of claims data tapes, access to reasonable support staff.. The Board and/or DOM will bear the cost of any fees charged by their respective independent reviewer. The independent reviewer will sign a confidentiality statement with the Contractor insuring that the Contractor's financial records, claims data, remittance data, contracts (including the details and terms of the Contractor's Contracts with Participating Providers and pharmaceutical manufacturers and intermediaries) and fees outlined in **Section 2.16.1** of this Contract will be treated as confidential to the Contractor and will not be revealed in any manner or form by or to any person or entity other than the Board and/or DOM and the Board's and/or DOM's attorney. Notwithstanding the aforementioned, the Board and/or DOM reserve the right to conduct a review of any and all records deemed necessary to any special investigation by the Board and/or DOM.

i) For the purpose of measuring compliance with Contract performance standards, the report and determination of the Board's independent reviewer shall be final, binding and conclusive on the Contractor and the Board; provided, however, that before a final report and determination is issued, the Board and the Contractor shall each have a reasonable opportunity to review the independent reviewer's non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer.

Nothing in this section shall limit or prevent, in any way, the remedies available to the Board as provided in **Section 3.20** of this Contract.

3.14 Accounting Requirements

The Contractor shall maintain books, records, documents, and other evidence pertaining to the premiums and administrative costs and expenses of the Contract to the extent and in such detail as shall properly reflect all revenues, all costs, direct and apportioned, and other costs and expenses of whatever nature as

relative to performance of contractual duties under the provisions of this Contract. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles, and the costs properly applicable to the Contract shall be readily ascertainable therefrom. The Contractor shall provide to the Board at the time frames specified by the Board invoices in a format as designated by the Board.

3.15 Release

Upon final payment of the amounts due under this Contract, the Contractor shall release the State from all liabilities and obligations whatsoever under or arising from this Contract. Payment to the Contractor by the State shall not constitute final release of the Contractor. Should an audit or inspection of the Contractor's records subsequently reveal outstanding Contractor liabilities or obligations, the Contractor shall remain liable to the State for such liabilities and obligations. Any payment by the State shall be subject to any appropriate recoupment to which the State is lawfully entitled. Any payment under this Contract shall not foreclose the right of the State to recover excessive illegal payments as well as interest, attorney fees, and costs incurred in such recovery.

3.16 Assignment/Subcontracting

The Contractor shall not assign or subcontract, in whole or in part, its rights or obligations under this Contract without prior written consent of the Board. Any attempted assignment or subcontract without said consent shall be void and of no effect.

3.17 Subcontractor Approval

Any Subcontractors deemed necessary by the Contractor shall be subject to prior approval of the Board. Said approval will not unreasonably be withheld and the Board shall respond to any inquires for approval hereunder in a timely manner.

Notwithstanding any Subcontract, the Contractor shall maintain prime responsibility for all services required by this RFP and any Subcontracts hereunder shall include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the Contractor.

The Contractor shall expressly understand and agree that he shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a Subcontract.

The Contractor shall also agree and understand that utilization of a Subcontractor to provide any of the equipment or services in the Contract shall in no way relieve the Contractor of the responsibility for providing the equipment or services as described and set forth herein.

3.16 Conflict of Interest

No member or employee of the Board and no other public official of the State of Mississippi or the Federal Government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Contract shall, prior to the completion of the Contract, voluntarily acquire any personal interest, direct or indirect, in the Contract. A violation of this provision shall constitute grounds for termination of this Contract. In addition, such violation will be reported to the Attorney General and appropriate Federal law enforcement officers for review.

The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under this Contract.

The Contractor further covenants that, in the performance of the Contract, no person having such known interests shall be employed. This is especially pertinent to subsidiaries or entities housed within the same facility that could be misconstrued as a joint relationship.

3.17 Modification or Renegotiation

This Contract may be modified, altered, or changed only by written agreement signed by the parties hereto. The parties agree to renegotiate the Contract if Federal and/or State revisions of any applicable laws or regulations make changes in this Contract necessary.

3.18 Termination of Contract

This Contract may be terminated by the Board as follows:

a) Default;

b) Convenience;

c) Contractor Bankruptcy; and

d) Non-availability of funds

3.19 Termination For Default

3.21.1 Default

If the Contractor refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified within this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of Contract, the Board may notify the Contractor in writing of the delay or nonperformance and if not cured in ten (10) days or longer as specified in writing by the Board, the Board may terminate the Contractor's right to proceed with this Contract or such part of this Contract as to which there has been delay or failure to properly perform. In the event of termination, in whole or in part, the Board may procure similar supplies or services in a manner and upon the terms deemed appropriate by the Board. The Contractor shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

3.21.2 Contractor's Duties

Notwithstanding termination of this Contract and subject to any directions from the Board, the Contractor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of the Contractor in which the Board has an interest.

3.21.3 Compensation

Payment for completed services delivered and accepted by the DOM shall be at the Contract price. The DOM may withhold from amounts due the Contractor such sums as the DOM deems to be necessary to protect the DOM against loss because of outstanding lien holders and to reimburse the DOM for the excess costs incurred in procuring similar goods and services.

3.21.4 Excuse for Nonperformance or Delayed Performance

Except with respect to defaults of Subcontractors, the Contractor shall not be in default by reason of any failure in performance of this Contract in accordance with its terms (including any failure by the Contractor to make progress in the prosecution of the work here under which endangers performance) if the Contractor has notified the State within 15 days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a Subcontractor to perform or make progress, and if such failure arises out of causes similar to those set forth above, the Contractor shall not be deemed to be in default, unless the services to be furnished by the Subcontractor were reasonably obtained from other sources in sufficient time to permit the Contractor to meet the Contract requirements.

Upon request of the Contractor, the Board shall ascertain the facts and extent of such failure, and, if such the Board determines that any failure to perform was occasioned by any one or more of the excusable clauses, and that, except for the excusable cause, the Contractor's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the State under the clause of this Contract entitled "Termination for Convenience".

3.21.5 Erroneous Termination for Default

If, after notice of termination of the Contractor's right to proceed under the provisions of this clause, it is determined for any reason that the Contractor was not in default under the provisions of this clause, that the delay was excusable under the provisions of this clause, or that the delay was excusable under the provisions of **Section 3.21.4** of this RFP the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to the clause of this Contract entitled "Termination for Convenience".

3.21.6 Additional Rights and Remedies

The rights and remedies of the Board provided under this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

3.22 Termination Due to Convenience

3.22.1 Termination

The Board may, when the interests of the State so require, and upon at least ninety (90) days prior written notice, terminate this Contract in whole or in part for the convenience of the State. The Board shall give written notification of the termination to the Contractor specifying the part of the Contract terminated and when termination becomes effective.

3.22.2 Contractor Obligations

The Contractor shall incur no further obligations in connection with the terminated work, and on the date set in the notice of termination the Contractor will stop work to the extent specified. The Contractor shall also terminate outstanding orders and Subcontracts as they relate to the terminated work. The Contractor shall settle the liabilities and claims arising out of the termination of

Subcontractors and orders connected with the terminated work. The Board may direct the Contractor to assign the Contractor's right, title, and interest under terminated orders or Subcontracts to the State. The Contractor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

3.23 Termination Due to Contractor Bankruptcy

In the event the Contractor shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets, or shall avail itself of, or become subject to, any proceeding under Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of the rights of creditors, the Board, may, at its option, terminate the Contract in whole or in part.

In the event the Board elects to terminate the Contract under this provision, it shall do so by sending Notice of Termination to the Contractor by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in the Notice of Termination. In the event the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise the Board. The Contractor shall assure that all tasks related to the Subcontract are performed in accordance with the terms of the Contract.

3.24 Termination for Non-Availability of Funds

It is expressly understood and agreed that the obligation of the Board to proceed under this Contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or federal funds. If the funds anticipated for the continuing fulfillment of this Contract are, at anytime, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds, or the discontinuance or material alteration of the program under which such funds were provided, or if funds are not otherwise available to the State, the Board shall have the right upon ten (10) working days written notice to the Contractor, to terminate this Contract without damage, penalty, cost, or expenses to the Board of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

3.25 Oral Statements

No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Contract. All modifications to this Contract must be made in writing by the Board.

3.26 Employment Practices

The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, age, marital status, political affiliations, or handicap. The Contractor must act affirmatively to ensure that employees, as well as applicants for employment, are treated without discrimination because of their race, color, religion, sex, national origin, age, marital status, political affiliation, or handicap.

Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this clause.

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, age, marital status, political affiliation, or handicap, except where it relates to a bona fide occupational qualification.

The Contractor shall comply with the non-discrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor and Subcontractors shall comply with related State laws and regulations, if any.

The Contractor and its Subcontractors shall comply with the Civil Rights Act of 1964, any amendments thereto and the rules and regulations thereunder; Section 504 of Title V of the Vocational Rehabilitation Act of 1973 as amended; and the Mississippi Human Rights Act of 1977.

If the Board finds that the Contractor is not in compliance with this requirement at any time during the term of this Contract, the Board reserves the right to terminate this Contract or take such other steps it deems appropriate, in its sole discretion, considering the interests and welfare of the State, to correct the deficiency.

3.27 Federal, State, and Local Taxes

The Contract amounts indicated in Appendix H shall include all applicable Federal, State, and local taxes.

The Contractor shall pay all taxes imposed upon it with respect to this Contract. The Board makes no representations whatsoever as to exemption from liability to any tax imposed by any governmental entity on this Contract.

3.28 Confidentiality of Information

The Contractor's physical security of all records pertaining to Members and/or related to the Board shall comply with HIPAA privacy and security standards and all other applicable State and Federal requirements. The Contractor and the Board will execute a Business Associate Agreement in accordance with the requirements of HIPAA.

All information as to personal facts and circumstances concerning Members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the Board and the written consent of the covered Member, his attorney, or his responsible parent or guardian, except as may be required by the Board or by law.

The Contractor's use or disclosure of information concerning Members should be limited to purposes directly connected with the Contractor's responsibilities under the Contract and in compliance with HIPAA.

All of the Contractor's officers and employees shall be instructed in writing of this requirement and required to sign such a document upon employment and annually thereafter.

The Contractor shall notify the Board promptly of any unauthorized possession, use, knowledge or attempt thereof, of the Board's data files or other confidential information. The Contractor shall promptly furnish the Board full details of the attempted unauthorized possession, use, or knowledge, and assist in investigating or preventing the recurrence thereof.

3.29 Representation Regarding Contingent Fees

The Contractor represents that it has not retained a person to solicit or secure a State contract upon agreement or understanding for a commission, percentage, brokerage, or contingent fee. The Board will not pay any commissions and/or any brokerage, percentage, finders, service, or contingent fees for securing or executing any of the services outlined in this Contract.

3.30 Lobbying

The Contractor shall comply with the Anti-Lobbying Act, Title 31 U.S.C., Section 1352 (added under Section 319 of Public Law 101-121) as revised by the Lobbying Disclosure Act of 1995 (P.L. 104-65) and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208). The Contractor certifies to the best of its knowledge and belief, that no Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or any employee of a member of Congress in connection with the awarding of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal Contract, grant, loan, or cooperative agreement. The Contractor shall require that the language of this certification be included in all Subcontracts and that all Subcontractors shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance is placed when entering into this Contract. Submission of this certification is a prerequisite for making or entering into this Contract imposed under Title 31, Section 1352, U.S. Code. Failure to file the required certification shall be subject to civil penalties for such failure. The Contractor will likewise abide by the lobbying laws of the State of Mississippi.

3.31 Representation Regarding Gratuities

The Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 7-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.32 Certificate of Independent Price Determination

The Contractor certifies that the prices submitted in response to the RFP have been arrived at independently and without - for the purpose of restricting competition - any consultation, communication, or agreement with any other proposer or competitor relating to those prices, the intention to submit a proposal, or the methods or factors used to calculate the prices proposed.

3.33 Small and Minority Businesses

The Board encourages the employment of small and minority business enterprises. Therefore, the Contractor shall report, separately, the involvement of small businesses and businesses owned by minorities and women. The Contractor shall provide annually a list of such Subcontractors, if any, utilized by the Contractor in relation to this Contract.

3.34 Indemnification

To the fullest extent allowed by law, the Contractor shall indemnify, defend, save and hold harmless, protect, and exonerate the State of Mississippi, its Commissioners, Board Members, officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by the Contractor and/or its partners, principals, agents, employees, and/or Subcontractors in the performance of or failure to perform this Contract.

3.35 Insurance

The Contractor shall be required to maintain throughout the term of this Contract, at its own expense, professional and comprehensive general liability insurance. Such Contract of insurance shall provide a minimum coverage in the amount of one million dollars ($1,000,000) per occurrence, three million dollars ($3,000,000) annual aggregate through an insurance company licensed by the Mississippi Department of Insurance, or self insurance approved by the Board, unless such requirement is waived by the Board. The Contractor will provide the Board a current Certificate of Insurance.

3.36 Performance Bond

The Contractor shall provide a performance bond to guarantee timely and complete establishment of the Contract and related administrative services in the amount of one million dollars ($1,000,000). The Board must be named as exclusive beneficiary. Any failure of the Contractor to perform timely and complete establishment of such services shall result in damages recoverable by the Board against the Contractor's performance bond. Upon the Board's agreement that the implementation of the Contractor's responsibilities for the Benefit Plan and related administrative services are complete, the performance bond shall be released.

3.37 Fidelity Bond

The Contractor shall maintain a blanket fidelity bond in the amount of two million dollars ($2,000,000) naming the Board as the exclusive beneficiary for the duration of the Contract. Pursuant to such bond, any losses incurred by the Board due to theft or dishonesty of a Contractor's employee shall be fully recoverable to the Board. The Contractor shall be responsible for procuring any such recovery and reimbursing the Board accordingly.

3.38 Notice

All notices given pursuant to this Contract shall be in writing and be personally delivered or mailed with postage prepaid, by registered or certified United States mail, return receipt requested to the address set forth below or such other address as a party may from time to time specify in writing to the other party. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address. The addresses to which notices are initially to be sent are as follows:

a) If to the Board:

Executive Director
Department of Finance and Administration
Post Office Box 267
Jackson, Mississippi 39205
Facsimile No: (601) 359-2405

with a copy of any notice to:
State Insurance Administrator
DFA - Office of Insurance
P.O. Box 24208
Jackson, Mississippi 39225-4208
Facsimile No: (601) 359-6568

b) If to the Contractor:

(To an address to be agreed upon following Contract award)

3.39 Incorporation of Documents

The Request for Proposal for Health Insurance Coverage for the Children's Health Insurance Program and the Contractor's response to the RFP will be attached as an Exhibit to the Contract or a letter of agreement.

The terms of the Contract shall control in the event there is a conflict between the terms of the Contract, Request for Proposal, or the Contractor's response to the Request for Proposal.

3.40 Stop Work Orders

3.40.1 Order to Stop Work:

The Board may by written order to the Contractor at any time, and without notice to any surety, require the Contractor to stop all or any part of the work called for by this Contract. This order shall be for a specified period not exceeding 90 days after the order is delivered to the Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Board shall either:

a) cancel the stop work order; or

b) terminate the work covered by such order as provided in the 'Termination of Contract' clause of this contract

3.40.2 Cancellation or Expiration of the Order

If a stop work order issued under this clause is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the Contract shall be modified in writing accordingly, if:

a) the stop work order results in an increase in the time required for, or in the Contractor's cost properly allocable to, the performance of any part of this contract; and

b) the Contractor asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the Board decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

c)

3.40.3 Termination of Stopped Work

If a stop work order is not cancelled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

3.40.4 Adjustments of Price

Any adjustment in Contract price made pursuant to this clause shall be determined in accordance with the 'Modification or Renegotiation' of this Contract.

3.41 Patents and Royalties

The Contractor covenants to save, defend, keep harmless, and indemnify the State and all of its officers, departments, agencies, agents, and employees from and against all claims, loss, damage, injury, fines, penalties, and cost - including court costs and attorney's fees, charges, liability, and exposure, however caused - for or on account of any copyright or patented or unpatented invention, process, or article manufactured or used in the performance of the Contract, including its use by the Board. If the Contractor uses any design, device, or material covered by patent or copyright, it is mutually agreed and understood without exception that the Contract price includes all royalties or costs arising from the use of such design, device, or materials in any way in the work.

3.42 Prohibited Nondiscriminatory Practices

The Contractor shall not discriminate against any Member or provider of service because of their race, color, religion, sex, national origin, age, marital status, political affiliation, or handicap in the performance of this Contract.

3.43 Approval (Third Party Administrator Contract Only)

It is understood that this Contract (Third Party Administrator Contract only) is void and no payment shall be made in the event that the Mississippi Personal Services Contract Review Board does not approve this Contract. The Contract shall be governed by the applicable provisions of the Personal Services Contract Review Board Regulations, a copy of which is available at 301 North Lamar Street, Jackson, MS, or by accessing the website at www.spb.state.ms.us. This section does not apply to a fully-insured insurance policy.

4. Comprehensive Benefits Package

4.1 General

Appendix A to this RFP contains the Rules and Regulations that govern the Children's Health Insurance Program's comprehensive benefits package. The Contractor must provide a comprehensive provider network that is available and accessible to Members to provide the covered medical services in accordance with **Section 8** of this RFP. In general, covered health services include inpatient and outpatient hospital services, physician (primary care and specialty) services, family planning services, prescription drugs, laboratory, radiology and other diagnostic services, supportive services, professional ambulance services, routine well baby and well child care visits including administration of immunizations, vision and hearing examinations, eyeglasses, hearing aids, preventive and diagnostic dental care and routine dental fillings. Covered health services may be subject to utilization management requirements in accordance with the provisions set forth in **Section 4.15** of this RFP.

4.2 Choice of Providers

The Contractor should allow Members free and open access to physicians and facilities from among the available group of network providers.

4.3 Out-of-pocket Maximum Administration

Once the out-of-pocket maximum, as specified in the Rules and Regulations, has been reached, the Contractor shall issue a letter to the Member and his/her family indicating that no further copayment requirements will apply for the balance of the benefit period and explaining that the letter should be presented to providers at the time services are received in order that no further copayment requirements are applied. In lieu of a letter to the Member, the Contractor may issue a revised Member ID card indicating no copayments. Under this alternative, the Contractor would be required to issue to the Member a new ID card at the start of the next benefit period which reinstitutes the copayment requirements.

4.4 Prescription Drug Administration

The Contractor shall provide benefits for prescription drugs through a Pharmacy Benefit Management (PBM) system that includes a network of participating pharmacies, as well as twenty-four (24) hour pharmacies for emergency services, processing prescription claims for network pharmacies, and processing paper-submitted prescription claims when a Member uses a non-participating pharmacy when either in an area where a network pharmacy is not available and/or not reasonably accessible or when the Member needs prescription drugs while traveling outside the State. Covered prescription drugs are to include those that are required for the medical management of mental health and substance abuse disorders, and dental conditions. The dispensing limits for any drug may be restricted to a 30-day supply at one time. The current plan of benefits does not include a mail order prescription drug program.

A Member must be allowed to obtain an early refill of a prescription drug under certain circumstances, such as change of dosage during the course of treatment, for lost or destroyed medication, or when the Member is going on vacation. The Member or his/her representative may be required to contact the Contractor to obtain authorization for an early refill or advance supply of a medication.

The Contractor may require prior authorization for certain drug therapies, e.g., growth hormones.

4.5 Immunizations

The Contractor must provide for administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards, a current copy of which is included as Appendix J to this RFP.

All vaccines for Members will be provided through the Mississippi State Department of Health, which will distribute vaccines to providers who are willing to participate in the vaccine program.

The cost of the vaccine will not be billed to the Contractor. The only cost associated with immunizations to be reimbursed under the Contract shall be the cost to administer the vaccine. Vaccines may be administered by network providers, including school-based nurses, pursuant to **Section 8.6** of this RFP, by a non-participating provider to whom the Contractor has referred the Member, or by the State Health Department. Providers administering CHIP vaccine must agree to participate in the State's Immunization Registry. The Contractor must reimburse these providers on a fee-for-service basis for the cost of administering any immunizations they provide to Members. Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, shall be covered as any other covered service. The Contractor shall submit a monthly report containing a list of providers, their contact information, claimant information and corresponding vaccine administrations to the Mississippi State Department of Health.

4.6 Professional Ambulance Services Administration

The Contractor will provide benefits for professional ambulance services to a hospital equipped to handle the Member's condition in connection with covered inpatient care or when related to an accidental injury or medical emergency within 72 hours. The Contractor will assume the cost associated with transferring a Member from an out-of-network hospital to a network hospital in the case of an emergency admission or for a new Member who is hospitalized in a non-network hospital on the effective date of coverage, once the Member's condition has stabilized.

4.7 Family Planning Services

The Contractor must provide benefits for family planning services to any qualified network provider which shall include the following required medical services for contraceptive management, health screening, health education, and counseling:

a) Medical history and physical exam;

b) Annual general physical assessment;

c) Laboratory- Hgb/Hct; pap smear; gonorrhea and chlamydia testing; syphilis serology; HIV testing (if indicated); and rubella titer (if applicable);

d) Client education – reproductive anatomy and physiology; fertility regulation;

e) Individual counseling – to assist Members in reaching an informed decision;

f) Method counseling – results of history and physical exam; mechanism of action, side effects and possible complications;

g) Special counseling (when indicated) – pregnancy planning and management; sterilization; genetics; nutrition; and

h) Pregnancy diagnosis, counseling and referral.

4.8 Female Health Services

The Contractor must assure direct access by female Members of childbearing age to an obstetrician/gynecologist within the Contractor's network for routine obstetrics/gynecology services.

The Contractor must provide benefits for pregnancy, childbirth, or related conditions for Members. As noted, the pregnant female Member must be assured direct access within the Contractor's network to routine obstetrical/gynecology services.

Note: Because of the higher eligibility level for pregnant women under Medicaid, only pregnant women under age 19 in families with annual incomes from 185% up to 200% of the FPL will be eligible under CHIP. Refer to Section 7.4 for information on Medicaid eligibility determination for pregnant female Members.

4.9 Maternity/Prenatal Benefits

The Contractor must assure access to maternity care furnished by a Hospital, Physician, Allied Health Professional, and Allied Health Facility. Maternity benefits are limited to pregnant women under age 19 who are deemed eligible for the program by DOM.

4.10 Dental Services – Anesthesia and Facility Charges

In addition to preventive and diagnostic dental care and routine dental fillings, including pediatric dentistry, and in accordance with Section 83-9-32 of the Mississippi Code, the Contractor must provide benefits for anesthesia and for associated facility charges when the mental or physical condition of the Member requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. Prior authorization of these services is required under procedures established and administered under the Contractor's utilization management program.

4.11 Audiology Services Administration

The Contractor must provide an annual hearing evaluation when a hearing loss/deficit is detected during a hearing screening. If the hearing evaluation indicates the need for a hearing aid, the Contractor will provide benefits for hearing aids subject to a frequency limitation of one per ear once every three years and replacement of hearing aids, as medically necessary.

Covered hearing aids are to include behind-the-ear, in the ear and in the canal models. Programmable and digital models are to be provided and may be subject to prior authorization requirements. Hearing aids are to be fitted by a licensed audiologist who does not have an exclusive arrangement to sell only a single brand of hearing aid.

The audiologist is expected to work with the parent/guardian in advising as to the appropriate handling and storage of these items.

The following items are specifically excluded:

a) The replacement of lost or stolen hearing aids within the three-year period following the initial receipt of the hearing aid;

b) Hearing aid batteries;

c) Swim molds;

d) Hearing protection devices; and

e) Hearing aid maintenance products.

4.12 Vision and Eyeglass Benefit Administration

The Contractor must provide benefits for an annual comprehensive routine eye examination and refractive services, including one pair of prescription eyeglasses once every benefit period, if determined to be necessary. Vision providers must offer Members a variety of frames to select from, the cost of which is fully reimbursed by the Contractor, including a selection of sturdy frames, which are appropriate for the different age ranges covered under the Benefit Plan.

Covered lenses are to include plastic and polycarbonate single vision, bifocal, trifocal and lenticular lenses, with scratch resistant coating provided for plastic lenses. Contact lenses are to be covered only if medically necessary and vision cannot be otherwise corrected with eyeglasses.

The following services are specifically excluded:

a) Vision training;

b) Special lens designs or coating, other than scratch resistant coating for plastic lens;

c) Replacement of lost eyewear;

d) Plano lenses;

e) Two pairs of eyeglasses in lieu of bifocals; and

f) Protective eyewear.

4.13 Diabetes Self Management Training and Education

In accordance with the requirements of Section 83-9-46 of the Mississippi Code, the Contractor must provide a $250 benefit per Benefit Period for self-management and education, including medical nutrition therapy, for the management of diabetes.

4.14 Subrogation Administration

The Contractor will make advance payment in the case of claimed third-party liability for injury or illness provided the Member gives written assurance of reimbursement in the event any third party makes settlement or is found to be liable. As a condition to receiving medical benefits under the Benefit Plan, the Member must agree to transfer to the Contractor their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. The Member may be required to execute or cause to be executed any and all documents required by the Contractor, including a subrogation reimbursement agreement. If the Member is a minor or incompetent to execute documents required by the Contractor, that Member's parent or spouse or legal representative must execute documents on request by or on behalf of the Contractor. In the event the Member is a minor, Chancery Court approval of such subrogation reimbursement agreement must be obtained prior to the payment of any benefits.

4.15 Utilization Management Program

4.15.1 General

The Board expects the successful Contractor to work proactively in developing utilization management and cost avoidance initiatives that positively impact health outcomes and result in cost-savings to the Children's Health Insurance Program.

The Contractor must establish and maintain a utilization management program to oversee the utilization of services under this Contract, which includes, but is not limited to; services provided in acute facilities, psychiatric and substance abuse facilities, including residential treatment programs, and inpatient rehabilitation facilities. The Contractor may have utilization management requirements for other services, such as home health care. The components of the Contractor's utilization management program may include precertification (also referred to as prior authorization), concurrent review with discharge planning, retrospective review and case management.

The purpose of the utilization management program is to assure that medically necessary care is rendered appropriately and in a cost-effective manner, without sacrificing the quality of care provided. Additionally, the utilization management staff is to direct the Member and physicians to use network providers when possible and appropriate.

The Contractor may require Members to obtain authorization prior to receiving non-emergency, non-primary care services. Please refer to Appendix A for situations in which prior-authorization is currently required. The Contractor must duplicate the current program approach. The Board reserves the right to approve the list of services requiring precertification.

4.15.2 Utilization Management Services

The Contractor must designate adequate and qualified individuals to serve as the utilization management (UM) staff, who have received comprehensive training with respect to the Contractor's internal policies, procedures, provider network, referral process, and Benefit Plan design, including exclusions and limitations.

Preferred features for the utilization management program include the following:

a) Verification of the Member's mailing address and eligibility with each request for precertification, continued stay review, and case management. The UM staff shall promptly advise the appropriately designated department within the Contractor if the Member's address has changed from the one indicated in the eligibility files and the eligibility files shall be updated and DOM notified accordingly.

b) Prompt written notification or other appropriate documentation of all review decisions (approval confirmation notices, denial notices and pended for additional information notices) to providers, forwarded via mail or facsimile or other appropriate methods. Denial notices must provide the specific reason for denial and contain all information necessary for the parties to request reconsideration. All forms/letters used to communicate review determinations must be easily understandable to providers. All review decisions are to be forwarded to the Contractor's claims processing department in a timely manner with sufficient detail to allow accurate processing of the claim.

c) For all inpatient hospital or residential facility admissions, including admissions for treatment of mental health disorders, and for other health care services determined by the Contractor to be subject to utilization management, the UM staff shall obtain clinical information from the Member's attending physician to determine if the service is medically necessary, is a covered benefit, and if the proposed treatment can safely be provided at a lower level of care, e.g., ambulatory surgical center, physician's office, or through home health. If the service is determined to be medically necessary and appropriate, the Contractor will authorize the service. In rendering a determination, the Contractor shall reference the clinical information against current national written screening criteria and current length of stay guides to ensure consistent review decisions. Further, at the time of precertification, utilization management staff will attempt to direct the provider to utilize network providers and facilities, as appropriate, and document reasons why the use of non-network providers occurred.

d) Reviews for continued hospital stay will be conducted based on the recommended number of reasonably necessary bed days that should be assigned to each specific acute care hospital admission.

In the event no written criteria exists or where the UM staff cannot justify the request based on the written screening criteria, the case shall be referred to a licensed physician advisor. No adverse determinations are to be issued until a physician reviewer assesses the case. Physician-to-physician contact may be needed to gather information prior to issuing a final review determination. All adverse determinations must be issued pursuant to the requirements of Section 41-83-31 of the Mississippi Code.

e) After receiving complete information, the Contractor will complete the review of an elective admission within two (2) business days and within one (1) business day for emergency admissions or for situations where the plan participant has already been hospitalized.

f) Use of qualified and impartial clinical peer reviewers, who are skilled in the subject being reviewed. Clinical peer reviewers should be: (1) currently licensed; (2) hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject under review; and (3) knowledgeable about the recommended health care services or treatment through actual clinical experience.

g) The UM staff shall direct care/services for Members to network providers, unless a network provider is not available or accessible to the Member, in which case the Member shall be promptly directed to an appropriately qualified non-participating provider.

h) The UM staff shall communicate directly with the hospital discharge planner, utilization review coordinator, and/or the attending physician(s) and develop appropriate, cost-effective, and timely plans for a Member's discharge from a hospital. The UM staff may assist the physician in developing alternative care arrangements covered by the Benefit Plan and should refer cases which qualify under the criteria developed by the Contractor to its case management staff.

i) In the event a Member suffers an illness or injury potentially requiring expensive and/or extensive care, a cost efficient treatment plan should be designed and implemented through case management. The Contractor must develop and implement criteria to identify cases for case management, which will include, at a minimum, coordination of care for: Members hospitalized at a non-network facility for more than two (2) days

- Transplant candidates
- Catastrophic episodes
- Chronic medical care cases
- Short-term alternative care services
- HHC services to include
    - Skilled nursing services
    - Hospice
    - Therapies
    - DME

The Contractor must have written procedures for case management which includes the timely identification and referral of cases appropriate for case management which the protocols case management staff is required to follow during the process of managing a case.

The Contractor must submit the criteria and procedures to the Board, upon request. This case management program will include at a minimum:

- Assessment of the Member to determine if the individual is a candidate for case management,
- Interface with the treating physician(s) and hospital staff in the development and implementation of a treatment plan,
- Timely identification of possible alternative services to facilitate early discharge or prevent hospitalization,
- Coordination and authorization of the delivery of medical services and follow-up care,
- Linkage of the Member with community resources,
- Support of the Member, family and/or caregiver, and,
- Continued monitoring, assessment, and evaluation to ensure continued well being.

The case manager will follow the Member and continue authorizing any additional services needed, if benefits are available, including skilled nursing services, hospice, durable medical equipment, etc., and encourage the Member to follow the established treatment plan.

Throughout the process, the case manager will maintain contact with the Member and/or their caregiver and the benefits department to assure that all parties are knowledgeable of the coverage that will be available for requested alternative services.

It is expected that the Contractor will identify Members through automated algorithms that consider information obtained through the Utilization Management and claims payment processes. Members may have a history of repeat hospital admissions, high utilization of medical outpatient services, potential quality of care issues, or an indication of multiple providers of services that appear to lack coordination.

Upon notification and/or identification of a potential high cost situation, the Contractor is required to evaluate the diagnoses and procedures to determine if they fall into the case management profile of illness, injury or cost.

Prior to the discharge of a Member from an acute care or rehabilitation facility, or in lieu of a hospital admission, case management will coordinate with the Member's attending physician and the alternative medical care provider.

The Contractor will inform the appropriate parties of all treatment facilities and modalities recommended and approved. Services that are not covered under the Member's benefit plan will not be authorized by the case manager.

Case management will include the review and evaluation of all requests for home health services and an authorization concerning the medical necessity of the proposed services based on the clinical data provided by the attending physician. Home health services are to be recommended, authorized and approved only when the services are provided in lieu of hospitalization and must be covered services under the Member's benefit plan. When the Contractor has completed its review of the proposed alternative services, the Contractor will inform the appropriate parties in writing of the dates and modality of treatment. If the Member receives alternative services longer than originally recommended in the treatment plan, the Contractor will evaluate additional services to determine if they are appropriate.

j) There may be a limited number of situations where the Board identifies Members who are incurring high dollar claims but have failed to pre-certify their care. It is expected that the Contractor will accept referrals to case management directly from the Board when these Members are identified. Provide a toll-free UM department telephone number available to providers at a minimum from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday, and an after-hours answering service capable of collecting caller information, with a UM staff member "on-call" to respond to after hour calls seven (7) days a week.

k) The UM department telephone line should be staffed with adequate and qualified service representatives to accommodate 90% of calls being answered within 30 seconds and a delay of no greater than three (3) minutes hold time. The average abandonment rate should be no greater than 5%. The Contractor will be required to provide system generated reports that track the daily availability of telephone service, the monthly telephone answering speed, the monthly average on-hold time and the average monthly abandonment rates exclusively for CHIP Members.

l) The Contractor should be willing to perform post-acute discharge outreach calls assuring patient/family understanding of treatment plan, to assess for additional discharge needs and to encourage compliance with prescribed follow-up care.

m) Produce quarterly reports, with an annual summary detailing the activity under the utilization management program including the number, type, e.g. medical, surgical, psychiatric/substance abuse, and length of stay data for inpatient admissions, the number and type of any other service subject to pre-certification or prior authorization, and the number and type of cases referred for case management services and effectiveness of case management intervention.

n) The Contractor should be willing to commit to performance goals based on program impact, e.g. return-on-investment based on mutually agreed-upon calculations

4.15.3 Prohibition Against Assessing Financial Penalties or Balance Billing of Members for Non-Compliance With Utilization Management Requirements

It is the responsibility of the Contractor to ensure that utilization management procedures are initiated and adhered to by both network providers and non-participating providers to whom a Member is referred by the Contractor. There shall be no financial penalties or balance billing of the Member or his/her family for:

a) The cost of any medical expense received from network providers and non-participating providers to whom the Member is referred by the Contractor due to the failure on the part of such provider to comply with the utilization management program.

b) For emergency medical care received through a network or a non-participating provider.

Furthermore, it is the Contractor's obligation to ensure that network providers and non-participating providers to whom a Member is referred by the Contractor are aware of the extent of coverage/benefits payable including the exclusions and limitations under the Benefit Plan, the use of network providers when possible and appropriate, and the consequences to the provider for failure to comply with the utilization management program.

4.16 Toll-Free Nurse Triage Hotline Telephone Services

The Contractor must maintain a toll-free nurse triage hotline telephone service. While the Contractor's regular Member services department will not be required to operate after regular business hours, the nurse triage telephone services must be staffed twenty-four (24) hours a day/seven (7) days a week with licensed health care professionals to respond to Member calls.

The nurse triage telephone service is to include the following:

a) A staff of licensed nurses to respond to incoming calls, who are trained to assess the nature of the caller's situation, provide appropriate medical information and advise Members how to obtain care after hours and on weekends. The nurses must be familiar with the availability of benefits under the Plan as well as any utilization management and service delivery requirements. The telephone staff must direct Members to network providers unless network providers are not available or accessible in which case the staff should follow the Contractor's utilization management/referral protocols to assist Members in obtaining prompt medical care. The telephone staff must maintain a current network provider directory for reference to assist Members with provider selection.

b) Assist the participant and/or caregiver in understanding the diagnosis and treatment options, finding providers within a network, if applicable and identifying potential alternatives for treatment.

c) Provide necessary translation assistance, including the provision of Telecommunication Devices for the Deaf (TDD) to assist Members with special needs.

d) Document calls including the nature of the medical condition and the outcome of the consultation.

e) Utilize current nationally accepted triage criteria/algorithm to ensure consistency in decision making.

f) Qualified physician resources should be available to assist the nurse triage staff in the resolution of critical/complex issues.

g) A telephone system staffed with adequate and qualified service representatives to accommodate 90% of calls being answered within 30 seconds and a delay of no greater than three (3) minutes hold time to speak with a triage nurse. The average abandonment rate should be no greater than 5%. The Contractor will be required to provide system generated reports that track the daily availability of telephone service, the monthly telephone answering speed, the monthly average on-hold time and the average monthly abandonment rates exclusively for CHIP.

h) Provide a warm transfer of callers to the member services department during the Contractor's normal business hours.

i) Produce quarterly reports, with an annual summary detailing at a minimum the number of calls, the nature of the calls, and the type of assistance provided by the nurse triage service.

4.17 Disease Management Program

a) The Contractor must implement a disease management program for the CHIP population addressing at least pharmacy, asthma and diabetes. The Contractor must research the available medical and prescription drug claims data to identify children with such diseases, identify which Members may not be compliant with recommended treatment protocols, and develop a program to bring those children in compliance with treatment protocols.

b) Disease management components must include:
- Population identification processes including but not limited to predictive modeling and stratification capabilities,
- Evidence-based practice guidelines,
- Collaborative practice models to include physician and support-service providers,
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance), and
- Process and outcomes measurement, evaluation, and management.
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

c) The Contractor must provide quarterly utilization reports detailing the activity under the disease management program including the number of children by type of disease, types of intervention activities. The Contractor must also produce an annual summary report that indicates utilization and savings.

d) The Contractor must be willing to commit to performance goals based on program impact, e.g. return-on-investment based on mutually agreed-upon calculations.

5. Grievance Appeal Procedures

(For Fully-Insured Proposers)

5.1 Grievance Appeal Procedures In General

The Contractor must establish procedures for receiving and responding to Grievances from Members and providers. The procedures must be designed to resolve Grievances as rapidly as possible, while protecting the rights and interests of the parties. At a minimum, the procedures must conform to requirements in federal regulations at 42 CFR 457.1100 et seq., must comply with provisions in Article 7 Appeals and Grievances of the State Children's Health Insurance Program Rules and Regulations, and must adhere to procedures and timelines outlined in this Section of the RFP.

The Contractor must publish its Grievance Appeal Procedures, including timeframes for each step of the review process, in its Member handbooks and in informational material shared with its network providers.

The Contractor's Grievance procedures must provide for a three-step appeal process. Step one in the process is considered a Grievance Review. Step two is considered a Grievance Reconsideration. Step three is a Grievance Review by an independent external review organization. The Contractor must also utilize the expertise of its designated independent external review organization for any expedited review where a denial has been proposed by Contractor staff.

The Contractor's standard Grievance procedures must provide for completion of the entire three-step process within ninety (90) calendar days and completion of expedited reviews within seventy-two (72) hours. Upon Member request and Contractor agreement, these timeframes may be extended.

5.2 Step One Review – Grievance Review

An individual (Member, his/her representative or a provider) may initiate the Grievance Review process through the filing of either an oral or written Grievance within 45 calendar days of the incident. If a Grievance is filed orally, the Contractor's Member services staff must obtain and document all pertinent information and promptly send documentation in writing to the Contractor's designated Grievance coordinator. If a Grievance is filed in writing, it must be referred upon receipt to the Contractor's Grievance coordinator.

If the Grievance involves an urgent or emergency medical situation such that an expedited review is appropriate, it must be immediately referred to a designated Contractor representative. The process explained in **Section 5.5**, below, must be followed.

The Contractor's Grievance coordinator must thoroughly investigate each Grievance using applicable statutory, regulatory and contractual provisions, as well as the Contractor's written policies. All pertinent facts must be collected during the investigation through telephone or face-to-face contact. The Contractor is encouraged to resolve Grievances at this level, to include the Contractor's Medical Director for all medical and/or quality of care issues, and, with Member approval where required, to include any other party that may assist in resolution of the Grievance.

5.2.1 Notice

An authorized representative of the Contractor shall, within fifteen (15) calendar days of receiving the Grievance, prepare and send a notice by first class mail to the individual that filed the Grievance. Such notice shall be written in a manner that is easily understood and that is not misleading or confusing. The notice must include the following information:

a) The name(s), title(s) and qualifying credential(s) of the Contractor staff participating in the step one Grievance Review process;

b) A statement of the Grievance coordinator's understanding of the Grievance;

c) The coordinator's decision in clear terms and the Contract basis or medical rationale in sufficient detail;

d) A reference to the evidence or documentation used as the basis for the decision; and

e) If the decision is a denial, a clear description of the individual's right to and the process required for further review.

The notice shall explain that, if the individual is dissatisfied with the decision, a step two review request (a Grievance Reconsideration) may be submitted. The notice shall state that such request must be in writing, where the request must be delivered or mailed, the date by which a request must be received to be timely, with such date being fifteen (15) calendar days from the date the notice is sent, and the timeframe within which the individual may expect a response. The notice shall also explain that additional documentation may be submitted with the request for consideration.

5.2.2 Exception

Upon Member request, and for both a legitimate reason and a reasonable period, the fifteen (15) calendar day timeframe referenced in this section for step one review may be extended. The Member must be informed that an extension of the timeframe for this step could also extend the total Grievance Appeal process timeframe to more than 90 days.

5.3 Step Two Review – Grievance Reconsideration

Upon receipt of a step two review request (a Grievance Reconsideration), the Contractor's Grievance coordinator shall determine if the request was submitted within the required timeframe, i.e., whether the request was postmarked within fifteen (15) calendar days of the Contractor's issuance of the step one notice. The timeliness, or lack thereof, shall be noted on the request.

Irrespective of whether the request was received within the required timeframe, the request and any additional documentation shall be packaged, with the file from the step one review, and given to a designated Contractor representative at a higher level than the Grievance coordinator, e.g., the Grievance coordinator's supervisor.

If the step two review request was not submitted within the required timeframe, the designated step two reviewer must determine if an adequate explanation for its lack of timeliness exists such that an exception should be granted and the request reviewed.

An example of an adequate explanation might be a Member's inability to respond in a timely manner due to an acute medical episode; another example might be a delay in delivery of the step one notice due to an incorrect address on it.

If the step two reviewer determines that the request was not submitted within the required timeframe and that an exception to the timeliness requirements is not appropriate, a notice must be issued as specified in **Section 5.3.1**.

For a timely step two review request, or an untimely one for which an exception has been granted, the step two reviewer must thoroughly review the step one documentation and notice as well as the step two review request and any additional documentation submitted with it. All pertinent facts must be collected during the review through telephone or face-to-face contact.

5.3.1 Notice

The step two reviewer or another authorized representative of the Contractor as appropriate shall, within fifteen (15) calendar days of receiving the step two review request, prepare and send a notice by first class mail to the individual that submitted the request. Such notice shall be written in a manner that is easily understood and that is not misleading or confusing. The notice must include the following information:

a) The name(s), title(s) and qualifying credential(s) of the Contractor staff participating in the step two Grievance Reconsideration process;

b) A statement of the step two reviewer's understanding of the Grievance;

c) The reviewer's decision in clear terms and the Contract basis or medical rationale in sufficient detail;

d) A reference to the evidence or documentation used as the basis for the decision; and

e) If the decision is a denial, a clear description of the individual's right to and the process required for further review.

A notice of a timeliness denial must include the date the step one notice was mailed, the date the step two review request was received, and an explanation of the required timeframe. The notice must also advise that timeliness denials by the Contractor are not subject to review by an independent external review organization and include a description of the individual's right to pursue the matter in a court of appropriate jurisdiction.

The notice shall explain that, for other than timeliness denials, if the individual is dissatisfied with the decision, a step three review request (Grievance Review by an independent external review organization) may be submitted. The notice shall state that such request must be in writing, where the request must be delivered or mailed, the date by which a request must be received to be timely, with such date being fifteen (15) calendar days from the date the notice is sent, and the timeframe within which the individual may expect a response. The notice shall also explain that the individual may submit additional documentation with the request for consideration and that submission of a step three request authorizes the Contractor to share protected health information with an independent external review organization.

5.3.2 Exception

Upon Member request, and for both a legitimate reason and a reasonable period, the fifteen (15) calendar day timeframe referenced in this section for step two review may be extended. The Member must be informed that an extension of the timeframe for this step could also extend the total Grievance Appeal process timeframe to more than 90 days.

5.4 Step Three Review – Grievance Review by Independent External Review Organization

Upon receipt of a step three review request (a Grievance Review by an independent external review organization), the Contractor's Grievance coordinator shall determine if the request was submitted within the required timeframe, i.e., whether the request was postmarked within fifteen (15) calendar days of the Contractor's issuance of the step two notice. The timeliness, or lack thereof, shall be noted on the request.

Irrespective of whether the request was received within the required time frame, the request and any additional documentation shall be packaged, with the file from the step one and step two reviews, and given to a designated Contractor representative at a higher level than the Contractor's Grievance coordinator and other than the step two reviewer.

If the step three review request was not submitted within the required time frame, the step three reviewer must determine if an adequate explanation for its lack of timeliness exists such that an exception should be granted and the request reviewed. An example of an adequate explanation might be a Member's inability to respond in a timely manner due to an acute medical episode; another example might be a delay in delivery of the step two notice due to an incorrect address on it.

If the step three reviewer determines that the request was not submitted within the required timeframe and that an exception to the timeliness requirements is not appropriate, a notice must be issued as specified in **Section 5.4.2**.

For a timely step three review request, or an untimely one for which an exception has been granted, the step three reviewer must thoroughly review the files associated with steps one and two as well as the step three review request and any additional documentation submitted with it. All pertinent facts must be collected during the review through telephone or face-to-face contact.

5.4.1 Independent External Review Organization Process

If the step three reviewer determines that a denial of the review request is appropriate for reasons other than timeliness, the reviewer shall, within ten (10) calendar days of the Contractor's receipt of the step three review request, submit all pertinent documentation relating to contractual determinations to the Contractor's legal department for final determination. The Contractor will refer the medical determinations to the Contractor's designated independent external review organization. Such documentation shall include:

a) All files associated with the step one, step two and step three Grievance reviews by Contractor staff, including all documentation assembled during the reviews;

b) The Member's pertinent medical records;

c) The attending physician's recommendations;

d) Consulting reports from appropriate health care professionals;

e) Other documents submitted by the Member, his/her representative, or a provider;

f) Any applicable generally accepted practice guidelines, including those developed by the federal government, national or professional medical societies, boards or associations; and

g) Any applicable clinical review criteria developed and/or used by the Contractor.

The independent external review organization must thoroughly review all documentation provided by the Contractor and make a final determination regarding the Grievance. Such review and written

notice to the Contractor shall be completed within fifteen (15) calendar days of receipt. The notice to the Contractor shall identify the qualifying credentials of the person(s) participating in the review and thoroughly explain the basis for the final determination.

The decision of the independent external review organization shall be binding on the Contractor.

5.4.2 Notice

The designated Contractor representative or another authorized representative of the Contractor as appropriate shall, within thirty (30) calendar days of receiving the step three review request, prepare and send a notice by first class mail to the individual that submitted the request. Such notice shall be written in a manner that is easily understood and that is not misleading or confusing. The notice must include the following information:

a) The name(s), title(s) and qualifying credential(s) of the Contractor staff participating in the step three Grievance review process;

b) A statement of the step three reviewer's understanding of the Grievance;

c) The reviewer's decision in clear terms and the Contract basis or medical rationale in sufficient detail;

d) A reference to the evidence or documentation used as the basis for the decision; and

e) A copy of the final determination notice received from the independent external review organization.

f) If the final decision is a denial, a clear description of the individual's right to pursue the matter in a court of appropriate jurisdiction.

If the final determination of the independent external review organization overturns a denial by the Contractor's step three reviewer, the notice must clearly state this fact.

A notice of a timeliness denial must include the date the step two notice was mailed, the date the step three review request was received, and an explanation of the required timeframe. The notice must also include a description of the individual's right to pursue the matter in a court of appropriate jurisdiction. Timeliness denials by the Contractor are not subject to review by the independent external review organization.

5.4.3 Exception

Upon Member request, and for both a legitimate reason and reasonable period, the thirty (30) calendar day timeframe referenced in this section for step three review may be extended. The Member must be informed that an extension of the timeframe for this step could also extend the total Grievance Appeal process timeframe to more than 90 days.

5.5 Expedited Review

The Contractor shall establish written procedures for the expedited review of a Grievance involving an urgent or emergency medical situation. This process shall also include all requests concerning admission, availability of care, continued stay or health care services for Members who have received emergency services but have not been discharged from a facility. The Contractor must utilize the expertise of its designated independent external review organization for any expedited review where a denial has been

proposed by Contractor staff and in any other expedited reviews where Contractor staff believe external review is necessary and appropriate.

A request for an expedited review may be submitted orally by a Member, by his/her representative or by a provider acting on the Member's behalf to a Member services or provider services representative of the Contractor. The Contractor representative accepting the request shall advise the caller of the requirement for external review and obtain verbal authorization for release of requisite protected health information. The expedited review procedures are intended to supplant the Grievance Appeal Procedures in **Sections 5.2** through **5.4** of this RFP.

In an expedited review, all necessary information, including the Contractor's decision, shall be transmitted between the Contractor, the independent external review organization, the Member, his/her representative and/or the provider by telephone, facsimile or the most expeditious method available.

5.5.1 Notice

The Contractor shall, after consulting with its designated independent external review organization, make a decision and notify the Member and his/her representative as expeditiously as the Member's medical condition requires, but in no event more than seventy-two (72) hours after the review is requested. The Contractor shall provide written confirmation of its decision concerning an expedited review within two (2) working days of providing notification of that decision, if the initial notification was not in writing.

The notice issued by the Contractor following an expedited review shall be written in a manner that can be easily understood and that is not misleading or confusing. The notice must include the following information:

a) The name(s), title(s) and qualifying credential(s) of the Contractor staff participating in the expedited review process;

b) The qualifying credentials of any independent external review organization staff participating in the review;

c) A statement of the Contractor's understanding of the issue;

d) The Contractor's decision in clear terms and the Contract basis or medical rationale in sufficient detail;

e) A reference to the evidence or documentation used as the basis for the decision; and

f) If the decision is a denial, a clear description of the individual's right to pursue the matter in a court of appropriate jurisdiction.

5.5.2 Exception

Upon Member request, and for both a legitimate reason and a reasonable period, the seventy-two (72) hours timeframe referenced in this Section may be extended by up to fourteen (14) calendar days.

5.6 Independent External Review Organization Requirements

The Contractor shall retain the services of an independent external review organization to review all adverse determinations as part of the step three review process, for any expedited reviews and for any other medical reviews where external review is believed necessary and appropriate. At a minimum, the independent external review organization must:

a) Establish and maintain written policies and procedures that govern all aspects of standard and expedited review processes, which include procedures to ensure reviews are conducted within the specified timeframes;

b) Provide a toll free telephone service capable of receiving information on a twenty-four (24) hours per day, seven (7) days a week basis, that is capable of accepting, recording or providing appropriate instructions to incoming callers during other than normal business hours; and

c) Use qualified and impartial clinical peer reviewers who are skilled in the subject of the external review. Clinical peer reviewers must be:

   1) Currently licensed;

   2) Hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

   3) Knowledgeable about the recommended healthcare services or treatment through actual clinical experience.

Neither the independent external review organization nor the clinical peer reviewer assigned by the organization to conduct an external review may have a material, professional, familial or financial interest with the Contractor, the provider or facility which is recommending the health care services or treatment that is the subject of the external review. Neither may the assigned clinical peer reviewer have a professional or familial interest with the Member for whom the review is being conducted.

The designation of an independent external review organization is subject to advance approval by the Board. Said approval will not be unreasonably withheld if it is shown to the satisfaction of the Board that all of the above requirements have been met.

5.7 Grievance Registers

The Contractor must maintain written registers documenting Grievances that contain the following information for each step in the review process:

a) Name of the Member for whom the Grievance was filed;

b) A general description of the issue;

c) Date received;

d) Date of review;

e) Resolution;

f) Date of notice to the Member; and

g) Determination by independent external review organization, if applicable.

Grievances that proceed through multiple review steps must be documented in the Registers such that the entire Grievance process is easily identified.

The Grievance Registers shall be maintained in a manner that is reasonably clear and accessible to the Board for review and shall be provided to the Board for inspection upon request. The registers shall be maintained by the Contractor for the length of the Contract and transferred to the Board upon termination of the Contract.

6. Appeals Process

(For Self-Insured Proposers)

The Contractor must establish procedures for receiving and responding to Appeals from Members and providers. The procedures must be designed to resolve Grievances as rapidly as possible, while protecting the rights and interests of the parties. At a minimum, the procedures must conform to requirements in federal regulations at 42 CFR 457.1100 et seq., and must adhere to procedures and timelines outlined in this Section of the RFP.

The Contractor must publish its Appeal Procedures, including timeframes for each step of the review process, in its Member handbooks and in informational material shared with its network providers.

If a participant believes that claims administrator incorrectly denied all or part of a claim, he has the right to obtain a full and fair review. A request for a review must be made in writing to the claims administrator.

The participant has 60 days to request a review after receiving notice of denial from the claims administrator. If the participant fails to request a review within this timeframe, the right to review is forfeited.

After the claim has been reviewed, if benefits are again denied, the decision will be sent to the participant in writing. The letter will include the reason(s) why benefits are denied, with reference to the Plan provisions on which the decision is based.

If, after following the appeal procedure described above, the participant still disagrees with the determination, a final appeal may be submitted in writing to the Department of Finance and Administration, Office of Insurance within 30 days of the second denial. The request to the Office of Insurance must include a copy of the claims administrator's review decision and all information pertinent to the claim. The decision of the State Insurance Administrator with the Department of Finance and Administration, Office of Insurance is final and concludes all administrative levels of appeal.

Failure to request a review within the above referenced time frames and in accordance with the procedures will result in the participant's right to an appeal and rights to sue being forfeited.

7. Enrollment and Eligibility

7.1 General Information on Enrollment

The State of Mississippi Division of Medicaid (DOM) staff is responsible for determining eligibility for the Children's Health Insurance Program and for providing timely and accurate information to the Contractor for those children determined eligible.

A joint application form is utilized by both CHIP and Medicaid applicants. In the future, if an application form is specifically designed for CHIP, the Contractor will be expected to submit suggestions on the design of the application. A sample of the current application form is provided in Appendix K of this RFP.

The Contractor will accept calls from persons inquiring about the Children's Health Insurance Program and will send applications, along with information describing the Program, to those wishing to apply for CHIP. The Contractor may also direct individuals to the online application available on the DOM website and instruct the family to forward the application to the appropriate DOM office.

Note: The benefit and eligibility structure of the program has essentially remained the same since 2000. The passage of the Children's Health Insurance Program Reauthorization Act 2009 (H.R. 2) in February allows states to modify benefit and eligibility; however Mississippi has made no changes as of the date of the release of this RFP.

7.2 Eligibility Determination

Children qualify for CHIP coverage based on family income and age as determined by the Division of Medicaid, provided such children have no creditable health coverage at the date of application. A newborn child in a family with annual income above 185% of the FPL, applying for CHIP eligibility within 31 days of birth, will not be subject to review of creditable health coverage. If eligible, the newborn's effective date of coverage will be the date of birth.

Ages of Children Eligible for Coverage	Annual Family Income
Birth to 12 months	185% to 200% of the Federal Poverty Level (FPL)
Ages 1 to 5	133% to 200% of FPL
Ages 6 through 18	100% to 200% of FPL

DOM will transmit, at least weekly, a complete record on all newly eligible children to the Contractor, including the data elements listed in Appendix L of this RFP, as well as updates for children already on file. File updates will include new adds, terminations (with termination reason codes), address changes, and other changes with effective dates. The Contractor will transmit file updates to DOM to include effective date of coverage for new adds, address changes, and other changes with effective dates.

The Contractor will determine the effective date of coverage (based on the effective date of eligibility as indicated by DOM) for the child and will transmit this date back to DOM on the next file update. For children whose eligibility is transmitted to the Contractor on or before the 21st of a month, the effective date of coverage under the Benefit Plan will be the first day of the following month.

In addition, for children whose eligibility is transmitted on a supplemental file to the Contractor on or before the third (3rd) day of the current benefit month, the effective date of coverage under the Benefit Plan

will be the first day of that month. After the third (3rd) day of the current benefit month, children whose eligibility is transmitted to the Contractor will have an effective date under the Benefit Plan of the first day of the month following the month in which eligibility was transmitted.

There are two (2) exceptions to the preceding rules. For newborn children applying for coverage within 31 days of the date of birth, the effective date of coverage will be the date of birth. Children whose coverage was denied or terminated due to agency error will be accepted by the Contractor retroactive to the first (1st) of the appropriate coverage month, not to exceed three (3) calendar months prior to the month in which eligibility was transmitted to the Contractor. Such additions will be limited to incidences of agency error for which there is no other legal means to provide coverage due the child.

The Contractor will provide to the parent/guardian of each newly added child the following:

a) ID card(s);

b) A provider directory; and

c) A Member handbook that defines covered health services, exclusions and limitations, precertification and utilization management requirements, and all responsibilities of the child's parent/guardian relative to coverage under the Benefit Plan.

7.3 Eligibility Period

Children determined eligible by DOM for CHIP are certified for a period of twelve (12) months of coverage under the Benefit Plan. A child will lose eligibility prior to expiration of twelve (12) months in the following circumstances:

a) The child becomes eligible for Medicaid;

b) The child no longer resides in Mississippi;

c) The child dies;

d) The child becomes nineteen years of age; or

e) The child becomes covered under other creditable coverage.

When DOM becomes aware of any of these events, DOM will transmit a termination of eligibility date to the Contractor, along with a code indicating the reason for the termination, via the eligibility/enrollment update. Terminations of coverage, including terminations due to death, will be effective the last day of the month in which eligibility terminated.

7.4 Medicaid Eligibility

In most cases, DOM will be the first to determine that a child enrolled in CHIP has become eligible for Medicaid. The Contractor, however, may become aware that a Member may be eligible for Medicaid in the event that a claim is received with a diagnosis related to pregnancy. Because pregnant women with incomes up to 185 percent of FPL are eligible for Medicaid, the Member may likely have become Medicaid-eligible. In this event, the Contractor will notify DOM of the potential eligibility for Medicaid, and DOM will determine if in fact the Member is Medicaid-eligible.

The Contractor will provide a report to DOM of members with a diagnosis of pregnancy. The content of this report and the method and frequency of transmission will be determined jointly with DOM. If the Member is determined to be eligible for Medicaid, DOM will transmit a termination of eligibility date to

the Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as the Contractor receives a termination code from DOM.

7.5 Effective Date of Coverage

The date DOM transmits the Member's eligibility information to the Contractor determines the Member's effective date of coverage. For children whose eligibility is transmitted to the Contractor on or before the 21st of a month, the effective date of coverage under the Benefit Plan is the first day of the following month.

In addition, for children whose eligibility is transmitted on a supplemental file to the Contractor on or before the third (3rd) day of the current benefit month, the effective date of coverage under the Benefit Plan will be the first day of that month. After the third (3rd) day of the current benefit month, children whose eligibility is transmitted to the Contractor will have an effective date under the Benefit Plan of the first day of the month following the month in which eligibility was transmitted.

There are two (2) exceptions to the preceding rules. For newborn children applying for coverage within 31 days of the date of birth, the effective date of coverage will be the date of birth. Children whose coverage was denied or terminated due to agency error will be accepted by the Contractor retroactive to the later of the first (1st) of the appropriate coverage month or the first (1st) of the month preceding the month in which eligibility was transmitted to the Contractor. Such additions will be limited to incidences of agency error for which there is no other legal means to provide coverage due the child.

7.6 Enrollment Updates

DOM will provide updates to the Contractor on at least a weekly basis via electronic media. The Contractor will also transmit updates to DOM via electronic media.

DOM will transmit at least weekly, a complete record on all newly eligible children, including the data elements listed in Appendix L of this RFP, as well as updates for children already on file. File updates will include new adds, terminations of eligibility (with termination reason code), address changes, and other changes with effective dates. The Contractor will transmit daily to DOM file updates to include Confirmation of receipt and disposition of each record received along with an error report of any records in error.

7.7 Annual Re-certification of Eligibility

Prior to the end of a child's twelve (12) month coverage period, DOM will send a letter (with application form attached) to the parent/guardian notifying them of their responsibility to re-apply, including participation in a face-to-face interview, for CHIP eligibility through DOM at least (30) thirty days prior to the end of the coverage period.

For children determined ineligible for re-certification or children who fail to re-apply, DOM will transmit a termination of eligibility date to the Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. For children determined to be eligible for continuation of coverage under CHIP, a new twelve (12) month coverage period begins immediately following the end of the first period. The Contractor and DOM will periodically match full eligibility files to reconcile any differences.

Should a child be determined eligible for CHIP after the child's termination of coverage date, the child will be considered a new eligible under CHIP and a new Member under the Benefit Plan. The effective date of coverage for the new Member is subject to **Section 7.5,** Effective Date of Coverage.

7.8 Contractor's Enrollment Responsibilities

7.8.1 Policies and Procedures

The Contractor must have written policies and procedures for the following:

a) Providing the Member an I.D. card, a provider directory, a Member handbook, and a letter/questionnaire regarding employer-sponsored health insurance, within five (5) business days of receipt of enrollment data from DOM.;

b) Receiving and transmitting daily eligibility/enrollment updates from and to DOM or its fiscal intermediary;

c) Providing a data file to DOM monthly at each billing cycle to be used for billing reconciliation purposes; and

d) Complying with all HIPAA privacy and security regulations including the security and safeguarding of documents and data files.

7.8.2 Acceptance of All Enrollees

The Contractor must agree to accept all children determined eligible by DOM regardless of the Member's race, ethnicity, gender, sexual or affectional preference or orientation, age, religion, creed, color, national origin, ancestry, disability, health status or need for health services as of the effective date of coverage.

7.8.3 Status Changes

In the event the Contractor becomes aware that a member may be covered under other creditable coverage, they will notify DOM of any available information. DOM will have the responsibility for investigating and concluding that such coverage actually exists. As necessary, DOM will terminate eligibility using the same mechanism/process as any other termination eligibility.

7.9 Hospitalization on Effective Date of Coverage

The Contractor shall assume financial responsibility for Members who are hospitalized on the effective date of coverage, even if the Member is hospitalized in a non-network facility.

7.10 Termination of Coverage Effective Date

The effective date of termination of coverage shall be the last day of the month in which eligibility terminated. DOM will transmit to the Contractor the effective date of termination of eligibility, along with the code indicating the reason for termination, via the eligibility/enrollment update. For deceased children, the termination date will be the last day of the month in which the member deceased.

7.11 Contractor Financial Liability Until Termination of Coverage

The Contractor shall be financially liable for covered health services, subject to the Benefit Plan's provisions, incurred by Members until the Member's termination of coverage effective date.

7.12 Communications

7.12.1 General

The Contractor will support promotional activities of the State relative to the CHIP plan. This includes allowing the use of the logo and name of the Contractor in any marketing or media campaigns developed by the State for CHIP.

The Contractor must submit all communications materials to the Board for approval prior to use. Communications materials include brochures, leaflets, and presentation materials used by its representatives as well as any other materials mailed to, distributed or aimed at providers, Members, potential enrollees or employers.

7.12.2 Communications Activities

The Contractor is required to conduct the following communications activities:

a) Develop and disseminate a provider educational/communications package that includes a general description of how the Benefit Plan works, including the Member's responsibilities, the provider responsibilities including billing requirements related to balance billing, a summary of available benefits, a description of how any general limitations and exclusions, how members access care, how to assist uninsured families with the completion and submission of the application for CHIP coverage, and the importance of enrolling uninsured children. The Contractor will be required to include State developed materials in the provider information package. The Contractor will work with the State in developing and implementing a plan to disseminate the provider communications material throughout the state. The Contractor will develop and disseminate to members, or member representatives, who inquire about educational literature that includes a general description of how CHIP works, the member's responsibilities, a summary of the available benefits, information on how members access care and information on how to apply for coverage.

b) Develop and maintain an informational website, accessible to all Members and providers, which includes Program benefits, provider directories, appeals process, and Program access information.

c) Have trained and qualified staff available to educate State and Community Based Organization (CBOs) outreach staff on issues including, but not limited to, how the plan works, including the Member's responsibilities, the provider responsibilities including billing requirements related to balance billing, a summary of available benefits, a description of any general limitations and exclusions, information regarding the provider network, information on how to apply for coverage and other information for the member and his/her family to make an informed decision about enrollment in CHIP.

d) Have trained and qualified staff available to represent and speak on behalf of the Contractor at enrollment drives, health fairs, and other community activities aimed at outreach, education and enrollment of uninsured children.

e) The Contractor is required to have copies of all communications materials available at any of its local offices in Mississippi.

7.12.3 Other Communications Requirements

a) All written communications materials to be distributed to or aimed at Members or potential Members shall be written at a sixth grade or lower reading level.

b) Communications materials shall not be misleading and shall not be designed to confuse or misrepresent the Benefit Plan. Communications materials will be disapproved if the Board determines that the material is materially inaccurate, misleading or otherwise makes material misrepresentations.

c) The Contractor shall not use the State's or the Board's logo or name or other identifying marks on any material produced or issued without the prior written consent of the Board.

In addition, the Contractor shall not use the name or logo of another State agency without the prior written consent of that agency.

d) No report, graph, chart, picture, or other document produced and included in whole or in part under this Contract shall be the subject of an application for copyright on behalf of the Contractor.

e) The Contractor shall not offer potential members material or financial rewards as an inducement to complete an application.

8. Provider Network

8.1 General Requirements

The Contractor must establish and maintain a network with sufficient numbers and variety of providers and in geographically accessible locations for the populations to be served. The Contractor should allow Members free and open access to physicians and facilities from among the available group of network providers.

The Contractor's provider network must have sufficient representation of all types of providers, to the extent possible, in order that all the benefits/services required by this RFP are available to Members in a timely manner, otherwise the Contractor must arrange for Members to utilize non-participating providers and must reimburse those providers the full negotiated cost of covered medical services rendered, less any applicable copayment requirements. When possible, the Contractor must negotiate discounts with approved out-of-network providers.

Because of the large number of physicians and specialists needed to serve the covered population, the Contractor is not required to maintain specified Member to provider ratios. Members must be allowed to voluntarily elect to utilize any provider within the Contractor's network regardless of the distance from their home.

Network physicians should have staff privileges at a network hospital.

8.2 Physician, Hospital and Other Supportive Services

8.2.1 Primary Care Providers

The Contractor must provide all Members adequate access (which may be through network providers and if none available, through non-participating providers) to primary care physicians in the following specialties:

a) Family Medicine

b) General Medicine

c) Pediatrics

d) Internal medicine

8.2.2 Specialty Care Providers

The Contractor must provide adequate access (which may be through network providers and if none are available, through non-participating providers) for at least the following specialty and subspecialty areas:

a) Allergy /Immunology

b) Anesthesiology

c) Cardiology

d) Dermatology

e) Endocrinology

f) Gastroenterology

g) Hematology/Oncology

h) Infectious Diseases

i) Medical Genetics

j) Neurology

k) Nephrology

l) Neurosurgery

m) Obstetrics and Gynecology

n) Ophthalmology

o) Orthopedic Surgery

p) Otolaryngology

q) Pathology

r) Pediatric (Subspecialties)

Cardiology
Craniofacial
Hematology/Oncology
Nephrology
Neonatal Medicine
Endocrinology
Neurosurgery
Orthopedic Surgery
Pulmonology
Gastroenterology
Intensive Critical Care
Adolescent Medicine
Urology

s) Physical Medicine and Rehabilitation - Physiatrist

t) Psychiatry

u) Radiology

v) Respiratory/ Pulmonary Medical Services

w) Surgery (General)

x) Surgery (Specialist)

Cardiac/Thoracic
Plastic
Pediatric
Vascular Surgery

y) Chiropractic

z) Certified nurse practitioner/nurse midwife/physician assistants

aa) Podiatry

ab) Oral and maxillofacial surgery

ac) Occupational, speech and physical therapists

ad) Psychologists, professional counselors and clinical social workers

ae) Audiologist

af) Home health services, including home infusion therapy

ag) Hospice service

ah) Orthodics/prosthetics/DME services

ai) Laboratory, radiology and other diagnostic services

aj) Skilled nursing facilities

ak) Dentists

al) Optometrists

am) Certified diabetes educators and dieticians

8.2.3 Hospitals, Ambulatory Surgical Facilities, Rehabilitation Facilities, and Facilities for Residential Treatment of Mental Health Disorders

The Contractor must provide Members with adequate access (which may be through network providers and if none available, through non-participating providers) to hospitals capable of furnishing a full range of acute and tertiary services, including inpatient and emergency room services, and to ambulatory surgical facilities, rehabilitation facilities and facilities for residential treatment of mental health disorders.

8.2.4 Dental and Vision Providers

The Contractor must provide Members with adequate access (which may be through network providers and if none available, through non-participating providers) to dentists for preventive and diagnostic dental care and routine dental fillings. To the extent available, the Contractor should include pediatric dentistry in its dental network.

The Contractor must also provide for a network of ophthalmologists and optometrists to deliver vision services to Members.

8.2.5 Pharmacy Services

The Contractor shall provide a network of retail pharmacies, including twenty-four (24) hour pharmacies for emergency services, through which Members receive covered prescription drugs. Prescription drugs are to be provided through a Pharmacy Benefit Management (PBM) system that utilizes a computer terminal-based Point-of-Sale/Prospective Drug Utilization System

(POS/ProDUR). The Contractor shall be responsible for all costs associated with the PBM services.

The Contractor shall utilize a PBM system for processing payment and reporting of pharmacy services provided to Members. The PBM system shall have the following components:

a) Electronic eligibility determination at point-of-sale;

b) Prospective review of drug therapy at point-of-sale;

c) Retrospective drug utilization review;

d) Provider/pharmacy manual;

e) Management reports/financial reports/disease management; and

f) Formulary rebate/generic substitution subsystem;

As per Section 83-9-6 of the Mississippi Code, any pharmacy, licensed without restrictions, which is qualified under the terms of the Benefit Plan and willing to accept the Contractor's/PBM's operating terms including, but not limited to, its schedule of fees and covered expenses and quality standards, shall be allowed to participate in the Benefit Plan.

Any formulary rebates received by the Contractor or its Subcontractors resulting from prescription drugs filled on behalf of Members must inure to the benefit of the Benefit Plan (if Fully-Insured) and must be remitted to the State (if Self-Insured), or must be fully reported in the annual year-end experience accounting.

The Contractor may develop a preferred drug list under the following circumstances:

(1) the preferred drug list must be used in accordance with clinical guidelines;

(2) the preferred drug list must cover all therapeutic classifications;

(3) the Contractor must provide the preferred drug list to Members upon request; and

(4) the Contractor must have written procedures for the coverage of prescription drugs which are not on the preferred drug list when prescribed by non-participating providers in the situations set forth in **Section 8.9** of this RFP.

If the Contractor uses a preferred drug list, then the Contractor must provide a brand name drug exception process whereby a Member or his/her representative may seek coverage for brand name drugs, not otherwise covered by the Benefit Plan.

The Contractor may substitute generic equivalent drugs whenever a substitution is considered both bio-equivalent and clinically efficacious, as allowed by law.

The current plan of benefits does not include a mail order prescription drug program.

8.3 Self-Referral Requirements

8.3.1 General

Except for the instances described below in **Sections 8.3.2 to 8.3.5**, the Contractor may require Members to obtain authorization prior to receiving non-emergency, non-primary care services. Please refer to Appendix A for situations in which prior-authorization is currently required. The Contractor must duplicate the current program approach. The Board reserves the right to approve the list of services requiring precertification.

8.3.2 Dental Services

The Contractor must allow Members to self-refer to a network of dental providers for non-emergency dental services, subject to the Benefit Plan's standard utilization management mechanisms.

8.3.3 Vision Services

The Contractor must allow Members to self-refer to any network ophthalmologist or optometrist for non-emergency refractive services, subject to the Contractor's standard utilization management mechanisms.

8.3.4 Family Planning Services

The Contractor must allow adolescent Members to obtain family planning services from any *qualified network provider.*

8.3.5 Immunizations

The Contractor must allow Members to self-refer to any network primary care physician, school-based clinic or the health department to receive routine immunizations. In accordance with **Section 4.5** the only cost reimbursable to such provider is the fee to administer the vaccine.

The Contractor must cooperate with the State Department of Health in providing the vaccine program to participating providers and in identifying providers who have been reimbursed for administering the vaccine.

8.4 Network Development in Border States

The Contractor shall extend its provider network into border state areas or Subcontract for an out-of-state network in order to provide a comprehensive range of specialty care (e.g., for specialists not available or fully accessible within the State of Mississippi) and to serve those Members who reside within a closer proximity to health care services in border states than within Mississippi.

Targeted areas for border state network development are: Memphis, Tennessee; Mobile, Alabama; Birmingham, Alabama; New Orleans, Louisiana; and Slidell, Louisiana.

8.5 Direct Contracting Requirements with Essential Community Providers

The Contractor shall include Essential Community Providers (ECPs) in its network. The Contractor shall contract with ECPs unless good faith negotiations fail, and mutually agreeable contract terms cannot be reached. Any ECP who is willing to accept the Contractor's operating terms including, but not limited to, its schedule of fees, covered expenses and utilization management requirements shall be allowed to participate as a network provider. A listing of ECPs is attached hereto as Appendix M to this RFP.

8.6 Direct Contracting with School Clinics and School-Based Providers

Certain school-based clinics have historically provided preventive health care services for children. The Contractor shall contract with school-based providers and clinics unless good faith negotiations fail, and mutually agreeable Contract terms cannot be reached. Any qualified school-based provider or clinic willing to accept the Contractor's operating terms including, but not limited to, its schedule of fees, covered expenses and utilization management requirements shall be allowed to participate as a network provider.

8.7 Direct Contracting with Providers who Deliver Services to Children with Special Health Needs

The Contractor shall coordinate with the Children's Medical Program (CMP) of the State Department of Health for the provision of specialized services for children with special health care needs. This does not preclude other providers from rendering treatment to these children.

Members receiving services through the (CMP) are defined as children who are under the age of 19 years and who have been diagnosed or are suspected of having certain chronic physical illnesses or serious disabilities which results in the significant limitation of major life functions and activities.

CMP children require timely and ongoing care from providers who must have access to pediatric medical and surgical subspecialists and other developmentally appropriate health care services and support services of appropriate duration, scope, planning and coordination of care. The offers the delivery of cost-effective comprehensive specialized services to children with special health needs.

The Contractor is financially responsible for covered medical services provided through the CMP.

The Contractor shall contract with providers in the CMP unless good faith negotiations fail, and mutually agreeable Contract terms cannot be reached. The CMP must be willing to accept the Contractor's operating terms including, but not limited to, its schedule of fees, covered expenses and utilization management requirements to participate as a network provider.

The name, address and telephone number of a key contact at the CMP is provided in Appendix N to this RFP.

8.8 Direct Contracting with the University of Mississippi Medical Center

The Contractor shall contract with the University of Mississippi Medical Center (UMMC) physicians and hospital unless good faith negotiations fail, and mutually agreeable Contract terms cannot be reached. The UMMC must be willing to accept the Contractor's operating terms including, but not limited to, its schedule of fees, covered expenses and utilization management requirements to participate as a network provider in the Contractor. The name, address and telephone number of a key contacts at UMMC is provided in Appendix O to this RFP.

8.9 Coordination with Non-Participating Providers

8.9.1 Use of Non-Participating Providers

The Contractor shall notify and advise all Members in writing of the provisions governing the use of non-participating providers.

If the Contractor's provider network cannot deliver the covered medical services required by this RFP to any Member within the availability and access standards specified in this RFP, the Contractor shall arrange, negotiate prices, and pay (insured product) for such services to be rendered by non-participating providers. The Member's financial liability for such services shall be limited to the copayment amount the Member would have had to pay, if any, had a network provider rendered the services. The cost of the services rendered beyond the Member's financial liability shall be the Contractor's financial responsibility in an insured product. Balance billing is prohibited.

The Contractor shall have written policies and procedures describing how Members and providers can contact the Contractor to receive individual instruction, referral and/or prior authorization for covered medical services when the Member is in a service area where network providers are not reasonably available or accessible, including instances where the Member is traveling outside the network's service area and needs care. The policies and procedures must be made available in an accessible and understandable format upon request.

For each specialty not represented in the provider network, the Contractor shall maintain a list of non-participating providers (at least two (2) per specialty), so that if a Member or network provider contacts the Contractor for a referral for specialty care, there will be no delay in identifying an appropriate provider.

If a Member receives medically necessary non-emergency services from a non-participating provider and the Contractor has not authorized such services in advance, the Contractor is not financially liable for these services. The Contractor shall not be financially responsible to non-participating providers for services that are not covered under the Benefit Plan.

The Contractor shall attempt to negotiate discounted fees for any non-participating provider. If the Contractor desires to meet this requirement by Subcontracting with specialty companies or networks that provided this service, such Subcontracting is permissible

8.9.2 Emergency Medical Services

The Contractor shall include provisions governing utilization and payment for emergency services received by a Member from non-participating providers, regardless of whether such emergency services are rendered within or outside the service area covered by the Benefit Plan.

Emergency services must be available at all times and provided upon arrival at the emergency room, or in the physician's office. If the physician or emergency room staff determines that the condition is not an emergency medical condition, the member may be referred back to his/her physician for treatment after they are stabilized. All services rendered in the emergency room or physician's office must be paid by the Contractor in a fully insured program or by the Board in a self-insured program.

Coverage of emergency medical services shall not be subject to prior authorization requirements by the Contractor, but the Contractor may include a requirement that notice be given to the Contractor of use of non-participating providers for emergency services. Such notice requirements shall provide at least a 48-hour time frame after the emergency for notice to be given to the Contractor by the Member and/or the emergency provider. Utilization of and payments to non-participating providers may, at the Contractor's option be limited to the treatment of emergency medical conditions, including medically necessary services rendered to the Member until such time as he/she can be safely transported to a network provider service location.

8.10 Service Accessibility Standards

8.10.1 Twenty-Four Hour Coverage

The Contractor shall provide coverage to Members on a 24-hours-per-day, seven-days-per-week basis. The Contractor must have written policies and procedures describing how Members and providers can contact the Contractor to receive individual instruction or referral for treatment of an emergency or urgent medical problem and to receive instructions concerning how to access benefits when either in an area where network providers are not available and/or are not reasonably accessible. The policies and procedures must be made available in an accessible and understandable format upon request. Direct contact with qualified clinical staff must be made available to Members through a toll-free nurse triage hotline telephone number, pursuant to **Section 4.16** of this RFP.

8.10.2 Travel Distance

The Contractor must agree, at a minimum, to make available to Members the opportunity to access network providers within the travel distances indicated below or must arrange/allow for care to be rendered by non-participating providers who are within a closer proximity.

For purposes of the following standards, the term urban/suburban areas shall be defined as a zip code with a population density of 1,000 or more persons per square mile and a rural area shall be defined as a zip code with a population density of less than 1,000 or more persons per square mile. A current listing of urban/suburban and rural areas within Mississippi by zip code, as measured by the latest version of GeoAccess software is provided in Appendix P of this RFP.

8.11 Maintaining Immunization Schedules

The Contractor will cooperate with the State Department of Health in matching CHIP enrollment data with immunization records. The Board will provide the Contractor with a report detailing Member compliance with the recommended immunization schedules for Members.

It is the responsibility of the Contractor to develop and implement procedures to contact Members and their parents/guardians who have not complied with the recommended schedule by the Advisory Committee on Immunization Practices (ACIP) and to arrange appointments for such Members to receive required immunizations.

8.12 Notification of Changes to the Contractor's Provider Network

The Contractor must provide to the Board prompt written notification of any material changes to the composition of its provider network.

A material change is defined as one that affects or can reasonably be foreseen to affect the Contractor's ability to meet the provider network requirements as described in this RFP. The Contractor is required to provide advance written notification to the Board of planned material changes in the provider network before the change process has begun.

Upon request of the Board, the Contractor shall provide a complete list of all changes, i.e., additions and deletions, which have been made to the provider network since the date the provider directory was last printed.

8.13 Second Opinion

The Contractor shall have policies and procedures for rendering second opinions by providers within the network, or by non-participating providers, if an appropriate network provider is not accessible or available, when requested by a Member. The Contractor is financially responsible for costs related to second opinions (insured products), including prior approved referrals to non-participating providers.

8.14 Mainstreaming

Mainstreaming of Members into the health care delivery system is an important objective of CHIP. The Contractor must ensure that network providers do not intentionally segregate Members in any way from other persons receiving services.

8.15 Prohibited Discriminatory Practices

The Contractor shall take affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, national origin, ancestry, marital status, or physical or mental handicap, except where medically necessary.

8.16 Contractor Payment to Providers

The Contractor shall make payment for all covered medical services directly to network providers. The Contractor shall also make payment for all covered medical services directly to non-participating providers when the Contractor refers the Member for treatment outside its provider network.

With the exception of copayments, as specified in Appendix A of this RFP, under no circumstances shall the Contractor, any Subcontractor of the Contractor, any network provider or non-participating provider to whom the Contractor has referred a Member seek payment or reimbursement from the Member or his/her family for the cost of covered medical services under the Benefit Plan. Balance billing of the Member by providers is prohibited.

9. Provider Services

9.1 General

The Contractor must staff a provider services department to be operated at least during regular business hours (e.g., 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday). Arrangements must be made to deal with emergency provider issues on a twenty-four (24) hours per day, seven (7) days a week basis. The Contractor must maintain a provider service office within the State of Mississippi throughout the term of the Contract. Provider services staff must be proficient in:

a) Assisting providers with questions concerning Member eligibility status.

b) Assisting providers with prior authorization and referral procedures, including the use of non-participating providers.

c) Assisting providers with claims payment procedures for the coverage provided through the Contractor, including supplemental coverage and electronic submission of claims in accordance with HIPAA EDI standards.

d) Handling provider complaints and Grievances.

e) Educating providers as to their responsibilities under the Benefit Plan.

f) Educating providers as to covered medical services, excluded medical services and benefit limitations.

g) Facilitation of medical record transfer among providers as necessary.

9.2 Provider Manuals

The Contractor shall develop, distribute, and maintain provider manuals. In addition, the Contractor will be expected to notify network providers of subsequent contract clarifications and procedural changes.

It is desired that the provider manual include at least the following information:

a) An introduction to the Benefit Plan which explains the Contractor's organization and administrative structure.

b) A description of the case management system and protocols.

c) A description of covered medical services, excluded medical services and benefit limitations.

d) Billing and encounter submission information, indicating which form, (e.g., UB92, HCFA 1500) is to be used for services and which fields/codes are required for a claim to be considered acceptable by the Contractor or the necessary protocol and procedural information for a provider to submit claims electronically in accordance with HIPAA EDI standards.

e) Provider performance expectations, including disclosure of utilization management and quality assurance criteria and processes.

f) Emergency room utilization (appropriate and non-appropriate use of the emergency room).

g) Claim filing procedures (paper and electronic).

h) A listing of key contacts and telephone numbers at the Contractor.

i) Prior authorization requirements, including rules for referrals for specialty care and use of non-participating providers.

j) How to register a complaint or Grievance with the Contractor.

9.3 Other Requirements

a) The Contractor shall develop, implement and maintain Grievance/Appeal Procedures, pursuant to **Section 5** or **Section 6** of this RFP.

b) The Contractor shall not prohibit or otherwise restrict a covered physician or other health care professionals from advising a Member about their health situation or medical care or treatment for the Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the Benefit Plan, if the professional is acting within his lawful scope of practice.

c) The Contractor shall not prohibit a network provider from advocating on behalf of the Member within the utilization management or Grievance/Appeal processes established by the Contractor.

d) The Contractor shall provide written notice of a provider's termination from the network within twenty (20) working days of receipt or issuance of a notice of termination to all Members who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Such notice shall provide instructions to the Member regarding how to choose another provider.

e) The Contractor shall notify network providers of their responsibilities with respect to the Benefit Plan's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, Grievance/Appeal Procedures, data reporting requirements and any applicable federal and state programs.

f) Neither the Contractor nor any Subcontractor shall offer any inducement to any providers to provide less than standard quality medical care to Members than is medically necessary.

g) The Contractor shall establish procedures for resolution of administrative, payment or other disputes between providers and the Contractor.

h) The Contractor shall have provider telephone service staffed with adequate service representatives to accommodate 90% of calls being answered within 30 seconds and a delay of no greater than three (3) minutes hold time. The average abandonment rate should be no greater than 5%. The Contractor will be required to provide system generated reports that track the daily availability of telephone service, the monthly telephone answering speed, the monthly average on-hold time and the average monthly abandonment rates.

10. Member Services

10.1 General

The Contractor must staff a Member Services Department to be operated at least during regular business hours (i.e., 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday) to address non-emergency issues encountered by Members. For emergency services, the Contractor is required to maintain a toll-free nurse triage hotline telephone number for Members to call, pursuant to **Section 4.16** of this RFP. The Contractor must maintain a Member service office within the State of Mississippi throughout the term of the Contract. The Member services staff must be proficient in:

a) Explaining the provisions of the Benefit Plan and the procedures of the Contractor.

b) Assisting Members in the selection of a network physician, hospital and other supportive services providers.

c) Explaining Member rights and responsibilities.

d) Explaining covered health services, excluded medical services, cost sharing requirements, and benefit limitations.

e) Assisting Members in making appointments and obtaining services.

f) Handling, recording and tracking Member complaints promptly.

g) Handling, recording and tracking Member Grievances/Appeals in accordance with **Section 5** or **Section 6** of this RFP.

10.2 Toll-Free Member Service Telephone Number

The Contractor must maintain a toll-free Member services telephone line. The toll–free telephone number is the property of the Board and shall be transferred to the Board in the event the Contract with the Contractor is terminated. The Member service telephone line must include the following features:

a) Provide necessary translation assistance, including the provision for Telecommunication Devices for the Deaf (TDD).

b) Be staffed by individuals trained in addressing the special needs of the covered population and be trained and familiar with the availability of benefits and service delivery requirements of the Benefit Plan.

c) Be staffed to handle, record and track Member inquires, complaints and Grievances/Appeals promptly, pursuant to **Section 5 or Section 6** of this RFP.

d) Be staffed with adequate service representatives to accommodate 90% of calls being answered within 30 seconds and a delay of no greater than three (3) minutes hold time. The average abandonment rate should be no greater than 5%.

The Contractor will be required to provide system generated reports that track the daily availability of telephone service, the monthly telephone answering speed, the monthly average on-hold time and the average monthly abandonment rates.

10.3 Member Services Website and Interactive Voice Response System (IVR)

The Contractor must have established, effective January 1, 2010, maintain, and update as necessary a website and an IVR system to provide general Member services and associated plan information including the Member handbook, provider directories, any communication materials, and the process for accessing care. Added features may include secured participant demographic information and eligibility verification.

10.4 Education

The Contractor is strongly encouraged to develop and implement programs for education of Members and their families. Topics of educational information may include:

a) Prenatal care;

b) Immunizations and other preventive services;

c) AIDS and HIV;

d) Accessing network health services;

e) How to resolve problems with the Contractor (including a complaint or Grievance);

f) Asthma and diabetes self-care;

g) Impact of lifestyles: ways to promote good health;

h) Family planning; and

i) Other topics as deemed necessary.

Methods of dissemination may include brochures, toll-free telephone health information, community meetings, one-on-one or group meetings and other such methods. Consideration must be given to meeting the educational needs of non-English speaking Members, functionally illiterate Members, visually impaired Members, etc. All educational materials must be approved by the Board before distribution or use.

The Contractor is encouraged to coordinate health educational materials, activities, and programs with public health entities, particularly as they relate to public health priorities and population-based interventions.

The Contractor is strongly encouraged to implement effective Member education programs, which include health education programs focusing on the leading causes of hospitalization, emergency room use, health initiatives, and disease management services that target high-risk population groups.

10.5 Multilingual Services

Interpreter services shall be made available as necessary by telephone or in person to ensure that Members are able to communicate with the Contractor and providers. If Members who speak a single language other than English as a primary language, comprise more than two hundred (200) Members or ten (10) percent of program membership (whichever is less) the Contractor must agree to make available general services and materials (i.e., Member handbook) in that language. Current enrollment by household language is included in Appendix D of this RFP.

10.6 Member Identification Cards

The Contractor must issue an I.D. card to all new Members within five (5) days of receipt of enrollment data from DOM. The card shall not be overtly different in design from the card issued to its commercially enrolled clients. The I.D. card and/or accompanying information must include at least the following information:

a) Member name and Member identification number;

b) Effective date of coverage;

c) Name of the Benefit Plan;

d) Toll-free nurse triage/nurse triage telephone number and that the service is available 24 hours a day, 7 days a week;

e) Telephone number for Member services (if different);

f) Telephone number for providers to verify eligibility;

g) Instruction on obtaining prior authorization for use of non-participating providers, including telephone number to call;

h) Instructions on what to do in an emergency; and

i) Copayment requirements.

10.7 Member Handbook

The Contractor must issue a handbook to all new Members within five (5) days of receipt of enrollment data from DOM. Handbooks must be written at a sixth grade or lower reading level, and must be approved by the Board before being printed.

Member handbooks must contain at least the following information:

a) Table of contents or index.

b) A general description of how the Benefit Plan works, particularly with regard to Member responsibilities, appropriate utilization of services, cost sharing requirements, recertification of eligibility process, and referral requirements for use of non-participating providers.

c) A description of the Members subject to copayments and out-of-pocket maximums, the amount of the copayments and out-of-pocket maximums and the mechanism for Members to make copayment payments for required charges.

d) Self-referral services.

e) A description of all covered health services and an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable for only those services authorized by the Contractor and how to access out-of-plan services, including out-of-town care if applicable.

f) A description of Member services and how to contact the Member service department.

g) A description of nurse triage services and how to contact the toll free telephone number.

h) Instructions on how to file a complaint or Grievance with the Contractor, along with a description of the Grievance Appeal Procedures, including the external independent review feature for all final adverse determinations.

i) Instructions on what to do in an emergency or urgent medical situation.

j) An explanation of what the Member should do if he/she moves.

k) An explanation that coverage will terminate at the end of the eligibility period if the Member is not re-certified.

l) Information on how to obtain educational materials described in **Section 10.4** of this RFP.

10.8 Provider Directory

The Contractor must issue a provider directory to all new Members within five (5) days of enrollment data from DOM. The provider directory shall include the names, telephone numbers and addresses/service sites of primary care physicians, specialists, hospitals and other providers available for selection.

Provider directories are to be updated and reprinted at the end of any calendar year in which there has been a material change in the provider network. Revised provider directories are to be mailed to all Members within the first quarter of the calendar year in which the material change occurs. A material change is defined as one that affects or can reasonably be foreseen to affect the Contractor's ability to meet the provider network requirements as described in this RFP.

10.9 Member Satisfaction Surveys

The Contractor must agree to conduct a satisfaction survey through application of a uniform instrument to a randomly selected sample of the Members prior to the end of each Contract year. The questionnaire should be designed to assess quality, accessibility, availability and continuity of care as well as the quality and effectiveness of communications between Members and the Contractor, e.g., Member services and nurse triage services. The survey instrument may be the same one used by the Contractor to survey its general membership; however, the results of the survey for the CHIP Members must be tabulated and reported to the Board, based exclusively on the responses of CHIP Members. The survey instrument and method used by the Contractor are subject to the advance approval of the Board. The survey results must be submitted to the Board no later than March 31st following the end of each Contract year.

11. Administrative and Management Information Systems

11.1 General

The Contractor shall maintain administrative and management information systems that will provide support for all functions of CHIP processes and procedures relative to the flow and use of data by the Contractor. The Contractor shall maintain an automated management information system (MIS) with sufficient capacity and functionality to administer the Children's Health Insurance Program. The system should have the ability to submit claims data for members to the Mississippi Division of Medicaid's Electronic Health Records System. The file layout will be defined upon completion of the E-Health Record System. This data feed will occur on a nightly or weekly schedule to be determined by the DOM. The system must be capable of adapting to changes in policies, procedures and benefit levels upon notification from the Board.

The Contractor shall be required to collect, report and transmit enrollment and claims/encounter data. This data will be used for the following purposes: to evaluate health care quality and cost containment performance, to evaluate Contract performance, to validate required reporting of medical service utilization, to evaluate the premium rate structure and to meet the standard federal and state CHIP reporting requirements in a timely manner. The Contractor must be capable of conducting all HIPAA EDI transactions in the required, compliant format.

11.2 System-Wide MIS Functions

Functions and/or features, which apply system-wide, are as follows:

a) Ability to update and edit data on a timely basis.

b) Maintain a history of change and adjustments and audit trails for current and retroactive data. Audit trails will capture date, item and reasons for change.

c) Allow input mechanisms through manual and electronic transmissions.

d) Have procedures and processes for accumulating, archiving and restoring data in the event of a system failure.

e) Maintain automated or manual interfaces between and among MIS and interfaces.

f) Ability to relate Member and provider data with utilization, service, accounting data, and reporting functions.

g) Ability to relate and extract data elements into summary reporting formats attached as Appendices Q and S.

h) Maintain written processes and procedures manuals, which document and describe all manual and automated system procedures and processes for all the above functions and features and the various subsystem components.

11.3 Specific Functions

The specific functions or features of the Contractor's administrative capabilities and management information systems are to:

a) Maintain historical data.

b) Receive, translate, edit and update files in accordance with the Board requirements. Updates will be received from the DOM and processed within one working day.

c) Provide error reports and a reconciliation process between the new eligibility data and eligibility data existing in the management information system.

d) Verify Member eligibility as provided by DOM.

e) Link covered children in the same family through the case number provided by DOM for the purpose of tracking the copayments and out-of-pocket maximums for children in families with annual income greater than 150% of the FPL up to 200% of the FPL.

f) Provide a certificate of creditable coverage to terminated Members, pursuant to the Health Insurance Portability and Accountability Act.

g) Generate and track referrals, including referrals to non-participating providers.

h) Identify providers by specialty(s).

i) Maintain provider history files to include audit trails and effective date of information.

j) Maintain provider fee schedules/remuneration agreements to permit accurate payment for services based on financial agreement in effect on date of service.

k) Support monitoring activity for provider enrollment, and provider network capacity.

l) Support multiple fee schedules and capitation rates for all Contract periods by provider, to the extent necessary.

m) Provide timely, accurate, and complete data for monitoring claims processing performance.

n) Provide timely, accurate, and complete data for reporting utilization.

o) Maintain and apply edits and audits to verify timely, accurate and complete encounter data reporting.

p) Maintain and apply edits to verify the accuracy and validity of claims data for proper adjudication.

q) Submit reimbursements to all non-participating providers in a timely and accurate manner.

r) Make claim and capitation payments, if applicable, to network providers in a timely and accurate manner.

s) Ensure accumulation of data, preparation and mailing of 1099 forms to providers.

t) Support the management of referral/utilization control processes and procedures including prior authorization and pre-certification and denials of service.

u) Validate approval and denials of pre-certification, prior authorization and referral requests during adjudication of claims/encounters.

v) Capture claims, encounter data and enrollment data and transfer electronically to the State's IMV.

w) Identify and pursue third party liability coverage and post any recoveries received to claims history.

x) Provide necessary data for all cost accounting functions relative to the experience under this Plan.

y) Provide fraud and abuse detection, monitoring and reporting.

z) Produce and distribute Member ID cards.

aa) Produce Member/provider mailing labels.

ab) Produce the certificates of creditable coverage, as required under HIPAA, upon a participant's termination of coverage under the Benefit Plan.

11.4 Reporting Functions

11.4.1 Standard Reports

The Contractor shall produce, as part of its rate structure, standard reports on a monthly, calendar quarter-to-date and calendar year-to-date basis. In some cases, the Contractor will be required to provide reports on a federal Fiscal Year-end basis.

As used in this section, the term sub-group means the following classes of coverage: children in families with annual income at or below 150% FPL, children in families with annual income greater than 150% through 175% of the FPL and children in families with annual income greater than 175% up to 200% of the FPL. All reports (unless otherwise indicated) should be sorted by subgroups, with a combined subtotal for all children in families with annual income greater than 150% up to 200% of the FPL and a grand total for the entire Benefit Plan. Certain reports do not require subgroups and are to be prepared on the basis of the total Benefit Plan.

Desired reporting elements include, but not limited to:

a) An executive management report that contains, at a minimum, billed charges, eligible charges, value of the copayments (if any), paid charges, number of hospital admissions, average length of stay, inpatient admissions per 1,000 Members, inpatient days per 1,000 Members and number of claims. This report is to be provided on a quarterly basis, and is to include the experience for the most recently completed calendar quarter, along with the cumulative calendar year-to-date total. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

b) Inpatient utilization data including, total number of admissions, total number of inpatient days, total billed inpatient charges, ineligible charges, total paid inpatient charges, admissions per 1,000 Members, inpatient days per 1,000 Members and a breakout of inpatient admissions by type, e.g., medical, surgical, psychiatric, substance abuse including the number of admissions, number of inpatient days and the paid charges. This information is to be provided on a quarterly basis, and is to include the experience for the most recently

completed quarter, along with the cumulative year-to-date totals. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

c) Outpatient utilization data, including the number of visits, total billed outpatient charges, ineligible charges, total paid outpatient charges and a breakdown of outpatient services by type, e.g., office visits, mental health, substance abuse, dental, vision, x-ray and lab, surgery, by number and paid charges. This information is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date totals. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

d) Prescription drug utilization data, including the number of prescriptions, submitted for single source, multisource and generic drug, total charges, ineligible charges, and paid charges. This report is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date total. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

e) High amount claimant reports, e.g., paid claim in excess of $75,000 listing the number of claimants separately and the total amount paid. This information is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date totals.

f) Separately for network and nonparticipating providers, utilization reports showing the same information as noted in (a) (b) (c) (d) and (e) above.

This information is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date totals.

g) Paid medical claims by major diagnostic categories for the total Plan (information by subgroups is not required). This report is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date total. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

h) Prescription claims paid by therapeutic categories and a listing of the top 25 dispensed drugs, sorted by total benefits paid for the total Benefit Plan. Information by subgroups is not required. This report is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date total. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

i) An annual claims lag report covering the most recent twenty four month period. Information by subgroups is not required. Self-insured proposers will be required to submit a monthly claims lag report for the purpose of actuarial analysis. Once a year, the Contractor will be required to provide a federal Fiscal Year-end report.

Note: Self-insured proposers shall submit a monthly claims lag report.

j) Activity under the utilization management program including the number, type, e.g. medical, surgical, psychiatric/substance abuse, and length of stay data for inpatient admissions, the number and type of any other service subject to pre-certification or prior authorization and the number and type of cases referred for case management services and effectiveness of case management intervention. Information by subgroups is not required. This report is to be provided on a quarterly basis, and is to include the experience for the

most recently completed quarter, along with the cumulative year-to-date totals. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

k) Activity under the disease management program including the number of Members identified for each type of by type of disease under management, and effectiveness of disease management activities. Information by subgroups is not required. This report is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date totals.

l) Activity under the nurse triage program, including the number of calls, the nature of the calls, and the type of assistance provide by nurse triage service. Information by subgroups is not required. This report is to be provided on a quarterly basis, and is to include the experience for the most recently completed quarter, along with the cumulative year-to-date totals.

m) Other standard reports routinely produced by the Contractor that the Board determines would be helpful to its management of the Plan.

The final reporting elements and format for the standard reporting package will be agreed upon between the Contractor and the Board within the first six months following the Contract effective date.

11.4.2 Reports Required to Monitor Contract Performance

The Contractor shall be required to provide the reports specified in **Section 11** of this RFP within the timeframes specified therein as required for the Board to monitor the performance standards under the Contract. These reports are to include, but are not limited to:

a) Telephone system generated reports documenting the daily availability of telephone service, call answering speed, on-hold time and abandonment rates separately for each of the following functions: utilization management; nurse triage hotline; Member services and providers services, exclusively for CHIP. These reports are to be provided at the end of each calendar quarter, and at the end of each Contract year.

b) The number of Grievances received by the Contractor in each calendar month, the number of open (or unresolved) Grievances, and the number of resolved Grievances within the following time periods: 30 days, 60 days, 90 days, more than 90 days. This report is to be provided at the end of each calendar quarter, and at the end of each Contract year.

11.4.3 Monthly Enrollment and Quarterly Activity Reports

Each month the Contractor shall provide enrollment information as of the first day of the month, with enrollment summarized for the current calendar quarter to date and calendar year to date. In addition, once a year the Contractor is required to run a complete set of enrollment reports based on the federal Fiscal Year, which ends on September 30.

The monthly enrollment reports must reconcile with the monthly premium invoice statement submitted by the Contractor before the State can pay the monthly premium. The enrollment report should be sorted separately for each income category by each age group and for each coverage category, with subtotals for the total enrollment in each income group and an overall total for all income groups as follows:

a) - Average annual family income categories:

less than or equal to 150% of the FPL;

greater than 150% up through 175% of the FPL;

greater than 175% up to 200% of the FPL;

greater than 150% up to 200% of the FPL; and

for all income levels combined.

b) Age groups of covered Members:

Under 1;

1 through 5;

6 through 12;

13 through 18; and

for all ages combined.

A sample Enrollment Report is provided in Appendix Q of this RFP.

The Contractor must also provide a calendar quarter-end, calendar year end, and federal fiscal year-to-date (October 1 through September 30) enrollment report (Activity Report) that indicates: (1) the unduplicated number of Members ever enrolled, (2) the unduplicated number of new enrollees, (3) the unduplicated number of disenrollees, (4) the number of member months of enrollment and (5) the average number of months of enrollment and the unduplicated number ever enrolled in the year. A sample Activity Report format is provided in Appendix Q of this RFP.

The Contractor must separately identify in the monthly enrollment and quarterly activity reports (1) the number of American Indians/Alaskan Natives covered by the above annual family income categories and age groups, (2) all other Members, excluding American Indians/Alaskan Natives, covered by the above annual family income categories and age group, and (3) a grand total for all Members covered by the above annual family income categories and age group.

11.4.4 Annual Experience Accounting Report

The Contractor shall provide an annual (12 month) experience accounting of paid claims, incurred but unreported claim reserves and administrative expense under the Contract following the close of each Contract year, or as necessary per Board request. Once a year the Contractor will be required to provide a federal Fiscal Year-end report.

11.4.5 Out-of-Pocket Maximum Report

At the Contract year-end, or upon request, the Contractor must provide a report on the number of households who have reached 25%, 50%, 75% and 100% of the annual out-of-pocket maximum limits by Federal Poverty Level category.

11.4.6 Members by Household Language

On a calendar quarter-end basis, or upon request, the Contractor must provide a report of the CHIP Members by household language with data elements as set forth Appendix D.2.

11.4.7 Maternity Claims Information

At the end of each calendar month, the Contractor shall provide an electronic report, in Excel or other agreed upon format, to DOM with information on any Members with a diagnosis of pregnancy. The report is to include a list of each Member by name, identification number, date of service, case number, and parent name.

11.4.8 Immunization Rate Report

At the end of each Contract year, or upon request, the Contractor shall provide an electronic report, in Excel or other agreed upon format, to Mississippi Department of Health on the Member immunization rates. The report is to include a listing of all claims for administration of vaccine by provider, vaccine codes, provider contact information, date of service, date of birth of Member, Member's Social Security number, identification number, and Member's name and address.

11.5 Data Interface Requirements

The State of Mississippi currently contracts with an Information Management Vendor (IMV) for data analysis (currently Thomson Reuters (Healthcare) Inc., but IMV may change subject to competitive bid requirements). The selected Contractor will be required to transfer enrollment and claims data, including outpatient prescription drug claims activity, by Member ID number, to the IMV. If the primary Contractor Subcontracts the responsibilities of this Contract, the primary Contractor must cause the Subcontractor to meet the terms and requirements of this Contract.

The current file format for transfer of enrollment and claims data to the State's IMV is set forth in Appendix S.

12. Administrative Staff and Procedures

12.1 Administrative Staff

The Contractor must have in place sufficient administrative staff and organizational components to comply with the requirements of this RFP. At a minimum, the Contractor must include each of the functions noted in this section. The Contractor may combine functions or split responsibilities across departments, as long as it demonstrates that the duties are being carried out. The Contractor may contract with a third party (Subcontractor) to perform the required functions, in which case the primary Contractor will be responsible for ensuring that each Subcontractor meets any State licensing requirements and complies with the RFP requirements.

The Contractor shall provide prompt notice to the Board of any change in the following key personnel - Executive Officer, Account Manager, Medical Director and Claims Supervisor and must agree to replace these key persons with qualified people.

The Contractor shall ensure that all staff has appropriate training, education, experience, liability coverage and orientation to this Benefit Plan to fulfill the requirements of their positions.

12.1.1 Executive Officer

The Contractor must have a full-time executive officer with clear authority over general administration and implementation of requirements set forth in this RFP.

12.1.2 Account Manager

The Contractor must designate an individual and one back-up staff member who will be responsible for coordinating all relevant administrative issues with the Board and DFA staff. The individual who serves as the Account Manager must have previous experience in working with larger accounts (10,000 employees plus) and providing assistance with program implementation as well as ongoing account support. The Account Manager should be available to attend meetings with the Board and DFA staff, upon request.

12.1.3 Medical Director

The Contractor must designate a Medical Director who shall be involved in all major clinical components of the Contractor's operations. The Medical Director's position need not be full time but must include sufficient hours to ensure that all Medical Director responsibilities are carried out in an appropriate manner.

The Medical Director must be a licensed medical doctor in Mississippi and must be board-certified in his/her area of specialty. The specific responsibilities of the Medical Director should include, but not necessarily be limited to, chairing the Contractor's utilization review/quality assurance committee, serving as a liaison between the Contractor and its providers, being available to the Contractor's staff for consultation on referrals, denials, complaints and Grievances, and reviewing potential quality of care problems and overseeing development and implementation of corrective action plans.

12.1.4 Claims Supervisor

The Contractor must have a full-time Claims Supervisor who is familiar with the day-to-day operations of the Contractor and who is available to resolve problems and provide information to the Board and DFA staff, as needed. The Claims Supervisor should be available to attend meetings with the Board and DFA staff, upon request.

12.1.5 Other Staff

The Contractor must include each of the administrative functions listed below:

a) Dedicated claims processing unit;

b) Utilization management coordinator;

c) Utilization management staff;

d) Member services staff;

e) Provider services staff;

f) Grievance/Appeal coordinator, pursuant to **Section 5** or **Section 6** this RFP;

g) Management information system director and support staff; and

h) Medical review coordinator and support staff.

12.2 Payment to Providers

The Contractor shall be allowed to enter into creative payment arrangements with providers intended to encourage and reward effective utilization management and quality of care. The Board will therefore give the Contractor and providers as much freedom as possible to negotiate mutually acceptable payment rates. However, regardless of the specific arrangements the Contractor makes with providers, the Contractor must agree to make timely payments to both its network and non-participating providers, pursuant to the performance standards specified in **Section 13** of this RFP.

12.3 Invoicing and Premium/Administrative Fee Payments

All invoices for health insurance premiums, self-insured administrative fees and any authorized pass-through payments rendered by the Contractor must be submitted, to the Board and DOM on a monthly basis, in sufficient detail and format as determined by the Board and/or DOM

Such invoices must include, at a minimum, a description of the service(s) provided, the quantity or number of units billed, the compensation rate, the time period in which the services were provided, total compensation requested for each individual service being billed and the total amount due the Contractor for the period invoiced.

Premiums for insurance coverage provided by the Contractor must be invoiced in advance on a monthly basis, in sufficient detail and format as determined by the Board and/or DOM. Premium invoices must provide separate counts and amounts for each enrollment category and rate/fee billed, and must agree to the appropriate statistical counts included in the Contractor's enrollment report for the period being billed. Premium invoices should be submitted to the Board and DOM at the first of each month for which coverage is to be provided. Self-insured administrative fee invoices will be paid in arrears, and must provide clear definition of the rate/fee billed. All invoices shall be submitted to the Board and DOM at the

first of each month for review and approval. Upon advice from the Board, a monthly payment for all approved invoices shall be made by the DOM utilizing electronic fund transfers. Payment for any undisputed amounts- should be received by the Contractor within ten (10) days from the date the invoice and supporting documentation was submitted to the Board and DOM.

For self-insured administrative fees, the DOM agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies", Section 31-7-301, et seq. of the 1972 Mississippi Code Annotated, as amended, which generally provides for payment of undisputed amounts within forty-five (45) days of receipt of the invoice.

Payments shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the Contractor's choice. The State may, at its sole discretion, require the Contractor to submit invoices and supporting documentation electronically at any time during the term of this Contract. The Contractor understands and agrees that the State is exempt from the payment of sales and use taxes. All payments shall be in United States currency.

The payment of an invoice by the DOM shall not prejudice the DOM's right to object or question any invoice or matter in relation thereto. Such payment by the DOM shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. The Contractor's invoice or payment may be subject to further reduction for amounts included in any invoice or payment theretofore made which are determined by the DOM, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment or increased for underpayment on subsequent invoices.

For any amounts which are or shall become due and payable to the DOM and/or Children's Health Insurance Program by the Contractor, the DOM reserves the right to:

1) deduct from amounts which are or shall become due and payable to the Contractor under Contract between the parties; or

2) request and receive payment directly from the Contractor within fifteen (15) days such request, at the DOM's sole discretion.

13. Performance Standards and Liquidated Damage

13.1 General

The Contractor must agree to abide by the performance standards and liquidated damages specified in this Section of the RFP. These performance standards apply to both the insured and self-insured Contracts.

The Board reserves the right to reduce or waive any liquidated damages if, in the Board's sole discretion, the failure of the Contractor to meet a performance standard was due to extraordinary circumstances.

A new Contractor will be granted an initial grace period, following the Contract effective date to prepare and submit accurate reports upon which performance will be measured. The length of the grace period is to be mutually agreed upon between the Contractor and the Board.

13.2 Performance Standards

The performance standards and liquidated damages applicable to this Contract are specified on the following pages.

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
1. Nurse Triage Telephone Hotline In accordance with **Section 4.16** of this RFP, telephone lines are operational twenty-four (24) hours per day, seven (7) days a week.	In accordance with **Section 11.4.2** (a) of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
2. Nurse Triage Telephone Hotline In accordance with **Section 4.16 (g)** of this RFP, 90% of all telephone calls answered within 30 seconds.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average telephone answering speed for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly answering speed achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
3. Nurse Triage Telephone Hotline In accordance with **Section 4.16 (g)** of this RFP, the maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. The Board will use the	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	inaccurate
4. Nurse Triage Telephone Hotline In accordance with **Section 4.16 (g)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete or inaccurate
5. Member Services Telephone Line In accordance with **Section 10.1** of this RFP, telephone lines are operational 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
		compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	
6. Member Services Telephone Line In accordance with **Section 10.2 (d)** of this RFP, 90% of all telephone calls answered within 30 seconds.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average telephone answering speed for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly answering speed achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
7. Member Services Telephone Line In accordance with **Section 10.2 (d)** of this RFP, the maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
8. Member Services Telephone Line In accordance with **Section 10.2 (d)** of this RFP, an average abandonment rate of no	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
greater than 5%.	Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	monthly abandonment rate achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	In addition, $500 for each calendar day any required report is late, incomplete or inaccurate
9. Utilization Management Telephone Line In accordance with **Section 4.15.2 (j)** of this RFP, telephone lines are operational 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete or inaccurate
10. Utilization Management Telephone Line In accordance with **Section 4.15.2 (k)** of this RFP, 90% of all telephone calls answered within 30 seconds.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average telephone answering speed for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly answering speed achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day a required report is late, incomplete or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	All reports are due by the last day of the month following the close of the reporting period.	Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	
11. Utilization Management Telephone Line In accordance with **Section 4.15.2 (k)** of this RFP, maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
12. Utilization Management Telephone Line In accordance with **Section 4.15.2 (k)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
13. Provider Services Telephone Line In accordance with **Section 9.1** of this RFP, telephone lines are operational 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
14. Provider Services Telephone Line In accordance with **Section 9.3 (h)** of this RFP, 90% of all telephone calls answered within 30 seconds.	Contractor is required to provide the Board calendar quarter-end reports and a Contract year end report of the automated telephone system, which documents the telephone answering speed for each calendar quarter in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the reporting period the Contractor was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
15. Provider Services Telephone Line In accordance with **Section 9.3 (h)** of this RFP, maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports a contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. Contractor is required to provide the Board a	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor.	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	report following the end of each calendar year quarter of the automated telephone system, which documents the on-hold time. The Board will use this report to monitor the performance of the Contractor. All reports are due by the last day of the month following the close of the reporting period.	Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	
16. Provider Services Telephone Line In accordance with **Section 9.3 (h)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide the Board calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by the Board or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
17. Grievance Resolution by Contractor The Contractor resolves all Grievances within the time frames specified in **Section 5** of this RFP.	In accordance with **Section 11.4.2 (b)** of this RFP, the Contractor is required to provide the Board with a Contract year-end (12-month) which documents the length of time in which Grievances are resolved. Performance may also be monitored by random checks the Grievance Register by the Board or its designee.	Contractor's compliance will be evaluated at the end of each Contract year, based on the number of Grievances during the Contract year, which were not resolved within the time periods specified in **Section 5** of this RFP. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each Grievance not resolved within the time periods specified in **Section 5** of this	$2,500 per incidence of non-compliance In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
		and/ or failed to meet the reporting requirements for the performance standard.	
18. Claims Processing Turnaround Time 90% of all claims to be completely processed within 30 calendar days after they are received For the purposes of this standard: ➢ A claim is a request for payment of a plan benefit by a member or provider (includes adjustments) ➢ A claim is deemed to have been received when it has been time-stamped by the Contractor ➢ Processing of a claim will be completed when it has been approved for payment, rejected or denied. ➢ The time that elapses between the time a claim is pended due to a request for additional information from an outside party and the time that the additional information is received may be deducted from the turnaround time provided the amount of time deducted does not exceed 14 calendar days per claim.	Contractor is required to provide the Board calendar quarter-end system generated reports and a Contract year-end system-generated report documenting the average claims turnaround time for the reporting period exclusively for the CHIP Plan. All reports are due by the last day of the month following the close of the reporting period. The Board reserves the right to confirm the accuracy of the Contractor's internal reports by conducting a statistically valid independent audit of the Contractor's claims operations using a qualified firm, of its own choosing, who is experienced in claims auditing. The Board will pay the expense of the independent auditing firm. The results of the independent audit will determine the Contractor's liability for liquidated damages, if any.	Contractor's compliance will be evaluated at the end of each Contract year, based on the average claims processing turnaround time for the Contract year. The Board will use the calendar quarter-end reports to monitor the Contract's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if the overall average annual claims turnaround time for the Contract year under review was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	**Average Annual Turnaround Time** **Per Member Fee** Less than 90% but greater than 85% of all claims are processed within 30 calendar days $2.00 85% or less of all claims are processed within30 calendar days $4.00 The total dollar amount of the liquidated damages shall be determined by multiplying the applicable per Member fee by the total number of enrolled members as of the last month of the measurement period. In addition, $1,000 for each calendar day any required report is late, incomplete or inaccurate.
19. Claims: Financial Accuracy (Dollar Value) 99% of claims dollars submitted for payment will be accurately processed and paid. Regardless of whether or not these standards of performance are satisfied, the Contractor is to adjust the paid claims component of its renewal rates by the amount of any overpayments that are discovered in the previous experience period upon which the renewal rates are based.	The total absolute value of all overpayments and underpayments are subtracted from the dollar amount audited and then divided by the total paid dollars audited to determine the level of payment accuracy. Depending on the sampling methodology used, the result may be statistically adjusted to reflect the entire population of claims for the audited period. Payments caused by the failure to provide adequate information that are corrected upon submission of the missing information, shall not be counted as errors for the purpose of determining financial accuracy performance. Contractor is required to provide the Board copies of internal audit reports at the end of each calendar quarter and a Contract (12	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall financial accuracy for the Contract year. The board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if the overall financial accuracy for the Contract year under review was not in compliance with the performance	**Financial Accuracy** **Per Member Fee** Less than 99%, but greater than 97% $2.00 97%, or less $4.00 The total dollar amount of the liquidated damages shall be determined by multiplying the applicable per Member fee by the total number of enrolled members as of the last month of the measurement period. In addition, $1,000 for each calendar day any required report is late, incomplete or inaccurate.

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	month) audit report, exclusively for the CHIP Plan, which includes the total dollar value of the claims audited, the total dollar value of claims in error and a detailed listing of each overpayment and underpayment, with an explanation of the error. All reports are due by the last day of the month following the close of the reporting period. The Board reserves the right to confirm the accuracy of the Contractor's internal reports by conducting a statistically valid independent audit of the Contractor's claims operations using a qualified firm, of its own choosing, who is experienced in claims auditing. The Board will pay the expense of the independent auditing firm. The results of the audit will determine the Contractor's liability for Liquidated damages, if any.	standard and/or for failure to meet the reporting requirements for the performance standard.	
20. Claims: Processing Accuracy (Number of Claims) 95% of all claims will be processed accurately. Accurate processing includes payment amounts; appropriate communication to the provider; payment issued to proper party; appropriate investigation of third party liability, and absence of data entry errors, which may affect current or future benefit determinations and management reports.	Every claim that has a processing error shall be subtracted from the total number of claims audited and divided by total number of claims audited to determine the percentage of claim processing accuracy. Errors are not to be weighted. Contractor is required to provide the Board with a Contract year-end (12 month) administrative internal audit report, exclusively for CHIP, which includes the total number of the claims audited, the total number of claims in error and a detailed listing of t[illegible] found, with an explanation of the er[illegible] Contract year-end report will be the b[illegible] which any liquidated damages are dete[illegible] All reports are due by the last day of the month following the close of the reporting period. The Board reserves the right to confirm the accuracy of the Contractor's internal reports by	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall processing accuracy for the Contract year. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. ed damages will be assessed if all claims processing accuracy for [illegible]ract year under review was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	**Processing Accuracy** **Per Member Fee** Less than 95%, but greater than 93.5% $2.00 93.5%, or less $4.00 The total dollar amount of the liquidated damages shall be determined by multiplying the applicable per member fee by the total number of enrolled members as of the last month of the measurement period. In addition, $1,000 for each calendar day any required report is late, incomplete, or inaccurate.

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	conducting a statistically valid independent audit of the Contractor's claims operations using a qualified firm, of its own choosing, who is experienced in claims auditing.. The Board will pay the expense of the independent auditing firm. The results of the audit will determine the Contractor's liability for Liquidated damages, if any.		
21. Network Access At the end of first twelve (12) months following the Contract effective date, and for each twelve (12) month period thereafter 85% of members are within the required access parameters. The access standards for primary care physicians, acute hospitals, and retail pharmacies are specified in **Section 8.10.2 (a)**, (c) and (e) of this RFP.	To be measured by access reports produced by the Contractor, the Board, or its designee (to be determined at the discretion of the Board, but no less than annually), using GeoAccess or similar software. If the Contractor is producing the access report information, the results must be provided to the Board within 45 days following the end of each calendar quarter and Contract year. The match is to be conducted separately for each provider type for urban/suburban zip code areas and for rural zip code areas. The term urban/suburban area is defined as a zip code with a population density of 1,000 or more persons per square mile and a rural area is defined as a zip code with a population density of less than 1,000 or more persons per square mile. The mapping or methodology used to measure distance must be based on actual driving distance The elements used to measure member access is as follows: ➢ The five digit zip code census of covered members as of the end of the measurement period; and ➢ The five-digit zip code census of the provider network (using the address of their practice locations) under contract as of the end of the measurement period. Note: PCPs with closed practices, who are not serving any CHIP members are to be excluded from the PCP provider match.	Contractor's compliance will be evaluated at the end of each Contract year. The Board will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed if the access for the Contract year-end under review for any provider type was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	$5,000 for each full percentage below the performance standard for each provider type each Contract year In addition, $500.00 for each calendar day any required report is late, incomplete, or inaccurate
22. Transfer of Data to the State's Information Management Vendor	Contractor is to provide written verification each calendar quarter to the Board as to the	Contractor's compliance will be evaluated at the end of each Contract	$1,000 per calendar day for each day the required data is late, incomplete, or

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
(IMV) Within fifteen (15) calendar days following the end of each calendar quarter, the Contractor must transfer to the State's IMV enrollment and claims data, including outpatient prescription drug claims activity, by member ID number in a file format to be specified by the State.	date on which the data transfer occurred and a Contract year-end report documenting the date each calendar quarter the required data was transfer by the Contractor to the IMV. In addition, performance may also be measured based on documented receipt date of the data by the State's IMV.	year. The assessment period will begin after the Board's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if the overall claims processing accuracy for the Contract year under review was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	inaccurate
23. Reporting Requirements In accordance with **Section 11.4** of this RFP, the Contractor is to produce and provide the Board with reports. The final reporting format and elements are to be agreed upon between the Board and the Contractor following Contract award.	Board's date-stamp of receipt. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. Liquidated damages will be assessed for failure to meet the reporting requirements for the performance standard.	$500 for each calendar day a required report is late, incomplete, or inaccurate

14. Fee Quotation Requirements

Vendors can provide financial proposals on a fully insured non-participating (no dividend or deficit accounting) basis, self-insured basis or both alternatives.

For the insured proposal, please review **Sections 14.1, 14.2** and **14.3**.

For the self-insured proposal, please review **Sections 14.2.2** and **14.4**. While rates for paid claims and incurred but unpaid (IBU) components are not guaranteed, please review **Sections 14.1** and **14.2.1** and provide an illustrative estimate of these components on a similar basis as the fully insured arrangement.

14.1 Premium Rate Components

Proposers are to quote a single per Member per month premium rate for each child covered under the Benefit Plan. The proposed monthly premium rate shall have three separately identifiable components, the sum of which equals the total monthly billable premium rate. The components of the per Member monthly premium rate are as follows:

a) A paid claim estimate designed to include, but not be limited to, fees for service reimbursements, capitation charges, if any, DRG payments, and any other type of payment for covered health services paid by the Contractor;

b) An incurred but unpaid (IBU) claim reserve estimate to establish and maintain a reserve for claims which were incurred during the Contract year, but not paid until after the end of the Contract year. The IBU claim reserve is to be held by the Contractor; and

c) An administrative rate component to cover all expenses other than incurred claims (items a and b above), including utilization management expenses, network access fees, claim processing expenses, underwriting, acquisition and setup costs, as well as any other elements of administrative expenses, such as taxes, profit, etc. The monthly administrative rate component is to include all expenses that would typically be referred to as "retention". Since this is a multiyear Contract, it is expected that first year start up and acquisition costs will be amortized by the Contractor over the length of the Contract.

14.2 Renewal Process

14.2.1 Paid Claim and IBU Components of the Premium Rate

The monthly per Member paid claim estimate and the IBU claim reserve estimate (items a and b in **Section 14.1**, which together comprise the incurred claim estimate) shall be set through December 31, 2010. The paid claim estimate and the IBU claim reserve estimate components of the premium rate shall be guaranteed for 12 months.

Throughout the remainder of the Contract the paid claims estimate and the IBU claim reserve components of the premium rate must be guaranteed for 12 months, subject to adjustment only on the annual Contract anniversary date.

Assuming a Contract effective date of January 1, 2010, this means that the paid claim component of the premium rate must be set from January 1, 2010, through December 31, 2010, subject to adjustment effective January 1, 2011. Thereafter the paid claims component of the premium rate is subject to adjustment on January 1 of each Contract year.

The IBU claim reserve component of the renewal rates shall be established and maintained in the same manner as the paid claim component of the premium rate and may be subject to adjustment at the next renewal based on actual paid claim experience and enrollment. The Contractor shall be given the latitude to establish the reserve using a reasonable and actuarially sound methodology, subject to review by the Board's actuary and/or consultant.

The Contractor is required to provide at least a 60-day advance written notice of any adjustment to the premium rate, in accordance with Mississippi Code § 83-9-5(7).

14.2.2 Administrative Cost Component of the Premium Rate

The proposed per Member monthly administrative cost component must be guaranteed for five years. The Contractor is to provide at least a 60-day advance written notice to the Board of any fully-insured renewal action (including a request to continue at the existing fees for another Contract year). Any renewal request must include documentation of historic and projected administrative expenses under the Contract. The per Member per month administrative rate schedule and the methodology used to determine the average monthly administrative rate component of the premium rate may be subject to renegotiation at the same time as the renewal. Any add-on costs to the administrative expense component of the premium rate during the course of a Contract year will not be allowed.

14.3 Basis for Insured Rate Quotations

In developing the components of the premium rate, proposers must consider the plan of benefits and the requirements outlined in this RFP including the following:

a) Commissions or finder's fees are <u>not</u> payable under this Contract.

b) All costs to develop print and disseminate Member and provider materials including, but not limited to, Member I.D cards, Member handbooks, provider directories, provider manuals, administrative forms, and communications materials must be included in the proposed administrative rate component of the total premium rate structure.

c) All start-up and implementation costs including, but not limited to, costs associated with attending implementation meetings with the Board, DFA, and other interested parties, the cost to develop, print and disseminate Member and provider materials, and the cost to have the member and provider service telephone lines staffed and operational at least thirty days prior to the Contract effective date, must be included in the proposed administrative fee component of the premium rate structure.

d) The administrative cost component must take into account all expenses associated with the Contractor's (if necessary) attendance at any required meetings, both prior to and after the Contract effective date, in Jackson, Mississippi with the Board, DFA staff and other interested parties.

e) Pooling coverage should <u>not</u> be quoted or included as a component to any portion of the premium rate.

f) There will be no administrative fees payable to the Contractor following termination of the Contract to process the claims run-out liability and any related expenses to be included in the quoted administrative component of the premium rate. The Administrative Expense Illustration Form provided in Appendix I must be completed using the enrollment assumptions and instructions provided and must be included in **Section 4** to the proposal.

g) The Fee Quotation Form, provided in Appendix H must be completed, signed by an authorized representative and included in Section 4 to the proposal.

h) If any significant changes are made to the plan of benefits or significant changes occur in enrollment, the Contractor will be permitted to renegotiate the premium rates. The Contractor must provide 60-day advance written notice to the Board of any requested change to the premium rates. Such written request must include documentation of the projected fiscal impact on claims and/or administrative costs due to changes in benefits and/or enrollment and any other relevant information, including historic and projected costs, which forms the basis for the requested premium rate change.

14.4 Basis for All Self-Insured Fee Quotations

In developing the components of the administrative fee, proposers must consider the plan of benefits and the requirements outlined in this RFP including the following:

a. For your medical provider network fee schedule, you must be willing to establish a separate network contractual arrangement whereby you will jointly work with the Board at the end of each year to determine the appropriate provider fee schedule increase for the following year.

b. Commissions or finder's fees are <u>not</u> payable under this Contract.

c. All costs to develop print and disseminate Member and provider materials including, but not limited to, Member I.D cards, Member handbooks, provider directories, provider manuals, administrative forms, and communications materials must be included in the proposed administrative fee rate.

d. All start-up and implementation costs including, but not limited to, costs associated with attending implementation meetings with the Board, DFA, and other interested parties, the cost to develop, print and disseminate Member and provider materials, and the cost to have the member and provider service telephone lines staffed and operational at least thirty days prior to the Contract effective date, must be included in the proposed administrative fee rate.

e. The administrative fee component must take into account all expenses associated with the Contractor's (if necessary) attendance at any required meetings, both prior to and after the Contract effective date, in Jackson, Mississippi with the Board, DFA staff and other interested parties.

f. Pooling coverage should <u>not</u> be quoted or included as a component to any portion of the administrative fee rate or illustrative premium equivalent rate.

g. The State will be the claim fiduciary.

h. There will be no administrative fees payable to the Contractor following termination of the Contract to process the claims run-out liability and any related expenses to be

included in the quoted administrative fee. The vendor will be required to administer run out claims for a period of at least eighteen months after the termination date. The Board will hold the IBU reserve throughout the Contract.

i. The Administrative Expense Illustration Form provided in Appendix I must be completed using the enrollment assumptions and instructions provided and must be included in **Section 4** to the proposal.

j. The Fee Quotation Form, provided in Appendix H must be completed, signed by an authorized representative and included in **Section 4** to the proposal.

k. If any significant changes are made to the plan of benefits or significant changes occur in enrollment, the Contractor will be permitted to renegotiate the administrative fees. The Contractor must provide 60-day advance written notice to the Board of any requested change to the administrative fees. Such written request must include documentation of the projected fiscal impact on administrative costs due to changes in benefits and/or enrollment and any other relevant information, including historic and projected costs, which forms the basis for the requested administrative fee rate change.

15. Cost Proposal

(for Fully-Insured and Self-Insured Proposers)

15.1 Introduction

The Financial Exhibits contained in Appendix V as Attachments V1 through V5 will be used to evaluate the Contractor's provider costs associated with the proposed services. The Contractor must adhere to the format of the Attachments and the instructions which follow. All Attachments must be completed by the Contractor and labeled according to the specifications noted below.

The Cost Proposals should be based on the Contractor's claims data and provider contracts for the Commercial market for members that are not eligible for Medicare.

The Board reserves the right to use its actual claims data to evaluate any portion of the Contractor's proposal.

15.2 Provider Capitation Contracts

Please provide a detailed description of any healthcare services that the Contractor is proposing that were subject to a capitated provider payment methodology in 2008. Capitation fees should be quoted per covered person per month, and Contractors are asked to provide an estimate of the average discount rate applicable to the capitated services.

15.3 Average 2007 and 2008 Fee-for-Service Discounts

Complete the requested average provider discounts in Attachment V1 for services delivered in the State of Mississippi or the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL for services that were reimbursed on a fee-for-service basis to children covered under group health plans that were not eligible for Medicare. Claims for members covered as an employee or spouse should not be included.

For the purpose of this request, the average discount is defined as one minus the ratio of allowed charges to billed charges, where:

- Billed charges are amounts submitted by participating providers for covered health care services. Charges for services not covered by the plans and duplicate billed amounts (due to claims submitted more than once) should be excluded.
- Allowed charges are the amounts payable to providers after billed charges are reduced for contractual payment provisions. Reductions in payments due to coordination of benefits and employee cost sharing should not be applied to reduce the allowed amount.

Describe any adjustments to the discount rates in Attachment V1 that are necessary to obtain a more accurate estimate of the discounts under the Contractor's provider payment rates applicable to this proposal. For example, if the discounts in the table are for a block of business that includes HMO, POS, and PPO products describe how the rates applicable to this proposal relate to the rates entered in the table.

Describe the Contractor's ability to reprice a claim tape against provider payment arrangements and the Contractor's ability to verify the accuracy of the discounts and contracting rates included in their proposal.

15.4 Hospital Fee-for- Service Claims Paid in 2008

Complete Attachment V2 with hospital specific inpatient and outpatient claims paid in 2008. The claims shown in this exhibit should include those covered under employer group health plans for services to children that were not eligible for Medicare. The requested inpatient data includes: number of admits, number of days, billed charges, and allowed charges. The requested outpatient data includes: number of cases, billed charges, and allowed charges.

Enter "Non-Participating" for hospitals that are not in the Contractor's network in 2008 and leave the rest of the row blank. If the hospital was in the network for only part of the year indicate the period in which they were participating and show only the data for the participating period.

The definitions of billed and allowed charges are the same as the definitions provided in the request for average discounts for participating providers by type of service.

15.5 Current Physician Fee Schedules

Complete Attachment V3 providing physician reimbursement rates for the dominant physician fee schedules the Contractor is proposing for the Children's Health Insurance Program. The rates in Attachment V3 need to reflect Global rates for each procedure listed. Do not provide separate rates for the Technical and Professional components. If payments vary by site of service, show the rates for each site of service in separate columns.

If the definition of "units" for any HCPCS procedures in Attachment V3 differs from the Medicare definition of units provide a description of the difference in "units."

The discount rate that applies to professional procedures that do not have rates listed in the rate schedule is also requested.

The second and third sheets in Attachment V3 request information for dental and vision fee schedules.

15.6 Current Hospital Contracting Rates

Complete Attachment V4 with current hospital contracting rates. The first sheet in Attachment V4 requests information for inpatient hospital contracting rates and accommodates reimbursement rates based on per diems, case rates, and discounts off billed charges. The categories provided for per diem rates include Medical, Surgical, Maternity, Behavioral Health (Mental Health and Substance Abuse), and Intensive Care and Cardiac Care (ICU/CCU).

For Contracts with Case Rates, provide the current 2008 base rates and a label for the DRG weights that apply to each hospital's Contract. The second sheet in Attachment V4 should be used to provide a copy of the DRG weights for each hospital's label of DRG weights shown on the first sheet. If a hospital's case rates are not structured by a the use of a base rate and DRG weights, enter a value of one for the base rate and show the case rates for each DRG on the second sheet.

The following information is requested for Contracts with per diems or case rates:

- Indicate whether billed charges are paid to the provider whenever they are lower than the payment based on the scheduled rates.

- Provide the threshold amounts for outlier payments and indicate whether the entire case reverts to a percent of charge basis (called a "First Dollar" outlier provision) or if an additional payment is made based on the excess of billed charges over the threshold amount. The payment percentage rate for outliers is also requested.

- Describe any inpatient hospital services that require an additional payment over and above the scheduled rates.

The third sheet in Attachment V4 requests information for outpatient hospital contracting rates. Descriptions of rate schedules applicable to outpatient hospital services are requested along with the discount rate that is applicable to all services that are not subject to a rate schedule to calculate their payment.

Enter "Non Participating" for hospitals that are not in the Contractor's network and leave the rest of the row blank. If there is a Letter of Intent or Letter of Commitment with the hospital show the date of the letter.

15.7 CHIP Provider Contracting Rates

The Contractor should describe the degree to which the anticipated provider fee schedules for the CHIP program will differ from their current Commercial provider payment rates. Any provider commitments to accept reimbursement rates different from the current Commercial contracting rates should be fully documented in the Contractor's Proposal.

15.8 Guaranteed Maximum Provider Payments in 2010 (Self-Insured Only)

The Board requests that the Contractor provide guaranteed maximum provider payment rates for the year 2010 in Attachment V5. The structure of the guaranteed maximum rates is sensitive to rate variations in Rural and Metropolitan areas. The definition of the Rural and Metropolitan areas for the application of these Guaranteed Rates is based on the zip codes provided in Appendix P. The Rural zip codes define the Rural service area, and the other zip codes (Urban and Suburban) make up the Metropolitan service area.

The maximum allowed per diems for inpatient hospital services delivered in 2010 by participating hospitals for CHIP members are requested separately for Medical, Surgical, Maternity, Mental health and Substance Abuse, and Intensive Care and Cardiac Care. The Contractor should assume that the type of service specifications for regular inpatient days (not identified as ICU/CCU days) is determined by reference to the DRG code associated with each case.

The guaranteed maximum payments for outpatient hospital services and professional services delivered in 2010 by participating providers for services to CHIP members is expressed as a percent of billed charges. For example, if the discount is guaranteed to be at least 55% enter "45%" in the table.

The definitions of billed and allowed charges are the same as the definitions provided in the request for average discounts for participating providers by type of service. Duplicate claims and claims for ineligible services are excluded from the calculations of payments.

The Board will compare its actual 2010 claims experience to the guaranteed maximum rates for inpatient hospital services, outpatient hospital services, and physician services. If the 2010 guaranteed maximum payments are not achieved in one of these categories of service, the Contractor(s) will reimburse The Board for the difference between the actual claim payments and the guaranteed amount. The total amount of reimbursements for claims incurred in 2010 is limited to 25% of the Contractor's administrative fees for services provided in 2010.

15.9 Site Visits

The Board reserves the right to review each Contractor's claims data and provider Contracts to confirm the accuracy of information provided in their proposals, and to evaluate the Contractor's contracting rates using the distribution of claims by provider and type of service consistent with the 2008 CHIP experience. This will be accomplished by site visits to the finalists to review the documentation of claims and provider contracts, including commitments made by providers to accept payment rates that differ from the Contractor's current Commercial payment rates.

The review will cover contracts for selected hospitals that represent at least 70% of allowed charges for hospital services and will include the review of a stratified sample of physician claims that will include the top twenty physicians (based on allowed charges) and an additional number of physicians that is needed to provide a 95% confidence level for measuring the accuracy of reporting.

A vendor representative will be present during each of the on-site visits.

16. Questionnaire

General Requirements

1. State the full legal name of the primary Contractor, headquarters address, and the name, title, mailing address, telephone number, email address and facsimile number of the contact person for this proposal.

2. Is the primary Contractor an insurance company, third-party administrator or other type of organization?

3. As of the proposal due date, how many years of experience does the primary Contractor have in providing services similar to those requested in this RFP? Please include in your response, the month and year the Contractor began to first provide the services.

4. As of the proposal due date, does the primary Contractor currently provide similar services to those requested in this RFP to at least one employer group, with at least 50,000 covered lives (includes active employees, retirees, COBRA, and dependents)? This requirement can be met if the proposer currently services a federal or state medical assistance program, i.e., Medicare or Medicaid. If yes, provide the following information:
   i. Name of Client
   ii. Number of Covered Lives
   iii. Name of Key Contact
   iv. Title of Key Contact
   v. Telephone Number
   vi. Fax Number
   vii. Email Address
   viii. Types of Services Provided

5. As of the proposal due date, what is the total covered population, in terms of number of covered lives (includes active employees, retirees, COBRA, and dependents) nationwide serviced by the primary Contractor?

6. Is the primary Contractor subcontracting with any other organization(s) for any services (e.g., provider networks, out-of-network price negotiation, PBM services, claim processing, utilization management, nurse triage and MIS services) required under this RFP?

   If yes, provide the following information for each Subcontractor arrangement:
   i. Full legal name.
   ii. Headquarters address.
   iii. The name, title, mailing address, telephone number and facsimile number of the contact person for this proposal.
   iv. A description of the services to be provided.
   v. As of the proposal due date, the number of years of experience in providing similar service to those which they will be performing under this contract for other clients.
   vi. As of the proposal due date, the total covered population, in terms of number of covered lives (includes active employees, retirees, COBRA, and dependents) serviced by the Subcontractor.

vii. Indicate whether the primary Contractor currently has a current Contract, letter of commitment or letter of intent to Contract with the Subcontractor. If so, attach as **Exhibit A** to your proposal copies of such agreements.

7. State if you currently provide any services, directly or indirectly, to the Board members, or any of the following:

i. Blue Cross & Blue Shield of Mississippi
ii. Thomson Reuters (Healthcare) Inc.
iii. PricewaterhouseCoopers, LLP
iv. WM. Lynn Townsend, FSA, MAAA
v. CareAllies/Intracorp
vi. Minnesota Life Insurance Company
vii. Advanced Health Services, Inc.
viii. Cavanaugh Macdonald Consulting, LLC
ix. Claims Technologies, Inc.
x. WebMD Health Services Group, Inc.
xi. Catalyst Rx
xii. State and School Employees Health Insurance Management Board Members: Kevin Upchurch, Jr., Liles Williams, Mike Chaney, Aubrey Lucas, Hank M. Bounds, Larry Fortenberry, John Mulholland, Pat Robertson, Christopher Burkhalter, Eric Clark, Johnny Stringer, Eugene Clarke, Walter Robinson, Jr., Alan Nunnelee.

If your firm currently provide services to, or receive services from, one of these vendors, provide a full description of services provided.

8. Confirm that you will cooperate with the Board and all other Contractors of the Board in the ongoing services outlined in this RFP and in any transition of responsibility.

Organizational/General Information

9. Provide a brief general description of your organization. Include in the description the length of time the organization has been in operation, the name of the parent company, if any, whether your organization is for profit or non-profit, and the state in which the company is incorporated.

Please attach as **Exhibit B** to your proposal a schematic of your organization's structure.

10. Within the last two years has your company been acquired by another organization, merged with another company, purchased another organization, or changed from privately held to publicly held status? If so, please identify what occurred and when. Are any ownership or name changes planned?

11. Name all organizations that have a 10% or more ownership interest in your company. Describe their relationship to your company in terms of percentage of stock held or amount of venture capital invested.

12. List the names, addresses and occupations for members of your Board of Directors.

13. Within the last three years has your organization, any affiliate of the company, or any senior officers or Board members been a party to a lawsuit or governmental investigation? If so, provide a brief description of each incident.

14. List any ownership interest your company has in any health care facility, provider or PBM and describe the relationship.

15. For the purpose of this question the term "complaint" is defined as a written or verbal expression of dissatisfaction.

For your organization's group health care business, what was the total number of complaints filed per 1,000 enrollees in the most recently available 12-month period? What was the total number of complaints filed per 1,000 enrollees in the prior 12-month period? Please include in your response the time period upon which your answer is based.

16. Is your organization currently accredited by:
   i. the American Accreditation HealthCare Commission Inc (AAHCC), formerly known as URAC,
   ii. the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
   iii. the National Committee on Quality Assurance (NCQA)?

If so, please indicate the type, current level and duration of continuous accreditation.

17. If you are subcontracting any services, are any Subcontractors currently accredited by:
   i. the American Accreditation Health Care Commission Inc (AAHCC), formerly known as URAC;
   ii. the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): and/or
   iii. the National Committee on Quality Assurance (NCQA)?

If so, please indicate the name of the Subcontractor, the type, current level and duration of continuous accreditation.

18. Do you currently have a member services and provider services office in Mississippi? If so, note the location and describe its functions. If you do not already have a member services and provider services office in Mississippi, confirm your agreement to establish such an office in the event your firm is awarded the Contract for CHIP and describe its functions.

Financial

Note: Your responses to questions # 19 through #23 are to be based specifically on the primary Contractor's enrollment and assets, and are not to be combined with those of parent, subsidiary or affiliated organizations.

19. Complete the following table based on your entire book of business:

	As of the End of the Most Recently Completed 12 Month Reporting Period, e.g., 2008 (Indicate reporting period)	As of the End of the Prior 12 Month Reporting Period, e.g., 2007 (Indicate reporting period)
a. Admitted Reserves as a Percent of Premium	%	%
b. Current Ratio (Cash to Liability) (For example if 100%, indicate 1.0)		
c. Days in Unpaid Claims	days	days
d. Medical Claims Loss Ratio (claims to premium)	%	%
e. Administrative Loss Ratio (defined as all administrative expense not including profit and risk charges)	%	%

20. Attach as **Exhibit C** to your proposal copies of the most recent reports on the claims paying ability ratings issued to your firm by any of the following rating agencies:
    i. A.M. Best;
    ii. Moody's;
    iii. Standard & Poor's; and/or
    iv. Duff and Phelps.

    Include in **Exhibit C** to your proposal the same information on ratings issued to your parent company, if any. If your organization is not rated by one or more of the referenced organizations, please so state.

21. Indicate your organization's present net worth (assets less liabilities) as a percentage of total premium revenue.

22. Does your organization presently purchase any reinsurance coverage or are special reserves set aside to continue paying claims on existing polices in the event your organization ceases to operate due to bankruptcy, liquidation or other factors?

    If yes, please explain the type of arrangement including the amount of reinsurance coverage and/or the amount of reserve levels established, i.e., number of days and reserves established as a percentage of premium.

23. Attach as **Exhibit D** to your proposal a copy of the most recently available audited financial statements for each of the last two years.

Renewal/Financial Underwriting

24. What is your definition of a paid claim for purposes of renewal?

25. How many calendar days will you need to accurately determine and report the amount of paid claims following the end of each month?

26. Confirm your understanding that there will be no administrative fees (insured or self-insured) payable to the Contractor following termination of the Contract to process the claims run-out liability and that any related expenses are to be included in the quoted administrative fee component of the premium rate.

27. Confirm you will be willing to continue your performance guarantees throughout the run-out period.

28. What is the basis upon which the incurred but unpaid (IBU) claim reserve component to the premium rates is established, e.g., a percentage of premium, a percentage of paid claims, actual lag studies or some other method? Please explain the methodology used in detail and indicate whether there would be any change in the way reserves are set between the first and subsequent Contract years.

29. Are there any charges that would be made against the paid claim and IBU claim reserve components of the premium rates? If so, please describe.

30. Please confirm that under a self-insured funding arrangement you will provide administration for at least 18 months after the termination date for claims incurred prior to the termination date. Please confirm that there will be no administrative fees due at termination for this service.

31. For renewal purposes for the insured proposal, please confirm the components to the rate and identify the methodology used in setting the next year's renewal rate. Identify any factors (e.g., trend) used and how they will be determined and which are guaranteed for the five year Contract.

Client Based/References

32. Provide the following information for each of your three current largest group clients:
    i. Client name and address
    ii. Name, title, telephone number, e-mail address and facsimile number of a key contact
    iii. Number of covered lives and services provided to client.
    iv. Duration of relationship with your organization

33. Provide the following information for each of your three current largest group clients located within the State of Mississippi:
    i. Client name and address
    ii. Name, title, telephone number, e-mail address and facsimile number of a key contact
    iii. Number of covered lives and services provided to client.
    iv. Duration of relationship with your organization

34. If when you answered questions #31and #32 above, you provided less than six <u>different</u> client references, please submit additional references for your largest clients so that six references are provided. For each additional reference provide the following information:
    i. Client name and address
    ii. Name, title, telephone number, e-mail address and facsimile number of a key contact
    iii. Number of covered lives and services provided to client.
    iv. Duration of relationship with your organization.

General Staffing

35. For the most recently available 12-month period, what is the average number of employees employed by your organization and what is the percentage of overall employee turnover? What was the average number of employees employed by your organization and what was the percentage of overall employee turnover for the prior 12-month period? Please indicate in your response the time period upon which your answer is based.

36. Provide the names, location, and brief resumes, including each person's credentials and tenure with the company, for each of the following positions (as defined in **Section 12.1** of this RFP):
    i. Executive Officer
    ii. Account Manager
    iii. Medical Director
    iv. Claims Supervisor
    v. The person representing your organization during this proposal process, if different from any of the persons listed above.

Claims Processing Services

Note: Answer questions #37 through #47 based on the existing office or unit that would process claims until such time as the new office or unit is fully staffed and operational within the State of Mississippi.

37. With regard to the claim office that is proposed to be used for CHIP, provide the following:

Location(s) _____
Years in operation _____
Days & hours of operation _____
Staffing

	# of	Avg. Yrs. Experience	Annual Turnover Rate (%)
Processors	_____	_____	____
Supervisors	_____	_____	____
Managers	_____	_____	____
RNs	_____	_____	____
MDs	_____	_____	____
Claims Support Personnel	_____	_____	____

Annual claim volume _____
# of plans presently _____

38. Do you propose to assign a dedicated unit of claim processors for the CHIP account?
    i. For the claim office proposed, what percent of all claims are processed within 30 working days of receipt, for calendar year 2008.

ii. For the claim office proposed, please provide the following from your internal audit reports for the calendar year 2008:

a) Financial accuracy as a percent of total claims dollars paid (total under and over payments, do not net these amounts);

b) Coding accuracy as a percent of total claims submitted.

39. Describe your claim processing quality review and audit procedures. What type of internal and external audits are done, how often and by whom?

40. Confirm that you are able to provide the quarterly and annual claim turnaround reports required in **Section 13.2** of this RFP for performance standard #18 exclusively for CHIP.

41. Please describe the sampling methodology you propose to use in preparing the quarterly and annual internal audit reports required in **Section 13.2** of this RFP for performance standards #19 and #20 regarding financial accuracy and processing accuracy and confirm that the internal audit reports provided will be exclusively for CHIP claim payment activity.

42. Attach a copy of the most recently available Statement of Auditing Standards (SAS 70 audit report) as **Exhibit E** to your proposal.

43. Please indicate whether your claims processing function currently includes any of the following and to what extent:
i. Electronic imaging of paper claims
ii. Online (real-time) claims processing
iii. Batch (overnight) claims processing
iv. Electronic data interchange (EDI)
v. Microfilm claim copies
vi. Microfilm Member correspondence
vii. Electronic imaging of Member correspondence

44. For each of the following processes please indicate with an (X) whether your claims system handles the task in an automated manner (A), uses processor/review manual intervention (PR), or is not routinely checked (NC).

Processes	A	PR	NC
Checks total charges against total payments			
Checks for duplicate charges			
Compares number of inpatient hospital days on each claim against admission and discharge dates			
Assures services are provided within the member's eligibility date and termination date.			
Recognizes historical lifetime and benefit maximums			
Identifies excess "usual, customary and reasonable" charges (R&C) for all procedures			
Verifies that a provider is licensed to perform the type of procedure billed			
Reconciles the diagnosis code to the procedure and sex code for consistency			

Processes	A	PR	NC
Accumulates co-pays			
Identifies potential coordination of benefits, subrogation, and other party liability situations			
Verifies out-of-pocket			
Reviews age limits for eligibility or special coverage limits			
Determines co-payment levels			
Identifies unbundling of services			
Identifies up coding of services			
Identifies obsolete or invalid codes			
Identifies ineligible services			
Applies multiple surgery guidelines			

45. What percentage of your current book of business represents claims which are electronically filed by providers versus traditional paper processing?

46. Describe your process for identifying potential third party liability/subrogation claims, e.g., worker's compensation and automobile accident injuries. How are claims handled during the process of establishing third party liability?

47. Will a different entity and/or claims office be used to process paper submitted claims for prescription drugs when a Member uses a non-participating pharmacy when either in an area where a network pharmacy is not available and/or not reasonably accessible or when the Member requires prescription drugs while traveling outside the State?

If so, please confirm the location of the claims office, the average number of working days for non-network drug claims to be processed (from date of receipt to date check issued), and the percentage of all claims processed within 30 calendar days from receipt.

Administrative Systems and Capabilities

48. With regard to your computer system, please outline the disaster recovery/ contingency plan that is in place. Does the plan include arrangements for processing at another site in the event of a disaster at the proposed hardware location? If so, please describe the alternative arrangements. Attach a copy of your disaster recovery plan as **Exhibit F** to your proposal.

49. For 2008, what has been the number of times and the percentage of time that the hardware has been "down"? Hardware down time percentage is measured by the ratio of total planned system availability to the planned availability when inquiry operators could not access the system to perform their functions.

50. Please describe how you handle backlogs (e.g., overtime, switch to another office).

51. Can your organization administer the comprehensive benefit package as outlined in **Section 4** of this RFP? If not, identify any plan design provision that you cannot administer or which you do not currently administer and would have to develop the capacity.

52. Have you implemented a new computer system within the last six months? Do you anticipate implementing a new computer system within the next 12 months? If so, please describe the changes.

53. Is your computer system owned by your firm? If not, who owns the system?

54. List the number of MIS personnel presently employed by your company, by job classifications. Please attach a current organizational chart for your MIS department as **Exhibit G** to your proposal response.

55. Are system programmers comprised of in-house staff or contracted professionals? In either case, please discuss staffing adequacy.

56. **Section 11.3** of this RFP lists desired administrative capabilities and management information system features. Is your organization able to provide each of the desired functions or features?

If not, please identify each function that you are not able to provide and indicate any alternative approach you may have for addressing the variance between the desired functions and those which you are able to provide.

HIPAA

57. Describe the process used by your company to comply with HIPAA EDI, privacy, and security requirements.

58. Describe your compliance with HIPAA's transaction standards, medical data code sets, unique identifiers, privacy, and security.

59. Who is the key individual in your organization leading efforts to comply with HIPAA's administrative simplification rules? Please identify that individual by name and title and identify the placement (level) of this individual within your organization.

60. Please identify any HIPAA accreditation your company has received or applied for or intends to apply for. If you have not yet applied for accreditation, when do you expect to? For what level of accreditation?

Electronic Data Interchange and Medical Data Code Sets

61. Does your computer system have the ability to receive a HIPAA X12 electronic transmission? Does your computer system have the ability to send a HIPAA X12 electronic transmission? How is this accomplished?

62. How do you handle non-HIPAA compliant transactions and their rejection?

63. Is your system capable of handling attachments of another standard format (e.g., HL7) within a HIPAA compliant X12 transaction?

64. What front-end editing capabilities are implemented in your system to ensure valid HIPAA transactions?

65. Indicate which HIPAA EDI transaction standards, based on the Implementation Guides, your system supports.

Privacy and Security Standards

66. What privacy policies or procedures are currently in place?

67. Are employees required to sign confidentiality agreements?

68. Do you have a Contract and procedures manual for each staff position?

69. Do you have any subcontractors that will handle the Benefit Plan's PHI? Does your Contract with those subcontractors contain privacy provisions?

70. When an entity (e.g., providers) or an individual make an inquiry to the Contractor about an individual's eligibility for benefits, how is the inquiry handled?
    i. What information is transmitted and how is it recorded?
    ii. Who responds to the inquiry?

71. Does your system presently meet requirements in the privacy regulations issued pursuant to HIPAA?

72. Does your system produce sufficient audit trails to satisfy the HIPAA privacy and security regulations?

73. Has there been any assessment of the various security levels currently available and their compatibility with the HIPAA security standards?

74. Have you conducted an analysis of the risks and vulnerabilities to protected health information in your system?

75. Does your system presently meet requirements in the regulations issued pursuant to HIPAA security standards? If not, have you identified areas in which your system does not meet the proposed standards?

Reporting Capabilities

76. Please review the desired reports listed in **Sections 11.4** of this RFP. Can your organization provide the desired reports included?

    If you are unable to routinely produce any of the desired data elements, please identify which ones in your response. If you produce standard reports that meet the desired report requirements, please attach a copy of the sample reports as **Exhibit H** to your proposal.

77. Please explain how you will determine or count the number of claims for reporting purposes.

78. Other than the standard claim report information listed in **Section 11.4.1**, list and describe any other claim/management reports you are able to provide regularly at no additional charge and the frequency with which this information can be provided. Would you be able to provide these reports by the subgroups identified in **Section 11.4.1**? Attach samples of each report as an **Exhibit I** to your proposal.

79. Describe your capabilities to produce ad hoc reports. Provide examples of previously prepared ad hoc reports for other clients and associated programming charges. Please identify your ad hoc report fee and the basis for the fee.

80. Do you currently offer a data management and analysis system (similar to Thompson Reuters (Healthcare), Inc.) to any of your clients? If so, please describe the system capabilities and indicate any additional setup issues associated with providing this feature for CHIP.

Disease Management Programs

81. For your proposed asthma disease management (DM) program answer the following questions:
   i. Length of time program has been in effect.
   ii. Number of individuals participating in the program.
   iii. Is any aspect of the disease management program Subcontracted? If so list the name of the Subcontractor and the services provided.
   iv. Source of data used to identify individuals with this disease.
   v. Outline how your DM program operates.
   vi. Percent of patients identified for disease management that are likely to comply with your care recommendations.
   vii. What is the most effective behavior change you have achieved through your DM program?
   viii. Discuss the qualifications of your staff who perform the actual DM services.
   ix. Savings you typically see per patient for this disease.
   x. Do you propose any changes to your DM program to better address the needs of the CHIP population?

82. For your proposed diabetes disease management (DM), answer the following questions:
   i. Length of time program has been in effect.
   ii. Number of individuals participating in the program.
   iii. Is any aspect of the disease management program Subcontracted? If so list the name of the Subcontractor and the services provided.
   iv. Source of data used to identify individuals with this disease.
   v. Outline how your DM program operates.
   vi. Percent of patients identified for disease management that are likely to comply with your care recommendations.
   vii. What is the most effective behavior change you have achieved through your DM program?
   viii. Discuss the qualifications of your staff who perform the actual DM services.
   ix. Savings you typically see per patient for this disease.
   x. Do you propose any changes to your DM program to better address the needs of the CHIP population?

83. You must provide the services as described in Appendix W for a Pharmacy Disease Management Program. Please answer the following questions:
   i. Length of time program has been in effect.
   ii. Number of individuals participating in the program.
   iii. Is any aspect of the disease management program Subcontracted? If so list the name of the Subcontractor and the services provided.
   iv. Source of data used to identify individuals with this disease.

v. Outline how your DM program operates.
vi. Percent of patients identified for disease management that are likely to comply with your care recommendations.
vii. What is the most effective behavior change you have achieved through your DM program?
viii. Discuss the qualifications of your staff who perform the actual DM services.
ix. Savings you typically see per patient for this disease.
x. Do you propose any changes to your DM program to better address the needs of the CHIP population?

84. During the DM process describe when and why you interact with the patient's physician.

85. What is the source of the clinical treatment guidelines that your staff uses as the basis for decisions and recommendations? (e.g. your own internally developed guidelines, nationally accepted guidelines, etc.)

86. Does your firm (or any Subcontractor you are using for these services) receive any revenues, gratuities or rebates through working relationship/referrals with drug manufacturers and/or Prescription Benefit Management (PBM) firms relative to Disease Management programs you currently administer. If so, please explain.

87. Explain how you remedy the situation when the patient is not being prescribed the medication/medical equipment your DM firm believes would be most appropriate for their condition. (*e.g.*, asthmatic patient discusses with your DM staff some moderate to severe asthma symptoms and recently saw their physician who has not prescribed a steroid inhaler, peak flow meter, SVN machine or other services/treatments you believe are crucial to adequate asthma management)

Member Access

Note: In accordance with Section 1.10.1 of this RFP, upon execution and return of the Confidentiality Agreement in Appendix C, an electronic file will be released to your firm containing the zip code distribution of the current CHIP population for purposes of measuring Member access under this RFP.

88. Conduct a match between the total number of Members in the CHIP population and your organization's proposed PCP, acute hospital and pharmacy networks, by five-digit zip code. **This match is to include those providers with whom you currently have contracts as well as those with whom you have letters of commitment and/or letters of intent.** The match is to be conducted separately for each provider type for urban/suburban zip code areas and for rural zip code areas. The term urban/suburban area is defined as a zip code with a population density of 1,000 or more persons per square mile and a rural area is defined as a zip code with a population density of less than 1,000 or more persons per square mile. A current listing of urban/suburban and rural areas within Mississippi by zip code, as measured by the latest version of GeoAccess software is provided in Appendix P. The mapping or methodology used to measure distance must be based on actual driving distance and the total count of Members used to perform the access match must equal the total count for the sample population. In other words, no zip code area or Member in the zip code census data is to be excluded when preparing the access information.

For purposes of preparing access reports for PCPs, eligible physicians are limited to the following specialties: family medicine, general medicine, pediatrics and internal medicine. Only those physicians who meet this definition of a PCP and who currently have open practices, i.e., are accepting new patients, should be included in the match. Based on the result of the Member match, please complete the following table:

Provider Type	**Percentage of Sample Population in Urban/ Suburban Areas within Access Standard:**	
	Standard A	**Standard B**
Two Primary Care Physician	Within 15 miles_____%	Within 10 miles_____%
One Physician of each Specialty, as listed in 8.2.2 (a through mm).	Within 20 miles_____%	Within 15 miles_____%
One Acute Hospital	Within 25 miles_____%	Within 20 miles_____%
One Dentist	Within 20 miles_____%	Within 15 miles_____%
One Vision Provider	Within 20 miles_____%	Within 15 miles_____%
One Retail Pharmacy	Within 15 miles_____%	Within 10 miles_____%

Provider Type	**Percentage of Sample Population in Rural Zip Code Areas within Access Standard:**	
	Standard A	**Standard B**
Two Primary Care Physician	Within 25 miles_____%	Within 20 miles_____%
One Physician of each Specialty, as listed in 8.2.2 (a through mm).	Within 30 miles_____%	Within 25 miles_____%
One Acute Hospital	Within 45 miles_____%	Within 30 miles_____%
One Dentist	Within 30 miles_____%	Within 25 miles_____%
One Vision Provider	Within 30 miles_____%	Within 25 miles_____%
One Retail Pharmacy	Within 25 miles_____%	Within 20 miles_____%

Please indicate the name and version of software you used to measure access:_____

89. Attach as **Exhibit J** to your proposal a summary level access report which indicates the total number of persons in the sample population which do not meet access standards in the above column titled "Standard A".

90. Attached as **Exhibit K** to your proposal a detailed access report by five digit zip code, by provider type, for each urban/suburban and rural zip code area in which 100% of the persons in the sample population do not meet the access standards in the above column titled "Standard A".

Provider Network

91. In what year did your proposed provider network first become operational in the State of Mississippi? What is the number of group plans currently participating in the provider network in Mississippi? To the extent you are subcontracting or leasing any provider networks, answer this question separately for each subcontracting arrangement.

92. What contractual requirements does your organization have with network providers to hold them accountable for timely scheduling of elective appointments?

93. Do your physician and hospital network Contracts have a "continuation of care" clause that says if a physician or hospital cancels or fails to renew its Contract, that care which began with the network provider will continue to be reimbursed as a network provider?

If yes, please outline the specific contractual terms, including the length of time the "continuation of care" clause would continue to apply following termination of the provider Contract.

94. Indicate the standard methods used to communicate provider terminations, additions and address/phone number changes to Members.

95. What plans, if any, do you have for growth in the number of PCPs, specialists and network facilities if you are awarded this contract? Please include target dates for any expansion in the number of network providers.

96. What percentage of the primary care physicians in your proposed Mississippi provider network currently have closed practices, i.e., are not accepting new patients?

97. Complete the following physician reimbursement table. To the extent you are subcontracting or leasing provider networks and reimbursement methodologies vary by network, then please answer this question separately for each subcontracting arrangement.

Name of Network

	Primary Care Physician	Network Specialist
Predominant reimbursement method, e.g., fee-for-service, discounted fee-for-service, capitation		
Source of Fee Schedule, e.g., HIAA, Medicare, MDR, in-house		
Frequency of updates to reimbursement/fee schedules, e.g., semi-annually, annually		
Are there any risk sharing arrangements, e.g., bonus pools, withholds or retroactive payments? If so, list		

98. Attach as **Exhibit L** to your proposal a directory or list indicating the full name, address and specialty of professional providers **currently under Contract** in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA;

Birmingham, AL; and Mobile, AL. If this information is available on CD, please also enclose a copy of the directory on CD with your proposal response.

99. Attach as **Exhibit M** to your proposal a directory or list indicating the full name, address and specialty of professional providers with whom your organization **has letters of commitment to Contract with** in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL. If this information is available on CD, please also enclose a copy of the directory on CD with your proposal response.

100. Please complete the following table with regard to your proposed professional provider network in the State of Mississippi and in the border cites of: Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL.

	Number of Providers Currently under Contract		Number of Providers with Letters of Commitment	
Provider Type	**Within State of MS**	**In border cities**	**Within State of MS**	**In border cities**
Internal Medicine (PCP)				
Internal Medicine Subspecialists				
General/Family Medicine (PCP)				
Pediatricians (PCP)				
Pediatric Subspecialists:				
Cardiology				
Craniofacial				
Hematology/ Oncology				
Nephrology				
Neonatal Medicine				
Endocrinology				
Neurosurgery				
Orthopedic Surgery				
Pulmonology				
Gastroenterology				
Intensive Critical Care				
Adolescent Medicine				
Urology				

	Number of Providers Currently under Contract		Number of Providers with Letters of Commitment	
Provider Type	**Within State of MS**	**In border cities**	**Within State of MS**	**In border cities**
Obstetricians/Gynecologists				
General Surgeons				
Surgery Subspecialists				
Dentists				
Ophthalmologists and Optometrists				
Audiologist				
Total Number of Providers				

101. Please complete the following table with respect to your proposed provider network in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL. If the percentages are unknown, please so indicate.

	% Board Eligible	% Board Certified
Primary Care Physicians		
Physician Specialist		

102. Please complete the following table regarding your credentialing procedures for **physicians.** To the extent you are subcontracting or leasing provider networks and the credentialing criteria varies by network, then please answer this question separately for each subcontracting arrangement

Name of Network_____

Criteria	Yes/No
Requirement that medical license has never been restricted or revoked?	
Is board eligible or board certification required?	
Is valid Drug Enforcement Administration (DEA) certificate required?	
Must physician currently have admitting privileges to at least one community or teaching hospital?	
Are the type and quantity of lawsuits investigated?	
Are references required and checked?	
Is the physician's status in the National Practitioner Databank checked?	
Is the physician's status on sanctions in Medicare/Medicaid programs checked?	
List any other credentialing requirements for physicians: _____ _____ _____ _____ _____	

103. How often are physicians re-credentialed? To the extent you are subcontracting or leasing provider networks and the answer to this question varies by network, then please answer this question separately for each subcontracting arrangement

104. Complete the following table by indicating your network provider overall average percentage discount off the average prevailing non-network (or non-managed) reasonable and customary charges statewide within Mississippi for the following categories:

Type of Service	Calendar Year 2008	First Three Months of Calendar Year 2009
Physician – non-surgical		
Physician – surgical		
Radiology		
Pathology		
Anesthesiology		
What is the source of your prevailing charge data, e.g., Ingenix (formerly HIAA) or internally developed? _____		

Note: the Board reserves the right to request more detailed information regarding provider discount arrangements (e.g., by network, type of provider, type of service) as part of Phase Three of the evaluation process.

105. Complete the following grid regarding your organizations credentialing criteria for the following types of health care providers by checking each column that applies. To the extent you are subcontracting or leasing provider networks, then please answer this question separately for each subcontracting arrangement.

Name of Network_____

	No credentialing process for these providers	Providers not part of network	Yes, credentialing process for these providers
Nurse practitioners			
Occupational and physical therapists			
Audiologist			
Dentist			
Optometrist			
Psychologist			
Professional counselors and clinical social workers			

106. Indicate the name and location of any facilities, e.g., acute hospitals, ambulatory surgical facility, freestanding rehab facility, skilled nursing facility or psychiatric facility, in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL, with whom you currently have a Contract or a letter of commitment which are not JCAHO accredited. What credentialing factors do you utilize to evaluate these types of facilities?

107. Please provide the information in the following table.

	Total Number of Facilities Currently under Contract		Total Number of Facilities with Letters of Commitment	
Facility Type	**Within State of MS**	**In border cities**	**Within State of MS**	**In border cities**
Hospital				
Other Health Care Facilities (not including hospitals)				
Total				

108. Attach as **Exhibit N** to your proposal a directory or list which indicates the full name and address of all hospital and other health care facilities **currently under contract** in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL. If this information is available on CD, please also enclose a copy of the directory on CD with your proposal response.

109. Attach as **Exhibit O** to your proposal a directory or list which indicates the full name and address of all hospital and other health care facilities with whom you **have letters of commitment** in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL. If this information is available on CD, please also enclose a copy of the directory on CD with your proposal response.

110. Do the network hospitals listed in response to the previous two questions include hospital-based physicians (including radiologist, pathologist, anesthesiologist and emergency room physicians)?

If not, please identify those hospitals for which the hospital-based physician staff are not currently under Contract or for whom you do not have a letters of commitment.

111. Attached as **Exhibit P** to this RFP is a listing of the most frequently utilized hospitals, primary care physicians, specialist, dentist and vision care providers under the Benefit Plan. Please indicate in the last three columns of the listing whether the provider is currently under Contract or whether you have a letter of commitment with the provider if you are awarded this Contract. Include a copy of the completed listing as **Exhibit Q** to your proposal.

112. Identify which of the following methods of reimbursement apply to facilities in your network. Also identify the average discount levels (off of billed charges) produced by whatever system of reimbursements you have negotiated.

	DRG W/Outlier	DRG No Outlier	Per Diem W/Outlier	Per Diem No Outlier	% Discount Billed Charges	Other _____	Average Discount Level
Acute Inpatient Med/Surg Hospital							
Hospital Based Surgery Center							
Outpatient Hospital (i.e., x-ray and							

	DRG W/Outlier	DRG No Outlier	Per Diem W/Outlier	Per Diem No Outlier	% Discount Billed Charges	Other _____	Average Discount Level
lab)							
Hospital Emergency Room							
Acute Inpatient Mental Health							

Note: the Board reserves the right to request more detailed information regarding provider discount arrangements (e.g., by network, type of provider, type of service) as part of Phase Three of the evaluation process.

113. Complete the following table by indicating the average percentage discount off of billed charges that apply to hospitals in your network for calendar year 2008 and for the first three months of calendar year 2009.

	Average for 2008	Average for first 3 months of 2009
Hospital – Inpatient Services		
Hospital – Outpatient Services		

Note: the Board reserves the right to request more detailed information regarding provider discount arrangements (e.g., by network, type of provider, type of service) as part of Phase Three of the evaluation process.

114. Complete the following table indicating whether such services are available under your proposed hospitals and other health care facility provider network in Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL. For the purposes of answering this question, please include all facilities that are currently under Contract as well as those with whom you have letters of commitment.

Services:	Are Services Available Through The Proposed Provider Network? (Y/N)	Total # of Facilities in Mississippi Providing Services	Total # of Facilities in Border Cities Providing Services
Alcohol/chemical dependency			
Ambulatory surgery			
Burn unit/care			
Cardiac care unit			
CT scanner			
Diagnostic radioisotope facility			
Emergency room			
Hemodialysis			

Services:	Are Services Available Through The Proposed Provider Network? (Y/N)	Total # of Facilities in Mississippi Providing Services	Total # of Facilities in Border Cities Providing Services
Home health services			
Hospice			
Intensive care unit			
Neonatal intensive care			
Magnetic resonance imaging (MRI)			
Obstetrics			
Occupational therapy			
Open heart surgery			
Pediatric inpatient unit			
Pediatric intensive care			
Physical therapy services			
Psychiatric services			
Rehabilitation (inpatient)			
Rehabilitation (outpatient)			
Skilled nursing home/facility services			
Therapeutic radioisotope facility			
Transplantation – bone marrow			
Transplantation – heart			
Transplantation – kidney			
Trauma center (Level I or II)			

115. For services listed above that are not available in the network, explain the process for providing these services to Members through arrangements with non-participating hospitals.

116. Please complete the following table indicating the percent of the network hospitals paid under the list methodologies. To the extent you are subcontracting or leasing provider networks and the reimbursement methodologies vary by network, then please answer this question separately for each subcontracting arrangement.

Name of Network_____

Payment Methodology	Percent
Per diem basis	
DRG basis	
Discount basis	
Other basis (describe other)_____ _____ _____	

117. For the purpose of this question, the term "Center of Excellence" means a facility screened and selected by your organization in a process above and beyond your usual credentialing program. It also means the facility has been designated as one of your organization's "Centers of Excellence" due to clinical expertise in a particular field.

Please list any "Centers of Excellence" facilities by name and location and the area of specialty, e.g., organ transplants, cancer, etc., that your organization contracted with or has letter of agreement.

118. Explain the process you propose to follow in negotiating discounted fees for services rendered to Members by any non-participating provider. Please include in your response:

i. Are any services subcontracted? If so list the name of the Subcontractor and the services provided.
ii. How non-participating providers are identified by the Contractor
iii. The qualifications of the staff utilized to negotiate provider discounts.
iv. Whether the negotiation of fees occurs before and/or after services are rendered.
v. The overall expected percentage discount off of billed charges you expect to achieve.

119. Describe your proposed procedures to assist Members in receiving recommended immunization, per **Section 8.11** of this RFP.

Pharmacy Network

Pharmacy Financials - Insured Product

120. What portion of the premium is for pharmacy services?

121. How is this determined?

122. Are there any other fees associated with the pharmacy program?

123. If yes, what are they and for what services?

124. Are rebates used to offset any portion of the pharmacy premium or cost for other pharmacy programs?

Pharmacy Financials - Self-Insured Product

125. What is the administrative fee for the pharmacy program? If included with medical, please identify what percent of the medical administrative fee is for pharmacy.

126. Are there any other fees associated with the pharmacy program?

127. If yes, what are they and for what services?

Pharmacy Network - Insured and Self-Insured Products

128. Do you provide a network of retail pharmacies that contract with you directly?

129. Are any aspects of your retail pharmacy network under subcontract with another vendor? If yes, with whom and for what services?

130. How do you ensure the quality of services provided by the retail pharmacies that are included in subcontracted arrangement?

131. How many retail pharmacies participate in your network?
- Nationally
- In Mississippi

132. What percent of your network retail pharmacies in Mississippi are open 24 hours?

133. If not open 24 hours, what percent of your network retail pharmacies in Mississippi offer 24-hour emergency service?

134. Which, if any, retail chains do not participate in your network nationally?

135. Which, if any, retail chains do not participate in your network in Mississippi?

136. What credentialing criteria must retail pharmacies meet in order to participate in your network?

137. How do you ensure that the retail pharmacies in your network comply with and adhere to your requirements for participation?

138. Please provide the minimum guaranteed discount as a percentage off Average Wholesale Price (AWP) at retail for brand name drugs, identifying the dispensing fee, your definition of a brand name drug (e.g., single source brand, multi-source brand, single source generic, etc.), what lesser of provisions are included, what package size is used to determine the price, what is included in the calculation of the minimum guarantee, any offsets used to meet the minimum guarantee.

139. Please provide the minimum guaranteed discount as a percentage off AWP at retail for generic drugs, identifying the dispensing fee, your definition of a generic drug (e.g., multi-source brand, single source generic, multi-source generic, etc.), what lesser of provisions are included, what package size is used to determine the price, what is included in the calculation of the minimum guarantee, any offsets used to meet the minimum guarantee.

140. When is a multi-source generic included on your Maximum Allowable Cost (MAC) list? How often is your list updated?

141. How often are MAC prices updated?

142. What is your pricing source for (AWP) and how frequently do you update your prices?

143. How often do you renegotiate the discounts and dispensing fees with your retail pharmacies?

144. How many specialty pharmacies do you own?

145. How many specialty pharmacies are subcontracted?

146. Please provide the minimum guaranteed discount as a percentage off AWP at specialty for brand name drugs, identifying the dispensing fee, your definition of a brand name drug (e.g., single source brand, multi-source brand, single source generic, etc.), what lesser of provisions are included, what package size is used to determine the price, what is included in the calculation of the minimum guarantee, any offsets used to meet the minimum guarantee.

147. Please provide the minimum guaranteed discount as a percentage off AWP at specialty for generic drugs, identifying the dispensing fee, your definition of a generic drug (e.g., multi-source brand, single source generic, multi-source generic, etc.), what lesser of provisions are included, what package size is used to determine the price, what is included in the calculation of the minimum guarantee, any offsets used to meet the minimum guarantee.

Pharmacy Network – Self-Insured

148. For what period of time will you guarantee the discounts at retail, and specialty?

149. How many Generic Code Numbers (GCNs) are on your MAC list?

150. What programs do you have in place to encourage your network pharmacies to dispense generic equivalents whenever possible?

151. What discount applies for specialty drugs when obtained through the retail network?

152. What discount applies when prescriptions are sent to a specialty pharmacy?

153. How often do you perform desktop audits on your retail pharmacies?

154. What percent of your retail pharmacy network is subject to desktop audit?

155. What areas do you include in your desktop audits?

156. How often do you perform on-site pharmacy audits?

157. What percent of your retail pharmacy network is subject to on-site audit?

158. Please describe how you select a retail pharmacy for on-site audit?

159. What procedures are in place to identify potential waste, fraud and abuse?

160. What actions do you take when fraud, waste or abuse is detected?

161. Are your criteria for auditing your specialty pharmacy the same as for the retail network? If no, please describe the differences and why they differ.

162. How often do you audit your specialty pharmacy?

163. Do you retain any audit recoveries? If yes, please describe and quantify.

164. What is the minimum per claim rebate at retail that you will guarantee? "Per claim" is defined as each individual paid claim whether brand or generic.

165. What is the minimum per claim rebate at specialty that you will guarantee? "Per claim" is defined as each individual paid claim whether brand or generic.

Pharmacy Clinical Programs - Insured and Self-Insured Products

166. Are your clinical pharmacists employed by you or subcontracted?

167. How many clinical pharmacists are on staff?

168. What type of specialized training do they receive to enhance their familiarity with government programs and how often do they undergo additional training?

169. Please describe in full how your formulary or preferred drug list is determined.

170. If your formulary is developed through a subcontracted entity, please identify the vendor and what oversight you provide to ensure that the decisions made are based on clinical superiority/equivalence, efficacy and safety; and not rebate return.

171. Is use of your formulary or preferred drug list mandatory under a fully insured arrangement?

172. Is use of your formulary or preferred drug list mandatory in order to meet the minimum discount guarantees?

173. How many formularies or preferred drug lists do you maintain?

174. How often is your formulary updated?

175. When and how often do you remove drugs from your formulary or preferred drug list?

176. When and how often are preferred drugs changed to non-preferred?

177. How do you communicate these changes to members?

178. Do you allow customization of your formulary or preferred drug list?

179. What utilization management (UM) programs are included as part of a fully insured program? Please describe each in detail including the drugs or drug categories that are subject to each UM program.

180. Will the State of Mississippi have the option to decline any of these programs under a fully insured arrangement?

181. If yes, which ones and what will be the impact or implications?

182. What drug utilization review programs are included in a fully insured arrangement? Please describe each in detail.

183. How is prescription drug data used to enhance care and health management? Please describe in detail.

Pharmacy Clinical Programs - Self-Insured Products

184. Are claims from each of your prescription drug delivery channels processed through the same system so that the data is integrated for concurrent drug utilization review purposes? If no, please describe in detail how and when data is integrated for drug utilization review purposes.

185. Are there additional fees for drug utilization management programs when prescription drug services are self-funded? If yes, please describe in full and quantify.

Pharmacy Account Management and Reporting - Insured and Self-Insured Products

186. Will you provide a clinical pharmacist who is dedicated to the Board for this program?

187. If no, how do you propose to manage prescription drug utilization and recommend changes to enhance quality and savings opportunities? Please describe in full.

188. How often will you provide detailed reports on the prescription drug program?

189. Please describe in full what reports will be provided and when.

190. Will on-line reporting be provided? Please describe in detail.

191. If yes, will the Board be able to develop ad hoc reports from the on-line system? Please describe.

192. How often is the data updated or refreshed in the on-line reporting system?

193. How often will your clinical pharmacist/account manager meet with the Board to discuss the prescription program?

194. Are there any fees for the on-line reporting program? If yes, please describe and quantify.

Provider Services

195. Indicate the days of the week and hours of the day your proposed provider service department and telephone lines will be open and staffed with live personnel.

196. Outline your provider services telephone system, including the system for receiving and responding to after hour and weekend calls. Indicate how you would know if the number

of incoming lines is insufficient and the steps you would take to correct the problem. Please confirm whether you are able to provide reports on call availability, answering speed, on-hold time and abandonment rates exclusively for this Plan.

197. How do you plan to educate providers regarding your policies and procedures for CHIP?

198. Are there any requirements listed in **Sections 9.1 or 9.3** of this RFP regarding provider services which your organization is not able to agree to or accept? If so, please identify those items and explain.

199. **Section 9.2** of this RFP lists desired features to be included in a provider manual. Are there any desired features which you do not envision incorporating into your provider manuals? If so, please identify which ones.

200. List the top three most common complaints by your network providers and indicate any quality improvement actions you have taken as a result of provider complaints.

201. Does your organization conduct provider satisfaction surveys? If so, in your most recent survey what percentage of providers was dissatisfied overall?

Utilization Management

202. With regard to the proposed entity and office that will be performing utilization management services (excluding nurse triage services) for CHIP, provide the following:

Full name of entity _____
Location(s) _____
Years in operation _____
Days & hours of operation _____

Staffing

	# of	Avg. Yrs Experience in UM
Non-licensed intake coordinators	_____	_____
RNs	_____	_____
LVNs/LPNs	_____	_____
Behavioral health counselors	_____	_____
MDs/DOs	_____	_____
Other	_____	_____

Average UM employee turnover for most recently available months _____%
Total # of covered lives for whom UM services are being performed _____
Total # of covered lives located in Mississippi for whom UM services are being performed _____

203. Is the entity proposed to perform utilization management services currently licensed and operating in accordance with all the requirements of **Section 41-83-1** through **Section 41-83-29** of the Mississippi Code? If not, please explain.

204. **Section 4.15** of this RFP lists the preferred features to be included in the utilization management program. Is the entity performing UM able to provide/administer each of the preferred features? If not, specifically note in your response to this question any functions you are not able to provide and how your organization proposes to administer any variances.

205. If a fully-insured proposer, **Section 5** of this RFP outlines the Grievance Appeal Procedures for Members and providers, including requirements for expedited review. Please confirm that the entity conducting UM agrees to adhere to the procedures outlined in **Section 5** of the RFP.

206. If a self-insured proposer, **Section 6** of this RFP outlines the Appeal Procedures for Members and providers, including requirements for expedited review. Please confirm that the entity conducting UM agrees to adhere to the procedures outlined in **Section 6** of the RFP.

207. Outline your utilization management telephone system, including the system for receiving and responding to after hour and weekend calls. Indicate how you would know if the number of incoming lines is insufficient and the steps you would take to correct the problem. Please confirm you are able to provide reports on call availability, answering speed, on-hold time and abandonment rates exclusively for CHIP.

208. Indicate the primary method for determining the appropriate length of stay for a hospital admission, e.g., Milliman, InterQual or, internally developed or other purchased tables? Does your criteria for determining length of stay vary by state or geographic region?

209. Please complete the following chart by confirming the outpatient services subject to utilization management, including the screening criteria used and the specific procedures or services subject to UM. If all services or treatment in a category are subject to utilization management, please so indicate rather than listing each service.

Service	Are services subject to UM? If yes, indicate the primary source for the written screening criteria used	To the extent UM only applies to specific procedures or services, please list
Surgery		
Diagnostic services		
Durable medical equipment		

Service	Are services subject to UM? If yes, indicate the primary source for the written screening criteria used	To the extent UM only applies to specific procedures or services, please list
Corrective appliances/prosthetics		
Home health, private duty nursing and home infusion therapy services		
Mental health and substance abuse outpatient visits		
Hospice home care		
Occupational and physical therapy		
Manipulative therapy		
Physician specialty care visits		
Other, please list _____ _____		

210. Indicate your procedure if no written screening criteria or length of stay guidelines exist for a particular diagnosis, case or service?

211. Are clinical indicators and the criteria upon which the UM firm's approval or denial was based routinely documented in the case file?

212. What is the process for assigning precertification, continued stay review and case management cases to physicians for review? What percent of precertification cases typically require physician involvement?

213. What criteria are used to identify cases for case management? If a list is used, please provide a copy of the list. When and how is case management initiated?

214. Does the entity proposed to perform UM have any experience case managing for a SCHIP population? If yes, describe the experience.

215. Will prior authorization or case management requirements apply to certain types of outpatient prescription drug therapies, such as growth hormones?

If yes, please: (a) provide a list of the drug therapies which will require prior authorization; (b) confirm the name and location of the entity performing the prior authorization services; and (c) describe the process under which prior authorization may be obtained.

216. Please explain the methods you will use to control cost and utilization for residential treatment and partial day treatment of mental health disorders?

217. Is any aspect of the case management program subcontracted? If so list the name of the subcontractor and the services provided.

218. Do you anticipate the need to make any changes to your case management program to better address the needs of the CHIP population? If so, please explain.

Referral Process

219. How do you propose to handle services not provided in-network?

Nurse Triage Service

220. With regard to the proposed entity and office that will be performing nurse triage services, provide the following:

Full name of entity _____
Location(s) _____
Years in operation _____

Staffing

	# of	Avg. Yrs. Experience
Non-licensed intake coordinators	_____	_____
RNs	_____	_____
LVNs/LPNs	_____	_____
Social workers	_____	_____
Behavioral health counselors	_____	_____
MDs/DOs	_____	_____
Other	_____	_____

Average employee turnover for most recently available 12 month period _____%
Total # of covered lives for whom nurse triage services are being performed _____
Total # of covered lives located in Mississippi for whom nurse triage services are being performed _____

221. Outline the telephone system used for nurse triage services. Indicate the call tracking capabilities. Indicate how you would know if the number of incoming lines is insufficient and the steps you would take to correct the problem. Please confirm whether you are able to provide reports on call availability, answering speed, on-hold time and abandonment rates exclusively for this Plan.

222. **Section 4.16** of this RFP lists desired features to be included in the nurse triage program. Is the entity performing nurse triage able to provide/administer each of the desired features?

If not, specifically note in your response to this question any features you are not able to provide and how your organization proposes to administer any variances.

223. What qualifications and/or experience do you require of the personnel who interact with Members using your nurse triage program?

224. What percent of your medical triage protocol necessitates:

	%
Staff to rely on past experience and training	
Staff to follow written computerized criteria	
Staff to ask specific questions on an algorithm directed toward prompt clinical assessment/triage	
Other: (Describe)	
Total	**100%**

225. What percent of your program contains computerized logic structured so that the most medically sensitive issues are addressed first? Provide an example.

226. Is the software logic used to conduct services internally developed or purchased? If you purchase the software logic what is the name of the software used?

227. Do triage tools prompt the nurses to direct the Member to the network providers?

228. How do you plan to educate Members and their parents/guardians to promote the use of the nurse triage program? Please describe both initial communication efforts to new Members as well as any on-going communication efforts.

229. How do you identify and refer callers who may be appropriate for case management or disease management?

230. Does your program provide for the nurse to re-contact a patient, if deemed necessary, to follow up regarding the course of action recommended?

If yes, describe those types of situations where this might occur.

231. How do you assure that information pertinent to a patient's on-going care is communicated to that patient's attending physician or the UM department? Explain how you secure the patient's consent to accomplish this communication.

232. List and describe any standard reports on nurse triage activities you are able to provide regularly at no additional charge and the frequency with which this information can be provided. Attached samples of each report as **Exhibit R** to your proposal.

Member Services

233. With regard to the office that is proposed to provide Member service functions for the CHIP Plan, provide the following:

Location(s) _____
Years in operation _____
Days & hours of operation _____
Staffing

	#of	Avg. Yrs Experience	Annual Turnover Rate (%)
Member service representatives	_____	_____	____
Supervisors	_____	_____	____
Managers	_____	_____	____
Other	_____	_____	____

Annual claim volume _____

# of plans presently administering _____

234. Indicate the days of the week and hours of the day your proposed Member services telephone lines will be open and staffed with live personnel.

235. Outline your Member services telephone system. How you would know if the number of incoming lines is insufficient and the steps you would take to correct the problem? Confirm whether you are able to provide reports on call availability, answering speed, on-hold time and abandonment rates exclusively for this Plan.

236. Complete the following table with regard to the proposed Member service department's performance for the most recently available 12 month period. Please indicate the time period for which measurement of the standard is being reported.

	Reporting Period _____ **Actual**	**Goal**
Average number of calls completed per hour per member service representative in an average week		
Length of time a member is on hold before speaking to a member service representative		
Overall abandonment rate	%	%

237. How do you propose to ensure that new Members understand the benefits and access requirements of the Plan?

238. Pursuant to **Section 10.4** of this RFP, the Contractor is strongly encouraged to develop and implement educational programs for Members and their families. What educational programs do you currently offer to members? What educational programs will you offer to Members covered under CHIP?

239. Given the unique characteristics of the population to be covered by CHIP, do you propose to develop and implement any educational programs, other than those identified in your answer to the above question? If so, please explain.

240. How often does your organization conduct general member satisfaction surveys? What characteristics listed below describe the member satisfaction survey tool currently used? Check only one.

[ ] Use the NCQA member health survey instrument
[ ] In-house proprietary instrument
[ ] Other nationally used instrument. Indicate name _____
[ ] Other: _____

241. Indicate the percentage of members who responded during the last completed survey that they were at least "satisfied" with your organization.

242. List the top three most common complaints by members and indicate any quality improvement actions you have taken as a result of Member complaints.

243. What percentage of all claims appealed within your organization proceeded to the final level of appeal?

244. On the final level of appeal, does your organization currently refer adverse determination to an independent review organization? If so, how long have you used an external review firm, what is the name of the review firm currently used and what percentage of all adverse determinations made by your organization are disapproved or overturned by the independent review organization?

245. What communication capabilities are available to accommodate special populations, including non-English speaking, hearing and/or visually impaired?

Implementation

246. Provide an outline of an implementation plan that demonstrates your understanding and ability, (and that of any and all sub-contractors) to meet the Board's requirements to have the Benefit Plan in place beginning on the anticipated effective date of January 1, 2010. This outline should include a description of the specific tasks, the responsibilities of all parties during each phase and a time table for initiation and completion of such tasks, beginning with the Contract award date of June 24, 2009 and continuing through the effective date of the Contract.

Please identify in the implementation plan any interim steps or temporary procedures that would be implemented to meet the intent of this RFP so that coverage can be offered to eligible children effective January 1, 2010. Highlight any steps that only apply to an insured or self-insured contract.

Attachment B
United's Response to RFP

SECTION 4 QUESTIONNAIRE

General Requirements

1. State the full legal name of the primary Contractor, headquarters address, and the name, title, mailing address, telephone number, email address and facsimile number of the contact person for this proposal.

UnitedHealthcare by AmeriChoice®, a division of UnitedHealth Group (UHG), is the primary bidder for the Mississippi Children's Health Insurance Program (MS CHIP) and will be conducting business for this program using the license of UnitedHealthcare Insurance Company (UHIC). UnitedHealthcare Insurance Company is an indirect wholly-owned subsidiary of UnitedHealth Group Incorporated, a Minnesota corporation. UnitedHealthcare by AmeriChoice and UHIC are referred to collectively as "UnitedHealthcare" throughout this section.

UnitedHealthcare is a nationally-recognized industry leader with a strong business presence in the State of Mississippi. Since 1973, the UnitedHealth Group companies collectively serve more than 180,000 Mississippians. Our extensive provider networks include 3,000 physicians and 85 Mississippi hospitals.

Primary Contractor Information	
Primary Contractor Name:	UnitedHealthcare (under licensure of UnitedHealthcare Insurance Company)
Headquarters Address:	450 Columbus Blvd. Hartford, CT 06103-0450
Contact Information:	
Name:	Norine Yukon
Title:	CEO, UnitedHealthcare by AmeriChoice
Mailing Address:	800 Woodlands Parkway, Suite 102 Ridgeland, MS 39157
Telephone Number:	512.608.1817
E-mail Address:	Norine_Yukon@uhc.com
Fax Number:	601.957.1306

2. Is the primary Contractor an insurance company, third-party administrator or other type of organization?

UnitedHealthcare will be conducting business under the license of UHIC, an insurance company licensed statewide in Mississippi (NAIC# 79413) and is bidding as both fully-insured and self-insured.

3. As of the proposal due date, how many years of experience does the primary Contractor have in providing services similar to those requested in this RFP? Please include in your response, the month and year the Contractor began to first provide the services.

UnitedHealthcare and its predecessor companies have served government programs exclusively since October 1982, earning a reputation as an innovative developer of public sector health care solutions with 27 years of experience.

4. As of the proposal due date, does the primary Contractor currently provide similar services to those requested in this RFP to at least one employer group, with at least 50,000 covered lives (includes active employees, retirees, COBRA, and dependents)? This requirement can be met if the proposer currently services a federal or state medical assistance program, i.e., Medicare or Medicaid. If yes, provide the following information:
   i. Name of Client
   ii. Number of Covered Lives
   iii. Name of Key Contact
   iv. Title of Key Contact
   v. Telephone Number
   vi. Fax Number

vii. Email Address
viii. Types of Services Provided

Today, UnitedHealthcare provides many services—from managed care and disease management to pharmacy, claims, and financial administration. Currently, we serve more than 2.3 million beneficiaries of government programs (for example, Medicaid, Medicare, SCHIP, and Uninsured) in 22 states (UnitedHealthcare plans operate in 21 states and the District of Columbia; throughout this proposal, we refer to 22 states). Seventeen of our plans provide CHIP or children's health-related services for our Members; we have been supporting CHIP programs since 2000. We submit information for the following health plans listed below to substantiate our contention that we are highly-experienced and have demonstrated our ability to perform the services required under this contract. While each plan is owned by the UnitedHealthcare family, many of them are marketed under their "legacy" names. UnitedHealthcare chooses to retain these legacy names at this time in an effort to avoid any confusion for Members, providers or state employees. The marketed name of the health plans appears at the top of each table.

- AmeriChoice—UnitedHealthcare Plan of the River Valley
- Arizona Physicians IPA, Inc.
- UnitedHealthcare of Florida
- AmeriChoice of Connecticut
- Unison Health Plan of the Capital Area
- Great Lakes Health Plan
- AmeriChoice--Healthy and Well Kids of Iowa Program (hawk-i)
- Unison Health Plan of Delaware
- Health Plan of Nevada
- UnitedHealthcare of Texas
- Unison Health Plan of Pennsylvania
- AmeriChoice of Pennsylvania
- UnitedHealthcare of Wisconsin
- Unison Health Plan of Ohio
- Unison Health Plan of South Carolina
- UnitedHealthcare of the MidAtlantic
- AmeriChoice of New Jersey
- UnitedHealthcare of New England
- UnitedHealthcare of New York
- UnitedHealthcare of the Midlands./ Share Advantage
- Georgia Enhanced Care Program
- County Medical Services (CMS) Program (San Diego County).

AmeriChoice (UnitedHealthcare Plan of the River Valley)
State of Tennessee
-- entered the Tennessee market in 1994 --

Client Name and Address
Bureau of TennCare
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Key Contact
Name/Title: Darin J. Gordon, Deputy Commissioner
Telephone: 615.507.6443
E-mail: Darin.j.gordon@state.tn.us
Fax: 615.253.5607

Contract Size

Average Monthly Covered Lives		Public Funded Contract Cost	
Eastern Region	166,000	Eastern Region	$420M
Middle Grand Region	181,000	Middle Grand Region	$520M
Western Region	162,000	Western Region	$406M

Contract Start Date		Most Recent Contract Duration	
Eastern Region	1994 (Originated)	Eastern Region	05/19/08 – 06/30/12
Middle Grand Region	04/01/2007	Middle Grand Region	08/15/06 – 06/30/10
Western Region	05/19/2008	Western Region	11/01/08 – 06/30/12

Scope of Work

Eastern, Middle Grand, and Western Regions: Since 1994, we have participated in the eastern region of the TennCare program, initially as a fully capitated health plan, and later, under the revised format of TennCare that converted the program to an administrative services contract. Over the years, we demonstrated strong and consistence performance contributed to our 2006 full-risk contract award in the Middle Grand region. In 2008, AmeriChoice was awarded risk contracts in the East Grand and West Grand regions. AmeriChoice was one of only two companies awarded contracts in the West Grand and East Grand regions, and the only company operating in all three regions. We provide a full continuum of health plan services for our 520,000 enrollees, including a fully integrated medical and behavioral care management program. Our TennCare programs consist of traditional Medicaid coverage groups and an expanded population of children.

TennCare Medicaid: covers all mandatory Medicaid eligibility groups and some categorically and medically needy voluntary groups, including children, pregnant women, the aged, and individuals with disabilities.

TennCare Standard: TennCare Standard includes children in these eligibility categories: Uninsured, children under age 19 a) who are TennCare eligible and with family incomes < 200 percent of the federal poverty level (FPL), b) who are TennCare eligible and meet "medically eligible" criteria (for example, a health condition that makes the child uninsurable) and c) who are no longer eligible for TennCare Medicaid and are either uninsured or medically eligible.

Covered Services: inpatient hospital, physician, outpatient hospital, ambulance, physical therapy, nursing care, speech therapy, durable medical equipment, home health care, hospice, hearing, vision, behavioral health and non-emergency transportation.

Community Outreach: Joining with a local Nashville community organization—United Neighborhood Health Services (UNHS), we launched a new program to reduce wait times at a number of Davidson County hospital emergency rooms (ER) by reducing non-emergency ER visits. It benefits all patients seeking non-emergent care at designated hospitals, regardless of insurance carrier or insurance status. Patients presenting at a participating ERs with non-emergency medical needs are referred directly to an on-site UNHS staff member who schedules a same-, or next-day, appointment at a UNHS clinic, many of which have extended hours. TennCare beneficiaries are offered transportation to the clinic, if needed. UNHS follows-up with these patients and ensures that any missed appointments are re-scheduled. For patients without a regular doctor, the program establishes a Primary Care "medical home" where education is provided on routine versus emergency health care.

Arizona Physicians IPA (APIPA) State of Arizona -- entered the Arizona market in 1982 --	
Client Name and Address	**(1) Acute Care & Uninsured Children contract:** Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, Phoenix, AZ 85034 **(2) Children's Rehabilitative Services – CRS contract:** Arizona Dept of Health Services, Office for Children w/ Special Health Care Needs 150 North 18th Avenue, Phoenix .AZ 85007 **(3) Developmentally Disabled contract:** Arizona Dept of Economic Security, Division of Developmental Disabilities 2200 N. Central Ave., Ste. 207, Phoenix, AZ 85013
Key Contact	1. Name/Title: Anthony Rodgers, AHCCCS Director Telephone: 602.417.4680 E-mail: Princeline.Roxbury@azahcccs.gov Fax: 602.252.6536 2. Name/Title: Joan Agostinelli, OCSHCN/CRS Administrator, Office for Children with Special Health Care Needs Telephone: 602.542.2584, 602.364.1463 E-mail: agostij@azdhs.gov Fax: 602.542.2589 3. Name/Title: Louetta Coulson, Health Care Services Administrator Telephone: 602.238.9028 x6012 E-mail: LCoulson@azdes.gov Fax: 602.238.9294
Contract Size	**Average Monthly Covered Lives** (1) 216,602 (2) 20,328 (3) 10,492 **Public Funded Contract Cost** (1) $798M (2) $ 83M (3) $ 52M
Most Recent Contract Duration (1) 10/20/08 – 09/30/13 (2) 10/01/08 – 09/30/10 (3) 1988 – 09/30/09	

Arizona Physicians IPA (APIPA)
State of Arizona
-- entered the Arizona market in 1982 --

Scope of Work

Acute Care (APIPA-AHCCCS) and Personal Care Plus (APIPA-PCP): APIPA-AHCCCS provides services to low-income pregnant women, families, children; blind, aged, or disabled SSI individuals; and, uninsured children in families at other income levels through the KidsCare SCHIP program. Awarded by CMS and governed by AHCCCS, our Personal Care Plus SNP program provides services to our AHCCCS Medicaid Members who also have Medicare coverage.

Children's Rehabilitative Services (APIPA-CRS): APIPA-CRS provides family-centered medical care, rehabilitation and support services to children and youth with chronic and disabling conditions or potentially disabling health conditions (for example, bone tumors, cerebral palsy, multiple sclerosis, muscular dystrophy, sickle cell anemia, etc.).

Developmentally Disabled (APIPA-DD): APIPA provides services to residents who have chronic disabilities attributable to mental retardation, cerebral palsy, epilepsy or autism manifested prior to age 18. Children under six may be eligible for services if demonstrated that the child is, or will become developmentally disabled.

AmeriChoice – Innovative Approaches

Shine Arizona: Our Shine Arizona campaign with its "Health on Wheels" tour brings preventive care services to Members directly via a mobile medical van.

Medical Home Model: APIPA participates in a patient-centered "medical home" pilot in Phoenix. Enhanced reimbursement incentives reward primary care doctors who use the "medical home" model and whose patients demonstrate measurable improvements in their overall health.

e-Health Connectivity: APIPA has new e-Health initiatives: online EPSDT, i-Exchange (online Prior Authorization) and EDI. We are developing Electronic Health Record (EHR) and Electronic Health Information Exchange (e-HIE) to make specific Member information more accessible and to improve continuity of care.

UnitedHealthcare of Florida
State of Florida
-- entered the Florida market in 1994 --

Client Name and Address

(1) M*Plus – Medicaid:
State of Florida Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308

(2) Florida Healthy Kids:
661 East Jefferson Street, 2nd Floor
Tallahassee, FL 32302

Key Contact

1. Name/Title: Melanie Brown-Woofter, Acting Chief, Medicaid Health Systems
   Telephone: 850.922.7339
   E-mail: brownme@ahca.myflorida.com
   Fax: 850 410 1676

2. Name/Title: Rich Robleto, Executive Director
   Telephone: 850.224.5437
   E-mail: robletor@healthykids.org
   Fax: 850 224 0615

UnitedHealthcare of Florida
State of Florida
-- entered the Florida market in 1994 --

Contract Size	Average Monthly Covered Lives	Public Funded Contract Cost
	(1) 100,000	(1) $275M
	(2) 27,000	(2) $ 35M

Contract Duration
(1) 07/01/06 – 08/31/09 (2) 10/01/08 – 09/30/09 with option for 3, 1-year renewals

Scope of Work – All Contract Areas Listed
Currently, AmeriChoice oversees two programs in the State of Florida: 1) M* Plus – Medicaid and 2) Florida Healthy Kids (SCHIP). Populations and services include:

M* Plus: Our Medicaid health plan (M* Plus) participates in 21 counties including reform (mandatory) and non reform programs. Services include those covered in Medicaid Fee-for-Service (FFS) plus other expanded services (for example, adult and children's dental, over-the-counter and personal hygiene items and circumcision, etc.).

Florida Healthy Kids: Through Florida Healthy Kids, we provide a full range of SCHIP health plan services for our Members. We participate in 15 counties. Services include primary, specialty, and acute care and comprehensive pharmacy benefits with low co-pays.

AmeriChoice – Innovative Approaches
Florida's Agency for Health Care Administration – Support Staff: Mr. John Kaelin, a Sr. VP for State Program Development in AmeriChoice Business Development and Marketing, was recently appointed to the Workgroup on Managed Care Reimbursement for the State of Florida, due to his extensive background in Medicaid. Mr. Kaelin will provide advice and counsel to the State on alternative reimbursement and incentive methodologies for managed care health plans. The goal of the workgroup is the submission of a final report to Florida's Agency for Health Care Administration (AHCA) with recommendations for, and implications of, various payment reform initiatives.

Member Incentives: AmeriChoice supports Medicaid reform activities through innovative Member incentives. Members earn financial credits for certain activities and behaviors that promote healthy lifestyles, such as medication compliance, well child visits, adult preventive visits, tobacco cessation and weight loss.

Member Retention Program: When UnitedHealthcare of Florida was awarded the SCHIP contracts in 13 new counties at the end of last year, we were tasked with transitioning thousands of children from other plans in a short period of time. Leveraging our clinical teams and our Personal Care Model, we worked directly with parents to facilitate the transition. We also developed a unique website for Florida Healthy Kids. UnitedHealthcare Florida Healthy Kids pioneered the first comprehensive Member retention program though the National Enrollment Retention Center (NERC). This Florida Healthy Kids outreach has been well received and is highly successful. Currently, outreach initiatives are expanding to include a Healthy Kids coordinator and field enrollment/re-enrollment support team.

AmeriChoice of Connecticut
State of Connecticut
-- entered the Connecticut market in 2008 --

Client Name and Address	State of Connecticut, Department of Social Services 25 Sigourney Street Hartford, Connecticut 06106	
Key Contact	Name/Title: Richard Spencer, Director of Medicaid Programs Telephone: 860.424.5913 E-mail: Richard.spencer@ct.gov Fax: 860.424.4958	
Contract Size	**Average Monthly Covered Lives** 400 (Projected 1,000/EOY 08)	**Public Funded Contract Cost** $8M
Contract Start Date 06/30/08	**Contract Duration** 06/30/13	

Scope of Work

AmeriChoice of Connecticut procured the Charter Oak Health Plan contract in early 2008. Through it, we deliver numerous services to the State of Connecticut. Populations and services include:

Charter Oak Health Plan (COHP): COHP brings affordable group health insurance rates to uninsured individuals and many adults experiencing financial hardship due to paying unaffordable, non-group premiums.

HUSKY A Program: This option provides a full health insurance package for children and teenagers up to age 19, regardless of family income. HUSKY A pays for doctor visits, prescriptions, vision, dental care, and other medically necessary covered services. HUSKY A provides health coverage for parents, relative caregivers, and pregnant women, depending on income.

HUSKY B Program: This option provides a full health insurance package for children and teenagers up to age19, regardless of family income. HUSKY B pays for doctor visits, prescriptions, vision, dental care, and other medically necessary covered services.

HUSKY Plus: This option offers additional services for children with special physical health care needs.

AmeriChoice – Innovative Approaches

Enhanced Provider Model: Currently, we are developing and maintaining provider outreach for the Charter Oak Health Plan. Previously, local providers were disillusioned with the managed care experience; we made it a priority to change this view. Through our commitment to local providers and outreach methods, we have developed an enhanced provider outreach model—incorporating techniques to allow providers' concerns to be heard; identify ways to augment their managed care experience; and to strengthen collaboration between ourselves and providers, and providers working "together" on individual patient care. Using this enhanced model, we project better health experiences and outcomes for providers and Members, alike.

Transportation Initiative: For Members receiving regularly scheduled appointments and treatment, we provide a means to get there. Transportation is available to those who need it—preventing missed appointments and ensuring continuity of care. To further encourage appropriate health and wellness behaviors, after appointments, our transportation staff stop at local pharmacies, allowing Members to obtain prescriptions and other necessary medical supplies—encouraging medication compliance and appropriate patient behaviors.

Community "Social" Teams: To improve Member health outcomes, we are building community "social" teams for those with like illnesses (for example, asthma, CHF, COPD, diabetes, HIV/Aids, etc.). Members are identified and notified of local groups in their areas. Locations and times are established and Members are invited and encouraged to attend regularly—building community and support, addressing medical needs and improving health and wellness.

Unison Health Plan of the Capital Area District of Columbia -- entered the District of Columbia market in 2008 --		
Client Name and Address	Department of Health Care Finance 825 North Capitol Street, NE, Suite 5135 Washington DC, 20002	
Key Contact	Name/Title: Tanya Ehrmann, Administrator, Office of Managed Care Telephone: 202.821.9680 E-mail: tanya.ehrmann@dc.gov Fax: 202.442.4808	
Contract Size	**Average Monthly Covered Lives** 28,335	**Public Funded Contract Cost** $70M
Contract Start Date 05/01/08	**Contract Duration** 04/30/09 with 4, 1-year renewals	

Scope of Work

Unison Health Plan of the Capital Area was awarded the contracts for DC Health Families and Alliance in mid-2008. Through it, we deliver numerous services to vulnerable populations:

District of Columbia Healthy Families Program: DC Healthy Families—covers TANF and other mom's and kid's Medicaid programs

District of Columbia Health Care Safety Net Program: Alliance—a District of Columbia funded indigent and high risk uninsured program for individuals who do not qualify Medicaid or Medicare coverage

Medically necessary services, including pharmacy benefits, are provided to our Members. Additional services covered under the DC Healthy Families program include behavioral health services, non-emergent transportation, and dental and vision.

AmeriChoice – Innovative Approaches

Face-to-face Outreach: When promoting health activities and preventive care, face-to-face outreach is the most successful means for engaging vulnerable individuals in lower income communities. Currently, we are conducting face-to-face outreach and engagement for both EPSDT services and prenatal care in the local communities. Participating Members receive gift card incentives.

Great Lakes Health Plan State of Michigan -- entered the Michigan market in 1996 --		
Client Name and Address	State of Michigan Department of Community Health Capitol View Building, 201 Townsend Street, Lansing, MI 48933	
Key Contact	Name/Title: Cheryl Bupp, MOCH Director Telephone: 517.241.9944 E-mail: buppc@michigan.gov Fax: 517.241.5713	
Contract Size Medicaid GLHP PCP	**Average Monthly Covered Lives** 175,000 300	**Public Funded Contract Cost** $417M $2.2M
Contract Start Date Medicaid 1996 (Originated) PCP– Medicare SNP 01/01/08	**Contract Duration** One year with 3 automatic re-extension periods. Re-bid process. One year renewed for 2009	

Great Lakes Health Plan
State of Michigan
-- entered the Michigan market in 1996 --

Scope of Work – All Contract Areas Listed

Great Lakes Health Plan (GLHP) has been providing services to Medicaid eligibles in the State of Michigan since 1996. Currently, GLHP/AmeriChoice oversees two programs: 1) Medicaid and 2) GLHP Personal Care Plus – Medicare. Populations and services include:

Medicaid: Our Medicaid health plan, available in 20 counties, provides comprehensive health plan services for our enrolled Medicaid population, which includes families with children receiving financial assistance; the aged, blind, and disabled Members; and a few other population groups defined as categorically needy. Services are those covered by Medicaid and other expanded services (for example chiropractics; emergency and urgent care; home health; hospice; inpatient hospital care; inpatient mental health care; outpatient substance abuse care; outpatient health care; podiatry; skilled nursing facilities; chiropractic services; outpatient substance abuse; outpatient health care; supplies—DME, prosthetic devices; diagnostics; diabetes—self monitoring and training; and preventive care (for example screenings, blood tests, etc.). Medical appointment transportation is provided for 16 one-way trips. Members receive an enhanced vision benefit, also.

GLHP Personal Care Plus – Medicare: This program is a Medicare Advantage Special Needs Plan. GLHP PCP Medicare staff work with thousands of doctors in our large provider network to offer excellent care to our Members. Other benefits include an enhanced podiatry benefit, $80 credit every three months for personal health care products (for example, vitamins and supplements, fitness items, blood pressure monitors, etc.).

AmeriChoice – Innovative Approaches

Pinnacle Awards: According to the results of the most recent "Consumer Assessment of Healthcare Providers and Systems (CAHPS)" survey, our Michigan health plan provides the best customer service of any Medicaid health plan in Michigan. The surveys include the following five major categories:

- Overall rating of health care
- Overall rating of health plan
- Getting needed care
- Getting care quickly
- Health plan customer service, information, and paperwork.

Center for Health Care Strategies (CHCS): GLHP participates in the CHCS' Reducing Disparities for the Practice Site (RDPS) project. Over the next three years, the RDPS project will strengthen chronic care delivery and reduce disparities in care delivered in selected primary care practices by meeting minimum requirements for Level I NCQA Patient Centered Medical Home designation.

Healthy and Well Kids of Iowa Program (hawk-i)
State of Iowa
-- entered the Iowa market in 1999 --

Client Name and Address	Iowa Department of Human Services ***hawk-i*** Program Hoover State Office Building, 5th Floor 1305 East Walnut Des Moines, Iowa 50319	
Key Contact	Name/Title:	Anita Smith, Chief Bureau of Medical Supports, Financial, Health, & Work Supports
	Telephone:	515.281.8791
	E-mail:	asmith@dhs.state.ia.us
	Fax:	515.281.8791

Healthy and Well Kids of Iowa Program (hawk-i) State of Iowa -- entered the Iowa market in 1999 --		
Contract Size	**Average Monthly Covered Lives** 6,000	**Public Funded Contract Cost** $12.9M
Contract Start Date hawk-I 1999 (Originated)	**Contract Duration** 07/01/2007 – 06/30/2010	Option for 3, 1-year renewals

Scope of Work – All Contract Areas Listed

Offering health care coverage for the uninsured children of working families, we provide a comprehensive array of health plan services for the State of Iowa's Healthy and Well Kids of Iowa program (hawk-i) in over 40 counties. Services include: inpatient hospital services (for example medical, surgical, intensive care unit, mental health and substance abuse services, etc.); physician services (for example surgical and medical: office visits, newborn care, well-baby and well-child care, immunizations, urgent care, etc.); specialist care; allergy testing and treatment; mental health and substance abuse visits; outpatient hospital services (for example, emergency room, surgery, lab and x-ray services, and other services, etc.); ambulance services; physical therapy; nursing care services (for example, health care, skilled nursing facility services, etc.); speech therapy; durable medical equipment; home health care; hospice services; prescription drugs; hearing services; and vision services and eye wear.

AmeriChoice – Innovative Approaches

Member Outreach and Retention: We work cooperatively with the State, developing innovative and creative program design. For Member outreach, we conduct many activities in cooperation with the State Outreach workers, including community events, school events, and health fairs. Our retention unit works with Members to ensure continuous health coverage (that is, no lapses) and appropriate health lifestyle choices.

Open Communication: We maintain "open" communication with the State to improve processes, to identify potential areas for risk and to discuss implementation; and with Members to demonstrate a better understanding of State programs and our roles. We work on State-driven initiatives, exploring new concepts and innovative measures, such as express lane eligibility and presumptive eligibility.

Unison Health Plan of Delaware State of Delaware -- entered the Delaware market in 2008 --		
Client Name and Address	State of Delaware Division of Medicaid and Medical Assistance 1901 N. Du Pont Highway, Lewis Bldg. New Castle, DE 19720 (For Medicaid – SCHIP Inclusive)	
Key Contact	Name/Title: Harry Hill, Director Telephone: 302.255.9626 E-mail: harry.hill@state.de.us Fax: 302.255.4454	
Contract Size	**Average Monthly Covered Lives** 37,000	**Public Funded Contract Cost** $150M
Contract Start Date AmeriChoice – Unison Delaware 07/01/207	**Contract Duration** 06/30/09	Renewed annually by negotiation thereafter

Scope of Work – All Contract Areas Listed

Currently, AmeriChoice's Unison Health Plan of Delaware provides medical services to the State's eligible Medicaid and CHIP recipients. Medically necessary services are provided for medical, physical and vision care. Other benefits include, for example, free health risk assessments, EPSDT screening, a Personal Care Card—

Unison Health Plan of Delaware
State of Delaware
-- entered the Delaware market in 2008 --

replenished with incremental amounts for keeping scheduled appointments, and a *Miracles* Pregnancy Program—with Member incentives for maintaining appropriate pre- and post-natal care and well-child immunization visits.

AmeriChoice – Innovative Approaches

Provider "Gold Star" Incentive Program: This program, available to our high-volume PCPs, is a clinical quality improvement program that seeks to improve provider/health plan relationships, while recognizing the effective and efficient delivery of health services to Members. Its purposes are:

- to improve the quality of health care services delivered to our Members
- to reward excellent providers
- to reduce administrative burdens for the providers and our health plans.

"Gold Star Providers" attain specific goals in practice efficiency, membership growth and availability, and quality of care. If a provider meets our specific criteria, they are rewarded by reduced prior authorization requirements, annual cash bonuses and recognition as a "Gold Star Provider" on all Member ID cards and in our provider directory.

Health Plan of Nevada, Inc.
State of Nevada
-- entered the Nevada market in 2006 --

Client Name and Address	State of Nevada Department of Health and Human Services Division of Health Care Financing and Policy 1000 East William Street, Suite 118 Carson City, NV 89701	
Key Contact	Name/Title: John Whaley, Chief – Medicaid Managed Care Telephone: 775.684.3692 E-mail: jwhaley@dhcfp.nv.gov Fax: 775.684.3720	
Contract Size	**Average Monthly Covered Lives** 57,000	**Public Funded Contract Cost** $113M
Contract Start Date Sierra Health (NV) 11/2006	**Contract Duration** 2009 with 3, 1-year renewal options	

Scope of Work – All Contract Areas Listed

AmeriChoice's Sierra Health Services operates Health Plan of Nevada, Inc. established in 1997. Currently, it provides health care coverage to the State of Nevada's TANF and Children's Health Assurance Plan (CHAP) Members.

Available through an extensive, stable, provider and dental network, medically necessary services are targeted towards Members' medical and social needs—ensuring a consistent medical home and continuity of care. Services include a wide range of options, such as readily accessible obstetrical care, Member incentive programs, EPSDT screenings, well-child care, immunizations, early prenatal and postpartum care and adult preventive health care. Our Health Education and Wellness (HEW) division offers bi-lingual instruction on pregnancy; asthma, cholesterol, diabetes, high blood pressure, and weight management; and smoking cessation. Other benefits include a 24 hour telephone advice nurse service, extended-hour clinics, supplemental non-emergency transportation and added non-covered medical benefits.

AmeriChoice – Innovative Approaches

Medical Technology: Over the last few years, AmeriChoice's Sierra Health Services invested in state-of-the-art medical technology, including e-prescribing, electronic medical records, and digital radiology—transforming health care delivery and management, improving health care quality and containing costs. For example, e-prescribing

Health Plan of Nevada, Inc.
State of Nevada
-- entered the Nevada market in 2006 --

generates more than 1,000,000 e-scripts annually, improving patient safety and reducing medical errors due to illegible prescriptions, enhancing patient convenience due to electronic transmittal to pharmacies and heightening generic drug utilization. Our automated web-based "@Your Service" system provides eligibility verification, claims payment information, benefit information, prior authorization status and medical record requests—all available to our Members and providers in real-time. This integrated approach provides immediate access to information, and coordinates all aspects of the health care process, such as prescriptions, referrals, radiology, laboratory results and physicians' orders. We operate a state-of-the-art call center with high volume capacity. For example, results showed for 130,561 calls from Medicaid and SCHIP/Nevada Check Up Members, we had a call handle rate of 95.6 percent, with 13 percent of those calls from Spanish-speaking Members.

Technology Awards: Our technological approach is widely recognized in the industry (for example, 2005—Intelligent Enterprise Award; 2006—CIO 100 Award, Innovation and Excellence in Health Information Technology Award— AHIP; *Modern Healthcare*'s CEO IT Achievement Award, etc.).

Committed to Quality: AmeriChoice's Sierra Health Services is committed to quality in all operational areas. For example, over the past eight years, we have excelled in each category audited by the Division of Health Care Finance and Policy's (DHCFP) External Quality Review Organization (EQRO). Scores ranged from 98 percent to 100 percent. In 2006, the DHCFP's EQRQ designated three areas of our program as "Best Practice Standards" for health plans among the other 11 states in which they conduct quality reviews of managed care plans.

UnitedHealthcare of Texas
State of Texas
-- entered the Texas market in 2006 --

Client Name and Address	State of Texas Health and Human Services Commission Mailing Address: P. O. Box 13247, Austin, TX 78711-3247 Headquarters: 4900 N. Lamar Blvd, Austin, TX 78751-2316	
Key Contact	Name/Title:	Pamela Coleman, Deputy Director – Medicaid & CHIP Managed Care Operations
	Telephone:	512.491.1302
	E-mail:	pamela.coleman@hhsc.state.tx.us
	Fax:	512.491.1969
Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	28,000	$44M

Contract Start Date		**Contract Duration**	
Texas STAR	09/2006	Texas STAR	09/01/2011 with annual extensions thereafter
CHIP	05/2007	CHIP	09/01/2011 with annual extensions thereafter

Scope of Work – All Contract Areas Listed

AmeriChoice provides services to eligible Members in the State of Texas via two programs: Texas STAR (Medicaid) and Texas CHIP (Children's Health Insurance Program).

Texas STAR (Medicaid): This program provides coverage in Brazoria, Fort Bend, Galveston, Harris, Montgomery, and Waller counties. Services cover EPSDT medical check-ups; occupational, hearing, speech therapy; hospital clinic services—as appropriate; regular examinations; immunizations; child delivery and newborn care; substance abuse and behavioral health services; laboratory and x-ray services—including tests to prevent birth defects; expanded vision care; podiatry; asthmatic care; dental services; and other specialty care benefits.

Texas CHIP (Children's Health Insurance Program): This program provides coverage in Austin, Brazoria,

UnitedHealthcare of Texas
State of Texas
-- entered the Texas market in 2006 --

Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Waller, Walker, and Wharton counties. Services include: medical care for children; immunizations; durable medical equipment; well child exams; laboratory and x-ray services; hospital care; physical, occupational, and speech therapy; case management for children with special needs (CSHCN); substance abuse and mental health services; vision care—including glasses, frames, and contact lenses; tobacco cessation benefits; sports physicals; and other specialty services.

AmeriChoice – Innovative Approaches

Disaster Recovery Enhancements/Medical Review Unit – Hurricane IKE: In 2008, our Texas health plan responded to Hurricane Ike, making preparations 48 hours ahead of state-mandated emergency procedures and evacuations. Health plan staff from all areas were involved (for example, Member and provider services, strategic planning and outreach, health services, special care needs/associated dependencies groups, medical management teams, executive management, etc.). We established a Hurricane Ike Medical Review Unit to bring together those with extensive medical/ clinical, administrative, and logistical expertise. Care continuance experienced little interruption.

Behavioral Inpatient Follow-up Program: Our Behavioral Inpatient Follow-up Program provides post-discharge management of Members hospitalized for a behavioral health condition (for example, mental health and substance abuse). Its process involves a number of specified interventions and identifies Members at highest risk for re-hospitalization. Seven day follow-up rates have risen 55 percent; 30 day follow up rates have risen 41 percent.

Community Education: Through our relationship with the Houston School District, we are enhancing the health conditions of the children, creating a proactive approach to health services, and identifying appropriate health activities for children via critical needs assessments.

Increasing Awareness of SCHIP: This program works with individuals who may not realize their children qualify for the State's SCHIP program. We host educational seminars with the employers, and educate parents. We partner with local Community Based Organizations and PTAs at schools. All of our outreach efforts increase awareness of the program in the community.

Unison Health Plan of Pennsylvania
Commonwealth of Pennsylvania
-- entered the Pennsylvania market in 2005 --

Client Name and Address	Pennsylvania Insurance Department Office of CHIP and adultBasic 333 Market Street Lobby Level Harrisburg, PA 17120	
Key Contact	Name/Title:	Lowware Holliman, Operations Manager, Division of Quality Assurance, Children's Health Insurance Program and adultBasic
	Telephone:	717.783.1437
	E-mail:	lholliman@state.pa.us
	Fax:	717.346.1368

Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
adultBasic	6,349	$17.7M
SCHIP	12,448	$16.8M

Unison Health Plan of Pennsylvania
Commonwealth of Pennsylvania
-- entered the Pennsylvania market in 2005 --

Contract Start Date		Contract Duration
adultBasic	2005 (Originated)	10/01/ 09
SCHIP	1999 (Originated)	11/30/11

Scope of Work

AmeriChoice – Unison Family Health Plan of Pennsylvania provides services to individuals in the Commonwealth of Pennsylvania via two programs: adultBasic and Children's Health Insurance Program (CHIP). Both programs are administered by the Department of Public Welfare.

adultBasic: We deliver all adultBasic program covered health services to low-income adults between the ages of 19 and 64 who do not have health insurance and are not eligible for Medicaid. This program is offered in 11 counties. Services include: inpatient, outpatient, emergency, and diagnostic services to uninsured Pennsylvania adults meeting certain eligibility requirements.

CHIP: CHIP provides free or low cost health insurance to Pennsylvania children under the age of 19 who meet eligibility requirements. This program is offered in 43 counties. We enroll eligible children and provide all CHIP-covered inpatient, outpatient, diagnostic, pharmacy, dental, vision and mental health services.

AmeriChoice – Innovative Approaches

"Providing Care and Education": We work extensively in local communities for many groups. For example, we provide breast health education to senior and minority women through the Capital Area Cancer Collaborative; Senior Outreach Services (SOS) was formed to conduct minority outreach. SOS establishing a "branch" to work with low-income families/Medicaid recipients. Other community outreach is conducted in soup kitchens and food banks of local churches. Brochures and contact information are placed in Salvation Army locations during holiday food application days. Through these activities, we have increased enrollment, and Member retention rates.

"Giving-Back": Every year, the AmeriChoice—Unison Family Health Plan of Pennsylvania gives back to the local community by celebrating the holiday with a festive event for 500 children.

"Health Literacy Task Force": Formed in 2008, the York County Health Literacy Task Force works to increase health literacy levels among vulnerable populations and to decrease health disparities among various populations. We work with this group at events and health fairs promoting their "Speak Up" initiative, which educates Members on appropriate communication between patient and physician.

Rapid Response Team: To help people transition between jobs when impending job loss is apparent, we have an established rapid response team to assist those in need. When notified by a company about layoffs, team visits those companies to provide transition support and education on medical options, job placement information, etc.

AmeriChoice of Pennsylvania
Commonwealth of Pennsylvania
-- entered the Pennsylvania market in 1989 --

Client Name and Address	Commonwealth of Pennsylvania Department of Public Welfare Room #515, Health and Welfare Building P.O. Box 2675 Harrisburg, PA 17105 (For Medicaid)	
Key Contact	Name/Title:	Jeff Bechtel, Director/Bureau of Managed Care Operations
	Telephone:	717.772.6303
	E-mail:	jbechtel@state.pa.us
	Fax:	717 772 6328
Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	70,000	$316 M
Contract Start Date	**Contract Duration**	
Medicaid	1989 (Originated)	12/31/09
Client Name and Address	Commonwealth's Department of Insurance Office of CHIP and adultBasic 333 Market Street Harrisburg, PA 17120 (Children's Health Insurance Program—CHIP)	
Key Contact	Name/Title:	Peter Adams, Deputy Commissioner
	Telephone:	717.783.3707 x 205, or 717.346.1366
	E-mail:	padams@state.pa.us
	Fax:	17.705.7341 or 717.705.1643
Contract Size	**Average Months Covered Lives**	**Public Funded Contract Cost**
	5,500	$8.8M
Contract Start Date		**Contract Duration**
CHIP	2000	2/1/2012

Scope of Work – All Contract Areas Listed

AmeriChoice provides services to Medicaid and CHIP eligibles in the Commonwealth of Pennsylvania via two programs: CHIP and Medicaid. These services are offered in five counties—Bucks, Chester, Delaware, Montgomery, and Philadelphia.

Medicaid Health Choices: Services cover a wide range (for example, unlimited visits to PCP; personal care available 24 hours a day, 7 days a week; ER care, when needed; immunizations; prescriptions and dental services; EPSDT screenings and treatment; vision exams and eyewear, etc.). Specialty care includes: asthma care; cancer awareness; diabetes control and support; healthy heart programs; a well mother/well baby program; teen pregnancy, AIDS, and substance abuse prevention; smoking cessation; and other community/health supports.

Children's Health Insurance Program (CHIP): Services to 7,412 children include PCP and specialist visits, hospital care, immunizations, dental services, prescription drugs, eye exams and glasses, laboratory tests and x-rays, emergency care, behavioral and substance abuse services, rehabilitation therapy, maternity care and family planning.

AmeriChoice – Innovative Approaches

Medical Management – ER Utilization Monitoring: Through Member education, ER field-based case management, management of those-at-risk, analysis of ER data, and provider partnerships, we experienced a 2 percent reduction in ER visits per 1,000 over the last year—providing an annual savings of approximately $.5M.

Physician Home Health Visits: Chronically ill Members receive care in their homes, through an innovative partnership with INSPIRIS, a physician-led Care Level Management program. INSPIRIS works with AmeriChoice

AmeriChoice of Pennsylvania
Commonwealth of Pennsylvania
-- entered the Pennsylvania market in 1989 --

to bring physician home visits to select chronically ill Members. Members receive regular physician visits at their homes as an alternative source of care, and they have access to INSPIRIS physicians for acute care needs.

Health Disparities – Screenings (Hepatitis B): The AmeriChoice Chinatown Community Service Center, which opened 6 years ago in the heart of Philadelphia's Chinatown, sponsors a series of healthy activities. Community residents participate in health screenings and educational sessions. Through these activities, AmeriChoice arranges for screenings for Hepatitis B, a condition that disproportionately affects the Asian population.

UnitedHealthcare of Wisconsin
State of Wisconsin
-- entered the Wisconsin market in 1984 --

Client Name and Address	Department of Health Services Division of Health Care Access & Accountability Jason Helgerson – Administrator 1 West Wilson Street, P O Box 309 Madison, WI 53701-0309 608.266.8922	
Key Contact	Name/Title:	Mark Prodoehl, Managed Care Analyst/Division of HCAA
	Telephone:	608.266.2833
	E-mail:	Mark.Prodoehl@dhs.wisconsin.gov
	Fax:	608.266.1096

Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	155,285	$326 M

Contract Start Date		**Contract Duration**	
Medicaid	1984 (Originated)	Medicaid	12/31/09
SSI	2005 (Originated)	SSI	12/31/09

Scope of Work

UnitedHealthcare / AmeriChoice has achieved approximately 33 percent of the market share of the total Medicaid/SSI enrollees in Wisconsin. We have approximately 50 percent of the market share in the counties in which we operate.

AmeriChoice provides services to Members via two programs: BadgerCare Plus (BCP) and Medicaid SSI. Our health plan programs have grown significantly over the past year, with plans to expand further during 2009, to include the State's Childless Adults Expansion Program.

BadgerCare Plus (BCP): This program covers children under 19 years of age and families needing health insurance. Children are covered, regardless of household income. Many families without access to health insurance, eligible childless adults, and pregnant women are also eligible. Currently, AmeriChoice is available in 26 counties throughout the state. The BadgerCare Plus program offers two levels of coverage—Standard Plan and the Benchmark Plan. The Standard Plan is a comprehensive health plan with minimal co-pays that range from 50 cents to $3.00 for medical and facility services. The Benchmark plan has reduced benefits and copays that mirror commercial coverage ($15.00 Physician copay, ER Copay $60.00, Inpatient Hospital Copay $100.00, Ambulance copay $50.00).

Medicaid SSI: This program provides services to beneficiaries 19 and older of Wisconsin's SSI program. Currently, it is available in 19 counties throughout Wisconsin. We have plans to expand further through 2009. The Medicaid SSI program utilizes the Standard Plan benefits without any copays for SSI Members.

AmeriChoice – Innovative Approaches

Pro-active Quality and Compliance: To maintain contract compliance and to be responsive to State needs, we

UnitedHealthcare of Wisconsin
State of Wisconsin
-- entered the Wisconsin market in 1984 --

apply proactive intervention across many areas of these programs (for example, dental programs, transportation vendors.), and we continually implement quality measures. In 2008, we adhered to the following, allowing for intervention tracking and open communication between our staff, providers, and local health network:

- Random internal audits to identify issues, preventing the necessity of CAPs
- Monthly functional area meetings to discuss compliance and risk
- Daily staff meetings to open lines of communication for potential risks areas
- Implementation of monthly compliance topics for entire staff education.

Lead Poisoning Prevention (Children): Other innovative measures included heightened awareness of lead poisoning and its prevention. We worked alongside local providers and honored the top 10 health care providers who achieved a score above 90 percent on the 2008 Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP) report card. Each year, the WCLPPP tracks child testing for lead poisoning—the primary environmental threat to children's health in Wisconsin.

Unison Health Plan of Ohio
State of Ohio
-- entered the Ohio market in 2005 --

Client Name and Address	State of Ohio – Bureau of Managed Health Care Ohio Department of Job and Family Services 50 West Town Street Suite 400 Columbus, OH 43215	
Key Contact	Name/Title:	Tracy Hale, Contract Administrator
	Telephone:	614.466.4693
	E-mail:	Tracy.Hale@jfs.ohio.gov
	Fax:	None

Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	96,292	$322 M

Contract Start Date		**Contract Duration**
AmeriChoice – Ohio	2005 (Originated)	One Year – Automatic renewal aligned with SFY Current SFY 2009: 07/01/08

Scope of Work – All Contract Areas Listed

AmeriChoice – Unison Health Plan of Ohio provides services to Medicaid eligibles in the State of Ohio via two programs: Covered Families and Children (CFC) and Aged, Blind, or Disabled (ABD). The CFC program encompasses Ohio's Healthy Families eligibles (that is Temporary Assistance to Needy Families or TANF-related Medicaid consumers) and Ohio's Healthy Start eligibles (SCHIP consumers). Our ABD eligibles are enrolled in our statewide full-risk managed care program.

The scope of work involves the delivery of all Medicaid-covered physical health services, including pharmacy, vision and dental to eligible recipients in the state of Ohio. Behavioral health care services are carved out and remain in the fee-for-service program, but we are responsible for coordination and management of care with community behavioral healthcare providers. We are responsible for coverage of prescription pharmaceuticals prescribed by providers in community behavioral health care programs.

AmeriChoice – Innovative Approaches

Provider Incentives and Measures: Unlike most incentive programs that reward providers with a financial benefit, our "Pay for Performance—Provider Incentive "Gold Star" Program" rewards with a combined financial benefit and

Unison Health Plan of Ohio
State of Ohio
-- entered the Ohio market in 2005 --

an administrative relief incentive. Used throughout some of our other health plans, we have established our own performance criteria for each practice in Ohio. They include:

- Commitment to Our Health Plan: To be available to our new Members with minimum participation of 200.
- Accessibility to Our Plan Members: To be accessible to our Members (for example., practice shows 10 percent decrease in ER visits per 1000, year-over-year).
- Effective Medical Management: To demonstrate provision of coordinated efficient and economical services, as evidenced by meeting targeted benefit-cost ratios (BCR).
- Quality of Care: To demonstrate clinical excellence as reflected in delivery of preventive services (for example, EPDST, anemia screening, blood lead completion, pap smear, mammogram, cholesterol, set immunization rates, pneumococcal vaccine for patients aged over 65, etc.)
- Administrative Efficiency: To demonstrate use of health information technology to improve provision of and payment for covered services (for example, no less than 60 percent electronically submitted using electronic claims system/clearing houses.)
- Member Satisfaction: No more than 5 per 1000 substantiated Member complaints.
- Quarterly updates are distributed to the providers, ensuring status of performance and program eligibility.

Unison Health Plan of South Carolina
State of South Carolina
-- entered the South Carolina market in 2004 --

Client Name and Address	South Carolina Department of Health and Human Services PO Box 8206 Columbia, SC 29202 (For Unison and Unison Kids)	
Key Contact	Name/Title:	Charles ("David") Smith, Program Coordinator
	Telephone:	803.898.2639
	E-mail:	smithc@scdhhs.gov
	Fax:	803.255.8232

Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	42,649	$77.3M

Contract Start Date		**Contract Duration**
AmeriChoice – Unison (SC)	2004 (Originated)	Renewed annually

Scope of Work – All Contract Areas Listed

AmeriChoice— Unison Health Plan of South Carolina, offers high-quality, accessible health care and customer service to Medicaid adult and child eligible populations (for example, TANF, ABD, SSI, SCHIP, etc.) in 41 counties (23 SCHIP) throughout the State. Medical coverage provides a broad range of services (for example, inpatient and outpatient hospital care, rural health clinic and federally qualified health center visits, family planning, EPSDT, laboratory and x-ray, mental disease and mental health clinic services, family support, and hospice, rehabilitative therapy for those with special needs, ambulance/ medical transportation, pharmacy services, and vision and dental services, etc.).

AmeriChoice – Innovative Approaches

Consistent Medical Homes for Adults and Children: Available through extensive provider and dental networks, medically necessary services are provided for Members' medical and social needs. Over the past year, we have worked diligently treating each Member and coordinating care on many levels—providing a consistent medical home and continuity of care for those with multiple health-related issues.

Unison Health Plan of South Carolina
State of South Carolina
-- entered the South Carolina market in 2004 --

Managing Diseases: Through analyses on medical care use, we work with the Special Needs Unit to identify specific populations with special health care needs. We assist those with multiple conditions and orient and educate those new to managed care, ensuring appropriate use of medical services and resource types available to them.

UnitedHealthcare of the MidAtlantic
State of Maryland
-- entered the Maryland market in 1996 --

Client Name and Address	State of Maryland Department of Mental Health & Hygiene 201 West Preston Street Baltimore, MD 21201	
Key Contact	Name/Title:	John G. Folkemer, Deputy Secretary, Health Care Financing
	Telephone:	410.767.5807
	E-mail:	folkemerj@dhmh.state.md.us
	Fax:	410.333.7687
	Name/Title:	Susan Tucker, Executive Director, Office of Health Services
	Telephone:	410.767.1431
	E-mail:	tuckers@dhmh.state.md.us
	Fax:	410.333.5185
Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	114,000	$350 M
Contract Start Date		**Contract Duration**
AmeriChoice-MidAtlantic	1996 (Originated)	Renews annually on 07/01 automatically

Scope of Work

We provide a full range of health plan services for the beneficiaries of Maryland's Medicaid and Children's Health (MCHP). These include: physician visits, prenatal care (for example Healthy First Steps Prenatal Program), family planning and birth control, prescription drugs, diagnostic services, inpatient services, home health, hospice, emergency services, OB/GYN care, eye exams for adults and children, primary mental health services through "medical home" PCP, substance abuse treatment and transportation services. Other services offered for adults include: adult dental care (for example, exam and cleanings twice a year, unlimited simple extractions, fillings and x-rays); adult vision care (one pair of glasses every two years and one replacement pair, if needed within a two) year period; and certain over-the-counter medications with doctor's orders. Other services offered for children under age 21 include: immunizations, vision care (for example, exams and glasses annually), dental care (for example, exams; cleanings; fillings; and braces, if medically necessary).

AmeriChoice – Innovative Approaches

Grass-Roots Efforts, Language Proficiency, Medical and Dental Awareness: We work cooperatively with the State and local community support groups to achieve goals and address any issues if they arise. We create Community Advisory Committees (CACs), establishing "grass-root efforts" to reach out to our eligible population/s. All of our staff are encouraged to participate in our conversational Spanish program—elevating language skills to further promote communication within our local communities. Our sickle cell program identifies and collaborates with Centers of Excellence to provide intensive care management for Level III Members. We encourage participation in our Baby Shower Program for expectant mothers. Diabetes awareness seminars are conducted on Type One and Type Two diabetes, gestational diabetes, warning signs, record accuracy, and screening exams (for example HbA1C, dilated eye, foot and dental exams, blood pressure checks, etc.). To heighten dental hygiene and preventive care awareness, we sponsor dental screenings, educational entertainment and assistance for children who attend schools in economically disadvantaged areas (for example, Prince George's County, Baltimore City, etc.).

AmeriChoice of New Jersey State of New Jersey -- entered the New Jersey market in 1995 --		
Client Name and Address	State of New Jersey Department of Human Services Division of Medical Assistance and Health Services 7 Quakerbridge Plaza; P.O. Box 712 Trenton, NJ 08625-0712	
Key Contact	Name/Title:	John Guhl, Director, Division of Medical Assistance and Health Services
	Telephone:	609.588.2705
	E-mail:	john.guhl@dhs.state.nj.us
	Fax:	609.588.3583
Contract Size	**Average Monthly Covered Lives** 213,680	**Public Funded Contract Cost** $552.2 M
Contract Start Date AmeriChoice (NJ)	1995 (Originated)	**Contract Duration** Automatically renews annually on 07/01

Scope of Work – All Contract Areas Listed

AmeriChoice provides services to Medicaid eligibles in the State of New Jersey via three programs: 1) Medicaid, 2) AmeriChoice Personal Care Plus – Medicare, and 3) NJ Family Care. Population types cover Medicaid; aged, blind and disabled; and uninsured children and adults.

Medicaid: Our statewide Medicaid health plan services over 250,000 New Jersey Medicaid program beneficiaries. A broad package of health services is offered to cover medically necessary care, such as inpatient and outpatient hospital care, physician services, laboratory tests and x-rays, home health care and nursing facility care, etc.

AmeriChoice Personal Care Plus – Medicare: Available in 10 counties, our AmeriChoice Personal Care Plus (Medicare) program services eligible Medicare Advantage beneficiaries with Medicaid coverage. Health care services cover medically necessary covered services, such as inpatient and outpatient care, physician services, mental health and substance abuse care, health screenings (for example, pap smears and pelvic exams, prostate cancer screening, blood tests, etc.), partial hospitalization, cardiac rehabilitation services, renal dialysis and other specialty care.

NJ Family Care: This statewide program is offered to eligible children and low-income parents, based on income guidelines. Children are eligible up to 350 percent of the FPL and adults up to 200 percent of the FPL. Health care services include doctor visits, hospitalization, regular screenings, behavioral health, prescriptions, vision needs and dental care.

AmeriChoice – Innovative Approaches

Top Health Plan – Care Management and Personal Care Model ™: The Division of Medical Assistance and Health Services (Medicaid) released the findings of its 2007 case management audit for Medicaid health plans. AmeriChoice achieved the top health plan results for care management of the ABD populations, and case management and care management for the Department of Youth and Family Services population, care management of children with elevated lead levels. AmeriChoice's Personal Care Model ™ has been refined through years of application in Medicaid programs. This approach uses leading-edge technology tools that enable our care managers to meet rigorous national standards, while personalizing interventions for the local population and individual Member.

Outreach to the Troops: Every year, our New Jersey health plan conducts a holiday military mailing to our troops overseas—particularly to those serving in Iraq and those recuperating at the Walter Reed Army Medical Center in Washington, DC. Boxes include: personal items, food, and Christmas goodies.

UnitedHealthcare of New England
State of Rhode Island
-- entered the Rhode Island market in 1994 --

Client Name and Address	State of Rhode Island Department of Human Services 600 New London Avenue Cranston, RI 02920	
Key Contact	Name/Title:	Deborah J. Florio, Administrator
	Telephone:	401.462.0140
	E-mail:	DFlorio@dhs.ri.gov
	Fax:	401.462.6353

Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	30,100	$108.8 M

Contract Start Date		**Contract Duration**
AmeriChoice (NE)	1994 (Originated)	12/01/2009

Scope of Work – All Contract Areas Listed

We provide care and services for three Medicaid products: 1) RIte Care Medicaid program (TANF/SCHIP), 2) Rhody Health Partners (RHP– Adult SSI), and 3) Children with Special Health Care Needs.

Comprehensive Member care includes medical and behavioral health, and pharmacy services. Local care managers (for example, RNs, community outreach, behavioral health clinicians, etc.) deliver "hands-on" care management, including risk assessments, and individualized care plans with monitoring and oversight. We work collaboratively with our network provides to ensure appropriate care is delivered to our Members. Our Rhody Health Partners (Adult SSI) program offers Members a 24 hours a day, 7 days a week telephonic Nurseline. RIte Care Medicaid child Members born after May 2000 are offered dental services.

AmeriChoice – Innovative Approaches

Quality (NCQA and HEDIS): AmeriChoice's New England health plan is ranked in the "Top Ten Best Medicaid Plans" by NCQA and *US News and World Report (USN & WR)* and has held this ranking for the past four years. New England has a performance goal program that focuses on improving quality, especially in operations, and meeting and exceeding HEDIS/CAHPS benchmarks for all plans. Working with the State, we achieved targeted improvement in various areas. For example, focusing on disease management in diabetes and conducting follow-up outreach after hospitalization for behavioral health illness has improved our HEDIS results in both of these areas, also (for example, comprehensive diabetes care LDL-C Level < 100 increased from 24.68 percent (2007) to 29.12 percent (2008), follow-up after hospitalization for mental illness, 7 days rate increased from 55.14 percent (2007) to 65.43 percent (2008.) Other areas, such as chlamydia screening in women aged 21 to 25 increased from 57.22 percent (2007) to 65.27 percent (2008) and childhood immunization status (combo 3) increased from 73.72 percent (2007) to 78.05 percent (2008)).

ER Diversion: We have actively pursued an ER Diversion initiative. Effective outreach to Members was compromised by lack of timely data and Member unavailability relative to poor contact information and lack of phones. To address this, we focused on more frequent users, who we redirected to their PCPs.

Other interventions include:

- Promoting and providing care management access for Members with high utilization of Emergency Services
- Providing Member education on appropriate use of Emergency Services
- Developing Member specific reports for physicians outlining their use of Emergency Services for non-emergent problems
- Developing strategies to promote better access to care in physicians' offices
- Providing the care management number to physicians and Members for referral purposes.

UnitedHealthcare of New York
State of New York
-- entered the New York market in 1994 --

Client Name and Address	State of New York Department of Health Corning Tower, Room 1911 Empire State Plaza Albany, NY 12237 (For Medicaid, Medicare, and Family Health Plus)	
Key Contact	Name/Title:	Valencia Lloyd, Deputy Director of Managed Care
	Telephone:	518.474. 0180
	E-mail:	Vml05@health.state.ny.us
	Fax:	518.474.3295
Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	196,279	$502M
Contract Start Date		**Contract Duration**
Medicaid, Medicare, FHP	1994 (Originated)	09/30/10 (Amendment #5)
Client Name and Address	State of New York Department of Health Corning Tower, Room 1629 Empire State Plaza Albany, NY 12237 (For Child Health Plus)	
Key Contact	Name/Title:	Judith Arnold, Director of Coverage & Enrollment
	Telephone:	518.474.0180
	E-mail:	jaa01@health.state.ny.us
	Fax:	518.474.3295
Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	12,465	$21.3M
Contract Start Date		**Contract Duration**
Child Health Plus	1997 (Originated) 01/01/08	12/31/12

Scope of Work – All Contract Areas Listed

AmeriChoice provides services to eligible beneficiaries in the State of New York and New York City for four programs: 1) Medicaid, 2) Family Health Plus, 3) Child Health Plus, and 4) AmeriChoice Personal Care Plus – Medicare. These services are offered to a highly diverse membership, with dedicated offices and programs for Chinese, Latino, and African-American Members.

Medicaid: Our Medicaid health plan is available in New York City and six counties within the State of New York. Medically necessary covered services are offered. Dental and transportation services are also provided.

Family Health Plus: Available in New York City and eight counties, Family Health Plus is offered to adult beneficiaries, aged 19 through 65, of New York State's Family Health Plus Program. Medically necessary covered services are provided. Dental services are also provided.

Child Health Plus: This program is available to beneficiaries of New York State's Child Health Plus Program in New York City and eight counties in the State of New York. Children's medical services are provided in compliance with the CMS contract, to include dental and prescription coverage.

AmeriChoice Personal Care Plus – Medicare: Available in three counties, our AmeriChoice Personal Care Plus – Medicare program services eligible Medicare beneficiaries who must be Medicaid recipients (for example dual eligibles). Medically necessary covered services are provided. Other benefits include a "Personal Care Catalog" for select over-the-counter items and a Medical Alert System. Special needs plan services are also provided.

AmeriChoice – Innovative Approaches

Enrollment and Local Outreach: Over the past year, our New York market has focused on CHP enrollment processes, increasing enrollment and enhancing communication between enrollees, ourselves and the State.

UnitedHealthcare of New York
State of New York
-- entered the New York market in 1994 --

Community outreach—for both adults and children—is promoted within our programs, encouraging healthy life and wellness practices. For example, in partnership with Syracuse Safe Kids coalition, we work with local schools to promote "Walking to School." Staff teach pedestrian safety, demonstrate the benefits of exercise and establish safer routes for walking and biking within local communities

UnitedHealthcare of the Midlands / Share Advantage
State of Nebraska
-- entered the Nebraska market in 1999 --

Client Name and Address	State of Nebraska Health and Human Services System Lincoln, State Office Building 301 Centennial Mall South, Lincoln, NE 68509	
Key Contact	Name/Title: Margaret Booth, Manager, Physical Health Service Unit Telephone: 402.471.2135 E-mail: Margaret.booth@dhhs.ne.gov Fax: 402.471.9092	
Contract Size	**Average Monthly Covered Lives** 34,600	**Public Funded Contract Cost** $81.8M
Contract Start Date AmeriChoice (Midlands – NE) 07/25/1999	**Contract Duration** 6/30/2009. Re-bid Preparations for 2010-2013 Contract.	

Scope of Work – All Contract Areas Listed

AmeriChoice's Nebraska health plan is the only managed care organization participating in the Nebraska Medicaid program. Its population covers Medicaid-eligible individuals in three counties, including the cities of Lincoln and Omaha, and their surrounding areas. Services offered are: inpatient and outpatient hospital services, clinical and anatomical laboratory services, radiology, EPSDT, physician services, home health agency and private duty nursing services, therapy, DME and medical supplies, podiatry, chiropractic services, ambulance services, medical transportation and vision services. Other services include: adult physical exams, immunizations, flu vaccinations, circumcision for males (all ages), non-emergent medical transportation, Diaper Rewards Program, Childhood Obesity Program, Summer Asthmatic Camp and translation assistance for our non-English speaking Members.

AmeriChoice – Innovative Approaches

High Quality Care and NCQA Accreditation: Working closely with the State for over 10 years, collaboratively, we have promoted access to high quality health care for our Members, ensuring a positive managed care experience. Innovative approaches to increase Member engagement and outreach are many. For example, our Diaper Rewards Program (DRP), mentioned above, awards three months of diapers to Members who achieve 80 percent of their prenatal visits. Member engagement for DRP has increased by 25 percent.

Maintaining high standards for Member quality of care and service is important to us. This year, for our NCQA accreditation, we were awarded the rank of "excellent."

Georgia Enhanced Care Program
State of Georgia
-- entered the Georgia market in 2005 --

Client Name and Address

State of Georgia Department of Community Health (DCH)
2 Peachtree Street, 37th Floor
Atlanta, GA 30303

Key Contact

Name/Title: Jerry Dubberly, Chief of Medical Assistance
Telephone: 404.651.8681
E-mail: jdubberly@dch.ga.gov
Fax: 866.283.0128

Contract Size

Average Monthly Covered Lives	Public Funded Contract Cost
40,000	Approx.$15 million/year

Contract Start Date
10/15/05

Contract Duration
Annual renewal through 2010

Scope of Work – All Contract Areas Listed

In October 2005, we began providing integrated chronic care and disease management services for Medicaid aged, blind, and disabled individuals in central and south Georgia through the Georgia Enhanced Care (GEC) program. While the program began as a disease management model, AmeriChoice brought our focus to a holistic care management model through the implementation of our Personal Care Model™, promoting self management, support for a medical home, and community partnerships to deliver a high-touch program, especially for the highest-risk Members. Like the eligible clients for the ECC program, the Georgia population faced a diverse set of diagnoses and conditions, including schizophrenia and other behavioral health disorders. To meet the needs of our enrollees in Georgia, we:

- Partner with primary care providers (PCPs), specialists, behavioral health providers, and other providers to ensure that each enrollee has access to an appropriate medical home;
- Promote evidence-based guidelines for participating providers;
- Provide in-person, intensive care management for high risk individuals; and
- Provide telephonic care coordination for medium and low-risk individuals.

We offer outreach and engagement with providers and clients through multiple collaborative relationships, and via an established call center with fully trained staff. Our field-based nurse care managers have demonstrated expertise in providing chronic care management to high risk individuals with complex medical, social, behavioral, and environmental challenges. We identify and manage our membership effectively through highly specialized and thorough claims analytics and risk stratification efforts and provide ongoing education for the membership through materials tailored to the Members' conditions.

When awarded this contract, we deployed our national implementation team rapidly and operationalized the program in sixty (60) days. During this short timeframe, we completed all activities to meet State objectives for program start-up and on-going operations including hiring staff, bringing systems on line, conducting Member outreach and education, and building relationships with providers and community-based organizations. We have had continued success over the past 2-1/2 years building key relationships with the State, Members, and providers that ultimately facilitate achieving the State's goals.

AmeriChoice – Innovative Approaches

- Using a multi-pronged approach to target enrollment and engagement efforts for clients with multiple and chronic medical conditions which has resulted in an 83 percent engagement rate for high-risk Members.
- Stratified care management for individuals at all risk levels, resulting in AmeriChoice's cost savings estimates of approximately $181.77 per Member per month compared to a DCH target of $70.49 per Member per month.
- Establishment of an emergency room (ER) utilization program with the 40 hospitals with the highest claims volume, promoting Members' appropriate use of ER, emphasis on identification of medical home.

Georgia Enhanced Care Program
State of Georgia
-- entered the Georgia market in 2005 --

- Solidification of strong partnerships with over 1,000 primary care providers and 16 Community Service Boards (Georgia's behavioral health providers) and engaging in collaborations with State and County agencies, community organizations, and advocacy groups who are vital for the successful implementation and operation of this program.

County Medical Services (CMS) Program
County of San Diego
-- entered the San Diego County market in 1983 --

Client Name and Address	San Diego County Health and Human Services Agency 8840 Complex Drive, Suite 225 San Diego, CA 92123-1423	
Key Contact	Name/Title:	Dale R. Fleming/Director, Strategic Planning and Operational Support
	Telephone:	619.685.2214
	E-mail:	Dale.Fleming@sdcounty.ca.gov
	Fax:	619.515.6730
Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	10,000	Approx.$6 million/year
Contract Start Date	**Contract Duration**	
1983	Annual renewal through 2012	

Scope of Work – All Contract Areas Listed

Since 1983, we have managed the County Medical Services (CMS) program for the County of San Diego. Over the years, the County has worked with AmeriChoice to expand our services to benefit eligible clients, which include the most clinically and financially vulnerable individuals in the County. The CMS program represents a partnership between San Diego County, California; AmeriChoice; and the Federally Qualified Health Centers (FQHCs). Its success has been built predominantly on our collaborative efforts with the County performing the regulatory role, AmeriChoice executing the management function, and the FQHCs serving in the capacity of medical homes for the population. Our services for CMS include:

Medical Management

- case and disease management;
- utilization management
- provider profiling
- Member/provider services

Pharmacy Management

- formulary development
- committee meetings
- pharmacy/drug utilization review in collaboration with contracted pharmacy benefits management

Quality Management

- data collection
- analysis and reporting
- patient and provider satisfaction surveys compliance reporting

County Medical Services (CMS) Program
County of San Diego
-- entered the San Diego County market in 1983 --

Financial Services

- claims processing and payment
- risk pool management
- Medi-Cal Recoveries

AmeriChoice – Innovative Approaches

- Extensive collaboration with County Government resulting in a 26 year presence in the County, demonstrating our commitment to long-term partnerships with our government clients and FQHCs to serve eligible individuals;
- Productive partnerships with key providers for the CMS population (for example, for San Diego: Scripps Mercy, Sharp Grossmont, Alvardo, UCSD, Paradise Valley, Palomar/ Pomerado etc), community clinics, specialty clinics, and San Diego County Medical Society.
- Collaboration with local projects to expand the management of diabetes through a successful public-private partnership, Project Dulce, and to increase access to specialty providers collaborated with the Council of Community Clinics on Project Access.
- Modification of enhanced medical management technology resulting in providers access to web-based Treatment Authorization Referral process to reduce administrative burden and which also improves speed to access services for Members.

5. As of the proposal due date, what is the total covered population, in terms of number of covered lives (includes active employees, retirees, COBRA, and dependents) nationwide serviced by the primary Contractor?

As of December 31, 2008, UnitedHealthcare Insurance Company had a total covered population of 23,872,227 Members, as shown in the table below. Additionally, UnitedHealthcare serves more than 2.3 million beneficiaries of government health care programs through such government programs as Medicaid, Medicare and CHIP in 22 states. UnitedHealthcare and its predecessor companies have been serving Americans for over 27 years through 23 health plans.

In 2008, UnitedHealth Group, including all subsidiary organizations, served 72.8 million Members.

People Served (millions)	Dec 2007	Mar 2008	June 2008	Sep 2008	Dec 2008
Commercial Risk-based	3,881	3,862	4,112	4,223	4,212
Commercial Fee-based	12,210	12,115	12,089	12,036	12,046
Total Commercial (millions)	16,091	15,977	16,201	16,259	16,258
Stand-alone Part D Prescription Drug Plans	4,392	3,870	3,847	3,841	3,810
Medicare Advantage	162	264	280	299	305
Medicare Supplement	3,512	3,505	3,496	3,505	3,499
Total Public and Senior (millions)	8,066	7,639	7,623	7,645	7,614
Total Health Care Services Medical Benefits (in millions of members)	**24,157**	**23,616**	**23,824**	**23,904**	**23,872**

6. [redacted]

UnitedHealthcare will be subcontracting with the following seven subsidiary organizations within UnitedHealth Group:

- ACN Group, Inc.
- United Behavioral Health (UBH)
- Dental Benefit Providers, Inc. (DBP)
- Ingenix, Inc.
- Prescription Solutions, Inc.
- Spectera, Inc.
- NurseLine℠.

The diverse structure and resources of UnitedHealth Group enable UnitedHealthcare to offer the services of our sister organizations and provide all subcontractor functions under the corporate umbrella. This approach greatly reduces the risks normally associated with maintaining subcontractor compliance and performance, and potential conflicts with contracted independent business entities.

If yes, provide the following information for each Subcontractor arrangement:

i. Full legal name.
ii. Headquarters address.
iii. The name, title, mailing address, telephone number and facsimile number of the contact person for this proposal.
iv. A description of the services to be provided.
v. As of the proposal due date, the number of years of experience in providing similar service to those which they will be performing under this contract for other clients.
vi. As of the proposal due date, the total covered population, in terms of number of covered lives (includes active employees, retirees, COBRA, and dependents) serviced by the Subcontractor.
vii. Indicate whether the primary Contractor currently has a current Contract, letter of commitment or letter of intent to Contract with the Subcontractor. If so, attach as Exhibit A to your proposal, copies of such agreements.

The following tables present required information for each subcontracting organization. Exhibit A contains the commitment agreement for each entity.

Subcontractor:		ACN Group, Inc.
i.	**Full Legal Name:**	ACN Group, Inc.
ii.	**Headquarters Address:**	6300 Olson Memorial Highway Golden Valley, MN 55427
iii.	**Contact Information:**	John DeSmet, Chief Operating Officer 6300 Olson Memorial Highway Golden Valley, MN 55427 763.797.4821 Fax: 866.323.6729

Subcontractor:	ACN Group, Inc.
iv. Services Description:	For over 20 years, ACN Group, Inc. has provided high-quality and efficient networks of physical and occupational therapists. Network affiliates provide clinical expertise endorsed by practitioner guidelines, credentialing, peer-to-peer support and communication. Subspecialties include, for example, orthopedics, pediatrics, and hand and post-surgical care. ACN Group, Inc. is our chosen subcontractor for therapy services for the MS CHIP program. UnitedHealthcare is using ACN Group, Inc. services for many other programs including Medicaid programs in Connecticut, New Jersey, Texas, Florida, Wisconsin and Tennessee and plans future expansion into other programs. ACN Group Inc. services projected for the MS CHIP program include network access and delegated credentialing.
v. Years of Experience:	20+
vi. Total Covered Lives:	23 million
vii. Commitment Type:	Signed Contract/Administrative Services Agreement (ASA) and Service Level Agreement (SLA)

Subcontractor:	United Behavioral Health (UBH)
i. Full Legal Name:	United Behavioral Health (UBH)
ii. Headquarters Address:	United Behavioral Health (UBH) 425 Market Street, San Francisco, CA 94105 415. 547.5000
iii. Contact Information:	Gregory Bayer, Ph.D. 425 Market Street, San Francisco, CA 94105 415.547.5000 Fax: 415.547.5999
iv. Services Description:	Clinical excellence, innovation, and a relentless commitment to the most scientifically-advanced health care solutions are hallmarks that distinguish UBH as the national leader in behavioral health. UBH has been guided by these principles for more than 30 years, and is recognized as a pioneer in the development of advancements that dramatically improve the clinical impact and delivery of behavioral health services. The company offers its services through a leading, national network of 80,000 providers and 2,593 facilities at 4,668 locations. UBH will be providing behavioral health services for the MS CHIP contract.
v. Years of Experience:	30
vi. Total Covered Lives:	43 million
vii. Commitment Type:	Signed Contract/Administrative Services Agreement (ASA) and Service Level Agreement (SLA)

Subcontractor:	Dental Benefit Providers, Inc. (DBP)
i. Full Legal Name:	Dental Benefit Providers, Inc. (DBP)
ii. Headquarters Address:	Three Irvington Centre 800 King Farm Boulevard, Suite 500 Mail Route MD051-1000 Rockville, MD 20850 240.632.8000 800.896.4831 Fax: 240.632.8100
iii. Contact Information:	Steven Klister, Senior Vice President Three Irvington Centre 800 King Farm Boulevard, Suite 500 Mail Route MD051-1000 Rockville, MD 20850 240.632.8000 800.896.4831 Fax: 240.632.8100
iv. Services Description:	Dental Benefit Providers, Inc. (DBP) has been supplying dental benefits successfully since 1984. Currently, DBP provides benefits to 6.6 million Members nationwide through a network of over 77,000 dentist access points. Highly experienced in integrating their dental service with health plans, they are committed to excellence and innovation in dental care delivery. They provide rapid claims payment, dental products, and administrative services for commercial, government (for example, Medicaid and Medicare) and federal employee markets. Dental Benefit Providers (DBP) is our chosen subcontractor for dental services for the MS CHIP program. Currently, other UnitedHealthcare plans using DBP's dental services are: ▪ AmeriChoice of New Jersey (Medicaid) ▪ AmeriChoice of Pennsylvania (Medicaid and CHIP) ▪ Arizona Physicians IPA (APIPA)(Medicaid and Medicare) ▪ AmeriChoice in Texas (Medicaid) ▪ United Health Plan of the River Valley (Medicaid in Tennessee) ▪ UnitedHealthcare of Florida (Medicaid) ▪ UnitedHealthcare of Maryland (Medicaid) ▪ UnitedHealthcare of New York (Medicaid). DBP dental services projected for the MS CHIP program include rapid claims payment, dental products, and administrative services.
v. Years of Experience:	25
vi. Total Covered Lives:	6.6 million
viii. Commitment Type:	Signed Contract/Administrative Services Agreement (ASA) and Service Level Agreement (SLA)

Subcontractor:	Ingenix, Inc.
i. Full Legal Name:	Ingenix, Inc.
ii. Headquarters Address:	12125 Technology Drive Eden Prairie, MN 55344 952.833.7100 888.445.8745 Fax: 952.833.7079
iii. Contact Information:	Andy Slavitt, Chief Executive Officer 12125 Technology Drive Eden Prairie, MN 55344 952.833.8448 Fax: 952.833.7079
iv. Services Description:	Ingenix, a wholly-owned subsidiary of UnitedHealth Group, is a healthcare technology company with more than 8,300 professionals worldwide who help clients solve the most important problems in health care using data, software and services. Ingenix partners with more than 250,000 clients around the globe, including: ▪ 1,500+ insurance companies and health plans ▪ 200,000+ physicians and health care providers ▪ 3,500+ hospitals ▪ 100+ FORTUNE 500 companies ▪ 75+ pharmaceutical and biotechnology companies ▪ Federal and state agencies. Ingenix will provide licenses and analytical software to enable data management and analyses.
v. Years of Experience:	13
vi. Total Covered Lives:	Not Applicable
vii. Commitment Type:	Signed Memorandum of Understanding

Subcontractor:	Prescription Solutions, Inc.
i. Full Legal Name:	Rx Solutions, Inc.
ii. Headquarters Address:	2300 Main Street Irvine, CA 92614
iii. Contact Information:	Sheela Andrews, VP Pharmacy Services 2300 Main Street; Irvine CA 92614 949.475.3302
iv. Services Description:	Prescription Solutions, Inc. is an innovative pharmacy benefit management company that manages the prescription drug benefit for commercial, Medicare, other governmental health plans, and employers and unions. It serves its Members through a national network of 60,000 community pharmacies and state-of-the-art mail service pharmacies. Using a broad range of generic utilization incentive programs, Member and physician education, and price incentives, it promotes safety and affordability, helping Members get best possible outcomes for their health, while supporting clients' bottom lines. Prescription Solutions, Inc. is the chosen PBM for the Mississippi program. Currently, other UnitedHealthcare plans using Prescription Solutions' pharmacy benefit manager services are:

Subcontractor:	Prescription Solutions, Inc.

- AmeriChoice of New Jersey (Medicaid)
- AmeriChoice—Unison Family Health Plan of Pennsylvania (AdultBasic and CHIP)
- AmeriChoice—Unison Health Plan of the Capital Area (DC)(Medicaid and Alliance)
- AmeriChoice—Unison Health Plan of Ohio (Medicaid and Medicare)
- AmeriChoice—Unison Health Plan of Pennsylvania (Medicaid and Medicare)
- AmeriChoice—Unison Health Plan of South Carolina (Medicaid and CHIP)
- AmeriChoice—Unison/Advantage in Tennessee/Mississippi (Medicare).

Prescription Solutions services projected for the MSi CHIP program include: claims adjudication, concurrent Drug Utilization Review (DUR), pharmacy network contracting, rebate program administration and pharmacy audits.

v. **Years of Experience:** 19

vi. **Total Covered Lives:** Greater than 10 million

vii. **Commitment Type:** Signed Contract

Subcontractor:	Spectera, Inc.

i. **Full Legal Name:** Spectera, Inc.

ii. **Headquarters Address:** 2811 Lord Baltimore Drive
Baltimore, MD 21244
800.638.3895
Web site: www.spectera.com

iii. **Contact Information:** Don Yee, President
2811 Lord Baltimore Drive
Baltimore, MD 21244
800.638.3895
Fax: 916.934.0369

iv. **Services Description:** Vision services will be provided by Spectera, a UnitedHealth Group company. Spectera is a pioneer in the vision care industry and has been providing innovative vision benefit solutions for more than 40 years. Spectera provides vision services for more than 17 million Members nationwide through a network of more than 24,000 private practice and retail chain providers, a state-of-the-art optical laboratory and consistently updated benefits. Spectera provides vision benefits within publicly funded health care programs around the country in conjunction with other physical health benefits.

Spectera, Inc. is our chosen subcontractor for vision services for the MS CHIP program. Currently, other UnitedHealthcare plans using Spectera's vision services include:

- AmeriChoice of Connecticut (Medicaid)
- AmeriChoice of New Jersey (Medicaid)
- AmeriChoice of Pennsylvania (Medicaid and CHIP)
- AmeriChoice in Texas (CHIP)
- Arizona Physician's IPA (APIPA) (Medicaid and Medicare)
- UnitedHealthcare of New York (Medicaid)
- UnitedHealthcare Plan of the River Valley, Inc. (Medicaid in Tennessee).

Subcontractor:	Spectera, Inc.
	Spectera services projected for the MS CHIP program include: rapid claims payment, vision and laboratory products, and administrative services.
v. Years of Experience:	40
vi. Total Covered Lives:	17 million
Vii. Commitment Type:	Signed Contract/Administrative Services Agreement (ASA) and Service Level Agreement (SLA)

Subcontractor:	NurseLine℠
i. Full Legal Name:	NurseLine℠
ii. Headquarters Address:	6300 Olson Memorial Highway Golden Valley, MN 55427
iii. Contact Information:	Rob Webb, President 6300 Olson Memorial Highway Golden Valley, MN 55427 763.797.2405 Fax: 763.797.2600
iv. Services Description:	NurseLine is a market leader in Symptom Support and health care information. Through a single point-of-contact, 24 hours-a-day, 365 days-a-year, NurseLine helps direct individuals to appropriate care resources to drive improved outcomes. NurseLine will provide telephonic nurse triage services for the MS CHIP contract.
v. Years of Experience:	28
vi. Total Covered Lives:	35 million
vii. Commitment Type:	Signed Contract/Administrative Services Agreement (ASA) and Service Level Agreement (SLA)

7. State if you currently provide any services directly or indirectly to the Board members or any of the following:

i. Blue Cross & Blue Shield of Mississippi
ii. Thomson Reuters (Healthcare) Inc.
iii. PricewaterhouseCoopers LLP
iv. WM. Lynn Townsend, FSA, MAAA
v. CareAllies/Intracorp
vi. Minnesota Life Insurance Company
vii. Advanced Health Services, Inc.
viii. Cavanaugh Macdonald Consulting, LLC
ix. Claims Technologies, Inc.
x. WebMD Health Services Group, Inc.
xi. Catalyst Rx
xii. State and School Employees Health Insurance Management Board Members:

Kevin Upchurch, Jr., Lies Williams, Mike Chaney, Aubrey Lucas, Hank M. Bounds, Larry Fortenberry, John Mulholland, Pat Robertson, Christopher Burkhalter, Eric Clark, Johnny Stringer, Eugene Clarke, Walter Robinson, Jr., Alan Nunnelee

If your firm currently provide services to, or receive services from, one of these vendors, provide a full description of services provided.

To the best of our knowledge and belief, after a review of our vendor profiles, we are currently providing or receiving the services described for the following organizations:

- Thomson Reuters (Healthcare) Inc.: formerly Medstat, provides licensed software programs for various decision analysis and reporting tools.
- PricewaterhouseCoopers, LLP: provides accounting and auditing services for several of the UnitedHealth Group companies.
- Minnesota Life Insurance Company Life Insurance: UHIC is the administrator of their employee medical benefit and also provides stop-loss services.
- WebMD (now Emdeon): provides clearinghouse services, sending us electronic data interchange (EDI) and real-time transactions.

8. Confirm that you will cooperate with the Board and all other Contractors of the Board in the ongoing services outlined in this RFP and in any transition of responsibility.

UnitedHealthcare will cooperate with the Board and all other Contractors of the Board in the ongoing provision of the services outlined in this RFP and in the orderly transition of any responsibilities as required by the Department of Finance and Administration (DFA). UnitedHealthcare prides itself on our reputation for cooperative customer relationships and the ability and willingness to adjust to clients' dynamic business needs.

Organizational/General Information

UnitedHealthcare by AmeriChoice is part of UnitedHealth Group (UHG), a diversified for-profit health and well-being company established in 1974. UHG, Incorporated is traded on the New York Stock Exchange under the symbol UHN. Since its inception, UHG and its affiliated companies have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions. UHG serves over 72 million people in all 50 states and internationally.

UnitedHealth Group, Inc. operates a diverse family of business groups covering a wide variety of products and services related to the health and well-being industry, investment and other income in the following business segments:

- UnitedHealthcare by AmeriChoice— incorporated in Delaware, facilitates and manages health care services for state-sponsored public and Medicaid (including CHIP) programs, serving over 2.3 million Medicaid, SCHIP and other government-sponsored Members on full-risk capitated and fee-for-service financial arrangements in 22 states. We employ over 3,000 people nationwide, with many National Committee on Quality Assurance (NCQA) accredited health plans and disease management programs.
- UnitedHealthcare—provides a comprehensive array of consumer-oriented health benefit plans and services on a dedicated basis to large, multi-site employers and coordinates network-based health care benefits for small to mid-sized employers, as well as individuals and families nationwide. It currently facilitates access to health care services on behalf of approximately 26 million Americans. Its innovative, data-driven programs of quality and affordability, along with its collaborative pilots to establish patient-centered medical homes, underscore UnitedHealthcare's commitment to promoting a streamlined and sensible health care system. UnitedHealthcare Insurance Company (UHIC) is a for-profit company incorporated in the state of Connecticut and licensed to issue life and health insurance products in the District of Columbia, several U.S. Territories and all states except New York.

- Ovations—is the largest business in the nation dedicated to meeting the growing health and well-being needs of Americans age 50 and older. Ovations provides services for these individuals, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. Ovations services, provided throughout the entire country, include 1) Medicare Advantage standard and special needs plans, 2) MediGap and hospital indemnity insurance, and 3) Part D pharmacy programs. Ovations provides these services to approximately 1.5 million, 3.8 million and 5.5 million Members, respectively.
- OptumHealth—is one of the nation's largest health and wellness companies. Employers, payers and public sector organizations use OptumHealth behavioral benefit solutions, clinical care management, financial services and specialty benefit products such as dental and vision to help consumers navigate the health care system, finance their health care needs and achieve their health and well-being goals.
- Ingenix—is a leader in the field of health care information, services and consulting, serving pharmaceutical companies, health insurers and other payers, physicians and other health care providers, large employers and governments.
- Prescription Solutions (Pharmacy Benefit Manager)—offers a comprehensive array of pharmacy benefit management and specialty pharmacy management services to employer groups, union trusts, seniors through Medicare prescription drug plans and commercial health plans. Prescription Solutions, with more than 19 years of experience, provides services for more than 10 million covered lives, delivering drug benefits through 60,000 retail network pharmacies and two mail service facilities.

Collaboratively, the UHG companies leverage advanced technology-based transactional capabilities; health care data, knowledge and information; health care resource organization; and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable. We are an open, inclusive, engaged health system, a health system designed to adapt to ever-changing market conditions and shifting demands in the health care landscape.

The UnitedHealthcare by AmeriChoice division is a large, highly-successful health care organization dedicated to the public sector within the UHG network. Like UHG, UnitedHealthcare by AmeriChoice is dedicated to making the health care system work better. Our mission is to ***help people live healthier lives***. Our corporate philosophy embodies the following:

- To improve the health and well-being of our Members through information and tools, helping them make the right health choices and offering expansive health care networks
- To collaborative with and support provider relationships and reliable claims payment methods, keeping our networks intact and always growing
- To invest in technology and evidence-based research, producing "next generation" solutions and effective health care mitigations for high-cost and debilitating chronic conditions
- To appreciate the diverse needs of our Members, striving to improve HEDIS and other quality measures while addressing factors that contribute to health care disparities
- To employ a diverse workforce, holding high standards of performance, business ethics, and accountability for delivering the results our state clients and program beneficiaries expect.

As evidence of our continued effectiveness in serving public sector customers, in 2008, we successfully re-procured our contracts in Arizona and Pennsylvania SCHIP covering 235,000 and 75,000 members respectively and we were successful bidders for new contracts in Arizona—Children's Rehabilitative Services (CRS), Tennessee—West and East Regions, Connecticut—Husky A & B and Charter Oak, and Florida—Expansion Counties.

Existing Products and Services—UnitedHealthcare by AmeriChoice's 2.3 million beneficiaries of government health care programs include nearly every category of eligibility including Temporary Assistance for Needy Families (TANF); Aged, Blind, and Disabled (ABD), Social Security Income (SSI), individuals with developmental disabilities, Family Health Plan (FHP) and the uninsured. Through this strong base of operations, many of our health plans participate in State Children's Health Insurance Programs (SCHIP), working with financially-vulnerable children and their families to ensure children receive appropriate preventive care, immunizations, and services. Within our Medicaid and SCHIP programs, we work with Children with Special Health Care Needs, including those with complex health care needs and diagnoses, such as sickle cell anemia and hemophilia. UnitedHealthcare by AmeriChoice administers programs for the uninsured and underinsured. Many uninsured individuals share demographic and socioeconomic characteristics with the Medicaid population, so we also apply the same holistic approach to care management for these individuals. We offer Medicare Advantage Part D (MAPD) plans, too. By offering these plans side-by-side with our Medicaid operations, we are able to coordinate care and services for our Members.

In addition to being one of the country's largest Medicaid health plan organizations, UnitedHealthcare by AmeriChoice partners with states to provide care management services for individuals with chronic conditions or who have demonstrated a history of high utilization of health care services. These services are provided through our Management Services Organization (MSO) and include disease management in NCQA-accredited programs (for example, asthma, diabetes, high risk pregnancy, HIV/AIDS, sickle cell, and schizophrenia), chronic care management, behavioral health integration, Member services, provider services, predictive modeling, and provider profiling.

UnitedHealthcare by AmeriChoice is committed to continuously improving the health care services delivered to vulnerable populations. We have developed our own clinical software to monitor Member access to services. We use a sophisticated clinical risk-stratification tool to ensure that our Members are receiving optimal care.

Our unique UnitedHealthcare by AmeriChoice Personal Care Model™ features direct Member contact by clinical staff that builds a support network for chronically-ill and acutely-ill Members involving family, physicians and government and community-based organizations. Our goal is to employ practical solutions to improve Members' health by coordinating the resources they need to maintain the highest possible quality of life in their own communities.

We present an organizational schematic in Exhibit B:

- Exhibit B1 shows the structure of UHG.
- Exhibit B2 shows the structure of UnitedHealthcare by AmeriChoice
- Exhibit B3 shows the Senior Operations Staff for UnitedHealthcare by AmeriChoice Mississippi operations.

10. Within the last two years has your company been acquired by another organization, merged with another company, purchased another organization, or changed from privately held to publicly held status? If so, please identify what occurred and when. Are any ownership or name changes planned?

Within the last two years, UHIC has not been acquired by another organization, has not merged with any other company, did not purchase another organization and did not change its status from privately-held to publicly-held. Several of its affiliates were involved in related transactions. Those pertaining to government programs business include:

- On February 25, 2008, UnitedHealthcare, Inc., a Delaware corporation, acquired Sierra Health Services, Inc., a Nevada corporation, and its subsidiaries and their Medicaid business.
- On May 30, 2008, AmeriChoice Corporation, a Delaware corporation, acquired all outstanding stock of Three Rivers Holdings, Inc., a Delaware corporation, and its wholly-owned subsidiaries including, but not limited to, Unison Health Plan of Ohio, Inc., Unison Health Plan of South Carolina, Inc., Unison Health Plan of Pennsylvania, Inc., Unison Family Health Plan of Pennsylvania, Inc., Unison Health Plan of Tennessee, Inc., Unison Health Plan of New Jersey, Inc., Unison Health Plan of the Capital Area, Inc. and Unison Health Plan of Delaware, Inc.

No ownership or name changes are planned at this time.

11. Name all organizations that have a 10% or more ownership interest in your company. Describe their relationship to your company in terms of percentage of stock held or amount of venture capital invested.

UnitedHealthcare Insurance Company is a wholly-owned subsidiary of UnitedHealth Group, Incorporated. UnitedHealth Group, Incorporated is a publicly-held company. There is no organization that owns 10 percent or more of the outstanding stock.

12. List the names, addresses and occupations for members of your Board of Directors.

The names, addresses and occupations for the current UnitedHealthcare Board of Directors follow:

- Jeffrey D. Alter, Sr. Vice President UHC, 48 Monroe Turnpike, Trumbull, CT 06611
- Kenneth A. Burdick, Sr. Vice President, Ovations: 9701 Data Park Drive, Minnetonka MN 55343
- Duane Downey, Senior Finance Executive of UHIC: 450 Columbus Blvd., Hartford, CT 06103
- Gerald J. Knutson, Chief Financial Officer of Ingenix, 12125 Technology Drive, Eden Prairie, MN 55344
- Thomas McGlinch, Senior Treasury Officer of UHG, 9900 Bren Road E. , Minnetonka MN 55343
- George L. Mikan III, Chief Financial Officer of UHG: 9900 Bren Road E. , Minnetonka MN 55343
- Eric S. Rangen, Senior Finance Executive of UHG: 9900 Bren Road East, Minnetonka MN 55343
- Allen J. Sorbo, Senior Finance Executive of UHIC: 48 Monroe Turnpike, Trumbull, CT 06611
- Brian Thompson, Senior Finance Officer of UHC, 5901 Lincoln Drive, Edina, MN 55436.

13. Within the last three years has your organization, any affiliate of the company, or any senior officers or Board members been a party to a lawsuit or governmental investigation? If so, provide a brief description of each incident.

Within the past three years, the UHG companies have been, and are, involved in various litigation matters in the normal course of business incidental to providing management of health care services and administrative services for more than 72 million Members nationwide. The majority of suits are brought by those seeking to challenge benefit decisions. Some have or may involve data issues. Since UHG is a publicly-traded company, any material litigation is described in UHG's Form 10-K filings which are public information, and is provided for your review as Attachment 13 10-K/A Annual Report in Section 7, Appendix of Other Materials. To the best of our knowledge and belief, neither UnitedHealthcare nor any of its officers or Board members have been involved in any litigation involving CHIP products in the last three years.

14. List any ownership interest your company has in any health care facility, provider or PBM and describe the relationship.

The UHG family of companies includes several subsidiaries that are health care facilities, providers and/or PBMs. These include:

- Dental Benefit Providers and affiliates: Dental network and services.
- Spectera, Inc. and affiliates: Vision network and services including a provider network consisting of more than 24,000 private practice and retail chain providers and a state-of-the-art optical laboratory
- United Behavioral Health: Behavioral health network and disease management
- ACN Group, Inc. and affiliates: Provides access to chiropractic, physical and occupational therapy, and complementary alternative medicine networks
- Prescription Solutions, Inc.: Comprised of retail pharmacy claims processing, Mail Service Pharmacies, Specialty Pharmacy Programs and Consumer Health Products. Prescription Solutions serves internal clients as well as external clients including the American Association of Retired Persons (AARP)
- Sierra Home Medical Products, Inc. d/b/a THC of Nevada: Comprised of home infusion, specialty, hospice, and long-term care pharmacy and home medical equipment suppliers

- Family HealthCare Services: Provides home care services including nursing, home health aide, physical therapy, occupational therapy, speech therapy, medical social services, and specialty home care services (fulltime certified wound and ostomy care registered nurses, pediatric home care, obstetric home care and telemonitoring)
- Family Home Hospice, Inc.: Provides hospice services including hospice physician (full-time Medical Director), nursing, home health aide, social work, pastoral/spiritual, bereavement and volunteer
- Southwest Medical Associates, Inc.: Health care Facility
- Innoviant Pharmacy, Inc.: Provides pharmacy supplies and services.

15. For the purpose of this question the term "complaint" is defined as a written or verbal expression of dissatisfaction.

For your organization's group health care business, what was the total number of complaints filed per 1,000 enrollees in the most recently available 12-month period? What was the total number of complaints filed per 1,000 enrollees in the prior 12-month period? Please include in your response the time period upon which your answer is based.

In calendar year 2008, UHC of Mississippi provided healthcare coverage and services to approximately 140,000 fully-insured and self-funded Members per month. There were a total of 16 fully-insured complaints filed against it during the entire year resulting in an average complaint ratio of lower than 0.00012. For calendar year 2007, approximately 135,000 fully-insured and self-funded Members per month filed 10 complaints for the year, resulting in an average complaint ratio of 0.000074.

16. Is your organization currently accredited by:

i. the American Accreditation HealthCare Commission Inc. (AAHCC), formerly known as URAC;
ii. the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
iii. the National Committee on Quality Assurance (NCQA)?

If so, please indicate the type, current level and duration of continuous accreditation.

In support of the UHG commitment to quality improvement, all UnitedHealthcare commercial health plans and most of our CHIP/Medicaid health plans have achieved NCQA accreditation. AmeriChoice also has obtained accreditation for several Disease Management programs. The original dates of continuous accreditation were not available; however, no AmeriChoice health plan has lost accreditation once received. Current information on our NCQA accreditation success and status is provided in the table below. NOTE: "Medicaid" plans include CHIP Products except in MI.

NCQA Accreditation					
State	Health Plan	Product Line	Accreditation Type	Accreditation Status	Effective Dates
Alabama	UnitedHealthcare of AL, Inc.	Commercial HMO/POS	MCO	Commendable	Oct. 16, 2007 Oct. 16, 2010
Arizona	Pacificare of AZ, Inc.	Commercial HMO	MCO	Excellent	Mar. 16, 2007 Mar. 16, 2010
	Pacificare of AZ, Inc.	Medicare HMO	MCO	Commendable	Mar. 16, 2007 Mar. 16, 2010
	UnitedHealthcare of AZ, Inc.	Commercial HMO/POS	MCO	Commendable	Dec.15, 2006 Dec.15, 2009
Arkansas	UnitedHealthcare of AR, Inc.	Commercial HMO/POS	MCO	Commendable	Oct. 16, 2007 Oct. 16, 2010
California	Pacificare of CA, Inc.	Commercial HMO/POS	MCO	Excellent	April 18, 2007 April 18, 2010

NCQA Accreditation					
State	Health Plan	Product Line	Accreditation Type	Accreditation Status	Effective Dates
	Pacificare of CA, Inc.	Medicare HMO	MCO	Excellent	April 1, 2007 April 1, 2010
Colorado	Pacificare of CO, Inc.	Commercial HMO/POS	MCO	Excellent	May 22, 2008 May 22, 2011
	Pacificare of CO, Inc.	Medicare HMO	MCO	Excellent	May 22, 2008 May 22, 2011
	UnitedHealthcare of CO, Inc.	Commercial HMO/POS	MCO	Excellent	May 15, 2008 May 15, 2011
Connecticut	Oxford Health Plans of CT, Inc.	Commercial HMO/POS	MCO	Commendable	July 11, 2008 July 11, 2011
	Oxford Health Plans of CT, Inc.	Medicare	MCO	Excellent	July 11, 2008 July 11, 2011
Delaware	Optimum Choice, Inc	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009
District of Columbia	MD - Individual Practice Association, Inc. (M.D. IPA)	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009
	Optimum Choice, Inc	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009
	Unison Health Plan of the Capital Area	Medicaid	MCO	Anticipate New HP Status	ISS Tool: Submission: Aug. 31, 2009 Onsite: Oct. 26-27, 2009
	UnitedHealthcare of Mid-Atlantic, Inc.	Commercial HMO/POS	MCO	Commendable	Jan. 10, 2007 Jan. 10, 2010
Florida	UnitedHealthcare of FL, Inc.	Commercial HMO/POS	MCO	Excellent	May 10, 2006 May 10, 2009
	Neighborhood Health Partnership	Commercial HMO/POS	MCO	Commendable	Nov. 21, 2007 Nov. 21, 2010
Georgia	UnitedHealthcare of GA, Inc.	Commercial HMO/POS	MCO	Excellent	June 7, 2006 June 7, 2009
	United Behavioral Health, Atlanta: Servicing Members in GA, FL, AR, LA, MS, NC, SC, DE, TN, TX	Commercial Medicare	Managed Behavioral Health	Full	Dec. 16, 2007 Dec. 16, 2010
Illinois	UnitedHealthcare Plan of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Plan of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare	Commercial	MCO	Excellent	April 20, 2006

NCQA Accreditation					
State	Health Plan	Product Line	Accreditation Type	Accreditation Status	Effective Dates
	Services Company of the River Valley, Inc.	HMO			April 20, 2009
	UnitedHealthcare Services Company of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare of IL, Inc.	Commercial HMO	MCO	Commendable	Oct. 31, 2007 Oct. 31, 2010
	United Behavioral Health, Chicago: Servicing Members in AZ, CO, CT, IA, IL, MA, MI, NY, NY, NV, TN, UT, WI, VA	Commercial and Medicaid	Managed Behavioral Health	Full	June 14, 2006 June 14, 2009
Indiana	UnitedHealthcare of IL, Inc.	Commercial HMO	MCO	Commendable	Oct. 31, 2007 Oct. 31, 2010
	UnitedHealthcare of KY, Inc.	Commercial HMO/POS	MCO	Excellent	May 11, 2007 May 11, 2010
Iowa	UnitedHealthcare Plan of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Plan of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Services Company of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Services Company of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare of the Midlands, Inc.	Commercial HMO/POS	MCO	Excellent	Oct. 26, 2006 Oct. 26, 2009
Kansas	UnitedHealthcare of the Midwest, Inc.	Commercial HMO/POS	MCO	Excellent	Dec. 4, 2008 Dec. 4, 2011
Kentucky	UnitedHealthcare of KY, Inc.	Commercial HMO/POS	MCO	Excellent	May 11, 2007 May 11, 2010
Louisiana	UnitedHealthcare of LA, Inc.	Commercial HMO/POS	MCO	Commendable	Oct. 16, 2007 Oct. 16, 2010
Maryland	UnitedHealthcare of Mid-Atlantic, Inc.	Commercial HMO/POS	MCO	Commendable	Jan. 10 2007 Jan. 10, 2010
	MD - Individual Practice Association, Inc. (M.D. IPA)	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009
	Optimum Choice, Inc. (OCI)	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009

NCQA Accreditation					
State	Health Plan	Product Line	Accreditation Type	Accreditation Status	Effective Dates
Massachusetts	UnitedHealthcare of New England, Inc.	Commercial HMO/POS	MCO	Excellent	Mar. 3, 2006 Mar. 3, 2009
Michigan	Great Lakes Health Plan (GLHP)	Medicaid	MCO	Excellent	Nov. 1, 2007 Nov. 1, 2010
Mississippi	UnitedHealthcare of MS, Inc.	Commercial HMO/POS	MCO	Commendable	Oct. 16, 2007 Oct. 16, 2010
Missouri	UnitedHealthcare of the Midwest, Inc.	Commercial HMO/POS	MCO	Excellent	Dec. 4, 2008 Dec. 4, 2011
	United Behavioral Health, St. Louis: Servicing Members in IL, IN, IA, KS, KY, MO, NE, OH, OK, PA	Commercial Medicare	Managed Behavioral Health	Full	Dec. 29, 2007 Dec. 29, 2010
Nebraska	UnitedHealthcare of the Midlands, Inc./ AmeriChoice	Medicaid	MCO	Excellent	Sept. 2, 2008 Sept. 2, 2011
	UnitedHealthcare of the Midlands, Inc.	Commercial HMO/POS	MCO	Excellent	Oct. 26, 2006 Oct. 26, 2009
Nevada	Pacificare of NV, Inc.	Commercial HMO	MCO	Commendable	April 18, 2007 April 18, 2010
	Pacificare of NV, Inc.	Medicare HMO	MCO	Commendable	April 18, 2007 April 18, 2010
New England	UnitedHealthcare of New England, Inc.	Commercial HMO/POS	MCO	Excellent	Mar. 3, 2006 Mar. 3, 2009
	UnitedHealthcare of New England, Inc.	Medicaid	MCO	Excellent	Mar. 3, 2006 Mar. 3, 2009
New Jersey	UnitedHealthcare Insurance Co. of NJ.	Commercial POS	MCO	Commendable	Feb. 22 2006 Feb. 22, 2009
	Oxford Health Plans of NJ, Inc.	Commercial HMO/POS	MCO	Commendable	July 11, 2008 July 11, 2011
	Oxford Health Plans of NJ, Inc.	Medicare	MCO	Commendable	July 11, 2008 July 11, 2011
New York	UnitedHealthcare Insurance Co. of NY	Commercial POS	MCO	Commendable	Feb. 22, 2006 Feb. 22, 2009
	Oxford Health Plans of NY, Inc.	Commercial HMO/POS	MCO	Commendable	July 11, 2008 July 11, 2011
	Oxford Health Plans of NY, Inc.	Medicare	MCO	Commendable	July 11, 2008 July 11, 2011
North Carolina	UnitedHealthcare of NC, Inc. (Covers Members in South Carolina, also)	Commercial HMO/POS	MCO	Excellent	April 23, 2007 April 23, 2010

NCQA Accreditation					
State	Health Plan	Product Line	Accreditation Type	Accreditation Status	Effective Dates
Ohio	UnitedHealthcare of OH, Inc.	Commercial HMO/POS	MCO	Excellent	Sept. 21, 2006 Sept. 21, 2009
	Unison Health Plan of Ohio, Inc.	Medicaid	MCO	New Health Plan	Dec. 29, 2008 Dec. 29, 2011
Oklahoma	Pacificare of OK, Inc.	Commercial HMO	MCO	Commendable	May 22, 2008 May 22, 2011
	Pacificare of OK, Inc.	Medicare HMO	MCO	Commendable	May 22, 2008 May 22, 2011
Oregon	Pacificare of OR, Inc.	Commercial HMO	MCO	Excellent	April 18, 2007 April 18, 2010
	Pacificare of OR, Inc.	Medicare HMO	MCO	Excellent	April 18, 2007 April 18, 2010
	United Behavioral Health, Portland: Servicing Members in AZ, NV, WA	Commercial Medicare	Managed Behavioral Health	Full	July 21, 2008 July 21, 2011
Pennsylvania	AmeriChoice of PA	Medicaid	MCO	Commendable	May 30, 2007 May 30, 2010
	United Behavioral Health, Philadelphia: Servicing Members in CT, MA, RI, MD, DC, VA, WV, DE	Commercial	Managed Behavioral Health	Full	June 11, 2007 June 11, 2010
	Unison Family Health Plan of Penn., Inc.	SCHIP Uninsured	MCO	New Health Plan	May 30, 2007 May 30, 2010
	Unison Health Plan of Pennsylvania, Inc.	Medicaid	MCO	Excellent	July 8, 2008 July 8, 2011
Rhode Island	UnitedHealthcare of New England, Inc.	Medicaid	MCO	Excellent	Mar. 3, 2006 Mar. 3, 2009
	UnitedHealthcare of New England, Inc.	Commercial HMO/POS	MCO	Excellent	Mar. 3, 2006 Mar. 3, 2009
South Carolina	Unison Health Plan of South Carolina, Inc.	Medicaid	MCO	New Health Plan	Jan. 11, 2008 Jan. 11, 2011
Tennessee	UnitedHealthcare Plan of the River Valley, Inc.	Medicaid HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Plan of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Plan of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009

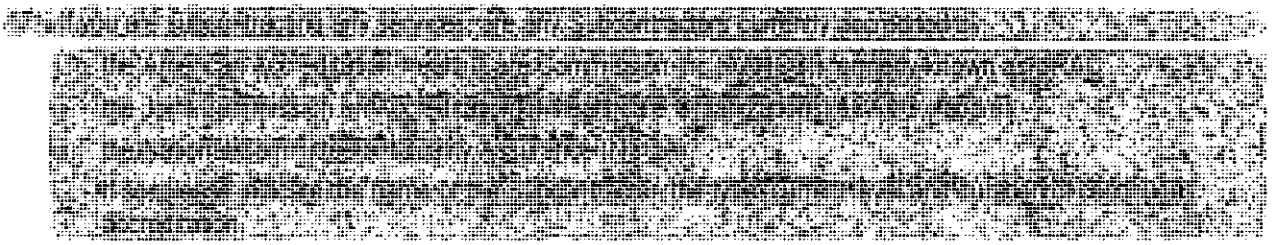
NCQA Accreditation					
State	Health Plan	Product Line	Accreditation Type	Accreditation Status	Effective Dates
	UnitedHealthcare Services Company of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Services Company of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare of TN, Inc.	Commercial HMO/POS	MCO	Excellent	Oct. 16, 2007 Oct. 16, 2010
Texas	Pacificare of TX, Inc.	Commercial HMO	MCO	Commendable	May 22, 2008 May 22, 2011
	Pacificare of TX, Inc.	Medicare HMO	MCO	Commendable	May 22, 2008 May 22, 2011
	UnitedHealthcare of TX, Inc.	Commercial HMO/POS	MCO	Excellent	May 25, 2006 May 25, 2009
	United Behavioral Health/ Houston Servicing: OK, TX	Commercial Medicare	Managed Behavioral Health	Full	Mar. 13, 2006 Mar. 13, 2009
Utah	UnitedHealthcare of UT, Inc.	Commercial HMO/POS	MCO	Commendable	Dec. 15, 2006 Dec. 15, 2009
Virginia	UnitedHealthcare Plan of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Plan of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Services Company of the River Valley, Inc.	Commercial HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare Services Company of the River Valley, Inc.	Medicare HMO	MCO	Excellent	April 20, 2006 April 20, 2009
	UnitedHealthcare of Mid-Atlantic, Inc.	Commercial HMO/POS	MCO	Commendable	Jan. 10, 2007 Jan. 10, 2010
	MD - Individual Practice Association, Inc. (MD-IPA)	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009
	Optimum Choice, Inc	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009
Washington	Pacificare of WA, Inc.	Commercial HMO	MCO	Excellent	April 18, 2007 April 18, 2010
	Pacificare of WA, Inc.	Medicare HMO	MCO	Excellent	April 18, 2007 April 18, 2010
West Virginia	Optimum Choice, Inc	Commercial HMO/POS	MCO	Commendable	Mar. 3, 2006 Mar. 3, 2009

NCQA Accreditation					
Wisconsin	UnitedHealthcare of WI, Inc.	Commercial HMO/POS	MCO	Excellent	Dec. 4, 2008 Dec. 4, 2011
	Pacificare Behavioral Health Western Reg.: Servicing Members in: CA, NM, AZ, FL	Commercial Medicaid	Managed Behavioral Health	Full	Nov. 28, 2008 Nov. 28, 2011

Excellence in NCQA Accredited Disease Management Programs

During 2006 and 2007, UnitedHealthcare Services Inc. was awarded disease management accreditation for the programs identified in the table below. UnitedHealthcare pursued accreditation for these programs based on the complexities of our Members' health conditions. The table below reflects NCQA Disease Management accreditation.

NCQA Disease Management Accreditation				
UHC Company	Disease Mgmt. Accreditation Type	Disease Mgmt. Program	Accreditation Status	Effective Dates
UnitedHealthcare Services Company of the River Valley, Inc.	Patient & Practitioner Oriented	Asthma	Full	April 20, 2006 April 20, 2009
	Patient & Practitioner Oriented	Diabetes	Full	April 20, 2006 April 20, 2009
UnitedHealthcare Services Inc.	Patient Oriented	Asthma	Full	Feb. 21, 2007 Feb. 21, 2010
	Patient Oriented	Diabetes	Full	Feb. 21, 2007 Feb. 21, 2010
	Patient Oriented	High Risk Pregnancy	Full	Feb. 21, 2007 Feb. 21, 2010
	Patient Oriented	HIV	Full	Feb. 21, 2007 Feb. 21, 2010
	Patient Oriented	Schizophrenia	Full	Feb. 21, 2007 Feb. 21, 2010
	Patient Oriented	Sickle Cell	Full	Feb. 21, 2007 Feb. 21, 2010
UnitedHealthcare Services Company of the River Valley, Inc.	Patient Oriented	Coronary Artery Disease	Full	Dec. 28, 2007 Dec. 28, 2010
	Patient Oriented	Diabetes	Full	Dec. 28, 2007 Dec. 28, 2010



UnitedHealthcare recognizes the importance of selecting subcontractors that have demonstrated their ability to provide the high quality of service to which UHG and its subsidiary organizations are committed. The following table presents required information for subcontractor accreditations.

Subcontractor Name	Type Accreditation	Current Level of Accreditation	Duration of Continuous Accreditation
ACN Group, Inc.	URAC – Health Network and Credentialing, Health UM	Full	1987 – September 1, 2010
Spectera, Inc.	URAC – Health UM, Case Management	Full	1983 – May 1, 2011
NurseLine	URAC – Health Call Center	Full	October 2008 – May 1, 2010
Prescription Solutions	URAC – Pharmacy Benefits Management, Drug Therapy Management	Full	November 1, 2007 – November 1, 2010
	Mail Service Pharmacy, Specialty Pharmacy Program	Full	November 1, 2008 November 1, 2011
United Behavioral Health (UBH)	NCQA Accreditation/Certification Effective Dates – Full Behavioral Health (MBHO): ▪ Georgia: Nov. 21, 2007 – Dec. 16, 2010 ▪ Illinois: June 14, 2006 – June 14, 2009 ▪ Missouri: Dec. 3, 2007 – Dec. 29, 2009 ▪ Oregon (Commercial/Medicaid): July 21, 2008 – July 21, 2011 ▪ Texas: March 13, 2006 – March 13, 2009 URAC Accreditation/Certification Effective Dates – Full Utilization Management: Feb. 01, 2008 – Feb. 01, 2011 ▪ California (San Diego) – Certificate Number: U070047R-741 ▪ California (San Francisco) – Certificate Number: U070047R-738 ▪ Georgia – Certificate Number: U070047R-733 ▪ Illinois – Certificate Number: U070047R-740 ▪ Minnesota – Certificate Number: U070047R-736 ▪ Missouri – Certificate Number: U070047R-746 ▪ Oregon – Certificate Number: U070047R-1139 ▪ Pennsylvania – Certificate Number: U070047R-768 ▪ Texas – Certificate Number: U070047R-767		

UnitedHealthcare currently has a sales and marketing office in Mississippi located at:

UnitedHealthcare of Mississippi, Inc.
800 Woodlands Parkway
Ridgeland, MS 39157

We also have a sales and marketing office in Hattiesburg located at

32 Milbranch Rd
Hattiesburg MS 39402

UnitedHealthcare agrees to establish a Member and Provider services office at the Ridgeland location upon contract award. We will offer multiple channels for Members and providers to resolve any questions, concerns, or issues, including telephonic, walk-in, and written inquiries. Refer to our responses to Questions 195-201 (provider services) and Questions 233-245 (Member services) for a detailed description of functions to be performed.

Financial

19. Complete the following table based on your entire book of business.

	As of the End of the Most Recently Completed 12 Month Reporting Period, e.g., 2008 (Indicate reporting period)	As of the End of the Prior 12 Month Reporting Period, e.g., 2007 (Indicate reporting period)
a. Admitted Reserves as a Percent of Premium	2.34%	2.22%
b. Current Ratio (Cash to Liability) (For example if 100%, indicate 1.0)	0.15	0.32
c. Days in Unpaid Claims	50 days	50 days
d. Medical Claims Loss Ratio (claims to premium)	82.4%	80.4%
e. Administrative Loss Ratio (defined as all administrative expense not including profit and risk charges)	9.3%	9.1%

20. Attach as **Exhibit C** to your proposal copies of the most recent reports on the claims paying ability ratings issued to your firm by any of the following rating agencies:

i. A.M. Best;
ii. Moody's;
iii. Standard & Poor's; and/or
iv. Duff and Phelps.

Include in **Exhibit C** to your proposal the same information on ratings issued to your parent company, if any. If your organization is not rated by one or more of the referenced organizations, please so state.

Exhibit C contains our Standard & Poor's rating which affirms a score of A minus. UnitedHealthcare Insurance Company achieved an A plus rating.

21. Indicate your organization's present net worth (assets less liabilities) as a percentage of total premium revenue.

UnitedHealthcare's present net worth is 8.7 percent of total premium revenue.

22. Does your organization presently purchase any reinsurance coverage or are special reserves set aside to continue paying claims on existing polices in the event your organization ceases to operate due to bankruptcy, liquidation or other factors?

No, the organization does not purchase reinsurance. Claims reserves are adequate to cover the claims costs and the company does establish Extended Benefit Reserves to cover the costs of adjudicating claims. Extended Benefit Reserves are set at 2.21 percent of claims payable.

If yes, please explain the type of arrangement including the amount of reinsurance coverage and/or the amount of reserve levels established, i.e. number of days and reserves established as a percentage of premium.

23. Attach as **Exhibit D** to your proposal a copy of the most recently available audited financial statements for each of the last two years.

Exhibit D contains audited financial statements for 2007 and 2006. The statement for 2008 will not be available until June 1, 2009.

Renewal/Financial Underwriting

24. What is your definition of a paid claim for purposes of renewal?

A paid claim is a claim that has been processed and through a check run, regardless of payment amount.

25. How many calendar days will you need to accurately determine and report the amount of paid claims following the end of each month?

UnitedHealthcare requires four calendar days to accurately determine and report the amount of paid claims following the end of each month.

[redacted]

UnitedHealthcare understands that we will not receive additional administrative fees following contract termination to process claims run-out. We have included the estimated administrative costs for this process in the quoted administrative fee component of the premium rate.

27. Confirm you will be willing to continue your performance guarantees throughout the run-out period.

UnitedHealthcare confirms our willingness to continue all our performance guarantees throughout the post-contract run-out period.

[redacted]

The incurred but unpaid claims reserve component to the premium rates was established based on standard factors developed using our national Medicaid experience. The standard factors where then adjusted using claims payment statistics for our commercial population in Mississippi, as well as publicly-available information on MS' CHIP population.

In subsequent years, the process would rely on actual lag studies of MS CHIP data.

29. Are there any charges that would be made against the paid claim and IBU claim reserve components of the premium rates? If so, please describe.

No.

UnitedHealthcare confirms that, under a self-insured funding arrangement, we will provide administration for at least 18 months after the termination date for claims incurred prior to the termination date. We also confirm that there will be no administrative fees due at termination for this service.

The components to the rate, as required by Appendix H, are paid claims estimate, incurred but unpaid claims reserve estimate and administrative fee. The process involved with setting next year's renewal will be to update the base data to include CY 2009 experience and add in an estimate for unpaid claims. That will be combined with 2008 experience to arrive at a base. That base will be adjusted to reflect our contractual arrangements and expected utilization efficiencies, and then trended forward to the rating period. The unit costs adjustment will be based on our network pricing versus that included in the base. The utilization efficiencies will be based on expected improvements in care management. The trend factors will consist of a unit cost and utilization estimates based on contractual provisions and UnitedHealth Group experience, as well as other Mississippi-specific patterns of care.

Client Based/References

32. Provide the following information for each of your three current largest group clients:

i. Client name and address
ii. Name, title, telephone number, e-mail address and facsimile number of a key contact
iii. Number of covered lives and services provided to client
iv. Duration of relationship with your organization

AmeriChoice (UnitedHealthcare Plan of the River Valley)
State of Tennessee
-- entered the Tennessee market in 1994 --

Client Name and Address	Bureau of TennCare 310 Great Circle Road, 4th Floor Nashville, TN 37243			
Key Contact	Name/Title:	Darin J. Gordon, Deputy Commissioner		
	Telephone:	615.507.6443		
	E-mail:	Darin.j.gordon@state.tn.us		
	Fax:	615. 253.5607		
Contract Size	**Average Monthly Covered Lives**		**Public Funded Contract Cost**	
	Eastern Region	166,000	Eastern Region	$420M
	Middle Grand Region	181,000	Middle Grand Region	$520M
	Western Region	162,000	Western Region	$406M
Contract Start Date		**Most Recent Contract Duration**		
Eastern Region	1994 (Originated)	Eastern Region		05/19/08 – 06/30/12
Middle Grand Region	04/01/2007	Middle Grand Region		08/15/06 – 06/30/10
Western Region	05/19/2008	Western Region		11/01/08 – 06/30/12

AmeriChoice (UnitedHealthcare Plan of the River Valley)
State of Tennessee
-- entered the Tennessee market in 1994 --

Scope of Work

Eastern, Middle Grand, and Western Regions: Since 1994, we have participated in the eastern region of the TennCare program, initially as a fully capitated health plan, and later, under the revised format of TennCare that converted the program to an administrative services contract. Over the years, we demonstrated strong and consistence performance contributed to our 2006 full-risk contract award in the Middle Grand region. In 2008, AmeriChoice was awarded risk contracts in the East Grand and West Grand regions. AmeriChoice was one of only two companies awarded contracts in the West Grand and East Grand regions, and the only company operating in all three regions. We provide a full continuum of health plan services for our 520,000 enrollees, including a fully integrated medical and behavioral care management program. Our TennCare programs consist of traditional Medicaid coverage groups and an expanded population of children.

TennCare Medicaid: covers all mandatory Medicaid eligibility groups and some categorically and medically needy voluntary groups, including children, pregnant women, the aged, and individuals with disabilities.

TennCare Standard: TennCare Standard includes children in these eligibility categories: Uninsured, children under age 19 a) who are TennCare eligible and with family incomes < 200 percent of the federal poverty level (FPL), b) who are TennCare eligible and meet "medically eligible" criteria (for example, a health condition that makes the child uninsurable) and c) who are no longer eligible for TennCare Medicaid and are either uninsured or medically eligible.

Covered Services: inpatient hospital, physician, outpatient hospital, ambulance, physical therapy, nursing care, speech therapy, durable medical equipment, home health care, hospice, hearing, vision, behavioral health and non-emergency transportation.

Community Outreach: Joining with a local Nashville community organization—United Neighborhood Health Services (UNHS), we launched a new program to reduce wait times at a number of Davidson County hospital emergency rooms (ER) by reducing non-emergency ER visits. It benefits all patients seeking non-emergent care at designated hospitals, regardless of insurance carrier or insurance status. Patients presenting at a participating ERs with non-emergency medical needs are referred directly to an on-site UNHS staff member who schedules a same-, or next-day, appointment at a UNHS clinic, many of which have extended hours. TennCare beneficiaries are offered transportation to the clinic, if needed. UNHS follows-up with these patients and ensures that any missed appointments are re-scheduled. For patients without a regular doctor, the program establishes a Primary Care "medical home" where education is provided on routine versus emergency health care.

Arizona Physicians IPA (APIPA)
State of Arizona
-- entered the Arizona market in 1982 --

Client Name and Address

(1) **Acute Care & Uninsured Children contract:**
AZ Health Care Cost Containment System (AHCCCS)
701 East Jefferson, Phoenix, AZ 85034

(2) **Children's Rehabilitative Services – CRS contract:**
AZ Dept of Health Services, Office for Children w/ Special Health Care Needs
150 North 18th Avenue, Phoenix AZ 85007

(3) **Developmentally Disabled contract:**
AZ Dept of Economic Security, Division of Developmental Disabilities
2200 N. Central Ave., Ste. 207, Phoenix, AZ 85013

Key Contacts

Name/Title: Anthony Rodgers, AHCCCS Director
Telephone: 602.417.4680
E-mail: Princeline.Roxbury@azahcccs.gov
Fax: 602.252.6536

Name/Title: Joan Agostinelli, OCSHCN/CRS Administrator, Office for Children with Special Health Care Needs
Telephone: 602.542.2584, 602.364.1463
E-mail: agostij@azdhs.gov
Fax: 602.542.2589

Name/Title: Louetta Coulson, Health Care Services Administrator
Telephone: 602.238.9028 x6012
E-mail: LCoulson@azdes.gov
Fax: 602.238.9294

Contract Size

Average Monthly Covered Lives	Public Funded Contract Cost
(1) 216,602	(1) $798M
(2) 20,328	(2) $ 83M
(3) 10,492	(3) $ 52M

Most Recent Contract Duration

(1) 10/20/08 – 09/30/13 (2) 10/01/08 – 09/30/10 (3) 1988 – 09/30/09

Scope of Work

- ***Acute Care (APIPA-AHCCCS) and Personal Care Plus (APIPA-PCP):*** APIPA-AHCCCS provides services to low-income pregnant women, families, children; blind, aged, or disabled SSI individuals; and, uninsured children in families at other income levels through the KidsCare SCHIP program. Awarded by CMS and governed by AHCCCS, our Personal Care Plus SNP program provides services to our AHCCCS Medicaid Members who also have Medicare coverage.
- ***Children's Rehabilitative Services (APIPA-CRS):*** APIPA-CRS provides family-centered medical care, rehabilitation and support services to children and youth with chronic and disabling conditions or potentially disabling health conditions (for example, bone tumors, cerebral palsy, multiple sclerosis, muscular dystrophy, sickle cell anemia, etc.).
- ***Developmentally Disabled (APIPA-DD):*** APIPA provides services to residents who have chronic disabilities attributable to mental retardation, cerebral palsy, epilepsy or autism manifested prior to age 18. Children under six may be eligible for services if demonstrated that the child is, or will become developmentally disabled.

AmeriChoice – Innovative Approaches

- ***Shine Arizona:*** Our Shine Arizona campaign with its "Health on Wheels" tour brings preventive care services

Arizona Physicians IPA (APIPA)
State of Arizona
-- entered the Arizona market in 1982 --

to Members directly via a mobile medical van.

- ***Medical Home Model:*** APIPA participates in a patient-centered "medical home" pilot in Phoenix. Enhanced reimbursement incentives reward primary care doctors who use the "medical home" model and whose patients demonstrate measurable improvements in their overall health.

e-Health Connectivity: APIPA has new e-Health initiatives: online EPSDT, i-Exchange (online Prior Authorization) and EDI. We are developing Electronic Health Record (EHR) and Electronic Health Information Exchange (e-HIE) to make specific Member information more accessible and to improve continuity of care.

AmeriChoice of New Jersey
State of New Jersey
-- entered the New Jersey market in 1995 --

Client Name and Address	State of New Jersey Department of Human Services Division of Medical Assistance and Health Services 7 Quakerbridge Plaza; P.O. Box 712 Trenton, NJ 08625-0712	
Key Contact	Name/Title:	John Guhl, Director, Division of Medical Assistance and Health Services
	Telephone:	609.588.2705
	E-mail:	john.guhl@dhs.state.nj.us
	Fax:	609.588.3583

Contract Size	**Average Monthly Covered Lives**	**Public Funded Contract Cost**
	213,680	$552.2M

Contract Start Date		**Contract Duration**
AmeriChoice (NJ)	1995 (Originated)	Automatically renews annually on 07/01

Scope of Work – All Contract Areas Listed

AmeriChoice provides services to Medicaid eligibles in the State of New Jersey via three programs: 1) Medicaid, 2) AmeriChoice Personal Care Plus – Medicare, and 3) NJ Family Care. Population types cover Medicaid; aged, blind and disabled; and uninsured children and adults.

Medicaid: Our statewide Medicaid health plan services over 250,000 New Jersey Medicaid program beneficiaries. A broad package of health services is offered to cover medically necessary care, such as inpatient and outpatient hospital care, physician services, laboratory tests and x-rays, home health care and nursing facility care, etc.

AmeriChoice Personal Care Plus – Medicare: Available in 10 counties, our AmeriChoice Personal Care Plus (Medicare) program services eligible Medicare Advantage beneficiaries with Medicaid coverage. Health care services cover medically necessary covered services, such as inpatient and outpatient care, physician services, mental health and substance abuse care, health screenings (for example, pap smears and pelvic exams, prostate cancer screening, blood tests, etc.), partial hospitalization, cardiac rehabilitation services, renal dialysis and other specialty care.

NJ Family Care: This statewide program is offered to eligible children and low-income parents, based on income guidelines. Children are eligible up to 350 percent of the FPL and adults up to 200 percent of the FPL. Health care services include doctor visits, hospitalization, regular screenings, behavioral health, prescriptions, vision needs and dental care.

AmeriChoice – Innovative Approaches

Top Health Plan – Care Management and Personal Care Model ™: The Division of Medical Assistance and Health Services (Medicaid) released the findings of its 2007 case management audit for Medicaid health plans. AmeriChoice achieved the top health plan results for care management of the ABD populations, and case

AmeriChoice of New Jersey
State of New Jersey
-- entered the New Jersey market in 1995 --

management and care management for the Department of Youth and Family Services population, care management of children with elevated lead levels. AmeriChoice's Personal Care Model ™ has been refined through years of application in Medicaid programs. This approach uses leading-edge technology tools that enable our care managers to meet rigorous national standards, while personalizing interventions for the local population and individual Member.

Outreach to the Troops: Every year, our New Jersey health plan conducts a holiday military mailing to our troops overseas—particularly to those serving in Iraq and those recuperating at the Walter Reed Army Medical Center in Washington, DC. Boxes include: personal items, food, and Christmas goodies.

33. Provide the following information for each of your three current largest group clients located within the State of Mississippi:
    i. Client name and address
    ii. Name, title, telephone number, e-mail address and facsimile number of a key contact
    iii. Number of covered lives and services provided to client
    iv. Duration of relationship with your organization

UnitedHealthcare submits the following four largest accounts currently serviced in Mississippi.

Howard Industries, Inc.

Client Name and Address	Howard Industries, Inc. 36 Howard Drive Ellisville, MS 39437	
Key Contact	Name/Title:	Becky Altmeyer, Human Resources Director
	Address:	36 Howard Drive Ellisville, MS 39437.
	Telephone:	601-422-1594
	E-mail:	baltmyer@howard-ind.com
	Fax Number:	601.422.1566
Contract Size	**Average Monthly Covered Lives:** 4,500	
Contract Duration	October 2007 – present	
Scope of Work	Medical and pharmacy coverage	

Hood Industries, Inc.		
Client Name and Address	Hood Industries, Inc. 15 Professional Parkway Hattiesburg, MS 39404	
Key Contact	Name/Title:	Terry Lawhead, SPHR, Director of Human Resources
	Address:	Hood Industries, Inc. 15 Professional Parkway Hattiesburg, MS 39404
	Telephone:	601-296-4811
	E-mail:	tlawhead@hoodindustries.com
	Fax Number:	601.296.4751
Contract Size	**Average Monthly Covered Lives:** 2,900	
Contract Duration	April 2008 – present	
Scope of Work	Medical (Choice + and ND PPO) with pharmacy (Traditional) coverage	

T. K. Stanley		
Client Name and Address	T. K. Stanley 6739 Hwy 184 W Waynesboro, MS 39367	
Key Contact	Name/Title:	Patti Cooley, Director of Human Resources
	Address:	T.K. Stanley 6739 Hwy 184 W Waynesboro, MS 39367
	Telephone:	601.735.5933
	E-mail:	pattic@tkstanley.com
	Fax Number:	601.735.1274
Contract Size	**Average Monthly Covered Lives:** 2,200	
Contract Duration	April 2007 – present	
Scope of Work	Medical and pharmacy ASO services	

Hinds County Board of Supervisors		
Client Name and Address	Hinds County Board of Supervisors 316 Presidents Street Jackson MS 39205	
Key Contact	Name/Title:	Bridgett Smith, Director of Human Resources.
	Address:	316 Presidents Street Jackson MS 39205
	Telephone:	601.968.6527
	E-mail:	bsmith@co.hinds.ms.us
	Fax Number:	601.968.6567
Contract Size	**Average Monthly Covered Lives:** 2,100	
Contract Duration	November 2003 – present	
Scope of Work	Medical and pharmacy services	

i. Client name and address
ii. Name, title, telephone number, e-mail address and facsimile number of a key contact
iii. Number of covered lives and services provided to client
iv. Duration of relationship with your organization

Not applicable.

General Staffing

The following table presents employee turnover rate information for the periods specified.

12-month Reporting Period	Average Number of Employees/Month	Turnover Rate
January 2008 – December 2008	2,987	17.5%
January 2007 – December 2007	1,871	24.5%

36. Provide the names, location, and brief resumes, including each person's credentials and tenure with the company, for each of the following positions (as defined in Section 12.1 of this RFP):

i. Executive Officer

Norine Yukon— Ms. Yukon brings to Mississippi over 30 years of experience in the health care industry. As the Executive Officer, she will lead the overall operations of the MS CHIP program including care coordination, health services, Member services, network development, contracting, finance, underwriting, provider relations, quality improvement, community outreach, claims and system support.

ii. Account Manager

Cindy Tullos Maddox—Ms. Maddox brings 25 years of experience in the insurance industry, working in all areas of employee benefit plans including nine years with two major Mississippi insurance agencies and two years with UnitedHealthcare of Mississippi.

iii. Medical Director

David O. Hollis, MD—A Mississippi licensed physician, David O. Hollis, M.D will provide our clinical leadership. Dr. Hollis has served as the Chief Medical Officer for the AmeriChoice TennCare program in Tennessee since 2007. Dr. Hollis' primary areas of responsibility for our Mississippi operations will not only include creating a high quality, robust medical management model for our Members, but also synthesizing the strengths of UnitedHealthcare's Personal Care Model into existing strategies.

iv. Claims Supervisor

Michael Policky, MBA—Mr. Policky is an operations professional with over 15 years experience in diverse arenas. Mr. Policky is responsible for transactional oversight and performance of the TennCare program for UnitedHealthcare.

v. The person representing your organization during this proposal process, if different from any of the persons listed above

Michael Radu, Senior Vice President—Mr. Radu is responsible for health plans operating in the Southeast Region.

Resumes for these individuals follow.

Executive Officer

Name **Norine Yukon**

Overview

Health plan executive with over 30 years of experience in the health care industry. Demonstrated experience in leadership, strategic planning, organizational, operational and technical skills. Experienced in details of managed care operations including finance, underwriting, health services, Member services, network development, contracting, provider relations, quality improvement, community outreach, claims and system support.

Professional Experience

Company Name	**UnitedHealthcare**
Title	CEO, UnitedHealthcare by AmeriChoice
Timeframe	2008 – present
Description	Executive oversight for health plan operations in Mississippi, serving Medicaid and SCHIP recipients. Responsible for managing a wide range of processes including but not limited to education, outreach and prevention services; provider relations; health care management activities, quality management, and community relations.
Company Name	**Bravo Health**
Title	Executive Director, Mid-Atlantic Region
Timeframe	2007 – 2008
Description	Bravo Health is a multi-state managed health care company which serves Medicare and dually-eligible Medicare and Medicaid consumers. Chief responsibilities included executive oversight for the health plan operations on Delaware, Maryland, and the District of Columbia. Exceeded budget growth and revenue targets.
Company Name	**AMERIGROUP Corporation**
Title	Senior Vice President, Health Plan Operations
Timeframe	2004 – 2005
Description	Executive oversight for health plan operations in multiple markets including New Jersey, Illinois, and the District of Columbia. Responsible for de novo start-up operations in Ohio and Virginia and responsible for the executive team transition and integration of a corporate acquisition in New York City.
Title	President and Chief Executive Officer, AMERIGROUP New Jersey, Inc.
Timeframe	1998 – 2004
Description	Executive oversight and accountability for operations of HMO serving Medicaid, SCHIP, FamilyCare and SSI recipients, including dually-eligible Medicaid and Medicare consumers. Led the state in quarterly market-share growth for six years.
Company Name	**Prudential HealthCare**
Title	Executive Director, Prudential HealthCare, Arkansas
Timeframe	1989 – 1998
Description	Executive accountability for Prudential's health care products and operations in the state of Arkansas. Responsible for HMO start-up from licensure to operational status. Oversight of PPO, POS, HMO, ASO and FEBHP products.
Title	Manager, Medical Services, Prudential HealthCare, Austin, Texas
Timeframe	1989 – 1991
Description	Responsible for in-sourcing utilization management and quality improvement. Developed both departments from the ground up and quickly achieved control of medical expenses and accountability for service and clinical quality.

Education / Credentials

The University of Texas at Austin, Bachelor of Science, Nursing
Center for Creative Leadership, Greensboro, NC, Leadership course
University of PA, Wharton School of Business, Strategic implementation course

Account Manager

Name Cindy Tullos Maddox

Overview

25 years experience in the insurance industry working in all areas of employee benefit plans, including 14 years with BCBS of Mississippi, 9 years with 2 major Mississippi insurance agencies and 2 years with UnitedHealthcare of Mississippi. Expertise in communicating with clients to meet employer needs.

Professional Experience

Company Name **UnitedHealthcare of Mississippi**
Title Small Business Account Consultant
Timeframe 2007 – current
Description Primary Marketing Support for 2-99 Sales

- Support AE in renewal activity and sales effort
- Ancillary Cross Sales on existing business
- Educate/consult with broker and employer on enrollment, benefits, and electronic service processes

Company Name **Barksdale Bonding and Insurance, Inc.**
Title Employee Benefits Account Manager
Timeframe 2004 – 2007
Description Primary Marketing Support for the employee benefit producers

- Daily customer service on enrollment/claims questions provided to employee benefit clients
- Assist in enrollment and establishment of current and new employee benefit clients
- Assist in the renewal and retention of employee benefits clients
- Providing ancillary products to clients to enhance employee benefits

Company Name **Ross & Yerger Insurance Agency, Inc.**
Title Employee Benefits Account Manager
Timeframe 1998 – 2004
Description Primary Marketing Support for the employee benefit producers

- Daily customer service on enrollment/claims questions provided to employee benefit clients
- Marketing support to employee benefit producers
- Assist in enrollment and establishment of current and new employee benefit clients
- Assist in the renewal and retention of employee benefits clients
- Providing ancillary products to clients to enhance employee benefits

Company Name **Blue Cross & Blue Shield of Mississippi, Inc.**
Title National Accounts Coordinator
Timeframe 1990 – 1999
Description Primary contact for BCBS internal staff and other BCBS Plans on the marketing, implementation and administration of national account groups

- Negotiated administrative fees for national account clients
- Responsible for the inter-office education of national account benefit plans including enrollment procedures and claims benefits and administration
- Provided network access information to other BCBS Plans on Mississippi locations
- Assisted in enrollment and benefit communication to Mississippi locations

Account Manager

Company Name	**Mississippi State University (MSU)**
Title	Administrative Assistant, MSU Police Department
Timeframe	1988 – 1990
Description	Assistant to the MSU Chief of Police ▪ Responsible for preparation of departmental payroll ▪ Handled all correspondence for the Chief of Police ▪ Maintained all confidential files for campus complaints and arrests ▪ Prepared purchase orders for departmental supplies and equipment
Company Name	**Blue Cross & Blue Shield of Mississippi, Inc.**
Title	Regional Marketing Coordinator
Timeframe	1981 – 1987
Description	In-house office sales and service of small group market ▪ Responsible for contacting potential prospects for the small group market ▪ Rating for prospective groups ▪ Enrollment and servicing of small group sales and market ▪ Primary contact for renewal of small group business ▪ Handled customer service for small group clients ▪ Primary contact for individual sales

Education / Credentials

University of Mississippi, Bachelor of Business Administration, Marketing

Medical Director

Name David Hollis, M.D.

Overview

Health plan executive with more than 13 years of managed care experience focusing on medical management with a particular interest in disease management. This includes experience with TennCare as Chief Medical Officer with AmeriChoice.

Professional Experience

Company Name	**AmeriChoice**
Title	Chief Medical Officer
Timeframe	2007 – present
Description	Participated in the start-up of a new managed care organization for over 500,000 Medicaid enrollees, Established health services department that included behavioral health. Responsible for the day today oversight of health services and quality management department.
Company Name	**Tennessee, XL Health**
Title	Chief Medical Officer
Timeframe	2005 – 2007
Description	Participated in the development of the Medicare Health Support Program in Tennessee. This three year pilot program tested the concept of disease management in the Medicare fee for service population.
Company Name	**State of Tennessee**
Title	Chief Medical Officer, TennCare
Timeframe	2003 – 2004
Description	Reporting to the Deputy Commissioner of TennCare, participated in oversight of the Managed Care Organizations who provide medical services for 1,300,000 enrollees. Directly managed the transition of a $2 billion pharmacy budget to a new pharmacy benefit manager and implemented a preferred drug list with savings of greater than $150 million annually. Chaired Reform Committee charged with development of comprehensive disease management program. Provided clinical leadership for TennCare on TENNderCare with goal of achieving compliance with John B Consent Decree.
Company Name	**CIGNA HealthCare of Tennessee, Inc.**
Title	Vice President, Senior Medical Director
Timeframe	1998 – 2003
Description	Reporting to the General Manager, functioned as Chief Medical Officer for health plan of more than 375,000 Members in Tennessee, Arkansas and Kentucky. Duties included responsibility for daily management of the utilization management and quality management departments as well as the preparation of the Annual Utilization Management and Quality Management Program Descriptions, Work plans and Annual Evaluations. Additional responsibilities included the hiring, development and performance management of the Physician Executives, chairing key committees including Quality Management Committee and the Physician Review Committee and participation on the Grievance Committee, Network Strategy Committee and the Southeast Regional Quality Management Governing Body.

Education / Credentials

University of Tennessee Center for the Health Sciences, Memphis, Tennessee, M.D., 1978
Mississippi State University, Mississippi State, Mississippi, B.S., 1974
American Board of Internal Medicine, Certified 2008-2018 Board Number 080429
Tennessee Medical License MD11472, Expiration Date December 2010
Mississippi Medical License 16713, Expiration Date June 2009

Claims Supervisor

Name	**Michael G. Policky**

Overview

Operations professional with over 15 years experience in diverse arenas. Responsible for transactional oversight and performance of TennCare program for AmeriChoice. In addition, accountable for existing AmeriChoice transaction activities spanning multiple health plans, serviced in Moline, IL, Eau Claire, WI, and Phoenix, AZ.

Professional Experience

Company Name	**AmeriChoice/ACME**
Title	Site Director, Transaction
Timeframe	2006 – present
Description	Accountable for overall transaction performance specific to claims processing and adjustments. Develop leadership team, at all levels, aimed at continually improving overall Member and provider experiences, with emphasis on quality and productivity metrics. Establish and maintain solid working relationships amongst all peers and partner areas to ensure regulatory and compliance results are achieved.
Company Name	**Express Scripts, Inc.**
Title	Director, Pharmacy Operations
Timeframe	2004 – 2006
Description	Oversight of front-end operations for mail order pharmacy. Front-end operations included prescription fulfillment activity spanning from mailroom, through data entry and exceptions processing, concluding with pharmacist verification. Led organizational realignment at all leadership levels, focused on employee engagement, pharmacist/technician retention, inventory performance, and overall business acumen.
Company Name	**CIGNA**
Title	National Accounts Director, Claim/Call Operations
Timeframe	2004
Description	Responsible for large (>5,000 lives) account management specific to claim and call operational performance for several key customers. Led successful turnaround efforts specific to accounts deemed as "at risk" through disciplined approach towards service response times and inventory management. Managed client relationship through effective, proactive communications tools, including on-site visits, demonstrations, and seminars.
Title	Regional Accounts Director, Claim/Call Operations
Timeframe	1996 – 2004
Description	Similar to National Accounts Director role, with emphasis on local clients (<5,000 lives). Accountable for call and claim results specific to local health plans and clients within the state of Arizona.

Education / Credentials

University of Phoenix, Phoenix, AZ, MBA – Global Management
University of Phoenix, Phoenix, AZ, BA – Project Management

Claims Processing Services

Note: Answer questions #37 through #47 based on the existing office or unit that would process claims until such time as the new office or unit is fully staffed and operational within the State of Mississippi.

37. With regard to the claim office that is proposed to be used for CHIP, provide the following:

Location(s): Moline, IL

Years in operation: 25 years

Days & hours of operation: Flex schedules: Monday – Friday 6:00 a.m. – 8:00 p.m.

Staffing

	# of	Avg. Yrs. Experience	Annual Turnover Rate (%)
Processors	141	3	*
Supervisors	7	15	*
Managers	4	15	*
RNs	N/A	N/A	N/A
MDs	N/A	N/A	N/A
Claims Support Personnel	200	4	*

*Turnover rate for the claims shop is not broken down by employee level but the turnover rate is less than 9 percent annually.

Annual claim volume: 4,251,112

# of plans presently: TN – Medicaid, Hawki (IA Medicaid and low income) SNP, Commercial (IA, IL, TN, VA)

38. Do you propose to assign a dedicated unit of claim processors for the CHIP account?

Yes, UnitedHealthcare will have a dedicated unit of claim processors for the MS CHIP account. The dedicated unit will have, based on membership, 22 total FTEs consisting of:

- 13 Claim processors
- 3 Claim adjustment processors
- 1 Claim specialist
- 1 Supervisor
- 1 Misc (Data Entry Reviewer, Scanner, Coding Analyst, Provider Dispute)
- 1 Clerical (including mailroom and support functions).

i. For the claim office proposed, what percent of all claims are processed within 30 working days of receipt, for calendar year 2008.

The percent for all claims processed within 30 working days of receipt for calendar year 2008 is 99.75 percent.

ii. For the claim office proposed, please provide the following from your internal audit reports for the calendar year 2008:

a) Financial accuracy as a percent of total claims dollars paid (total under and over payments, do not net these amounts).

The financial accuracy for total claims in the Moline, IL office is 99.10 percent (based on paid dollars Dollar Accuracy).

b) Coding accuracy as a percent of total claims submitted

The coding accuracy of total claims submitted for Moline, IL office is 92.80 percent (based on Claims Payment Accuracy).

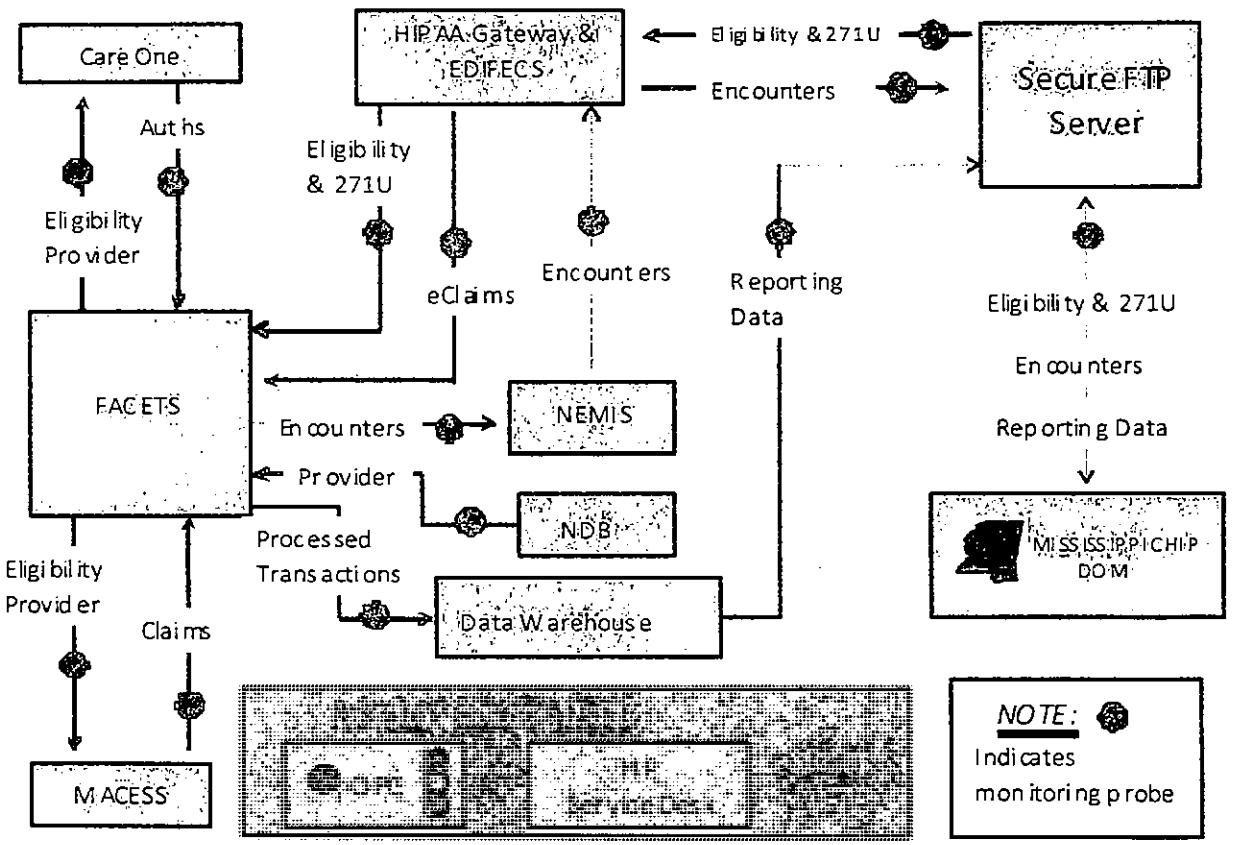
39. Describe your claim processing quality review and audit procedures. What types of internal and external audits are done, how often and by whom?

Quality Review Program

Our Claim Quality Review Program is a comprehensive review program that incorporates multiple audits. It is provides a consistent process for measuring the quality of claim processing, satisfying internal and external performance reporting requirements and facilitating continuous quality improvement and defect reduction.

Our quality review programs are centrally managed and administered. The quality teams are staffed with dedicated quality review professionals who evaluate the performance of all customer groups/policies processed within the transaction centers. This dedicated staff also evaluates individual transaction specialists' performance.

Key Data Exchanges and Monitoring Controls; example



UnitedHealthcare is committed to continually improving the efficiency of our work processes and service. Our audit and quality control programs provide statistically reliable data, are aligned with industry norms and drive improvement to meet the needs of our customers as outlined below:

- **Statistical Review (Office and Policy)**
  - Test financial and procedural accuracy of claims processing.
  - Monitor our claims lag, paid cash amounts and pend inventories
  - Provide statistically valid results.
  - Satisfy internal and external reporting needs, including performance guarantees

The Statistical Review is conducted monthly by ACME Quality Assurance on a *monthly* basis.

- **Post Training Certification Review**
  - Test financial and procedural accuracy of each trainee
  - Includes an expanded sample volume to quickly identify training gaps and/or training opportunities
  - Audits continue until processor meets minimum accuracy levels

The Post Training Certification Review is conducted *continuously for the trainee's first ninety days*. This review is conducted by the Supervisor at the local plan.

- **High Dollar Reviews**
  - Test financial and procedural accuracy of benefit payment of claims that have the greatest impact on financial results.
  - >$10,000 High Dollar Review

The High Dollar Reviews will be *conducted daily* by the Manager at the Mississippi plan.

- **Focus Audit Review/Data Mining**
  - One time audit to examine transactions for specific problematic topics to identify error types sources

The Focus Audit Review/Data Mining is conducted on an *ad hoc basis* by the Manager at the Mississippi plan.

- **Individual Processor Review**
  - Ongoing sample at the processor level to provide daily feedback and identify training opportunities.
  - Results are tied to individual performance programs (incentive, performance management, etc)

The Individual Processor Review is conducted on a *continuous basis* by the Mississippi plan Claims Manager.

- **Auditor Validation Review**
  - Examines sub-sample of auditors work to ensure consistency in quality review procedures.

As a result of these types of audits, when we began to enforce NPI requirements we began to see lower payments and a slower claims "lag" because providers were still learning how to include that number. As we educated providers on the importance and necessity of the NPI, we saw a reversal of these trends.

The Auditor Validation Review is conducted by ACME End 2 End Audit Team on a *monthly basis*.

National Encounter Management Information System (NEMIS)—NEMIS, an advanced encounter submission system uses our proprietary, relational database design which is based on years of experience with encounter submission scenarios and supports rapid identification of problems with submitted encounters. NEMIS supports the tracking, correcting and reporting needed for remediation of identified problems. Defects in submissions are logged and analyzed for identification of any systemic issues, allowing for the ongoing improvement in the quality of encounters submitted. Encounter adjustments, recoriciliations, and post submission completeness reports provide detailed insight into the process with key checkpoints that ensure all transactions are balanced and reported. NEMIS completeness reports provide a systematic approach to data quality that further improves claims adjudication accuracy; all the way back to the source if necessary.

NEMIS acts as an automated supervisor, reporting monitor, and data interface exclusively for the encounter submission process. NEMIS allows us to easily manage the entire "loop" of encounter submissions: from Facets™ claims processing through encounter submission and back. We find NEMIS to be of tremendous value in enhancing the quality of encounter data submitted, thus increasing our acceptance rate.

Internal Audits

The UnitedHealthcare internal audit is a continuous and comprehensive audit process performed by UHG's Quality Management (QM) Department, which is separate and independent from Claims Operations, and therefore ensures the utmost integrity in the audit oversight process.

UnitedHealthcare pays all claims except for vision. All claims are included in our reports and audit processes. Audit personnel in UHG's QM Department have broad experience in claims processing, possess strong analytical skills, and work closely with the Claims Department to address any issues that may arise resulting from the audits. This collaboration enables UnitedHealthcare to make corrections to the system as needed, and to provide the type of feedback and mentoring needed for examiners, in order to support performance improvement. The Claims Department quarterly audit results consistently show that we will meet or exceed the MS CHIP standards.

External Audits

Ernst & Young and Deloitte & Touche perform ongoing Sarbanes Oxley audits which include tests of our IT controls.

40. Confirm that you are able to provide the quarterly and annual claim turnaround reports required in Section 13.2 of this RFP for performance standard #18 exclusively for CHIP.

Yes, UnitedHealthcare is able to meeting the performance standard #18, Claim Processing Turnaround Time of 90 percent of all claims to be completely processed within 30 calendar days after they are received in Section 13.2. The current UnitedHealthcare Claim Processing Turnaround time for all claims processed within 30 working days of receipt for calendar year 2008 is 99.75 percent.

UnitedHealthcare's reporting capabilities through Facets, Crystal and Business Objects report writing tools, and our internally designed and developed Strategic Management Analytic Reporting Tool (SMART) is a robust data warehousing and decision support tool used for analytics and enhanced reporting. Our SMART Data Warehouse analytics and reporting system is used for enhanced claims lag reporting, and other claims analytical capabilities. UnitedHealthcare is cognizant of the importance of this report to the Board and can produce and deliver these reports within the time frames required.

UnitedHealthcare exceeds the performance standard #19 Claims: Financial Accuracy (Dollar Value) with 99.10 percent financial accuracy. UnitedHealthcare processing accuracy is 92.8 percent for the performance standard #20 Claims: Processing Accuracy.

The sampling methodology required by Section 13.2 for performance standards #19 Claims: Financial Accuracy (Dollar Value) and #20 Processing Accuracy (Number of Claims) regarding financial accuracy and processing accuracy is the same standard set that is used for all UnitedHealthcare contracts.

On a weekly basis, the QM Department will conduct a random sample of at least 100 claims processed or paid for the MS CHIP program, using statistically valid sampling functionality provided within Facets. The sample is designed so that there are claims representing all provider types.

We store the results for all audits in a secured claims auditing database. At a minimum, UnitedHealthcare documents and retains the results of all audits conducted for the MS CHIP plan. We provide audit findings exclusively for CHIP claim payment activity via the Claims: Financial Accuracy (Dollar Value) and Claims: Processing Accuracy (Number of Claims). Claims Management uses reports from this database to monitor individual examiner accuracy. Summary audit data, work papers and individual claim records are retained in the database for seven years.

Based on audit results, Quality Management works with the Claims Department to develop any required corrective action plans, make system configuration adjustments if necessary, and/or mentor individual claim examiners as described above. If a corrective action is needed, a five-phase process occurs: 1) Report, Review and Analysis; 2) Examiner follow up; 3) Program Analysis; 4) Implementation; and 5) Monitoring and Evaluation. The auditing database is used to track any frequently identified errors, and trend reports are analyzed to identify systemic improvement opportunities. If minor changes are called for, they are implemented immediately. More complex alterations are planned, implemented, and monitored per standard UnitedHealthcare project planning disciplines.

42. Attach a copy of the most recently available Statement of Auditing Standards (SAS 70 audit report) as Exhibit E to your proposal.

A copy of the most recently available statement of Auditing Standards (SAS 70 audit report) has been provided as Exhibit E in Section 6, Required Exhibits.

43. Please indicate whether your claims processing function currently includes any of the following and to what extent:

i. Electronic imaging of paper claims

Yes, UnitedHealthcare captures images of paper claims through MACESS, a combined imaging and workflow system, which receives images from our scanning vendors and integrates it into a workflow system used for processing claims. Upon receipt, paper claims are converted to electronic data via the MACESS imaging and workflow system. The process scans the paper documents and attachments using optical character recognition which prepopulates claims electronically. Data entry examiners perform verification of the text "vertexing" of the images by reviewing the scanned images against the pre-populated fields and correcting any errors that exist. MACESS assigns unique document control numbers (DCN) that permanently links images of the original claims to data in Facets. A claim pend queue and aging report is also supported through MACESS.

ii. Online (real-time) claims processing

UnitedHealthcare has online claims filing but does not have online (real-time) processing. Claims are viewable through the online Provider Portal twenty four to forty eight hours after posting. Providers can also view their claims status, request claim adjustments, view claim trends and view summary data. This innovative capability will allow providers to monitor their own performance and progress toward goals including financial incentives. Our Provider Portal supports our providers through many innovative features and tools, and is integrated with our key systems.

iii. Batch (overnight) claims processing

Yes, the front-end Windows servers perform batch claims processing. The database servers perform all Sybase database requests, whether from batch or on-line. We manage all processing through a combination of load balancing software and hardware that employs data replication technologies to maintain peak performance and maximum availability by allowing multiple paths for Facets to retrieve and store data. This architecture accommodates scalable expansion in two ways.

- The vertical option allows the addition of CPUs and disk storage to existing servers so that we can increase capacity of machines already in place.
- The horizontal option allows the addition of new front-end servers to increase the number of machine "footprints."

iv. Electronic data interchange (EDI)

Yes, we receive electronic (EDI) claims from Clearinghouses through our HIPAA Gateway system, which is compliant with HIPAA and MS CHIP standards. UnitedHealthcare accepts EDI claims directly from providers. The providers do not incur the cost of using a clearinghouse with UnitedHealthcare.

v. Microfilm claim copies

Yes, Firstsource is our scanning vendor responsible for the microfilming process of claims. UnitedHealthcare sends paper claims to Firstsource where the appropriate steps for microfilming is completed and returned to UnitedHealthcare for claim adjudication.

vi. Microfilm Member correspondence

Yes, Firstsource is our scanning vendor responsible for the microfilming process of Member correspondence. UnitedHealthcare sends Member correspondence to Firstsource where the appropriate steps for microfilming is completed and sent back to UnitedHealthcare in order for Member Service Representatives to follow up on Member's needs.

vii. Electronic imaging of Member correspondence

Yes, UnitedHealthcare captures images of Member correspondence through MACESS, a combined imaging and workflow system, which receives images from our scanning vendors.

44. For each of the following processes please indicate with an (X) whether your claims system handles the task in an automated manner (A), uses processor review manual intervention (PR), or is not routinely checked (NC).

Processes	A	PR	NC
Checks total charges against total payments	X		
Checks for duplicate charges	X		
Compares number of inpatient hospital days on each claim against admission and discharge dates		X	
Assures services are provided within the Member's eligibility date and termination date.	X		
Recognizes historical lifetime and benefit maximums	X		
Identifies excess "usual, customary and reasonable" charges (R&C) for all procedures	X		
Verifies that a provider is licensed to perform the type of procedure billed	X		
Reconciles the diagnosis code to the procedure and sex code for consistency	X		
Accumulates co-pays	X		
Identifies potential coordination of benefits, subrogation, and other party liability situations	X		
Verifies out-of-pocket	X		
Reviews age limits for eligibility or special coverage limits	X		
Determines co-payment levels	X		
Identifies unbundling of services	X		
Identifies up coding of services		X	
Identifies obsolete or invalid codes	X		
Identifies ineligible services	X		
Applies multiple surgery guidelines	X		

45. What percentage of your current book of business represents claims which are electronically filed by providers versus traditional paper processing?

Currently UnitedHealthcare receives approximately 72.8 percent of all claims electronically. UnitedHealthcare continues to provide on-going training to providers to increase the percent of claims filed electronically. UnitedHealthcare recognizes electronic filing is a value to providers. The value of electronic filing lessens the turn-around payment time to providers. Payment to the provider is as short as five business days, thus increasing provider satisfaction. UnitedHealthcare also provides for direct transmission of EDI claims at no expense to the providers.

46. Describe your process for identifying potential third party liability/subrogation claims, e.g., worker's compensation and automobile accident injuries. How are claims handled during the process of establishing third party liability?

UnitedHealthcare dedicates staff to third party liability (TPL) recovery to ensure that the Board is the payer of last resort for all covered services. Mr. Ashok Sudarshan, Vice President, Claims Cost Management is responsible for all TPL activities. Our TPL staff will make every reasonable effort to determine the legal liability of third parties to pay for services rendered to our MS CHIP Members. UnitedHealthcare will provide the Board with all required reporting information in a format and media prescribed by the Board, and will cooperate with the Board in any manner required on cost avoidance and third party collection efforts. We will dedicate a staff person whose responsibility will be to interact with the Board on TPL activities. These resources, the support we receive from our parent organization, UnitedHealth Group (UHG), our policies and procedures and guidance we receive from the Board will enable us to provide an effective TPL program in Mississippi.

Capturing and Using TPL Data—As an initial step for appropriately coordinating benefits, TPL information from DOM will be loaded into Facets. We also receive monthly feeds from DOM to supplement our COB/TPL process; this data is loaded into Facets as well.

In addition to the monthly files received from DOM, we have set up direct connections with commercial insurance carriers to receive electronic feeds of their membership data. Upon receipt of these files, we attempt to match the recipient records on the file against our membership to obtain policy information and coverage spans for overlapping Members. This information is stored in our Facets system in order to process claims in accordance with coordination of benefit and cost avoidance practices.

Data that is downloaded from the TPL and carrier files update the Member's COB extension in Facets with the following information:

- 5 digit COB indicator
- Policy Number
- Group Number
- Effective Date
- Termination Date.

When we identify a Member who has health coverage through another payer that is primary with respect to CHIP, we document the information about the primary insurance by applying a coordination of benefits (COB) flag in Facets. This flag allows us to make COB determinations at the time of claims processing. When the system encounters a claim for a flagged Member, that claim is pended for manual adjudication. In the manual adjudication process, we coordinate benefits with the primary carrier's explanation of benefits (EOB), which should be submitted with the claim. If a claim is received without the primary carrier's EOB, we reject the claim and instruct the provider to pursue payment from the other payer.

We validate TPL information using the EOBs and explanation of Medicare benefits (EOMBs) received with claims, as well as through outbound calls to other carriers. New and updated TPL information is sent to DOM via a weekly 834 outbound file. Our core transaction system, Facets, is also updated with the same information. Medicaid is the payer of last resort, and as such, any insurance benefit identified is the primary payer.

Exceptions to this process are made for the following types of claims:

- EPSDT
- Prenatal
- Other State or Federal mandated exceptions.

We do not automatically reject these claims; rather, we reimburse the provider and bill the correct third party payer for the amount paid. If we have reason to believe there may be other carrier liability, and a flag is not loaded in the system, we send a COB questionnaire to the Member. If we find that a MS CHIP Member has a primary payer after claims have been paid, we run a claims sweep to recover primary payments from the COB effective date forward.

The same flagging process is followed when Medicare is the primary payer. However, when we receive a claim, we do not coordinate benefits with Medicare. The charges are denied and the provider is responsible for submitting their claim to Medicare If Medicare denies the charges, certain criteria must be met to pay as primary under MS CHIP.

UnitedHealthcare utilizes the services of our parent company, UHG to determine whether there is TPL. On a monthly basis, we send a file of paid claims to the SubroAnalytics department using secure File Transfer Protocol (FTP). The SubroAnalytics department performs specified queries, by diagnoses, which are often associated with accidental injuries. Included in the diagnosis code edits are codes in the 800-999.99 range, (excluding 994.6), which are generally trauma specific. Claims submitted with an accident trauma indicator of 'Y' are also included.

When such claims are identified, an automated inquiry letter and questionnaire are sent to the Member. At the same time, the system opens a file in the case tracking database, SubroTrack. We mail up to two additional follow-up letters if no response is received. All preliminary investigation, case creation, auditing and monitoring are done automatically. The questionnaire sent to the Member is used to validate whether the services paid are related to an accident or trauma injury. If the Member replies with a yes, the SubroAnalytics department works directly with the third party payer, the provider, or the Member's attorney to recover the funds that were paid by MS CHIP. The funds that are recovered are returned to the health plan to offset those claim payments. If the Member replies no, the case is considered closed.

The initial investigative sequence takes between 60-70 days. The entire subrogation process, from date of the original injury to the time the funds are received "in the door" averages 18 months to two years.

Retrospective and Post Payment Activities (Pay and Chase)—UnitedHealthcare has established detailed policies and processes for pay and chase activities. We utilize an auto-recoupment process for overpayments through our core transaction system, Facets. When we identify an overpayment to a provider, post claims payment, we notify the provider via letter and give them 30 days to refund us the overpayment or appeal the overpayment notice. If the provider does not appeal or refund the overpayment within 30 days the affected claim is down-adjusted and the overpayment is off-set from a future remittance. In accordance with our established procedures, post payments from third parties are recorded as offsets to claims payments.

Generally, the above process is the preferred way for 'chasing' overpayments. However, there are exceptions; those would be identified through subrogation and COB processes for Pay and Chase. UnitedHealthcare will act as the primary (even if our records indicate the Member has other insurance), if the claim is for EPSDT, prenatal care or other State or Federal mandated exceptions. In these cases, the funds are recovered from the other carrier and applied to the claim.

Adjudicating TPL Claims—when our system encounters a claim that is flagged for possible TPL, the claim is pended for manual adjudication. In the manual adjudication process, our claim examiners coordinate benefits with the primary carrier's EOB. If a claim is received without the primary carrier's EOB, we reject the claim and instruct the provider to pursue payment from the other payer.

47. Will a different entity and/or claims office be used to process paper submitted claims for prescription drugs when a Member uses a non-participating pharmacy when either in an area where a network pharmacy is not available and/or not reasonably accessible or when the Member requires prescription drugs while traveling outside the State?

UnitedHealthcare's pharmacy subcontractor, Prescription Solutions, is responsible for processing all claims. Members who use a non-participating pharmacy when a network pharmacy is not available and/or not reasonably accessible or who travel outside the State and require prescription drugs will be instructed to mail claims to the UnitedHealthcare Mississippi plan office. The staff at the UnitedHealthcare Mississippi office will key these few claims into the Prescription Solutions online system and send a copy of the electronic image to Prescription Solutions.

If so, please confirm the location of the claims office, the average number of working days for non-network drug claims to be processed (from date of receipt to date check issued), and the percentage of all claims processed within 30 calendar days from receipt.

Paper pharmacy claims will not be sent to another office for adjudication. All pharmacy paper claims are to be sent to the UnitedHealthcare Mississippi plan office, and will be entered into the Prescription Solutions claim payment system for adjudication.

The turnaround time for this type of claim is under 30 days, with an average of approximately 21 days. When a claim is received, typically the claim is processed within 5 business days, and then put into the check cycle, which is run bi-weekly.

99.9 percent of claims are processed within 30 calendar days from receipt.

Administrative Systems and Capabilities

48. With regard to your computer system, please outline the disaster recovery/ contingency plan that is in place. Does the plan include arrangements for processing at another site in the event of a disaster at the proposed hardware location? If so, please describe the alternative arrangements. Attach a copy of your disaster recovery plan as **Exhibit F** to your proposal.

Our wholly owned network of datacenters in the Minneapolis, Minnesota area ensures ongoing business continuity from a core systems perspective, significantly mitigating the risks from datacenter site disabling events. These installations are tier three data centers with fully redundant infrastructure. Backup mirrors of the production systems are located in a separate data center from production, so full redundancy is available should a disaster strike one of the data centers. We check this redundant capability on an annual basis by executing a complete disaster recovery desktop walk through with the entire Disaster Recovery team. Regular testing of our Disaster Recover infrastructure ensures that we can recover our systems within 72 hours of practically any disaster scenario.

Our formally structured, documented, and tested Business Continuity/Disaster Recovery plans help ensure that we can recover our business operations. Our business users assist in this process by participating in a formal exercise to identify and prioritize their business applications so they can be recovered in a timely fashion. Our backups are physically protected and stored at secure locations sufficiently distant from their production processing systems. UnitedHealthcare's parent company, UnitedHealth Group (UHG), has purposely staffed distinct corporate level departments that are solely responsible for the continued enhancement of our business continuity and disaster recovery plans and processes. Our Business Continuity/Disaster Recovery plans are in place and available for onsite review. We file our Disaster Recovery plans with UHG in Minneapolis for our critical applications. These applications include the key systems we will use for MS CHIP for transaction processing, including our core transaction processing system Facets, MACESS, and HIPAA Gateway. In the event that our local MS CHIP offices are inaccessible or disabled, depending on specific circumstances, our affected staff would use our other Mississippi offices which are connected to our internal network with full access to all systems, or would be able to access our systems securely from home via our internal virtual private network (VPN).

Annual review of each Disaster Recovery plan takes place via a desktop walk through with each entire Disaster Recovery team assigned to the application plan. Each plan addresses a particular set of scenarios; others may be added if the Board prefers that other scenarios be included. UnitedHealthcare's Disaster Recovery plans include the following actions:

- Notification of appropriate organizations
- Establishment of a temporary site
- Establishment of claim handling procedures
- Obtaining field office hardware
- Re-establishment of communications network
- Review of personnel requirements
- Pre-establishment of recovery timelines.

All of our data security controls, including our business continuity and disaster recovery safeguards and plans, are reviewed as part of annual Sarbanes Oxley (SOX) audits and regular SAS/70 Type II audits.

UnitedHealthcare's business continuity strategy also includes daily incremental backups of data files, application programs and the operating system at our datacenter in Minneapolis. Full system backups are performed on a weekly basis. On a daily basis, we send backup tapes to an off-site storage facility located at least ten miles away from our data center. A bar-coding system is used to track tapes that are sent off-site, and the tape management system indicates the location of tapes at any point in time. The storage facility provides physical security and maintains a list of individuals authorized to access our tapes.

Our philosophy is that no unplanned downtime is acceptable. We prioritize our systems by business impact to our customers and our plans emphasize recovery of these systems first. Facets, MACESS, our call centers and e-mail are all included in the highest level of criticality. Restoration processes for data are fully addressed, including how to recover from full or incremental backup. Our Business Continuity plans are audited by our internal and independent Compliance Department on an annual basis. Disaster Recovery plans are tested annually. The Board is invited to review our Business Continuity/Disaster Recovery plan onsite.

A copy of UnitedHealthcare's Disaster Recovery Plan has been provided as Exhibit F in Section 6, Required Exhibits.

49. For 2008, what has been the number of times and the percentage of time that the hardware has been "down"? Hardware down time percentage is measured by the ratio of total planned system availability to the planned availability when inquiry operators could not access the system to perform their functions.

UnitedHealthcare experienced zero number of hardware down time. UnitedHealthcare experiences less than 1 percent of down time.

Continually Monitoring System Functions—We use Hewlett-Packard's (HP) OpenView enterprise software for the large-scale system and network management needed for UnitedHealthcare's IT assets. An innovative feature we use with HP OpenView is to detect and pre-empt any availability threatening failures. For example, HP OpenView places probes at the system level that sends SMTP alerts to our engineers at preset thresholds to alert us prior to failure. This helps avoid situations where a disk drive becomes full, or process routines abort unexpectedly. We utilize our failure management processes and help desk service to identify and provide notification of issues with critical systems.

50. Please describe how you handle backlogs (e.g., overtime, switch to another office).

The transaction team manages to proven staffing or capacity plans and aggressive daily inventory management. The goal is to avoid the need for inventory reduction plans. Should an inventory reduction plan be required, the transaction strategy would differ depending on volume and turn-around impacts.

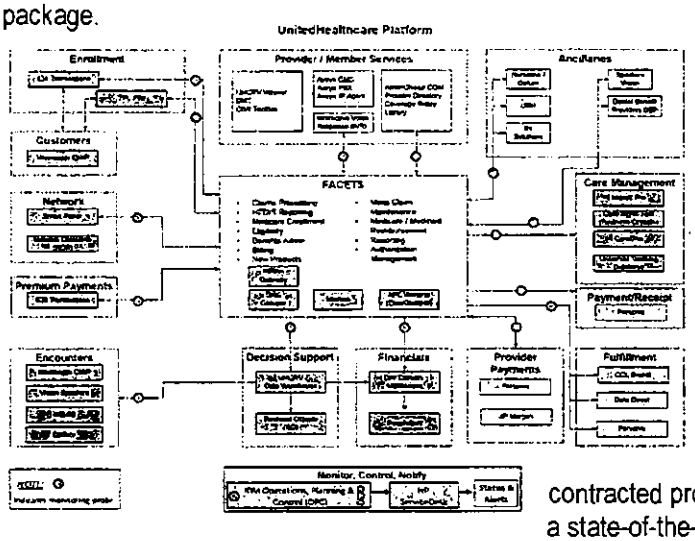
The first step for this transaction strategy is to build an inventory reduction plan with daily production/inventory goals. Most reduction plans rely on overtime. When overtime is warranted, we identify top performers for inventory reduction efforts. Mandatory overtime is a tool to reduce critical inventory. All employees understand that mandatory overtime may be required to meet business goals.

In addition, Business Continuity Plans are built to recover from minor to major disasters if backlogs are caused by disasters. The Business Continuity Plans include load balancing from other UnitedHealthcare transaction shops as well as reliance on processing vendors.

51. Can your organization administer the comprehensive benefit package as outlined in Section 4 of this RFP? If not, identify any plan design provision that you cannot administer or which you do not currently administer and would have to develop the capacity.

Yes, UnitedHealthcare's administrative systems and capacity is able to perform all the requirements for Section 4 in order to deliver the comprehensive benefit package to MS CHIP Members, The following overview of the UnitedHealthcare systems and capacity will show you how we can deliver the MS CHIP comprehensive benefit package requirements to the Members of this program and why UnitedHealthcare is the best solution for the MS CHIP program.

The UnitedHealthcare Platform illustrates the systems we use in order to deliver the MS CHIP comprehensive package.



Claims Processing Systems

UnitedHealthcare is committed to using advanced technology to enable us to accurately and timely process claims while eliminating unnecessary hurdles for providers through innovative interfaces, including electronic data interchange (EDI) and web portals. We strive to optimize service as we introduce new technologies and capabilities to contracted providers. Facets, our core claims processing engine is a state-of-the-art platform with advanced functionality that enables us to achieve efficiency and accuracy in our claim processing operations. Facets is currently in use for nine UnitedHealthcare health plans across the country, combined, managing more than one million Members.

Facets supports a full continuum of claims processing steps and functionality including:

- Maintenance of covered benefits for various eligibility groups
- Maintenance of reference files including CPT, HCPCS, ICD-9
- Utilization management—prior authorizations and referrals
- Claims logging and tracking
- Claims aging
- Claims edits and denial codes
- Claims pricing and adjudication
- Check writing and electronic funds transfer (EFT)
- Production of paper and electronic remittance advices
- Claim adjustments and voids
- Production of claims management reports.

Key components of our claims management solution include:

- ***MACESS***—A combined imaging and workflow system, which receives images from our scanning vendors and integrates it into a workflow system used for processing claims; a claims pend queue and aging reporting is also supported through MACESS
- ***NEMIS***—Our advanced encounter submission system, based on our proprietary, relational database design
- ***HSS EasyGroup***—Manages prospective payment for DRG, ASC and APC payments
- ***National Credentialing Database —*** Facets is updated with information from our credentialing database for regular verification that paid providers are appropriately credentialed
- ***SMART Data Warehouse***—An analytics system for enhanced reporting for predictive care models, episodes of care, claims lag, utilization, unit costs, provider profiling, Member retention and other analytical capabilities
- ***MRR***—A Member capitation payment reconciliation engine
- ***FSDB / RPS***—Used to manage financial transactions to our GL (general ledger) and reserving process
- ***Vendor Systems***—Pharmacy, dental, and vision claims are processed through vendor systems, which are then loaded into our data warehouse and encounters system (NEMIS).

Proactive Monitoring Probes—Used to monitor system availability and data exchange throughput/issues

Attachment 51, MIS Overview gives a detailed overview of the UnitedHealthcare platform consisting of core transaction systems and interfaces with our trading partners and vendors.

52. Have you implemented a new computer system within the last six months? Do you anticipate implementing a new computer system within the next 12 months? If so, please describe the changes.

No, UnitedHealthcare has not implemented a new computer system with the last six months nor do we anticipate the implementation of a new computer system in the next 12 months. UnitedHealthcare will continue to implement upgrades and new software versions to enhance services to Members and customers such as MS CHIP.

53. Is your computer system owned by your firm? If not, who owns the system?

Yes, UHG, the parent company for UnitedHealthcare, owns all components of the computer system.

54. List the number of MIS personnel presently employed by your company, by job classifications. Please attach a current organizational chart for your MIS department as **Exhibit G** to your proposal response.

UHG employs approximately 10,000 technology professionals responsible for computing hardware, software and communications. The UnitedHealthcare IT department consists of approximately 240 technology professionals.

UnitedHealthcare MIS personnel who will be responsible for the MS CHIP account are:

- 2 Project Managers
- 7 Business Analysts
- 10 Developers
- 2 Quality Assurance (QA) Analysts
- VP of Integration Services

In order to meet the requirements of the MS CHIP contract additional resources will be assigned and engaged to ensure that timelines and deliverables are met.

The organizational chart for MIS has been provided as Exhibit G in Section 6, Required Exhibits.

55. Are system programmers comprised of in-house staff or contracted professionals? In either case, please discuss staffing adequacy.

UnitedHealthcare MIS will use ten in-house professional programmers averaging twelve years of experience and an additional two or three contract programmers to support implementation programming needs as required until the MS CHIP program is implemented. In addition to our in-house staff, UnitedHealthcare has a pool of experienced contract programmers who have experience with the UnitedHealthcare systems and who have been engaged on large scale implementations such as the recent implementations in TN and CT.

Based on the many Medicaid and CHIP programs we have implemented, UnitedHealthcare understands the needs associated with implementations and how critical the experience with the MIS programmers is to the success of an implementation. If unforeseen challenges occur, we have the backing and resources of our parent company, UHG.

56. **Section 11.3** of this RFP lists desired administrative capabilities and management information system features. Is your organization able to provide each of the desired functions or features?
If not, please identify each function that you are not able to provide and indicate any alternative approach you may have for addressing the variance between the desired functions and those which you are able to provide.

Yes, UnitedHealthcare currently meets all of the functions and features required by Section 11.3 of the RFP. Key highlights of such are described below.

a) Maintain historical data.

Yes, the Strategic Management Analytic Reporting Tool (SMART) is our robust data warehousing and decision support tool used for analytics and enhanced reporting. It is a multi-dimensional data warehouse that collects information from the various operational systems on a daily, weekly and monthly basis; depending on the data source. Information stored in this warehouse includes geographic, line of business, service category, product data; Member and provider demographics, provider contracts; revenue capitation data by rate cell; claims/encounters for each service category; appeals; service authorizations by day, diagnosis and level of care; actuarial reserving completion factors; and disease management categorizations and risk stratification scores by Member.

b) Receive, translate, edit and update files in accordance with the Board requirements. Updates will be received from the DOM and processed within one working day.

Yes, our transaction systems receive, translate, edit, create and house data required for the day-to-day operations of the health plans we administer, including MS CHIP. These include our core transaction processing system, Facets, for enrollment, eligibility and claims administration; HIPAA Gateway and EDIFECS for electronic data interchanges with trading partners. Updates from the DOM will be processed within one working day.

HIPAA Gateway receives eligibility data daily from DOM (or its Fiscal Agent); Facets receives eligibility data from HIPAA Gateway daily; CareOne sends pre-authorization data to Facets twice daily; Facets sends processed claims data to the data warehouse weekly; OPC monitors the processing of eligibility data by Facets continuously and sends Simple Mail Transport Mail (SMTP) status messages to the ServiceDesk as needed in real time, and so on. The bottom line is that each of these components in our technology platform are integrated and interoperate where they need to, but they are independent enough to allow rich functionality for the specialized functions they are designed to deliver.

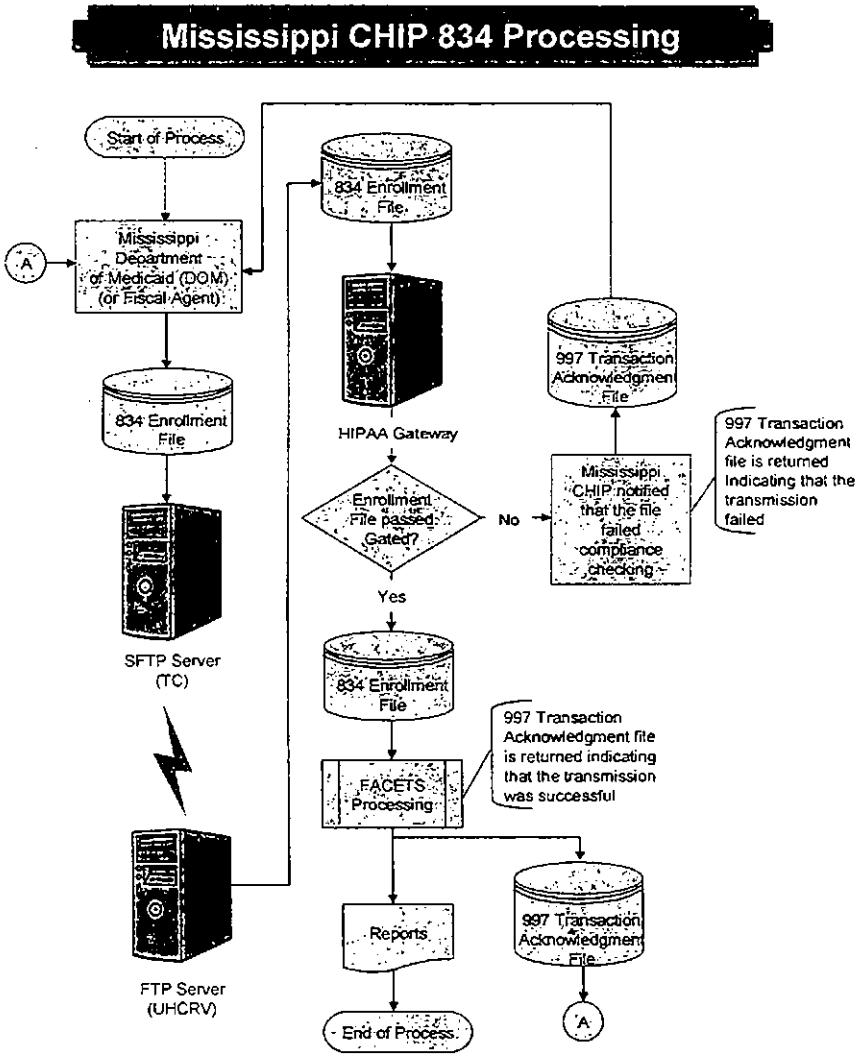
Common Syntax in Data Elements—Both Facets and HIPAA Gateway are produced by the same company, The TriZetto Group, Inc. and share a common data dictionary, naming and format convention. SunGard (maker of MACESS) and TriZetto have a formal partnership to provide interfaces into each other's products. Through Facets extended integration connectors (FXI), TriZetto has afforded us vendor supported data connectivity with our MACESS system. These vendor supplied interfaces provide standard data element naming conventions and formats. The UnitedHealthcare data warehouse, implemented in Oracle, utilizes standard industry practices for documented data dictionaries, extract/transfer/load (ETL) processing, and data quality assurance processes. To ease ad-hoc user reporting in the data warehouse, a series of internal data exchange data element names are translated into more end user friendly names that are cross referenced using data dictionaries. For all data interfaces, similar data elements have equivalent names across systems to accommodate interface maintenance and ongoing enhancements, and are formatted to allow the most flexibility for growth (for example, allowing where possible more spaces than is currently needed). This is similar to HIPAA's approach for name fields. Data types are also the same for similar elements. The frequency of updates/refreshes of similar data elements varies with the business purpose of the interface.

c) Provide error reports and a reconciliation process between the new eligibility data and eligibility data existing in the management information system.

Yes, UnitedHealthcare has dedicated resources, produces error reports and has an established reconciliation process in place to address and resolve eligibility data discrepancies. While receiving and loading standard eligibility files is automatic and typically processes with few problems or manual intervention, we understand and plan for discrepancies between data from our core system, Facets and that of our state partners. The following steps outline this process:

- Enrollment coordinators receive e-mail when file is processed.
- Error reports are printed from the e-mail. We work these reports on a daily basis in accordance with enrollment guidelines outlined in our Enrollment and Eligibility Policy and Procedures. The reports include:
- MS CHIP Match Report: Identifies Members who need to have a key change made in Facets, usually due to a temporary ID changing to the Member's social security number. Medicare information is reviewed from this report and updated in Facets, or reported back to MS CHIP for discrepancies.
- Multiple Match Report: Errors shown include Members requiring a Member key change, Members with multiple MS CHIP policies in Facets requiring voiding or terming eligibility events and zip code errors.
- Enrollment Error Report (MMS log): The reason for the error is researched. Errors may be for rate data, eligibility, group change or discrepancies between the file and Facets. Enrollment coordinators reconcile errors and make appropriate changes in Facets. For errors from the MS CHIP file, enrollment coordinators call DOM, and new information is provided UnitedHealthcare, either via a new file or fax.
- Enrollment coordinators receive weekly internal audit reports that monitor for information that is initially loaded into Facets, but do not match how the product is set up. Examples include discrepancies in rate data, billing codes, group plans, family links (IDs' that tie family Members together, such as mother and baby). These error reports are generated from the data warehouse and need to be completed by Friday of same week in order for the Data Warehouse to be updated before the next weekly set of audits are generated. Errors not corrected completely show on the following weeks audit file.

The following diagram depicts an example of our 834 enrollment process:



d) Verify Member eligibility as provided by DOM

Yes, our Operations team manages the automated receipt and processing of enrollment files from DOM, and/or its Fiscal Agent. All inbound 834 Enrollment and 271U (unsolicited eligibility response) files are automatically acknowledged upon receipt with issuance of standard 997 Functional Acknowledgement transactions. All HIPAA compliant 834 files are kept on our HIPAA Gateway server for 7 years. This allows us to quickly answer any questions on recent transmissions—and even re-apply a file if requested by DOM. Enrollment records are updated to the database the next business day following receipt, after application of edits to check for format, completeness, and validity. Today, our eligibilty systems interface with our contracted state Medicaid/CHIP agencies on a monthly basis.

This data is immediately distributed electronically to our provider web portal, UnitedHealthcare On-Line, for online eligibility verification support and to our Interactive Voice Response (IVR) system for automated telephonic support of eligibility inquiries. As we become aware of changes to a Member's address, telephone number, or PCP we communicate these changes to DOM via outbound 834 transactions, using appropriate segments in the 834 file and according to DOM requirements.

Yes, UnitedHealthcare has the capability to link covered children in the same family through the case number for the purpose of tracking the copayments and out-of-pocket maximums for children in families with annual income greater than 150 percent of FPL and up to 200 percent of the FPL and is standard procedure in 16 states covering CHIP.

f) Provide a certificate of creditable coverage to terminated Members pursuant to the Health Insurance Portability and Accountability Act

Yes, UnitedHealthcare provides a certificate of creditable coverage to terminated Members, pursuant to the HIPAA through Facets.

g) Generate and track referrals including referrals to non-participating providers

Yes, UnitedHealthcare is able to generate and track referrals, including referral to non-participating providers through our core system, Facets, with input from CareOne and the NDB, our national provider database.

h) Identify providers by specialty(s)

Yes, UnitedHealthcare identifies providers by specialty(s) through the NDB (our national provider database). NDB is an IBM DB2 based system, housing information, including specialty, on all providers having contractual relationships with UnitedHealthcare.

We monitor to ensure that within 30 days of receiving completed and credentialed provider applications, contracting data is also built in Facets correctly which includes provider specialty(s). Daily updates from NDB ensure provider data is current within Facets.

i) Maintain provider history files to include audit trails and effective date of information

Yes, UnitedHealthcare maintains provider history files including audit trails and effective date of information in the NDB (our provider database) and the SMART data warehouse.

j) Maintain provider fee schedules/remuneration agreements to permit accurate payment for services based on financial agreement in effect on date of service

Yes, UnitedHealthcare is able to maintain provider fee schedules/remuneration agreement in order to achieve accurate payment for services based on financial agreements in effect with date of services. Business rules are written for each financial agreement and the effective date of service for each provider fee schedules/remuneration agreements. Provider data in the NDB is electronically loaded and updated on a daily basis into Facets, our core transaction system.

k) Support monitoring activity for provider enrollment and provider network capacity

Yes, once the provider is credentialed and contracted, all data contained in our credentialing system is loaded into our NDB (provider database). NDB is an IBM DB2 based system, housing information on all providers having contractual relationships with UnitedHealthcare, as well as other UnitedHealth Group affiliates. Provider data in the NDB is electronically loaded and updated on a daily basis into Facets, our core transaction system. Our system tests all new contract data to ensure 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 monitor the entire process to ensure that within 30 days of receiving completed and credentialed provider applications, contracting data is built in Facets correctly.

Our Network Management team conducts ongoing monitoring and updates to our contract files, such as:

- Fee schedule maintenance and updates
- Amendments to ensure regulatory compliance
- Fraud and abuse monitoring
- Routine reviews of data
- Unit cost management.

l) Support multiple fee schedules and capitation rates for all Contract periods by provider, to the extent necessary.

Yes, Facets supports multiple fee schedules and capitation rates for all Contract periods by provider. Additionally, Facets supports enrollment, eligibility, claim validation adjudication, payment, reporting functions and provides the source data for our encounter submissions. The Facets system is versatile and flexible, providing UnitedHealthcare with the capability to configure the MS CHIP business rules. The system is able to handle all standardized payment rules including but not limited to DRG, ASC/APGs, per diems, case rates, outliers, percentage of charge and CPT fee based payment methods; and allows multiple fee schedules to match payment to particular specialties, regions or general reimbursement levels. The system's numerous edits enforce appropriate coding to enhance inappropriate cost avoidance. In addition, the system is configured to capture and report data elements critical to supporting effective enrollment, claims adjudication and utilization management processes.

m) Provide timely, accurate, and complete data for monitoring claims processing performance.

Yes, UnitedHealthcare uses Facets, an IBM AIX-based managed care information system that provides advanced claims processing capabilities, to fulfill the Plan's information system requirements. The Facets system is versatile and flexible, providing UnitedHealthcare with the capability to configure business rules, such as claims payments for specific services, authorization requirements, benefits, benefit limits, and reporting requirements. The system is configured to capture and report data elements critical to supporting effective claims adjudication and reports automatically delivered to management on a daily, week, monthly basis.

Capacity—UnitedHealthcare routinely monitors our MIS' capacity to determine key thresholds of the hardware and software capacity that affects the performance of the Facets system. Through our parent organization UHG, we employ 10,000 technology professionals responsible for computing hardware, software and communications. We have over six petabytes of storage (equivalent of 450 billion pages of text, enough to fill 20 million four-drawer filing cabinets). We have virtual contact center that dynamically routes a million calls daily across more than 40 contact centers and 20,000 service agents.

n) Provide timely, accurate, and complete data for reporting utilization.

Yes, UnitedHealthcare provides timely, accurate and complete data through CareOne, our proprietary clinical platform supports disease, case and utilization management. UnitedHealthcare designed CareOne, a sophisticated electronic care management system that includes clinical decision pathways and uses assessment information to create individualized treatment plans based on the participant's health care needs and goals. We call this our Personal Care Model. CareOne is a robust care management application that integrates evidence-based guidelines and clinical data, including data generated through Impact Pro and the comprehensive assessments performed by our care managers. CareOne allows UnitedHealthcare care managers to update and manage care plan records and create care plans, in coordination with the Member/Member's family, primary care provider and any specialist providers, which are objective, measurable, appropriate and achievable. Further, it integrates all clinical interactions from our care management and disease management interventions. CareOne is able to provide monthly, quarterly and annual reports to UnitedHealthcare's internal and external customers.

Universal Tracking Database (UTD)—The UTD is an internally designed/custom relational database that accommodates multiple data inputs and has a web-style interface which enables secure but efficient online use by UnitedHealthcare clinical quality staff, ensuring comprehensive, timely encounter and service information on each unique Member. UnitedHealthcare staff can, using UTD, focus on Members in need of outreach or intervention and monitor adherence to care in an existing treatment regimen. For example, we use UTD to support TENNderCare; one of our specialized programs in our Tennessee health plan.

o) Maintain and apply edits and audits to verify timely, accurate and complete encounter data reporting.

Yes, UnitedHealthcare consistently submits encounter data to over ten state partners with a 97 percent to 100 percent acceptance rate.

Our efforts to ensure complete and accurate encounter data start with UnitedHealthcare's encounter data submission process, which was designed by UnitedHealthcare's Encounter and Finance teams to include administrative and organizational systems. These systems ensure accurate processing and timely submission of encounter data and reports.

To support much of the process described above UnitedHealthcare will use our innovative NEMIS application for the MS CHIP program. NEMIS is our advanced encounter submission system that utilizes an UnitedHealthcare proprietary, relational database design. NEMIS supports rapid identification of problems with previously submitted encounters, and it supports the tracking, correcting, and reporting needed for remediation. Defects in submissions are logged and analyzed for identification of any systemic issues, allowing for the ongoing improvement in the quality of encounters submitted. UnitedHealthcare/NEMIS fully supports the 837 HIPAA standard encounter file formats.

Encounter adjustments, reconciliations, and post submission completeness reports provide detailed insight into the process with key checkpoints that ensure all transactions are balanced and reported. NEMIS completeness reports provide a systematic approach to data quality that further improves claims adjudication accuracy; all the way back to the source if necessary. This feature greatly enhances our ability to meet or exceed the MS CHIP turnaround time and audit requirements related to encounters.

p) Maintain and apply edits to verify the accuracy and validity of claims data for proper adjudication.

Yes, Facets uses front-end edits to validate claims data to ensure proper adjudication. Additionally, Facets supports enrollment, eligibility, claim validation and adjudication, payment, reporting functions and provides the source data for our encounter submissions. The Facets system is versatile and flexible, providing UnitedHealthcare with the capability to configure business rules. The system is able to handle all standardized payment rules including but not limited to DRG, ASC/APGs, per diems, case rates, outliers, percentage of charge and CPT fee based payment methods; and allows multiple fee schedules to match payment to particular specialties, regions or general reimbursement levels. The system's numerous edits enforce appropriate coding to enhance inappropriate cost avoidance. In addition, the system is configured to capture and report data elements critical to supporting effective enrollment, accurate claims adjudication and utilization management processes. Managing over one million public sector Members, currently, Facets auto-adjudicates 80 percent of all medical claims and processes 12 billion transactions annually.

q) Submit reimbursements to all non-participating providers in a timely and accurate manner.

Yes, UnitedHealthcare is able to submit reimbursements to all non-participating providers in a timely and accurate manner using the provider information from the provider database, NDB, Facets, the core claims systems, and authorizations, if necessary, from the CareOne system.

r) Make claim and capitation payment, if applicable, to network providers in a timely and accurate manner.

Yes, UnitedHealthcare makes claim and capitation payments to network providers in a timely and accurate manner. The percent for all claims processed within 30 working days of receipt for calendar year 2008 is 99.75 percent.

Upon loading of credentialing data into the NDB, providers are automatically set up to receive payments at the address provided on their credentialing application. Providers can also choose to receive EFTs.

Provider payment files are processed daily. UnitedHealthcare's Finance team sends a provider payment file to our print vendor daily, who prints checks once a week. The print vendor sends a check register to UnitedHealthcare's Finance team weekly. Our Finance team then reconciles the check register to Facets' check register.

s) Ensure accumulation of data, preparation and mailing of 1099 forms to providers.

Yes, annually, after year-end, UnitedHealthcare's Finance team extracts 1099 data out of Facets claims platform. Our Finance team validates the data against our general ledger, creating a list of "fallout" providers which shows discrepancies in data, such as conflicts with NPI numbers. Our Provider Administration research and rectify all fallout issues, and then forwards the final data to our corporate tax area to generate the actual 1099 forms. In 2008, UnitedHealthcare sent out 1099s to providers in 22 states.

t) Support the management of referral/utilization control processes and procedures including prior authorization and pre-certification and denial of service.

Yes, UnitedHealthcare's proprietary system, CareOne has functionality for tracking referral/utilization, prior authorizations, pre-certification and denial of services as well as reporting of the same.

Denial of service is accomplished through the configuration of plan benefits in Facets. If a service is not covered or denied for any appropriate reason, Facets is configured to automatically deny the claims with the appropriate explanation. For example, if a precertification is required for a procedure and is not included with the claim, the claim will automatically be denied for payment.

u) Validate approval and denials of pre-certification, prior authorization and referral requests during adjudication of claims/encounters

Yes, UnitedHealthcare can validate approval and denials of pre-certification, prior authorization and referral requests during adjudication of claims/encounters. Our claim system, Facets receives through an interface, the pre-certifications, prior authorizations and referrals from CareOne system in order to either approve or deny a claim/encounter twice daily.

v) Capture claims, encounter data and enrollment data and transfer electronically to the State's MV

Yes, our transaction system receives, creates and houses data required for the day-to-day operations of the health plans we administer, including MS CHIP. These include our core transaction processing system, Facets, for enrollment, eligibility and claims administration; HIPAA Gateway and EDIFECS for electronic data interchanges with trading partners; CareOne for integrated physical care and disease/case management, prior authorizations, referrals and utilization management; and MACESS for Member and provider inquiry management and correspondence as well as document imaging and associated workflow. HIPAA Gateway receives eligibility data daily from DOM, Facets receives eligibility data from HIPAA Gateway daily; CareOne sends pre-authorization data to Facets twice daily; Facets sends processed claims data to the data warehouse weekly.

National Encounters Management Information Systems (NEMIS)—Our NEMIS application is an advanced encounter submission system, which utilizes our proprietary, relational database design. This design is based on years of experience with encounter submission scenarios in most of our 22 states; and supports rapid identification of problems with submitted encounters. It also supports the tracking, correcting, and reporting needed for remediation of individual encounters. UnitedHealthcare consistently submits encounter data to state partners with a 97 percent to 100 percent acceptance rate.

w) Identify and pursue third party liability coverage and post any recoveries received to claims history

Yes, Facets enforces the claims edits necessary to identify and capture third party liability (TPL) coverage. The table driven, rule based set up in Facets has the ability to track other health insurance (OHI) for a Member. Accident diagnosis codes are also flagged for possible TPL. Facets sets a coordination of benefits (COB) flag in the system which determines COB status at the time the claim is processed.

Once any recoveries from TPL is received, the recovery is posted to the Member's claims history in Facets

x) Provide necessary data for all cost accounting functions relative to the experience under this Plan

Yes, UnitedHealthcare extracts data elements from the Facets to accomplish all cost accounting functions. Currently, UnitedHealthcare retrieves this type of data elements for other public sector contracts.

y) Provide fraud and abuse detection, monitoring and reporting

Yes, UnitedHealthcare has a dedicated Fraud and Abuse Special Investigations Unit (SIU) that coordinates and oversees all UnitedHealthcare fraud and abuse activities. We overlay our SIU services with the powerful software detection tools of Ingenix® Detection Software (IDS), which allow us to identify and scrutinize questionable claims before payments are actually made, and also to conduct detailed post payment reviews. IDS rigorously reviews all post adjudicated claims before payment. Among other edits, IDS screens for unbundled codes; up-coded, invalid and duplicate codes; code fragmentation; patient age (if CPT code is age specific); patient gender (if the CPT code is gender specific); place of service (must be appropriate to the procedure performed); pre and post operative intervals (days); and modifiers (verify that modifier is billed with an appropriate CPT code). IDS identifies providers who have been flagged, based on factors such as previous suspect billing practices.

Pre/Post Payment Claims Review—Facets, our core transaction processing system, contains a number of edits specifically designed to identify suspect claims, which are then subjected to further review. In addition, Ingenix Prospective 2.0 claims software performs a continuous editing on all post-adjudicated claims before payment. This program identifies providers who have been flagged based on factors such as previous suspect billing practices. Using its imbedded rule logic, the program scrutinizes claims before they are paid and suspect claims are then held for further review.

Quarterly, our SIU data analysts run all claims data through the ViPS STARS product, as part of our post claims processing review activities. STARS examines more than 50 elements on a claim to reveal abnormal patterns in utilization, billing practices, procedure coding, diagnosis coding, referral patterns, and provider identification. To identify which providers should be subjected to field audit, SIU ranks providers using the following criteria:

- Financial indicators, such as high cost claims and above average cost per patient
- Coding anomalies, including suspect CPT analyses and/or CCI edits
- Referrals from internal or external sources.

The numerical ranking determines whether initial suspicions warrant further desk audits and monitoring, or whether they require field audits. The Field Audit Unit gathers further data on providers targeted because of suspicious claims activity, and if an audit is required, the RNs review randomly selected medical records to determine if the provider billed appropriately.

z) Produce and distribute Member ID cards.

Yes, UnitedHealthcare produces and distributes Member ID cards to new Members and to existing Members based on PCP and other changes. Enrollment changes are processed through Facets, our core transaction processing system, and it automatically triggers the generation of Member ID Cards. When an Enrollment Coordinator facilitates Member changes, they enter the new information into the Member's record in Facets, which will then automatically generate a new ID card. After the new ID card is produced for the Member, the card is mailed directly to that Member.

aa) Produce Member/provider mailing labels.

Yes, through our print vendor we can produce Member and provider mailing labels for the purposes of mailing Member enrollment packets, Member ID cards and provider directories to new Members, updates on benefits, information to our providers, etc.

ab) Produce the certificates of creditable coverage, as required under HIPAA, upon a participant's termination of coverage under the Benefit Plan.

Yes, Letters go out to all Members at a Member level unless the group is on our exclusion list. If a group terminates participation of coverage, Members do not receive letters unless the group requests letters to be sent to the Members.

HIPAA

57. Describe the process used by your company to comply with HIPAA EDI, privacy, and security requirements.

UnitedHealthcare has comprehensive processes to maintain compliance with Health Insurance Portability and Accountability Act (HIPAA) electronic data interchange (EDI)/code set, privacy, and security requirements, as well as the state-specific requirements of our customers. UnitedHealthcare has access to national resources that we rely on to support our efforts to comply with HIPAA regulations. Our Chief Information Officer, Les A. Sowa, and our Privacy Officer, Paul E. Sturm, monitor CMS and legislative activities and work through these resources to continually verify our compliance with HIPAA and other mandates, and ensure that our information systems and operations are adaptable to future requirements, innovations, and adoption of best practices.

Our compliance with current HIPAA regulations is built on our strong suite of information systems, selected in part based on their capabilities and their flexibility to adapt to the evolving HIPAA regulations. We achieve further compliance with non-systems-related privacy and security mandates through comprehensive physical security systems and documented, proven administrative approaches.

EDI/Code Sets: Our core processing system, Facets, interfaces with the TriZetto HIPAA Gateway which performs HIPAA editing, translation, and compliance-checking for inbound and outbound electronic transactions. We configure these systems to remain responsive to changing requirements and in compliance with HIPAA. Since Facets is also a TriZetto product, we are afforded a crucial degree of integration between the compliance/translation software and the business processing engine. All system configuration and maintenance is performed using our System Delivery Process (SDP). SDP is the formal and structured process we use to build and make changes to accommodate HIPAA requirements, or modify any other system processes. SDP is our disciplined approach for development and change management and it contains test controls for validity and accuracy. We developed SDP according to industry best practices from the Software Engineering Institute (SEI) and the Institute of Electrical and Electronics Engineers (IEEE). SDP consists of six phases which each include review steps, approval steps and required approvals within each phase. As a notable part of the SDP, UnitedHealthcare emphasizes testing as part of the electronic transaction submission change process. To ensure smooth introduction of new standards at either the federal or state level, we use the EDIFECS Ramp Manager software. Ramp Manager allows us to efficiently test and troubleshoot any changes in electronic transaction formats down to the segment and element level, well before these changes go into effect. To ensure all required processes are followed and required documentation is created, we conduct internal and Sarbanes-Oxley (SOX) compliant reviews between phases.

To further support the System Delivery Process and ensure standardization, UnitedHealthcare follows a formal Change Management process. Our Management Information Systems Service Management process ensures standardized methods and procedures are used for efficient and prompt handling of all changes. The process minimizes the impact of change-related incidents upon service quality and improves the day-to-day operations of the organization. The process also ensures a smooth implementation of new health plan programs without impacting existing programs on the same technology platform. High-impact changes must be submitted, reviewed and approved by the Change Advisory Board (CAB). The CAB comprises representatives from all key workgroups who can assess change impacts and ensure funding and resources are available and scheduled to develop and implement the changes.

Like our SDP, the Change Management methodology is outlined by a formal and auditable process, including structured submissions, required artifacts, scheduled review meetings and approval dates. This allows us to implement high volumes of changes to benefit our businesses and business partners, while at the same time protecting the integrity and stability of our environment. It allows us to manage our changing environment with discipline and urgency while mitigating the risk to the critical services we provide.

Security: We ensure the *security*—that is, the *confidentiality*, *integrity* and *availability*—of all of our clients' data in our integrated systems. In addition to adhering to the HIPAA Security Rule, UnitedHealthcare has developed auditable internal management and system controls that enable us to be accountable for meeting Sarbanes-Oxley (SOX) legislative requirements. UnitedHealthcare also undergoes regular Statement of Auditing Standards (SAS)-70 Type II audits. All UnitedHealthcare locations also employ company-standard physical security measures that protect company assets, information, and resources, and promote full HIPAA security compliance.

Privacy: HIPAA privacy requirements and processes form integral components of employee training, job descriptions, documented policies, human resources policies, desk procedures, and other documentation. The Privacy Officer, Paul Sturm, administers HIPAA Privacy safeguards throughout the organization and ensures that administrative controls are documented, implemented, and rigorously followed and reported. An essential component of our HIPAA privacy compliance process is our extensive employee training program. The Privacy Officer develops and maintains privacy training curricula and monitors that employees receive required training. New hires receive extensive privacy training and employees receive mandatory annual refresher courses, as well as periodic updates and reminders. The Privacy Officer is also the central point of contact for reporting suspected privacy violations and pursuing these cases to resolution.

At UnitedHealthcare, we take our HIPAA compliance responsibilities seriously since our level of compliance directly affects our ability to safeguard our customers' data assets and maintain the integrity of the protected health information (PHI) entrusted to us.

To demonstrate the application of our proven processes, the following table summarizes key components of HIPAA compliance monitoring and maintenance. Our management, human resources, information technology, and quality assurance resources constantly monitor compliance and seek ways in which to improve our processes to enhance compliance levels and effectively incorporate future requirements into our business operation.

Process	Description/Purpose
Restrict information to least privilege.	Security controls are established for system, application and data layers based upon functional roles and responsibilities being performed (**Role Based Access Control** or "RBAC"). For new users, supervisors fill out an access request form for subordinates, choosing a pre-defined role. That translates into role based security profile in our systems to ensure that users have access to only the functions and information needed to complete their work. Roles are regularly monitored and audited as part of our Internal Control Questions (ICQ) for SOX compliance.
Individual user profiles determine access	Each user is assigned a unique user id. IBM's Remote Access Control Facility (RACF) and Microsoft Active Directory are used to manage authorizations to individual systems. Some technical roles require the use of global capabilities. **No global (superuser) capability exists today; nor do we plan on this capability in the future, per UnitedHealthcare policy.**
System locks out and records anything over three failed access attempts.	Automatic lock-outs are engaged after **three failed credential attempts.** Login attempts and lockouts are logged. The user must call the systems help desk and correctly provide two or more personal identifiers in addition to the user id in order to get the password reset.
System information will be available to representatives upon request.	We currently make system information available to state/customer and other authorized agents upon request.
Controls to maintain information integrity will be in place and tested.	We undergo regular **SAS-70** audits and annual Sarbanes-Oxley audits to ensure that data integrity controls are in place for all our systems. Integrity controls range from referential integrity in our relational databases, automated job monitoring and record balancing of data exchanges, PKI authentication of external exchanges, administrative and clinical edits, and a variety of identifier validations (Member, provider, organizations). In addition, intrusion detection and file change control technology is also deployed throughout our security architecture model, ensuring that data is represented in our systems as legitimately intended.
Audit trails include logon, terminal ID, date/time of modification, system job identification	Our audit trails include logon, computer name, date and time of modifications and, for batched or scripted changes, the job identifier. Audit logs are regularly monitored and audited as part of our ICQ for SOX compliance.
Timestamp is displayed on any online inquiry against that information.	Timestamps are applied to online inquiry and transaction logs. Those timestamps are displayed when history is reviewed. Date and time are also captured when a report is generated and can be displayed on the report.
Data can be traced from last recording to its source.	Through the use of unique IDs and key information (document control number, claim/Member/provider ID, transaction date), it is possible to trace data from any place in the system back to the source data, including paper documents.

Process	Description/Purpose
Audit trail function is supported by reporting, error logs, transaction logs, etc.	Our HIPAA, SOX and SAS-70 controls mandate that we have evidence to prove that our controls are in place and functioning. This necessarily means we must produce system listings, transaction reports, update reports, and transaction logs. These are reviewed as appropriate by either IT staff or by supervisors and managers within the business area.
Audits are conductible at an individual record level and a batch level	Our systems are able to facilitate both batch audits and audits of individual records. We do this at the batch level via notifications of job completion and/or file transmission, balance control reports and EDI 997 functional acknowledgements. We support individual record audits via inquiry capabilities in our applications as well as secured access to back-end database records for authorized personnel.
System will prevent alteration of finalized records.	Once a record is finalized it is always available without capability for alterations. Changes would require the use of additional records. For example, a change to a claim that has completed adjudication would require an offset and correcting record to be added. The accumulation of all the records tied to the same claim ID gives a complete and accurate view.
Data processing systems are physically protected.	Security systems are in place for the data center and require electronic credentials to be presented before entry is allowed.
Perimeter access to general facilities is physically protected.	Access to the data center facility is restricted to credentialed individuals. Monitoring devices are in place and staffed **24 hours a day, 7 seven days a week**. Processes are in place to admit approved guests.
Fire protection is in place for processing site.	**FM-200** and a pre-action sprinkler system are deployed for fire control in our data center. A **dry pipe sprinkler system** is present on the loading dock.
Network is secured, particularly provider and Member service applications should not be directly accessible to the Internet.	UnitedHealthcare has procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of our span of control. All Internet connections, whether outbound or inbound, are filtered through corporate approved firewalls, layers of firewalls and/or physically isolated from internal network connections. Our firewalls are configured to protect against unauthorized intrusions and limit external access to the internal company networks. Vulnerability assessment technology is used throughout our internal operational infrastructure to assist with preemptively detecting and addressing operating system risks. Vulnerability assessments are performed at the **external** entry points as well to ensure ongoing appropriate control posture for UnitedHealthcare customer and proprietary information. Content filtering is established for virus detection and worm detection. Appropriate credentials are required to log on to the internal network and automatic lockouts and password expiration are enabled. Some Member and provider service applications are available directly from the Internet, in line with customer requirements; for example, provider claims status inquiry, provider directory and some wellness tools. However, any application that contains private information is secured and requires appropriate credentials. Regardless, UnitedHealthcare's internal applications, including those used for account administration, are **not accessible** via the open Internet. Information on our password access control policy is available upon request.

Process	Description/Purpose
Remote access to systems only takes place over VPN and must have two-factor authentication.	UnitedHealthcare's innovative 'remote access' solution for broadband and dial-up is provided to employees via the iPass and Cisco VPN software clients. UnitedHealthcare recently implemented the use of RSA SecureID strong two-factor authentication. We have invested heavily in remote access technology—in part to support our public sector field staff serving rural, remote areas. The iPass / Cisco combination allows the same PC client to be used for all access connectivity needs - whether the UnitedHealthcare user already has an Internet connection (broadband) or needs to use a phone line. We allow secure yet stable connectivity via the use of redundant nodes thru four of our parent company's locations. This helps to enable quick connectivity and multiple, yet secure entry points. Particularly with the use of the SecureID option, we can support simplified logins—using the employee's Microsoft domain user name and password. Secure and efficient remote access is a must for mobile public sector staff members.
A security risk assessment has been conducted and an information security plan is in place	Internal and corporate audits are conducted to ensure that systems and employees are in compliance with the information security plan. All employees completed online compliance training courses by November 30, 2007. SAS-70 Audit results are available upon request.

58. Describe your compliance with HIPAA's transaction standards, medical data code sets, unique identifiers, privacy, and security.

UnitedHealthcare, through the support of our parent, UnitedHealth Group (UHG), supports the goal of administrative simplification and the national standardization of health care transactions. We actively participate on the Workgroup for Electronic Data Interchange (WEDI), the X12 standards development organization, the National Uniform Billing Committee (NUBC) and National Uniform Claims Committee (NUCC). UnitedHealthcare and its business associates implemented all applicable HIPAA transactions in October 2002. Subsequently, we complied with requirements for the employer identifier and national provider identifier. We are currently planning for the proposed update of transactions to version 5010 and ICD-10. We will implement these mandates by the applicable compliance dates when they are published.

UnitedHealthcare ensures compliance with HIPAA mandates through the auditable internal management and system controls that UnitedHealthcare has developed as a publicly-held company accountable to Sarbanes-Oxley legislation. UnitedHealthcare also undergoes regular SAS-70 Type II audits. The following subsections outline our HIPAA compliance in each of the mandated areas.

Transaction Standards

UnitedHealthcare processes electronic transactions for our clients using the Facets core processing system, and HIPAA Gateway and EDIFECS for electronic data interchange with trading partners. These systems are fully HIPAA-compliant and support all currently-mandated transaction formats, medical code sets, and unique identifiers including the National Provider Identifier (NPI) and the Employer Identification Number (EIN). At present, we are compliant with HIPAA version 4010A, and are actively tracking version 005010 and the development of ICD-10 coding so that we can prepare and be compliant on the respective effective dates.

Supported transactions include:

- Benefit Enrollment and Maintenance transaction (834)
- Payroll Deduction and Other Group Premium Payment for Insurance Products transaction (820)
- Medical claims transactions (837I, P, D) including institutional, professional, dental, and vision
- Pharmacy claims transactions (NCPDP 5.1)

- Electronic remittance (835)
- Prior Authorization requests (278)
- Enrollment Response (271)
- Claims Status Inquiry/Response (276/277)
- Functional Acknowledgement (997).

Supported medical code sets include:

- Health Care Common Procedure Coding System (HCPCS)
- Current Procedure Terminology (CPT) codes
- International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes)
- International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedure codes)
- National Drug Code (NDC).

Both our automated systems and administrative processes fully implement all current requirements of the HIPAA Privacy and Security rules.

Privacy

The UnitedHealthcare Privacy Program is designed to promote compliance with UnitedHealthcare's mission and various federal and state privacy regulations, including HIPAA and the Gramm-Leach-Bliley Act (GLBA). It is structured into two major components. The first is to provide employees with various training and resources to support their day-to-day compliance activities. Second, through various monitoring and control tools, it seeks to ensure employees are actually complying with existing processes and promotes ongoing compliance through a proactive change management approach. The UHG Privacy Office and business segment privacy and compliance teams are responsible for the oversight of this program.

Automated/systems controls: Facets, our core transaction processing system, our EDI processes, our Interactive Voice Response (IVR) system, our Websites and portal, our MACESS claims imaging and inquiry tracking system, and our other integrated applications are all HIPAA-compliant and adhere to all HIPAA standards and rules.

Administrative controls: All Member Services staff is specially trained to assist Members and providers in filing quality-of-care concerns. The Member Services staff is the primary point-of-contact with Members and, therefore, they are trained to solicit specific information without violating any HIPAA and/or confidentiality regulations.

Security

UnitedHealthcare manages and supports a robust Information Security Program. Its protocols are based on industry practices, all applicable regulatory obligations, and customer considerations. Policies and standards are used to manage the specific requirements and basic premise of general computing, audit, and security controls. The Information Security Policies and Standards represent the foundation of security applied to and within the UnitedHealthcare proprietary network infrastructure and critical application services. These controls are audited on an annual basis, for which a SAS-70 Type II report is issued and provided to all customers upon request.

Administrative controls: Our Chief Information Officer, Les A. Sowa, and our Privacy Officer, Paul E. Sturm, monitor CMS and legislative activities and work through these resources to continually verify our compliance with HIPAA and other mandates, and ensure that our information systems and operations are adaptable to future requirements, innovations, and adoption of best practices.

A key component of our HIPAA compliance effort is our staff training program. When our staff accesses, transmits, and stores data files containing protected health information or individually-identifiable health information, it is always protected. We train our staff to recognize and adhere to HIPAA security, confidentiality and privacy requirements.

Staff undergoes mandatory HIPAA training during our New Employee Orientation program, along with annual refresher training, and their completion of these courses is required for ongoing employment.

We provide ongoing training through LearnWell, an online portal that contains hundreds of web-based training sessions. Certain training sessions are mandatory to be completed annually, such as Cultural Competency, Ethics & Integrity, HIPAA, and Corporate Compliance. On the LearnWell portal, each employee's development status is split into two segments—"My Development Plan," and "My Development History." The mandatory programs are posted on each employee's "My Development Plan" site, along with the length of the course and a due date. As employees progress through training, new courses are added. As the employee continues service with UnitedHealthcare, mandatory courses will refresh on the site. The "My Development History" site records the completed courses for each individual employee. A course is only considered "completed" when the employee passes the pre- and post-training tests associated with the course (most courses have tests), and/or the employee views the entire presentation. The following table lists some of the available LearnWell courses.

Training Curriculum	
Course Number	Course Name
Course 1	Integrity and Compliance
Course 2	HIPAA Compliance
Course 3	Technical Refresh Course
Course 4	DBA Administrator Refresh Course
Course 5	System IS Security Officer (SISO) Refresh Course
Course 6	Six Sigma
Course 7	PMP / PMI
Course 8	Medicaid Concepts

Additionally, company HIPAA policies and procedures are published on our intranet site for employees to reference. We also provide ongoing HIPAA awareness training and issue monthly e-mail security reminders to the entire organization, many from our Segment Information Security Officer (SISO), Lee deBruin. Topics include strong password selection, workstation security, incident reporting, and viruses and malicious software.

Physical controls: Access to the data center facility is restricted to credentialed individuals. Security systems are in place for the data center and require electronic credentials to be presented before entry is allowed. Monitoring devices are in place and staffed 24 hours a day, 7 days a week. Processes are in place to admit approved guests.

Technical controls: UnitedHealthcare has procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of our span of control. All Internet connections, whether outbound or inbound, are filtered through corporate approved firewalls, layers of firewalls and/or physically isolated from internal network connections. Our firewalls are configured to protect against unauthorized intrusions and limit external access to the internal company networks.

Vulnerability assessment technology is used throughout our internal operational infrastructure to assist with preemptively detecting and addressing operating system risks. Vulnerability assessments are performed at the external entry points as well to ensure ongoing appropriate control posture for UnitedHealthcare customer and proprietary information. Content filtering is established for virus detection and worm detection. Appropriate credentials are required to log on to the internal network and automatic lockouts and password expiration are enabled. Some Member and provider service applications are available directly from the Internet, in line with customer requirements (for example, provider claims status inquiry, provider directory and some wellness tools). However, any application that contains private information is secured and requires appropriate credentials. Regardless, UnitedHealthcare's internal applications, including those used for account administration, are not accessible via the open Internet. Information on our password access control policy is available upon request.

Security controls are established for system, application and data layers based upon functional roles and responsibilities being performed (Role Based Access Control or "RBAC"). For new users, supervisors request access for subordinates through our automated Security Access Tracking System (SATS), choosing a pre-defined role. That translates into a role-based security profile in our systems to ensure that users have access to only the functions and information needed to complete their work. Roles are regularly monitored and audited as part of our ICQs for SOX compliance.

We use secure file transfer protocol (SFTP) for all transaction/data files into and out of our HIPAA Gateway. We also have secure e-mail capabilities when communicating with our state partners.

59. Who is the key individual in your organization leading efforts to comply with HIPAA's administrative simplification rules? Please identify that individual by name and title and identify the placement (level) of this individual within your organization.

UnitedHealthcare's Chief Information Officer, Les A. Sowa, is the key individual leading the company's efforts to comply with HIPAA administrative simplification mandates. Mr. Sowa reports to Dr. John Blank, the Chief Operational Officer. For HIPAA privacy matters, Mr. Sowa collaborates with the Privacy Officer, Paul E. Sturm, and with Lee deBruin, Segment Information Security Officer, for security matters.

60. Please identify any HIPAA accreditation your company has received or applied for or intends to apply for. If you have not yet applied for accreditation, when do you expect to? For what level of accreditation?

At this time, UnitedHealthcare has no initiatives underway to obtain formal 'certification' with respect to the HIPAA Security Rule, Privacy Rule or Transaction and Code Sets. As part of our ongoing HIPAA Security program enhancement and maturation, we are considering different alternatives for certification (for example, HITRUST).

Electronic Data Interchange and Medical Data Code Sets

61. Does your computer system have the ability to receive a HIPAA X12 electronic transmission? Does your computer system have the ability to send a HIPAA X12 electronic transmission? How is this accomplished?

Yes, the Facets core processing system fully supports HIPAA X12 electronic transmission formats and has the ability to receive and send these transactions. UnitedHealthcare tightly integrates Facets with TriZetto's HIPAA Gateway translation engine. All incoming and outgoing transactions pass through the HIPAA Gateway which receives, edits, and reformats incoming data for Facets, and accepts outbound transactions from Facets which it reformats into HIPAA-compliant X12 format and sends to trading partners.

62. How do you handle non-HIPAA compliant transactions and their rejection?

The HIPAA Gateway translation engine detects non-compliant transactions through its extensive editing processes and returns the entire transmission file to the submitter with the appropriate error information. We follow the standard HIPAA guideline edits and return a standard 997 acknowledgement/response file. The 997 indicates if (1) all occurrences of a transaction were accepted or (2) if one or more were rejected, it identifies the segment(s) and element(s) in error.

63. Is your system capable of handling attachments of another standard format (e.g., HL7) within a HIPAA compliant X12 transaction?

UnitedHealthcare's systems do not currently support receipt of attachments within HIPAA-compliant X12 transactions, but we can work with the Board to understand and satisfy the requirements.

64. What front-end editing capabilities are implemented in your system to ensure valid HIPAA transactions?

The HIPAA Gateway software fully edits each incoming transaction to determine compliance with HIPAA. Additionally, after the HIPAA validation, each claim is pre-edited before adjudication to verify the Member's and servicing provider's IDs. If either of these IDs is invalid, the claim is rejected for adjudication, and notification is sent to the originating provider, noting the error. Claims passing these edits are loaded into our core transaction system, Facets, where they are adjudicated and processed for payment.

65. Indicate which HIPAA EDI transaction standards, based on the Implementation Guides, your system supports.

Our systems currently support mandated HIPAA Electronic Transmission Standards, 4010A1, as defined in the associated HIPAA Implementation Guides.

Privacy and Security Standards

66. What privacy policies or procedures are currently in place?

UnitedHealthcare maintains comprehensive policies and procedures that govern privacy and security. The following table summarizes policies within Security and Privacy subcategories, found on our Shared Policy and Resource Knowledgebase (SPARK) Policy Center. Each policy is supported and administered through numerous procedures that are documented and applied throughout the organization as appropriate to specific functions. Additionally, every employee in our organization is required to complete an annual privacy and security training and certification process. Employees, newly hired or long term, undergo Computer Based Training in cultural competency, integrity and compliance via our web-based training tool, LearnWell.

Policy Subcategory	Policy Title
Information Security	Access Control Policy
Information Security	Application Development Policy
Information Security	Business Continuity and Disaster Recovery Policy
Information Security	Communications Management Policy
Information Security	Network Security Policy
Information Security	Operations Management Policy
Information Security	Personnel Security Policy
Information Security	Physical Security Policy
Information Security	Risk Management Policy
Information Security	Security Management Policy
Information Security	Security Monitoring and Response Policy
Information Security	Third Party Security Policy
Privacy	Information Security and Privacy Incident Response and Communications Policy
Privacy	Privacy Practices
Privacy	Protecting Information Assets & Confidential Information
Privacy	UnitedHealth Group Personal Information and Data Protection
Information Security	Application Development Policy

67. Are employees required to sign confidentiality agreements?

Yes, all employees are required to sign confidentiality agreements at the time of hire. These agreements clearly define the employee's requirements with respect to confidentiality, including adherence to HIPAA privacy rules and handling of protected health information. The confidentiality agreement also clearly defines sanctions should confidentiality be violated. Additionally; as previously stated, employees complete mandatory HIPAA privacy training upon hire and annually, thereafter.

68. Do you have a Contract and procedures manual for each staff position?

We do not anticipate that any employees working on the MS CHIP project will have a Contract. However, UnitedHealthcare maintains standard job descriptions and training for specific job functions (for example, claims processors must complete a nine-week training program to ensure payment accuracy when manually adjudicating or adjusting claims). We will provide workflows, job descriptions and training programs for each MS CHIP position and employees will receive our comprehensive HIPAA, ethics, integrity, and Medicaid training, in addition to job-specific training.

69. Do you have any subcontractors that will handle the Benefit Plan's PHI? Does your Contract with those subcontractors contain privacy provisions?

Yes, we anticipate that the following subcontractors, who are all UnitedHealthcare-related companies, may handle protected health information (PHI) in their delivery of services to Members, or use of Member data:

- ACN Group, Inc.
- United Behavioral Health (UBH)
- Dental Benefit Providers, Inc. (DBP)
- Ingenix, Inc.
- Prescription Solutions, Inc.
- Spectera, Inc.
- NurseLine℠.

Since all subcontractors are UnitedHealthcare sister entities, their employees are subject to the same rigorous training and performance requirements that govern UnitedHealthcare. We can, therefore, ensure that they are fully compliant with HIPAA requirements and the management and protection of PHI. Further, to define and enforce performance requirements, including privacy provisions, we execute an Administrative Services Agreement (ASA) with each entity that specifically defines the role, responsibilities, and requirements that the subcontracting organization must meet. Additionally, to further secure protected health information, we execute HIPAA Business Associate agreements with each company, specifying, in detail, the mandated privacy requirements.

70. When an entity (e.g., providers) or an individual make an inquiry to the Contractor about an individual's eligibility for benefits, how is the inquiry handled?

i. What information is transmitted and how is it recorded?

ii. Who responds to the inquiry?

Eligibility inquiries may originate from several sources including the Interactive Voice Response (IVR) system, the provider web portal, and telephone inquiries to the Call Center. All eligibility inquiries use the Facets database as the single source-of-truth for Member enrollment information.

Automated Inquiries: The system manages automated inquiries according to the security and formatting requirements configured for each customer and type of inquiry. The system maintains an audit trail for each transaction by creating a record in an SQL Server database that an inquiry was made, the date it was made, and who made the inquiry. This feature enables system-wide logging and tracking of transactions with traceability to the source. The information returned in each response is governed by the information access privileges/restrictions defined for the inquirer and the data content limitations/requirements of the transaction format. We provide the information shown in the following table.

Data Furnished for Provider Web Portal Inquiries	Data Furnished for IVR Inquiries
Subscriber Information ■ Name ■ Member ID ■ Birth Date ■ Gender ■ Plan Sponsor ■ Group ■ Address ■ City, State and ZIP Code **Patient Information** ■ Name ■ Benefit Begin Date	**Patient Information** ■ Name ■ Address ■ City, State and ZIP Code ■ Telephone Number ■ Benefit Begin Date ■ Benefit End Date ■ Group Name ■ Plan ■ Birth Date ■ Gender ■ Relationship ■ Primary Care Physician (PCP)

Data Furnished for Provider Web Portal Inquiries	Data Furnished for IVR Inquiries
▪ Benefit End Date ▪ Plan ▪ Birth Date ▪ Gender ▪ Relationship ▪ Primary Care Physician (PCP) ▪ PCP Telephone Number ▪ Other Insurance **Benefit Summaries** **Benefit Plan Information** **Benefit Maximums**	▪ PCP Telephone Number **Coverages** **Copays** **Deductibles** **Out of Pocket Maximums**

Telephone Inquiries: Telephone eligibility inquiries received in the Call Center are answered by trained Customer Services Representatives (CSR). These individuals receive extensive job training in use of UnitedHealthcare systems, program eligibility requirements, use of telephone equipment and software, telephone etiquette, and HIPAA and other applicable privacy and security requirements. CSRs log all inquiries in MACESS, our document imaging, workflow and call tracking system. MACESS allows us to capture, track, manage and monitor provider (and Member) inquiries. Customer Services Representatives document all calls, including eligibility inquiries, in MACESS and record extensive information including date, time, Provider ID, Member ID, type of information requested, and call resolution status (that is, resolved, open, referred, etc.). CSRs are highly trained in determining what information can be released and strictly adhere to the "minimum necessary" rule. Information conveyed for an eligibility inquiry would include confirmation of program/benefit eligibility and eligibility dates, and the information listed in the table above, as appropriate for the question(s) asked. The MACESS system enables full tracking and recall of information concerning any inquiry received in the Call Center.

71. Does your system presently meet requirements in the privacy regulations issued pursuant to HIPAA?

Yes, UnitedHealthcare fully satisfies the overall requirements of the HIPAA Privacy Rule and continuously monitors our compliance against those regulations.

72. Does your system produce sufficient audit trails to satisfy the HIPAA privacy and security regulations?

Yes, for all UnitedHealthcare information technology systems containing confidential or protected Information, logs are always activated and monitored on a regular basis to ensure individual accountability and to enable incidents to be investigated and resolved. Specific retention periods are determined by the criticality of the application. Audit trail logs are active at all times and protected from unauthorized access, modification or destruction. We maintain formal documentation that describes these monitoring activities as part of the *UnitedHealth Group – Policies – Information Security, June 2008* manual, Section 06_0, Security Monitoring and Response Policy. Upon request, we will make this highly-confidential document available for review by the Board.

73. Has there been any assessment of the various security levels currently available and their compatibility with the HIPAA security standards?

Yes, the accounting firms of Ernst & Young and Deloitte & Touche perform ongoing Sarbanes Oxley (SOX) audits that include tests of our IT controls.

74. Have you conducted an analysis of the risks and vulnerabilities to protected health information in your system?

Yes, risk and vulnerability assessments of UnitedHealthcare's network environment and applications are performed on a regular basis. Assessment results are analyzed and any identified issues are prioritized and remediated based on risk level. We maintain formal documentation that defines our risk management policies for information security (*UnitedHealth Group - Policies - Information Security, June 2008*, Section 02.2 Risk Assessments) and our Vulnerability Management Program (*UnitedHealth Group – Vulnerability Management – Vulnerability Management Program Overview, August 2008*). The Information Risk Management organization executed the most recent network vulnerability scan during the week of March 6, 2009. Upon request, we will make these highly-confidential documents available for review by the Board.

75. Does your system presently meet requirements in the regulations issued pursuant to HIPAA security standards? If not, have you identified areas in which your system does not meet the proposed standards?

Yes, UnitedHealthcare fully satisfies the overall requirements of the HIPAA Security Rule and continuously monitors our compliance against those regulations and standards.

Reporting Capabilities

76. Please review the desired reports listed in **Sections** 11.4 of this RFP. Can your organization provide the desired reports included?

If you are unable to routinely produce any of the desired data elements, please identify which ones in your response. If you produce standard reports that meet the desired report requirements, please attach a copy of the sample reports as **Exhibit H** to your proposal.

UnitedHealthcare has reviewed the reporting requirements in Section 11.4 of this RFP. The following table summarizes our ability to produce these reports and shows the report requirement, confirmation that our systems have the capabilities to produce each type of report, any data elements that are not currently reported, and the name of the report as provided in Exhibit H. While our reports do not allow a one-to-one correspondence with the requested reports, our systems capture and can make available all required data elements in the structures and formats desired, as validated by our Reporting Analyst. The reports listed below and submitted as samples are representative of the wide range of information reporting that we support and attest to our capability to satisfy our customers' comprehensive reporting requirements. We provide more than 2,000 operational reports throughout our systems.

Many of our reports contain multiple views of the same data, the data may be grouped or aggregated differently to create different views, and some reports may have a Summary Tab, as well as additional detail tabs. Therefore, the same report may appear multiple times in response to multiple requirements. In addition, our reports are generally developed to allow a user to enter the desired date range, as well as many other report run parameters, as needed for a specific request.

Reporting Requirement	Available (Y/N)	Data Elements Not Provided	Report Name (Exhibit H)
a. Executive management report	Yes	All specified data elements can be provided, with the exception of co-payments which is available and could be added to the report.	CM Inpatient Facility Cost Analysis/Admissions by Business Segment
b. Inpatient utilization report	Yes	All specified data elements can be provided, with the exception of Ineligible Charges which is available and could be added to the report..	CM Inpatient Facility Cost Analysis/Admissions by Type
c. Outpatient utilization report	Yes	All specified data elements can be provided.	Utilization Summary/Utilization Line Cost Drilldown

Reporting Requirement	Available (Y/N)	Data Elements Not Provided	Report Name (Exhibit H)
d. Prescription drug utilization report	Yes	All specified data elements can be provided with the exception of Total Charges and Ineligible Charges which are available and could be added to the report.	Pharmacy Summary – Employer Prescription Claims Summary/G-MS-SS
e. High amount claimant report	Yes	All specified data elements can be provided.	Catastrophic Members – Medical Drug Aggregate
f. Network and nonparticipating provider utilization reports	Yes	All specified data elements can be provided, with the exception of co-payments which is available and could be added to the report.	Employer Provider Utilization
g. Paid medical claims by major diagnostic category	Yes	All specified data elements can be provided.	CM Inpatient Facility Cost Analysis/by MDC View – available for Inpatient DRG
h. Prescription claims paid by therapeutic categories/list of top 25 dispensed drugs	Yes	All specified data elements can be provided.	Pharmacy Summary/ Drug Class Utilization w/Chart
i. Annual and monthly claims lag report	Yes	All specified data elements can be provided.	Claim Lag Demo
j. Utilization management activity report	Yes	All specified data elements can be provided, except that this report does not show inpatient authorizations by Type.	Member Utilization. Referral Approvals & Denials Home Health Care Analysis – Referrals With Cost
k. Disease management program activity report	Yes	All specified data elements can be provided.	Case Management Utilization Management Service Groups Demo
l. Triage program activity report	Yes	All specified data elements can be provided.	NurseLine Outcomes Report NurseLine Utilization Report
m. Other standard reports	Yes	UnitedHealthcare systems produce a broad variety of additional standard reports to satisfy diverse user needs. The Report Inventory submitted in Exhibit I lists the more than 2,000 available reports.	Not Applicable

During the contract implementation period, UnitedHealthcare technical staff and business analysts will collaborate with the Board to review and select the appropriate standard reports, determine required modifications, develop an approach for generating any reports/data elements not currently produced and schedule report production according to state requirements.

77. Please explain how you will determine or count the number of claims for reporting purposes.

Counted claims are those that successfully pass front-end edits, receive a Document Control Number, and enter the Facets system. UnitedHealthcare performs rigorous automated front-end editing for all incoming claims and encounters to verify submitter validity, format, and data content/integrity. Prior to loading into Facets, the system applies automated edits to claims for formats and specific content rules such as presence of valid provider/Member IDs, valid birth year, and dollar amounts. Claims that do not pass these edits are returned to the provider and do not enter the system to be included in claims counts. These "up front" measures ultimately ensure the completeness and accuracy of claims/encounters received, the adjudication process, data transmissions of encounters to DOM, and reporting.

The claims receipt, editing, adjudication, and payment processes also include extensive balancing and reporting controls that immediately identify potential discrepancies and maintain the integrity of our claims statistics. We produce a variety of Crystal and Business Objects reports that are made available to our Operations and Claims management teams for review of claims for completeness and accuracy of data.

78. Other than the standard claim report information listed in **Section 11.4.1**, list and describe any other claim/management reports you are able to provide regularly at no additional charge and the frequency with which this information can be provided. Would you be able to provide these reports by the subgroups identified in **Section 11.4.1**? Attach samples of each report as an **Exhibit I** to your proposal.

As previously stated, UnitedHealthcare produces more than 2,000 standard reports. Our comprehensive data warehouse and sophisticated reporting tools enable us to meet virtually any reporting requirement. Our reports are designed to provide maximum flexibility and choice for the user so that customization for individual needs can occur through an interactive selection process and without the need for intervention by technical resources. Our robust reporting capabilities allow reports to be easily configured to meet specific requirements using powerful features such as:

- Summary and detail tabs
- User-defined date range for production
- User-furnished selection parameters
- Multiple views showing data in various groupings
- Ranking and filtering parameters within the report
- Summary reports that have associated drilldown reports
- Multiple sorting and aggregation options.

As an example, the Member Utilization Report, provided as Exhibit H in Section 6, Required Exhibits, provides a year-to-date and rolling 12-month statistical report. This report will show statistical information by month for a 12-month period. The information provided for each month includes Admits, Discharges, Discharge Days, Admits/1000, Discharges/1000, Days/1000 and Average Length-of-Stay. The user can customize this report using any or all of the following prompts:

- End Date
- Member Line Of Business
- Super Group
- Employer Group(s)
- Risk Pool
- Op Site - Defined by the risk pools associated with that Op Site.
- Place of Service
- Facility.

Thus, a single report may satisfy dozens of individual reporting requirements.

UnitedHealthcare is confident that we can meet and exceed the Board's reporting requirements. To further illustrate our extensive reporting capability, we have selected six additional reports for Board review; these reports are listed below and have been provided as Exhibit I in Section 6, Required Exhibits:

- **Case Management EPSDT Demo**—provides Case Management EPSDT data and has a Detail Tab and a Summary. Tab. The report can be configured through the following prompts:
  - Service Dates based on Case Begin and Case End Dates
  - Member Line of Business
  - Employer Group
  - Member Risk Pool
  - Ops site Code-Defined by the risk Pools associated with the Op Site
  - Case Manager ID
  - Supergroup ID
  - Member Key
  - User Name.
- **Electronic vs. Paper Receive Rates: Level 2**—shows the receive rate percentages of electronic versus paper for providers. Selection criteria include beginning and ending dates, Provider ID, and Provider Tax ID.
- **Employer Provider Utilization Summary**—may be used to provide a summary of Hospital, Medical and Pharmacy utilization for the selected Employer Groups(s). The data is summarized at the provider level. User selection parameters include Service Begin and End Dates, Payment Begin and End Dates, Supergroup, Employer Group and Client ID.
- **MACESS Monthly Summary Report**—provides a count for specific categories and broad categories and includes sections for Satisfaction Level, Caller Type, and Benefit Type. User selection parameters include:
  - Start and End Dates
  - Op Site(s)
  - Caller Type(s)
  - Employer Group(s)
  - Contact Method(s)
  - Satisfaction Level(s)
  - Department Number(s)
  - Supergroup ID(s)
  - HMO Indicator.
- **Provider Ranking Report**—is a production report for a UnitedHealthcare client and is designed to assist in targeting suspected providers for potential Audit Selection. User selection parameters include:
  - First and Last Service Dates
  - First and Last Payment Date
  - Last Payment Dates
  - Specialty Code
  - Provider Type
  - Ops Region
  - Ops Area
  - Provider Risk Pool.
- **Call Count Summary**—provides a count of calls by State, Member Line of Business, Originating Department or OP Site. This report also features multiple user selection criteria.

Additionally, we are able to provide any reports identified by the Board in the sub-groupings specified in RFP Section 11.4.1, provided enrollment data is supplied with identifying sub-group data. We will configure existing reports during the implementation process to achieve the desired aggregations and totals.

79. Describe your capabilities to produce ad hoc reports. Provide examples of previously prepared ad hoc reports for other clients and associated programming charges. Please identify your ad hoc report fee and the basis for the fee.

UnitedHealthcare recognizes the need for information support that is specialized to key areas of care management, plan operations, and financial indicators. We have the capability to provide reports and data sets for report generation on an ad-hoc basis to the Board. We have a standard and enhanced reporting data warehouse and reporting tools. UnitedHealthcare management has access to our decision support system in a secure, inquiry-only environment, linked to our comprehensive, mirrored data warehouse. This access will allow for real-time reporting and analysis without affecting our core production systems. Role Based Access Control (RBAC) is in place to ensure appropriate access for individuals. Authorized UnitedHealthcare users will have access to integrated MS CHIP data across a variety of reporting domains and subject areas including eligibility, enrollment, claims, utilization and service cost, provider, and other clinical data. Users will have the ability to set a wide variety of reporting parameters within these domains (for example, time period, region, service category, and key Member demographics) and execute the inquiry and resulting ad hoc reports online. This capability will allow UnitedHealthcare management to drill down to analyze clinical indicators and costs among particular subgroups and compare trends over time. UnitedHealthcare is looking forward to coordinating efforts on a methodology for creating and providing ad hoc reports to support the Board's data analysis and general reporting requirements.

Reporting System—The primary source of data for standard and ad hoc reports is our data warehouse, Strategic Management Analytic Reporting Tool (SMART). Statistical computations and final reports will be generated using pre-defined templates built from the Business Objects (BO) and Crystal Reports suite of decision support tools.

UnitedHealthcare's Reporting team supports many standard and ad hoc reporting needs, using our National Queue (NQ) report request application, the data warehouse/data repository, HEDIS reports and the BO/Crystal Reports suite of tools. UnitedHealthcare's MS CHIP management team will be able to request new standard and ad hoc reports through the NQ. They are then able to securely access standard, pre-defined and ad hoc reports through the Reporting Portal. They can also modify variables to some reports and run them on demand to satisfy new or one-time reporting needs. Some pre-defined reports have been established to provide general statistics, while others are specific to the individual health plans. Security, inherent in the Reporting Portal, ensures managers and internal teams only have access to the reports and data to support their current role and function.

Reports will be provided to the Board via Secure FTP, e-mail or secure e-mail, depending on state requirements and the nature of the data within the reports.

Ad hoc Reporting Fee—UnitedHealthcare has historically worked with our customers to respond to reporting requests and satisfy client informational needs. Most reports can be readily produced from the data warehouse and do not require significant resources. For more robust reports that require additional resources UnitedHealthcare charges a blended rate of $78/hour. This rate is based on our existing agreement with our vendor, Cognizant, which provides development support and support with the ad hoc reporting needs of our customers. We will work with the Board to define the level of ad hoc reporting activity necessary to support the MS CHIP program and jointly agree upon the amount of services that can be accommodated without additional charges.

Report Examples—Examples of previously-developed ad hoc reports for clients include the following reports; no additional fees were associated with a producing these reports:

- Claim adjustments by reason codes
- Claims by adjudication date
- Daily adjusted claims
- Maternity claims
- Special pended claims

- Check posting of pended claims
- Procedure code verification
- 1099 miscellaneous report
- High dollar claims report.

Data—Data is fed to the UnitedHealthcare data warehouse from Facets, our core transaction processing systems (claims, eligibility, provider data), CareOne (authorizations and related clinical operations data), and MACESS (Member and provider inquiries). Member risk stratification and scoring is also loaded into our data warehouse, resultant from processing through ImpactPro, a state-of-the-art analytical tool developed and supported by our sister segment, Ingenix. Call statistics (for example, total talk time, time on hold) are generated from our Virtual Call Center database. Data reports also include the HIPAA-compliant transaction files (837 outbound transaction sets for institutional, professional, dental, and vision claims, and NCPDP 5.1 pharmacy claims).

Resources—Our MS CHIP leadership team will have access to, and support from the various technical, financial and reporting teams, ultimately to support the standard and ad hoc reporting needs of the Board and to satisfy our contractual agreement. Our UnitedHealthcare Reporting Team is dedicated to support our various health plans' reporting needs and has access to data from our data warehouse and other data processing mechanisms, as well as innovative reporting tools and approaches, like our Reporting Portals, National Queue User Report Request System, and SMART data warehouse/data analytics and reporting system, to further support state reporting needs.

80. Do you currently offer a data management and analysis system (similar to Thompson Reuters (Healthcare), Inc.) to any of your clients? If so, please describe the system capabilities and indicate any additional setup issues associated with providing this feature for CHIP.

Yes, UnitedHealthcare offers data management capabilities that are comparable to Thompson Reuters (Healthcare), Inc. Our data management systems are built on our data warehouse, SMART. The data warehouse is populated with information from our core systems which themselves produce a multitude of standard reports. The data warehouse enables overall reporting and provides a longitudinal and comprehensive view of all key operating metrics of our health plan operation.

The SMART Data Warehouse is an analytics system for enhanced reporting for predictive care models, episodes of care, claims lag, utilization, unit costs, provider profiling, Member retention and other analytical capabilities. It is a multi-dimensional data warehouse that collects information from the various operational systems on a daily, weekly and monthly basis; depending on the data source. Information stored in this warehouse includes geographic, line of business, service category, product data; Member and provider demographics, provider contracts; revenue capitation data by rate cell; claims/encounters for each service category; appeals; service authorizations by day, diagnosis and level of care; actuarial reserving completion factors; and disease management categorizations and risk stratification scores by Member.

SMART is integrated with key systems and tools that, together, enable program and budget performance evaluation, fraud and abuse investigation, management of special populations, and legislative and policy development support activities. The following table summarizes these tools and their capabilities. UnitedHealthcare does not anticipate any significant setup issues associated with providing these products for the MS CHIP program.

Product	Use	Capabilities
CareOne	Care/case/disease management of special/target populations	Our proprietary clinical platform, CareOne, supports disease, case and utilization management. UnitedHealthcare designed CareOne, a sophisticated electronic care management system that includes clinical decision pathways and uses assessment information to create individualized treatment plans based on the participant's health care needs and goals. CareOne is a robust care management application that integrates evidence-based guidelines and clinical data, including data generated through ImpactPro (see below) and the comprehensive assessments performed by our care managers. CareOne allows UnitedHealthcare care managers to update and manage care plan records and create care plans, in coordination with the Member/Member's family, primary care provider and any specialist providers, which are objective, measurable, appropriate and achievable. CareOne integrates care, disease and utilization management activities for all physical and behavioral health services and provides automated workflow tasking, reminders and triggering to ensure provider and care management adherence to protocols.
ImpactPro	Member risk stratification and scoring	ImpactPro® is our proprietary, evidenced-based predictive modeling and care management analytics solution. ImpactPro enables us to analyze clinical, risk, and administrative profile information. The Medical Management team uses ImpactPro to support our comprehensive utilization and disease management programs. ImpactPro is a state-of-the-art predictive modeling system that is based on simple, yet core principles. Care managers use ImpactPro to easily identify, profile and stratify plan Members into actionable groups based on one of the industry's leading predictive modeling systems. ImpactPro helps care managers determine which Members require specialized intervention programs and which intervention programs will have the most impact on the quality of Members' health.
Ingenix Detection Software (IDS)	Fraud & Abuse activities	Ingenix® Detection Software (IDS) allows us to identify and scrutinize questionable claims before payments are actually made, and also to conduct detailed post payment reviews. IDS rigorously reviews all post-adjudicated claims before payment. Among other checks, IDS screens for unbundled codes; up-coded, invalid and duplicate codes; code fragmentation; patient age (if CPT code is age specific); patient gender (if the CPT code is gender specific); place of service (must be appropriate to the procedure performed); pre and post operative intervals (days); and modifiers (verify that modifier is billed with an appropriate CPT code). IDS also identifies providers who have been flagged, based on factors such as previous suspect billing practices. UnitedHealthcare's Special Investigations Unit (SIU) utilizes IDS as a major component of its Fraud and Abuse detection activities.
Facets Data Warehouse	Statistical reporting	The data warehouse supported by our core processing system, Facets, houses claims, financial, administrative data and reporting applications to enable a broad array of statistical/analytical reporting supporting program management activities.

Disease Management Programs

81. For your proposed asthma disease management (DM) program answer the following questions:

i. Length of time program has been in effect.

We have been providing an asthma disease management (DM) program since 1982, when UnitedHealthcare was first established. We have focused on optimizing the health and well-being of Members with chronic illnesses and at high risk for adverse medical outcomes. The program continues to improve with clinical and technology advances.

ii. Number of individuals participating in the program.

We estimate that over 55,000 participates are served through our asthma DM programs in 23 health plans covering 2.3 million lives in 22 states. We are unable to provide an exact number of individuals participating in the asthma DM program due to the fluctuation of enrollment in the programs and characteristics of our Members.

iii. Is any aspect of the disease management program Subcontracted? If so list the name of the Subcontractor and the services provided.

No, we do not anticipate subcontracting any aspect of our asthma DM program.

iv. Source of data used to identify individuals with this disease.

We use retrospective and prospective methods to ensure potential Members are identified as early as possible. Prospectively we conduct a brief Health Risk Assessment (HRA) during new Member calls and assign risk scores to stratify Members for DM interventions. We also continuously forecast risk through predictive modeling of our claims data. Our multi-dimensional, episode-based predictive modeling tool, Impact Pro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services. We supplement these primary data sources with additional sources including, but not limited to:

- Member reported health needs in calls made to our Member Services Department
- Pharmacy and lab data indicating the incidence of a specific condition (for example, inhalers)
- Emergency room utilization reports, hospital census reports, authorization requests and transitional care coordination requests
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare clinical staff referrals.

v. Outline how your DM program operates.

UnitedHealthcare DM programs are part of our innovative Care Management Program. Our Care Management (CM) program is guided by the principles of the UnitedHealthcare Personal Care Model. We developed the Personal Care Model to address the needs of medically underserved and low-income populations. We have successfully implemented the Personal Care Model for CHIP Members in 17 states. The Personal Care Model emphasizes the whole individual, including environment, background and culture.

Identifications and Stratification

As described above, the HRA and ImpactPro are primary tools for identifying Members for the asthma disease management program.

Health Risk Assessment.

Health Risk Assessments are scored to determine risk. Members assessed to have a HRA score greater than 4.73 are stratified as high risk, while Members assessed to have a HRA score less than 4.73 are stratified as low to moderate risk. HRAs are stores in our CareOne System which prompts Care Managers when a Member's data shows non-compliance with asthma clinical practice guidelines.

ImpactPro

Our multi-dimensional, episode-based predictive modeling tool, Impact Pro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

On a monthly basis, Impact Pro uses algorithms to identify Members for disease management and stratify them into risk levels by severity of disease and associated co-morbidities. For asthma, the algorithm takes into consideration inpatient and emergency room (ER) use. An "Overall Future Risk Score" is assigned to each Member based on the Impact Pro algorithm and represents the degree to which the asthma DM program has the opportunity to impact Members' health status and clinical outcomes This assists Care Managers in identifying Members who are most likely to benefit from interventions.

Impact Pro produces provider letter notifications of Members who have generated care opportunities related to the asthma DM program. These evidence-based medical guidelines highlight opportunities for improving care. Impact Pro also produces reports that identify for providers their at-risk Members and all missed care opportunities. These reports can be accessed online through our secure provider portal.

Outreach and other Identification Processes

While HRAs and retrospective data are the first line of identification of new Members in the UnitedHealthcare DM programs, we have developed an extensive outreach program that supports real-time identification and referral for our asthma DM services. Through community partnerships and relationships, our staff encourages and educates providers, ER staff, and hospital discharge planners to refer program Members for a greater intensity and frequency of asthma DM interventions when the situation requires it.

We supplement the HRA and ImpactPro identification process through several other methods. One of these approaches is an extensive outreach program that supports real-time identification and referral for our asthma DM services. Our staff encourages and educates providers, ER staff, and hospital discharge planners to refer program Members for a greater intensity and frequency of asthma DM interventions when the situation requires it. We also rely on partnering programs and agencies to identify those Members most at need. Our DM staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities in order to identify Members. Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the DM software system. This data provides real-time identification of Members experiencing health care barriers and self-care deficits.

DM Interventions

After a Member has been identified, the asthma Care Manager contacts the Member's parent or caregiver by telephone and sends program and health education materials targeted to the Member's specific care opportunities. The accompanying letter informs the Member's parent or caregiver on how to use the asthma DM services, how the Member became eligible to participate in the asthma program and how to opt out if they do not wish to participate.

Because our DM program provides benefits and quality-of-life improvements that ultimately impact the overall costs in care, our enrollment staff makes every attempt to enroll Members in the asthma DM program. We employ a number of strategies to locate and contact the Member's parents or caregivers, including after hours calls, searching for updated Member information by contacting the PCP/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to ensure that all options have been exhausted prior to reporting failure to contact.

Once a Member agrees to enroll in the asthma DM program, the Care Manager performs a comprehensive pediatric asthma health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of Members.

We have developed evidence-based interventions for our asthma DM program. The following general interventions have been structured to improve Members' health status.

- Health risk assessment
- Health review phone calls
- Provide assigned Care Manager's phone number to the Member/family
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program website
- Episodic educational interventions, as needed
- Post hospitalization and emergency room assessment
- Educational materials are sent to Member
- Letter is sent to the provider identifying the Member's involvement, intervention and point of contact for the asthma DM program.

Additional asthma specific interventions are also conducted. An asthma DM program participant may experience the following disease specific interventions:

- Assessment of the Member's weight and compliance with daily monitoring
- Evaluation of the Member's need for oxygen during increased activity
- Assessment of the Member's knowledge of causes, treatment, and follow-up care related to asthma
- Teaching Member to monitor and control environment for possible allergens
- Demonstration of the effective use of bronchodilator
- Discussion of effective coughing techniques
- Information on the importance of knowing and understanding ABGs pulse ox and pulmonary function tests
- Advisement of the Member to premedicate with bronchodialators before doing deep-breathing and coughing exercises.

Plan of Care

All of our DM programs are part of Personal Care Model™ our overall care management program, in which we pioneered a Member-centric approach to the development of the plan of care for program participants. Our unique Personal Care Model™ features direct Member, parent and caregiver contact by clinical staff who work to build a support network for high risk chronically and acutely ill Members involving family, providers, and community-based organizations. The goal is to employ practical solutions to improve Members' health and keep them in their communities with the resources they need to maintain the highest possible functional status.

The goals of the plan of care implementation are two-fold: 1) Care Manager interventions support self-management/ self-efficacy and patient education; and 2) Care Manager interventions are defined to ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the Member is connected with available and appropriate community support groups, for example, nutrition programs or caregiver support services. When the plan of care is implemented, our goals are:

- To assure the Member is leveraging personal, family, and community strengths when able
- To ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities
- To modify our approach or services based on the feedback from the Member, family, and other health care team Members
- To document services and outcomes in a way that can be captured and modified in order to continually improve
- To communicate effectively with the primary care provider/specialist and other providers involved in the Member's care
- To monitor Member satisfaction with services, adjusting as needed.

The Care Manager develops and implements an individualized plan of care for Members requiring services, reviews the Member's progress and adjusts the plan of care, as necessary, to ensure that the Member continues to receive an appropriate level of care. The Care Manager will involve the PCP/specialist in the plan of care development process and assist them in directing the course of treatment in accordance with the evidence-based clinical guidelines that support our DM Program. The plan of care addresses the following areas of care:

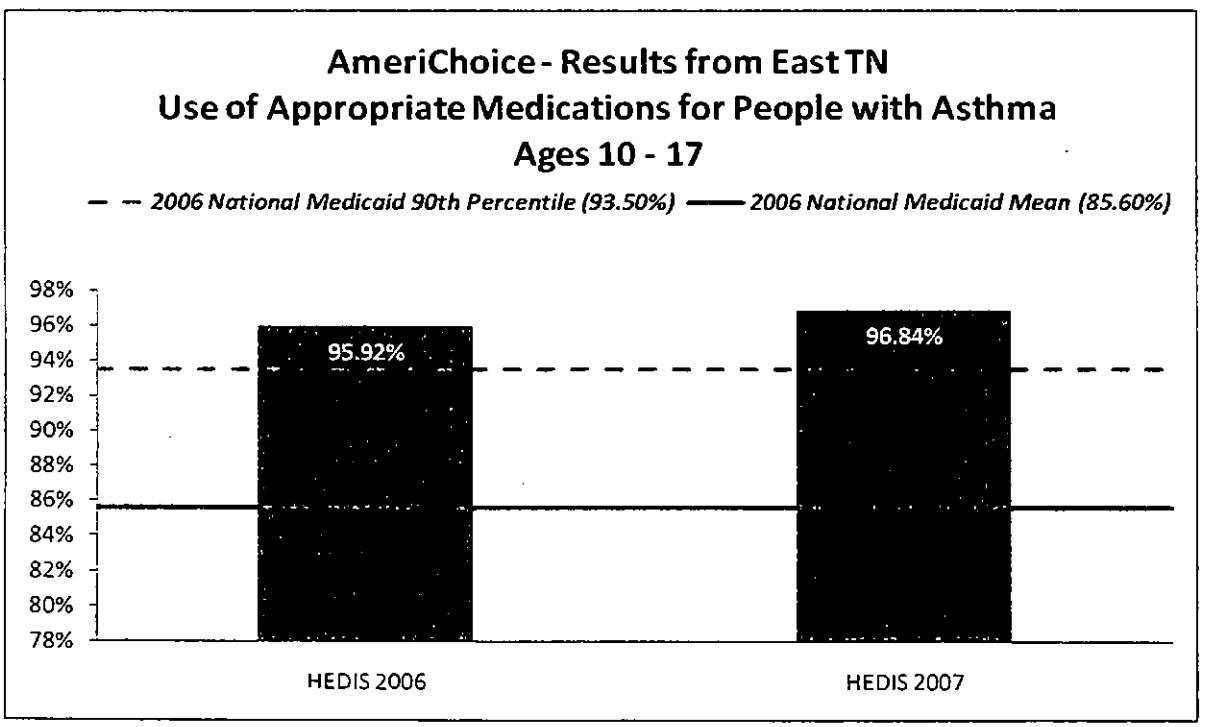
- Psychosocial adjustment
- Nutrition
- Complications
- Pulmonary/ Cardiac rehab
- Medication
- Prevention
- Self-monitoring, symptoms and vital signs
- Emergency management/co-morbid condition action plan
- Appropriate health care utilization.

vi. Percent of patients identified for disease management that are likely to comply with your care recommendations.

The level of compliance with our disease management program varies significantly from program to program. Presently, approximately 55 percent of asthma patients are likely to comply with our care recommendations. Program variability is linked to program maturity, member turnover, provider engagement and other factors.

vii. What is the most effective behavior change you have achieved through your DM program?

UnitedHealthcare has a long history of successful engagement with our Members in our asthma DM program Our innovative outreach and educational efforts have significantly changed the behaviors of our Members. For example, in Eastern Tennessee, our asthma program significantly increased the rate of appropriate use of medications for our TENNderCare Members with asthma aged 10-17 years. Our HEDIS measure for Use of Appropriate Medications for People with Asthma increased from 58 percent in 2000 to 96.4 percent in 2007. Our measures exceeded the 95th percentile for 2006 and 2007 as illustrated in the chart below.



viii. Discuss the qualifications of your staff who perform the actual DM services.

Our asthma DM program services are primarily performed by Care Managers who are licensed registered nurses, including managers trained in pediatric asthma. They are supported by a team of Medical Directors who are licensed physicians, Social Workers with MSW or BSW degrees, licensed Pharmacists, Quality Managers, Health Educators and Information Systems personnel. In general, these professionals have a minimum of three to five years of experience. Administrative staff supports all functions in the asthma DM program. A comprehensive orientation is provided to all DM program staff. This includes several weeks of structured classroom training as well as on-the-job training using experienced preceptors. Training topics include but are not limited to:

- Role of the Clinician in Disease Management
- Motivational Interviewing
- Critical Thinking
- Milliman Overview
- Applying Guidelines
- Desktops, Milliman Workflows and Templates
- CareOne Software System
- Cultural Competency
- Diversity Training
- Ethics and Integrity.

Dedicated regional staff is also available to assist in the training. A standardized schedule and list of functions is provided to each employee at the start of their employment. Staff is also encouraged to participate in external educational programs and conferences to maintain their competency in the subject matter. A formal Medical Director Training Program is provided to new Medical Directors. In addition, on an as needed basis, Medical Directors receive one-on-one training sessions with other experienced Medical Directors and are encouraged to participate in regular Continuing Medical Education programs.

ix. Savings you typically see per patient for this disease.

The savings estimated for our asthma DM programs varies based upon the characteristics of the population and design benefits of the overall programs. On average, our asthma DM programs have reduced medical cost by 4.2 percent, reduced inpatient hospital admissions per 1,000 of 7.3 percent and reduced emergency room visits per 1,000 of 7 percent.

Our methodology for measuring disease management cost savings ranks among the health field's most valid methodologies, and reflects the most accurate means of determining savings and/or return on investment. Our disease management measurement approach focuses on four distinct domains of value. While not completely independent of each other, they are views of different aspects of value. Together, these domains provide a holistic perspective of the value of our services:

- Medical cost savings shows the impact of the program on health care expenditures
- Health care utilization supports the causality link between programs and cost saving
- Clinical improvement demonstrates the effect of the program on improved patient and physician adherence to evidence based medicine (EBM), which can prevent conditions from worsening which can avert future high cost health care expenses and deteriorating function
- Member satisfaction reflects the population's willingness to engage in the care management process which, in turn, can result in individuals taking a more active role in making decisions that affect their health and use of services.

A pre-post design with trend adjustment is used to measure the medical cost savings of our disease management programs. This methodology identifies savings at a population level.

x. Do you propose any changes to your DM program to better address the needs of the CHIP population?

Because UnitedHealthcare currently provides DM services for CHIP Members in 17 states, our asthma DM program includes a pediatric component to address the needs of the CHIP population. We are conducting a number of quality improvement activities to improve our asthma DM programs and their outcomes. We are piloting targeted outreach calls to asthma DM participants through the year to remind our asthmatic Members of the importance of medication adherence. In Pennsylvania, we are piloting an expansion to our education and outreach activities by partnering with the Center for Healthy Hearts & Souls, a faith-based community organization that interfaces with 65 churches with minority-based congregations. Healthy Hearts & Souls is able to educate not only our Members, but the community at large about the importance of medication adherence and establishing a relationship with a primary care provider. Based on the successes of these types of activities, we may be incorporating them into our DM program to better address the needs of the MS CHIP population.

Encouraging Members to make lifestyle changes to improve their health is a challenge that is often best met by coordinating the efforts of multiple resources. to improve their health is a challenge that is often best met by coordinating the efforts of multiple resources. We have found that working with community based and faith based organizations, schools, and advocacy groups helps to reinforce educational efforts to assist Members and families in learning and adapting better health behaviors. In Mississippi, we have identified and begun discussions with over 50 of these organizations and we plan to develop more of these resources as we work to improve health outcomes in the State. Examples of MS groups that have expressed an interest in working with us include The Faith Based Coalition, the Urban League of Greater Jackson, and MS Friends of Children. On March 5, 2009, we attended a meeting at the MS Primary Health Care Association where we were able to visit with leaders from the FQHCs in the state. This leadership is very open to working with us to increase health education opportunities in their communities

82. For your proposed diabetes disease management (DM), answer the following questions:

i. Length of time program has been in effect.

We have been providing a diabetes DM program since 1982, when UnitedHealthcare was first established, although the program has evolved with medical and technology advances. We have always focused on optimizing the health and well-being of Members with chronic illnesses and those at high risk for adverse medical outcomes.

ii. Number of individuals participating in the program.

We estimate that over 65,000 participates are served through our diabetes DM programs in 23 health plans covering 2.3 million lives in 22 states. We are unable to provide an exact number of individuals participating in the diabetes DM program due to the fluctuation of enrollment in the programs and characteristics of our Members.

iii. Is any aspect of the disease management program Subcontracted? If so list the name of the Subcontractor and the services provided.

No, we do not anticipate subcontracting any aspect of our diabetes DM program.

iv. Source of data used to identify individuals with this disease.

We use retrospective and prospective methods to ensure potential Members are identified as early as possible. Prospectively we conduct a brief HRA during new Member calls and assign risk scores to stratify Members for DM interventions. We also continuously forecast risk through predictive modeling of our claims data. Our multi-dimensional, episode-based predictive modeling tool, Impact Pro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services. We supplement these primary data sources with additional sources including, but not limited to:

- Member reported health needs in calls made to our Member Services Department
- Pharmacy and lab data indicating the incidence of a specific condition (for example, inhalers)
- Emergency room utilization reports, hospital census reports, authorization requests and transitional care coordination requests
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare clinical staff referrals.

v. Outline how your DM program operates.

Like the asthma DM program, the diabetes DM program is part of our overall Care Management Program guided by our Personal Care Model. Because we developed the Personal Care Model to address the needs of medically underserved and low-income populations, we have successfully implemented the Personal Care Model for CHIP Members in 17 states. The Personal Care Model emphasizes the whole individual, including environment, background and culture.

We use retrospective and prospective methods to ensure potential Members are identified as early as possible. Prospectively we conduct a brief HRA during new Member calls and assign risk scores to stratify Members for DM interventions. We also continuously forecast risk through predictive modeling of our claims data. Our multi-dimensional, episode-based predictive modeling tool, Impact Pro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services. We supplement these primary data sources with additional sources including, but not limited to:

- Member reported health needs in calls made to our Member Services Department
- Pharmacy and lab data indicating the incidence of a specific condition (for example, inhalers)
- Emergency room utilization reports, hospital census reports, authorization requests and transitional care coordination requests
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare clinical staff referrals.

DM Interventions

After a Member has been identified, the diabetes Care Manager will contact the Member's parent or caregiver via a telephone call and will send relevant program and health education materials to the Member. The accompanying letter informs the Member's parent or caregiver how to use the diabetes DM services, how the Member became eligible for the program, and how to opt out if they do not wish to participate.

We make every attempt to enroll Members in the diabetes DM program. We employ a number of strategies to locate and contact the Member's parents or caregivers, including after hours calls, searching for updated Member information by contacting the PCP/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to ensure that all options have been exhausted prior to reporting failure to contact.

Once a Member agrees to enroll in the diabetes DM program, the Care Manager performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of Members.

We have developed evidence-based interventions for our diabetes DM program. The following general interventions have been structured to improve Members' health status:

- Health risk assessment
- Health review phone calls
- Provide assigned Care Manager's phone number to the Member/family
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program website
- Episodic educational interventions, as needed
- Post hospitalization and emergency room assessment
- Educational materials are sent to Member
- Letter is sent to the provider identifying the Member's involvement, intervention and point of contact for the diabetes DM program.

Additional diabetes specific interventions are also conducted. A diabetes DM program participant will experience the following disease specific interventions:

- Reinforcement with Member of the importance of not skipping meals or delaying meals
- Education about exercise and its effects on blood glucose levels
- Reinforcement with Member the importance of taking insulin as directed by their primary care provider (PCP) and not to increase dose without the PCP's order
- Instruction on how to assess for signs of hypoglycemia such as cold sweats, weakness, hunger, trembling, nervousness, dizziness, irritability, pallor, fatigue, feeling confused, have a rapid heartbeat
- Education on the importance of taking quick-acting carbohydrate source such as 6-8 oz of orange juice 1 cup of milk, candy, glucose gel or tablets or 6-8 oz soft drink
- Education about the disease process and treatments for diabetic neuropathy such as acupuncture, biofeedback, massage, relaxation training, TENS and medication
- Coordination of an ophthalmology and dental appointments for Members
- Education of Member to contact their PCP if they are having signs and symptoms of eye problems such as blurry vision, eye pain or pressure or if their eyes are red most of the time.
- Instruction on how to take care of feet such as checking for cuts, making sure feet are warm and wearing comfortable shoes
- Counsel on weight loss if appropriate
- Appropriate follow-up and monitoring, such as HbA1C, LDL-C, urine for microalbuminuria, blood pressure and appropriate physical exams (such as retinal exams)
- Appropriate medications/dosages, such as insulin or oral hypoglycemic, blood pressure medications, lipid lowering drugs and beta blockers.

Plan of Care

The goals of the plan of care implementation are two-fold: 1) Care Manager interventions support self-management/ self-efficacy and patient education; and 2) Care Manager interventions are defined to ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the Member is connected with available and appropriate community support groups, for example, nutrition programs or caregiver support services. When the plan of care is implemented, our goals are:

- To assure the Member is leveraging personal, family, and community strengths when able
- To ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities
- To modify our approach or services based on the feedback from the Member, family, and other health care team Members
- To document services and outcomes in a way that can be captured and modified in order to continually improve
- To communicate effectively with the primary care provider/specialist and other providers involved in the Member's care
- To monitor Member satisfaction with services, adjusting as needed.

The Care Manager develops and implements an individualized plan of care for Members requiring services, reviews the Member's progress and adjusts the plan of care, as necessary, to ensure that the Member continues to receive an appropriate level of care. The Care Manager will involve the PCP/specialist in the plan of care development process and assist them in directing the course of treatment in accordance with the evidence-based clinical guidelines that constitute our DM program, including appropriate use of steroid inhalers, peak flow meters and Small Volume Nebulizers.

The POC will address the following areas of care:

- Psychosocial adjustment
- Nutrition
- Complications
- Pulmonary/ Cardiac rehab
- Medication
- Prevention
- Self-monitoring, symptoms and vital signs
- Emergency management/co-morbid condition action plan
- Appropriate health care utilization.

Our DM program is supported by UnitedHealthcare's integrated clinical system; *CareOne* which includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools. *CareOne* serves as the framework within which to share clinical information across clinical domains and departments and to serve as the health plan's virtual medical record, tracking clinical information longitudinally. *CareOne* can produce reports that can be shared with providers to aid in their decision making.

vi. Percent of patients identified for disease management that are likely to comply with your care recommendations.

The level of compliance with our disease management program for diabetes varies significantly from program to program. On average, approximately 70 percent of patients identified for diabetes disease management are likely to comply with our care recommendations.

vii. What is the most effective behavior change you have achieved through your DM program?

During the past 25 years, UnitedHealthcare has gained experience and expertise improving quality of care and performance in specific measures of health care services. Our extensive experience and expertise is illustrated in our overall strength in conducting disease management programs for diabetics. Our results for adult diabetes management have shown continuous and sustained improvement. In our Arizona health plan the measures of adult diabetes management were considerably above average from a national perspective. The HbA1c testing was above the national 75th percentile HEDIS Medicaid rate of 84.1 percent. The HbA1c control measure, for which a decrease indicates improvement, almost reached the HEDIS 90th percentile rate. We attribute our strong performance on the diabetes DM interventions that included improving systems for the early identification of diabetic Members; engaging the care manager, physician and Member in treatment planning; having care managers contact the physician for the results of the HbA1c tests; and reviewing compliance through our pharmacy benefit manager.

viii. Discuss the qualifications of your staff who perform the actual DM services.

In general, these professionals have a minimum of three to five years of experience. Administrative staff supports all functions in the diabetes DM program. A comprehensive orientation is provided to all DM program staff. This includes several weeks of structured classroom training as well as on-the-job training using experienced preceptors. Training topics include but are not limited to:

- Role of the Clinician in Disease Management
- Motivational Interviewing
- Critical Thinking
- Milliman Overview
- Applying Guidelines
- Desktops, Milliman Workflows and Templates
- CareOne Software System

- Cultural Competency
- Diversity Training
- Ethics and Integrity.

Dedicated regional staff is also available to assist in the training. A standardized schedule and list of functions is provided to each employee at the start of their employment. Staff is also encouraged to participate in external educational programs and conferences to maintain their competency in the subject matter. A formal Medical Director Training Program is provided to new Medical Directors. In addition, on an as needed basis, Medical Directors receive one-on-one training sessions with other experienced Medical Directors and are encouraged to participate in regular Continuing Medical Education programs.

ix. Savings you typically see per patient for this disease.

The savings estimated for our diabetes DM programs varies based upon the characteristics of the population and design benefits of the overall programs. On average, our diabetes DM programs have reduced medical cost by 2.0 percent, reduced inpatient hospital admissions per 1,000 of 2.2 percent and reduced emergency room visits per 1,000 of 4.1 percent.

Our methodology for measuring disease management cost savings ranks among the health field's most valid methodologies, and reflects the most accurate means of determining savings and/or return on investment. Our disease management measurement approach focuses on four distinct domains of value. While not completely independent of each other, they are views of different aspects of value. Together, these domains provide a holistic perspective of the value of our services:

- Medical cost savings shows the impact of the program on health care expenditures
- Health care utilization supports the causality link between programs and cost saving
- Clinical improvement demonstrates the effect of the program on improved patient and physician adherence to evidence based medicine (EBM), which can prevent conditions from worsening which can avert future high cost health care expenses and deteriorating function
- Member satisfaction reflects the population's willingness to engage in the care management process which, in turn, can result in individuals taking a more active role in making decisions that affect their health and use of services.

A pre-post design with trend adjustment is used to measure the medical cost savings of our disease management programs. This methodology identifies savings at a population level.

x. Do you propose any changes to your DM program to better address the needs of the CHIP population?

UnitedHealthcare continuously evaluates our DM programs to better address the needs of our Members. We pilot various initiatives to evaluate their potential effectiveness. Two of our innovative pilots have been conducted at our Pennsylvania health plan. We have partnered with a local group to provide in-home physicians services. Frequently Members are in need of a physician's care but are unable to present to their provider's office. We are piloting a program to bring physicians into the Member's home to provide medical care and treatment. We also are piloting mobile phlebotomy services to our Members. The vendor is able to visit Members in their own homes to conduct blood draws for diabetic monitoring. We believe by offering these blood draw services to Members in their own homes, more efficient monitoring will result with better health outcomes. We will be evaluating the mobile phlebotomy services for potential expansion into other community settings such as school-based services. Based on the successes of these programs, we may be incorporating them into our diabetes DM program.

We will work with the American Diabetes Association, County Health Departments, and other Federally Qualified Health Centers (FQHCs), to identify religious congregations, social and civic groups, resident associations, and other community-based organizations hosting health fairs and screening events, such as Blood Pressure monitoring, glucose screenings, and, where possible, the monitoring of BMI. UnitedHealthcare will distribute screening supplies at such events, and our Care Managers will hand out educational material.

Addressing the needs of those with chronic diseases is a challenge that is often best met by coordinating the efforts of multiple resources. Working with community based and faith-based organizations, schools, and advocacy groups helps to reinforce educational efforts to assist Members and families in learning and adapting better health behaviors. Thus, we will collaborate with rural health centers, FQHC, and numerous community based organizations, such as the Jackson Medical Mall, to host health fairs and screening events to improve Member's health. In Mississippi, we have identified and begun discussions with over 50 of these organizations and we plan to develop more of these resources as we work to improve health outcomes in the State. Examples of MS groups that have expressed an interest in working with us include The Faith Based Coalition, the Urban League of Greater Jackson, and MS Friends of Children. On March 5, 2009, we attended a meeting at the MS Primary Health Care Association, where we were able to visit with leaders from the FQHCs in the state. This leadership is very open to working with us to increase health education opportunities in their communities.

83. You must provide the services as described in Appendix W for a Pharmacy Disease Management Program. Please answer the following questions:

UnitedHealthcare's pharmacy disease management is integrated with our other DM programs into our Care Management Program and like the other DM program is based on our Personal Care Model (PCM) which emphasizes the whole individual, including environment, background and culture.

With the exceptions of the asthma component, pharmacy disease management services, UnitedHealthcare provides pharmacy disease management through Prescription Solutions, our pharmacy benefit manager, and a United Health Group (UHG) company. Prescription Solutions administers Disease Therapy Management (DTM) programs that are clinical, patient-focused programs offered as part of Specialty Pharmacy Care Management services. The objective of our DTM programs is to improve patient quality of care through education and communication.

UnitedHealthcare integrates pharmacy disease management for asthma into our regular asthma disease management program described in our response to Question 81

Prescription Solutions Specialty Pharmacy offers DTM programs for the following disease states/ conditions required by the Board for the MS CHIP program:

- Rheumatoid Arthritis
- Growth Disorders
- Hemophilia
- Risk of Respiratory Syncytial Virus due to Prematurity

Additional programs to be provided to MS CHIP Members include:

- Hepatitis C*
- Multiple Sclerosis*
- Anemia Related to Chemotherapy*

i. Length of time program has been in effect.

Launched in 2003, Prescription Solutions' value-added Disease Therapy Management programs provide personal care to high-risk Members to optimize clinical outcomes and reduce overall health care costs.

ii. Number of individuals participating in the program.

Prescription Solutions currently provides services to 11,500 individuals.

iii. Is any aspect of the disease management program Subcontracted? If so list the name of the Subcontractor and the services provided.

Yes, with the exception of the asthma component, we subcontract the pharmacy disease management program to our pharmacy benefit management subcontractor, Prescription Solutions. Asthma pharmacy management is included in our Asthma Disease Management Program described in our response to Question 81.

iv. Source of data used to identify individuals with this disease.

We use retrospective and prospective methods to ensure potential Members are identified as early as possible. To identify Members who meet criteria for our pharmacy management program, we continuously forecast risk through predictive modeling of our claims data. We supplement this approach with authorization requests, assessment results and referrals from providers, Members and their family/caregivers as well as UnitedHealthcare clinical staff. Our multi-dimensional, episode-based predictive modeling tool, Impact Pro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services. We also use additional data sources to identify Members including but not limited to:

- Short health risk assessment conducted during new Member welcome calls
- Emergency room utilization reports, hospital census reports, authorization requests and transitional care coordination requests
- Referrals from health departments, rural health clinics and FQHCs.

The Prescription Solutions claims system supports and complements our collection and tracking of Member demographics, pharmacy claims history and physician information. PS populate this system based on input from UnitedHealthcare and prescribers who submit requests to the PS Specialty Pharmacy. We provide Prescriptions Solution with basic information on such as eligibility and fundamental demographic data (for example, birth date, gender), and information on physicians, such as closed prescriber panels. We also provide clinical information from our claims system, such as diagnosis codes, allergy information, special population status, and other unique information.

v. Outline how your DM program operates.

We offer our DTM programs as "opt out" services. Our enrollee targeting methods include identifying patients taking drugs to treat the three key DTM conditions that we support. We then distribute program information to targeted Members and follow up with telephonic outreach. Members may choose to opt out of these programs at any time.

Members are eligible for enrollment in the Specialty Pharmacy DTM programs if Prescription Solutions' Specialty Pharmacy dispenses their injectable medications. Enrolled Members are provided with ongoing and intensive pharmacy based intervention efforts in order to enhance compliance and avoid catastrophic medical events. The availability of a Clinical Pharmacist and Nurse Care Manager provides an additional level of support for Members to help understand their disease state, medications, and the impact of their decisions.

Enrolled Members receive one-on-one consultations with a clinical pharmacist or registered nurse. Individualized care plans* detailing key issues and recommendations discussed during the Members' consultations with the nurse or pharmacist and scheduled education mailings **that include, but not limited to, topics like**:

- Understanding your disease and treatment plan
- Ways to better manage your symptoms
- Understanding the importance of medication adherence in achieving treatment goals
- Managing medication side effects
- How to properly administer injectable medication
- Importance of a healthy diet and regular exercise.

We diligently document all case review and prior authorization activities and related information in a single data management system. We collect data through direct contact with patients and prescribers, as well as information exchange with clients and their disease and medical management vendors.

This data capture system allows our staff clinicians to track and review each patient or physician contact, evaluate clinical progress of each patient, and document pertinent laboratory results, side effects, and patient compliance to evaluate continuation of a medication. For example, our pharmacists routinely monitor effectiveness of Epogen or Procrit therapy by checking the patient's serum iron levels, as well as, hemoglobin and hematocrit values. Neupogen patients are monitored for their neutrophil response to therapy. Hepatitis patients on PEG-Intron are evaluated for viral load, as well as liver function tests, in addition to potential adverse reactions to combination drug therapy.

Our case review and prior authorization system also supports proactive notification to physicians regarding upcoming authorization expirations and the need for a renewal, thereby ensuring no lapse in the Member's drug therapy. During physician outreach, our clinicians support appropriate therapies by discussing Member response to medications and side effects and making therapy recommendations as appropriate through our DTM programs, we offer advanced care and support to Specialty Pharmacy patients with rheumatoid arthritis, multiple sclerosis, or hepatitis C. Our DTM services include telephonic outreach and counseling conducted by qualified nurses and pharmacists, ongoing monthly support that is tailored to match the patient's degree of risk, development of personalized care plans, distribution of targeted education pieces, and frequent contact with the patient's physician to ensure ongoing coordinated management of the patient's condition.

We track all DTM-related data and activities in a comprehensive, internally-developed database. This information includes patient demographics, medication adherence data, and patient-reported responses on a wide range of clinical issues related to onset of disease, signs and symptoms, history of hospitalization/ER visits, provider history, current medication list, side effects, diet and exercise, home environment, social network, work status, and financial needs. All data is maintained in a secure environment and is used to support ongoing assessment of patient status, coordination of care, and ongoing DTM program evaluation.

UnitedHealthcare supplements the Member-focused activities provided by Prescription Solutions with provider education and information-sharing as described in our response to Question 84.

vi. Percent of patients identified for disease management that are likely to comply with your care recommendations.

Although we do not directly measure compliance for every recommendation made by the clinician as there are many different types of recommendations (such as improving self-management skills/ changing behavior, improving communication with provider, seeking a physical therapist or occupational therapist, being more adherent to prescribed medication), 97 percent of Members who have completed our disease management program stated that the program was very helpful or somewhat helpful in improving their overall health. From this recent survey, we believe that 97 percent of Members who completed the program were likely to comply with at least one of the recommendations made by the clinician during the participating period.

vii. What is the most effective behavior change you have achieved through your DM program?

We believe the most important change achieved for each of the conditions in the DTM program is increased injectable medication adherence, because of the impact on overall health and quality of life for Members. To achieve increased adherence we implement the following activities:

- Proactive calls to Member to schedule refills
  - 3 Calls approximately 10-8-5 days before projected refill date
  - 1 Call approximately 7 days post projected refill date
- Provider notification of unfilled medication
- Administration of Adherence questionnaire on selected medications
  - Modified Morisky questions
  - Additional questions if Member indicates they are not refilling
- Triage to Clinician for adherence interventions/consultation
- Quarterly adherence reports.

viii. Discuss the qualifications of your staff who perform the actual DM services.

These programs give Members the chance to receive medication counseling from a Nurse Care Manager or licensed Pharmacist who understands the complexities of their disease state and the medications used to treat it. The Specialty Pharmacy DTM staff includes Clinical Pharmacists, a Nurse Care Manager, and Pharmacy Technicians, all of whom have been trained specifically to work with injectable case review and fulfillment.

ix. Savings you typically see per patient for this disease.

Prescription Solutions' pharmacy prior authorization and case review services promote appropriate medication use that is consistent with their clients' benefits. These services are an integral part of the overall clinical and cost management of injectables.

Prescription Solutions conducts systems-based review and drug utilization review (DUR) components at *no charge and* delivers complete review by a pharmacist—including medical director input when necessary—at *a low service fee of $55 per review.*

We calculate ROI results by determining the cost of the medication denied, subtracting our service fee, and then extrapolating total cost averted for standard duration of therapy. Our average case review return on investment (ROI) results indicate an average savings of $10 for every $1 spent on case review fees. For example, one client experienced the following annual results:

- **Enbrel:** Averted costs of $467,259 and an ROI of 20.9 with a 92 percent approval rate
- **Gamunex:** Averted costs of $39,218 and an ROI of 88.1 with a 87.5 percent approval rate
- **Genotropin:** Averted costs of $80,868 and an ROI of 85.2 with a 77.8 percent approval rate.

Another client averted a total of $3,000,000 for case review denials. Service fees for these denials totaled $138,000, which equated to a net savings of $2,862,000, or an ROI of 21 to 1.

Additional examples of client ROI results from the first post-implementation year are included in the following table.

Drug Class	Approval Rate	ROI
Hematopoietic Growth Factors	84.2%	10.4
Multiple Sclerosis Agents	90.4%	23.6
Anti-Rheumatic Agents	89.7%	70.7
Hepatitis C Agents	82.1%	19.1

This clinical and cost management expertise will help UnitedHealthcare maximize the benefits of case review, both in terms of improved health outcomes and reduced plan costs. We will work directly with Prescription Solutions to select guidelines that have the potential to yield the most significant results, based on our claims information. We can also customize guidelines to include criteria that will help us manage and approve medication requests in accordance with specific benefit requirements identified by the Board.

Intervention programs, such as the Specialty Pharmacy DTM program are developed on an ROI foundation. Pre- and post-intervention measurements are taken from database extraction and are compared to yield an economic ROI. Using data collected through our pharmacy claims system, client medical claims, patient assessments, and patient surveys, we can measure the impact of interventions on emergency room visits, hospitalizations, medication compliance, functional outcomes, and Member satisfaction.

x. Do you propose any changes to your DM program to better address the needs of the CHIP population?

As noted earlier, the pharmacy disease management program is a component of the UnitedHealthcare DM program. Through our experience providing CHIP DM services in 17 states, we have refined our DM program services to specifically meet the needs of CHIP Members. UnitedHealthcare continuously evaluates our DM programs to better address the needs of our Members. We will use available data and feedback from the Board and our community partners to further customize the program to the specific needs of MS CHIP Members.

84. During the DM process describe when and why you interact with the patient's physician.

As Members are enrolled in the DM programs, UnitedHealthcare staff ensures that each Member is assigned a if they have not yet chosen one or wish to change providers. Each Member is strongly encouraged and steered toward the optimal use of the PCPs the medical home for community-based health and preventive services. PCPs receive regular reports, through the mail and on the provider portal, regarding the health status of Members participating in specific DM programs. As this link is established, we involve the PCP in the plan of care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines.

The care manager collaborates with the Member's PCP/ specialist and attending physician on an ongoing basis to ensure integration of physical and behavioral health issues. In addition, the care manager will ensure the plan of care supports the Member's preferences for psychosocial, educational, therapeutic and other non-medical services. The care manager ensure the plan of care supports providers' clinical treatment goals and builds the plan of care to reflect personal, family and community strengths.

The care manager and Member will review the Member's compliance with the treatment during each assessment cycle. Treatment, including medication compliance, is established as a health care goal with interventions and progress towards that goal documented in each assessment session. At any point that the care manager recognizes that the Member is non-compliant with part or all of the treatment plan, the care manager will:

- Work to identify and understand the Member's barriers to success
- Problem solve for alternative solutions with the Member
- Report non-compliance to the treating provider/specialist, offer potential solutions and integrate provider feedback
- Facilitate agreement for change between all parties and monitor progress of the change.

As the Member's medical home, the PCP/specialist is continuously updated on the Member's participation in the DM program(s), the Member's compliance with the plan of care and any unscheduled hospital admissions and emergency room visits by the Member. The PCP/specialist receives notifications of when Members are enrolled and disenrolled from the DM programs, the assigned care manager for the DM program, and how to contact the care manager. In addition, the PCP/specialist receives notification of Members who have generated care opportunities related to specific DM programs. These evidence-based medical guidelines are generated from our multi-dimensional, episode-based predictive modeling tool, Impact Pro.

We also distribute clinical practice guidelines on the provider portal and in hard copy upon the provider's request and provide training for providers and their staff on how best to integrate practice guidelines into everyday physician practice. When a provider demonstrates a pattern of non-compliance with clinical practice guidelines, the medical director may contact the provider by phone or in person to review the guideline and identify any barriers that can be resolved.

85. What is the source of the clinical treatment guidelines that your staff uses as the basis for decisions and recommendations? (e.g. your own internally developed guidelines, nationally accepted guidelines, etc.)

UnitedHealthcare uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including Milliman USA Healthcare Management Guidelines, Apollo Medical Review criteria and CMS policy guidelines. Milliman is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best-practice care templates, and key milestones for the best possible treatment and recovery. These guidelines are integrated into CareOne, our health management system.

For specific state benefits or services not covered under national guidelines, we develop criteria through the review of current medical literature and peer reviewed publications, Medical Technology Assessment Reviews and consultation with specialists.

The Medical Director oversees the adoption/approval of medical policies and evidence-based guidelines. Both nationally recognized evidence-based guidelines and internally developed guidelines are reviewed, updated and approved at least every two years by the national Executive Medical Policy Committee (EMPC) and the National Quality Management Oversight Committee (NQMOC). The Health Plan Utilization Management Committee, Provider Advisory Subcommittee and Quality Management Committee also evaluate and approve these guidelines.

Medical guidelines are available and shared with practitioners upon request and are available on the provider website, unitedhealthcareonline.com. Policies and guideline updates are communicated through provider notices prior to implementation.

For pharmacy, DM, use of guidelines helps to ensure appropriate use at the initiation of therapy. Prescription Solutions implements and manages a preferred product listing, which lends itself to standardization, consistency and cost savings. In addition, they offer a case review process, which includes clinical pharmacist review of the clinical progress of the patient, any pertinent labs, and patient compliance to evaluate continuation of a medication. For example, the pharmacists routinely monitor effectiveness of Epogen or Procrit therapy by checking the patient's serum iron levels, as well as hemoglobin and hematocrit values. Neupogen patients are monitored for their neutrophil response to therapy. Hepatitis patients on PEG-Intron are evaluated for viral load and liver function tests, in addition to potential adverse reactions to combination drug therapy.

Clinical Practice Guidelines

UnitedHealthcare adopts clinical practice guidelines as the clinical basis for the DM Programs. Clinical guidelines are systematically developed, evidence-based statements that help providers make decisions about appropriate health care for specific clinical circumstances. We adopt clinical guidelines from recognized sources as defined by the National Committee on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC).

Board Certified Specialists perform a review of government research sources and clinical and technical literature prior to the adoption of guidelines and upon review of new information. All protocol information undergoes a review of the information source and an assessment of costs and benefits to Members in terms of the ability to improve outcomes prior to the decision to implement the change. We review and revise the clinical practice guidelines annually.

The clinical practice guidelines for our three programs described above include the following:

Asthma

- NIH, NHLBI, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma – Full Report 2007
- American Academy of Allergy, Asthma, and Immunology, 1996-2006.

Diabetes

- Standards of Medical Care for Patients with Diabetes Mellitus Diabetes Care, 30: (Supplement 1):S3-S41 (2007).

Pharmacy

The guidelines and criteria used in the Pharmacy Disease Management programs are a combination of modified "Morisky" questions and medication compliance questions. Prescribing guidelines provided by UnitedHealthcare, for example our prior authorization guideline for Synagis® Injection (palivizumab) are utilized by Prescription Solutions when initially reviewing and dispensing requested medications.

Our pharmacy benefits manager, Prescription Solutions, is a wholly owned subsidiary of UHG, and operates independently from pharmaceutical manufacturers. Prescription Solutions contracts with pharmaceutical manufacturers for rebate purposes only. Pharmaceutical manufacturers seek to partner with Prescription Solutions because of its ability to effectively manage utilization on behalf of clients through formulary compliance and utilization management programs to leverage drug market share. This reputation is valuable when negotiating contracts with the drug manufacturers.

UnitedHealthcare uses a number of processes to ensure all patients receive all of the medications/medical equipment prescribed for the most appropriate treatment of their specific condition including:

- Using our proprietary, state of the art clinical profiling tool, Impact Pro we identify any potential gaps in care or services
- Care Managers administer disease specific health risk assessments to identify prospective gaps in care
- Providers are given comprehensive written and electronic reports that identify their patients that are not receiving appropriate care in accordance with clinical practice guideline for the patient's specific condition
- Patients, parents and caregivers are provided education on the importance of compliance with treatment plans
- Care Managers interact with physicians and their practices to obtain appropriate orders and to encourage clinical follow up, as needed
- Physicians who are not meeting the standards of care are contacted by our Medical Director through either a telephone call or personal visit.

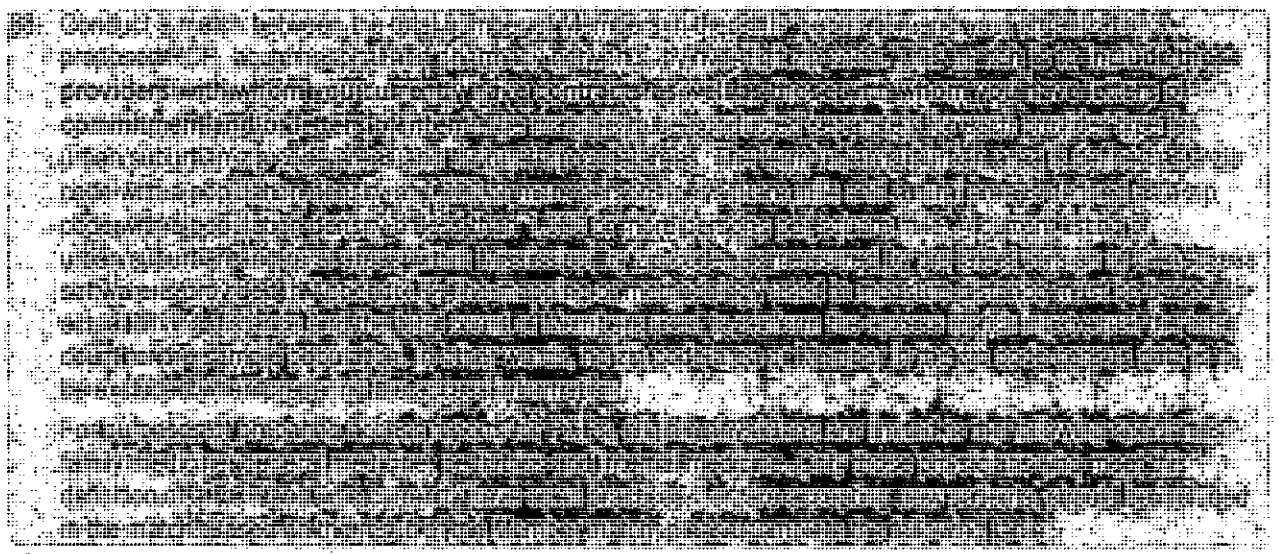
As stated above, UnitedHealthcare uses innovative tools and technology to identify situations when a patient is not being prescribed the medication/medical equipment most appropriate for their condition. Our medical management programs, including our DM programs, are supported by an evidence-based, predictive modeling system. Impact Pro is a proprietary technology through which we synchronize health care management and deliver personalized health management solutions. This platform encompasses the processes to identify and segment populations, execute clinically robust, but highly personalized health management programs, engage and activate at the Member and provider level, and monitor and measure outcomes. Included in the Impact Pro intelligence system is a powerful predictive algorithm that identifies individuals who are likely to need intensive health care services in the next 12 to 18 months. The predictive model uses medical, pharmacy and laboratory data to develop a confidential profile of the individual, and then ranks his or her risk relative to other enrolled individuals.

Impact Pro also identifies opportunities to engage the population to use the right provider, seek the right care, take the right medications and live the right lifestyle. It identifies evidence-based care opportunities (gaps in care and proactive opportunities), wellness and behavioral interventions, preventive care, appropriate service utilization and other opportunities to enhance overall health. Within Impact Pro, a sophisticated intelligence system constantly scans the entire population to identify opportunities for intervention before a major health event occurs, as well as calling out gaps in care to DM program nurses.

Care Managers also use disease specific health risk assessment data stored in CareOne, our integrated clinical management system, to proactively identify Members' specific needs. CareOne contains basic and comprehensive supplemental assessments which facilitate the development of integrated care plans. CareOne also includes tools for ongoing monitoring and evaluation. The system serves as the framework within which to share clinical information across clinical domains and departments, tracking clinical information longitudinally. CareOne can produce reports that can be shared with providers to aid in their decision making.

After reviewing the data and reports, the DM nurse calls the patient, parent or caregiver and/or the physician to address any gaps in education or health care needs. The system drives communication to physicians through comprehensive, Member-specific health management reports. In the example provided of an asthmatic patient with moderate to severe asthma symptoms, the Impact Pro tool will identify for the DM nurse the gaps in prescribed medication and medical equipment. The DM nurse will directly contact the physician to determine why these items have not been prescribed and will share evidence-based care opportunities. If the physician does not address these care opportunities, the DM nurse will consult with our Medical Director. The Medical Director may contact the physician and conduct peer-to-peer counseling.

Member Access



Provider Type	Percentage of Sample Population in Urban Suburban Areas within Access Standard	
Two Primary Care Physician	Within 15 miles: 100%	Within 10 miles: 100%
One Physician of each Specialty, as listed in 8.2.2 (a through am).		
a) Allergy /Immunology	Within 20 miles: 87%	Within 15 miles: 86%
b) Anesthesiology	Within 20 miles: 98%	Within 15 miles: 97%
c) Cardiology	Within 20 miles: 100%	Within 15 miles: 100%
d) Dermatology	Within 20 miles: 90%	Within 15 miles: 88%
e) Endocrinology	Within 20 miles: 88%	Within 15 miles: 87%
f) Gastroenterology	Within 20 miles: 99%	Within 15 miles: 98%
g) Hematology/Oncology	Within 20 miles: 99%	Within 15 miles: 98%
h) Infectious Diseases	Within 20 miles: 98%	Within 15 miles: 98%
i) Medical Genetics	Within 20 miles: 19%	Within 15 miles: 15%
j) Neurology	Within 20 miles: 99%	Within 15 miles: 98%
k) Nephrology	Within 20 miles: 84%	Within 15 miles: 76%
l) Neurosurgery	Within 20 miles: 89%	Within 15 miles: 88%
m) Obstetrics and Gynecology	Within 20 miles: 100%	Within 15 miles: 98%
n) Ophthalmology	Within 20 miles: 99%	Within 15 miles: 96%
o) Orthopedic Surgery	Within 20 miles: 100%	Within 15 miles: 100%
p) Otolaryngology	Within 20 miles: 98%	Within 15 miles: 97%
q) Pathology	Within 20 miles: 96%	Within 15 miles: 95%
r) Pediatric (Subspecialties)	Within 20 miles: 98%	Within 15 miles: 93%

Provider Type	Percentage of Sample Population in Urban/ Suburban Areas within Access Standard:	
	Standard A	Standard B
s) Physical Medicine and Rehabilitation – Physiatrist	Within 20 miles: 98%	Within 15 miles: 98%
t) Psychiatry	Within 20 miles: 96%	Within 15 miles: 96%
u) Radiology	Within 20 miles: 99%	Within 15 miles: 98%
v) Respiratory/ Pulmonary Medical Services	Within 20 miles: 98%	Within 15 miles: 98%
w) Surgery (General)	Within 20 miles: 98%	Within 15 miles: 98%
x) Surgery (Specialist)	Within 20 miles: 90%	Within 15 miles: 88%
y) Chiropractic	Within 20 miles: 100%	Within 15 miles: 100%
z) Certified nurse practitioner/nurse midwife/physician assistants	Within 20 miles: 100%	Within 15 miles: 100%
aa) Podiatry	Within 20 miles: 90%	Within 15 miles: 90%
ab) Oral and maxillofacial surgery	Within 20 miles: 76%	Within 15 miles: 68%
ac) Occupational, speech and physical therapists	Within 20 miles: 89%	Within 15 miles: 87%
ad) Psychologists, professional counselors and clinical social workers	Within 20 miles: 90%	Within 15 miles: 88%
ae) Audiologist	Within 20 miles: 68%	Within 15 miles: 67%
af) Home health services, including home infusion therapy	Within 20 miles: 19%*	Within 15 miles: 19%*
ag) Hospice service	Within 20 miles: 0%*	Within 15 miles: 0%*
ah) Orthodics/prosthetics/DME services	Within 20 miles: 89%	Within 15 miles: 88%
ai) Laboratory, radiology and other diagnostic services	Within 20 miles: 99%	Within 15 miles: 98%
aj) Skilled nursing facilities	Within 20 miles: 87%	Within 15 miles: 85%
ak) Dentists	Within 20 miles: 100%	Within 15 miles: 100%
al) Optometrists	Within 20 miles: 100%	Within 15 miles: 100%
am) Certified diabetes educators and dieticians	Within 20 miles: 39%*	Within 15 miles: 29%*
One Acute Hospital	Within 25 miles: 100%	Within 20 miles: 98%
One Dentist	Within 20 miles: 100%	Within 15 miles: 100%
One Vision Provider	Within 20 miles: 100%	Within 15 miles: 100%
One Retail Pharmacy	Within 15 miles: 100%	Within 10 miles: 100%

Provider Type	Percentage of Sample Population in Rural Zip Code Areas within Access Standard: Standard A	Standard B
Two Primary Care Physician	Within 25 miles: 99%	Within 20 miles: 98%
One Physician of each Specialty, as listed in 8.2.2 (a through am).		
a) Allergy /Immunology	Within 30 miles: 46%	Within 25 miles: 36%
b) Anesthesiology	Within 30 miles: 67%	Within 25 miles: 58%
c) Cardiology	Within 30 miles: 78%	Within 25 miles: 68%
d) Dermatology	Within 30 miles: 45%	Within 25 miles: 38%
e) Endocrinology	Within 30 miles: 45%	Within 25 miles: 37%
f) Gastroenterology	Within 30 miles: 55%	Within 25 miles: 47%
g) Hematology/Oncology	Within 30 miles: 60%	Within 25 miles: 51%
h) Infectious Diseases	Within 30 miles: 44%	Within 25 miles: 37%
i) Medical Genetics	Within 30 miles: 2%	Within 25 miles: 1%
j) Neurology	Within 30 miles: 73%	Within 25 miles: 63%
k) Nephrology	Within 30 miles: 57%	Within 25 miles: 46%
l) Neurosurgery	Within 30 miles: 44%	Within 25 miles: 37%
m) Obstetrics and Gynecology	Within 30 miles: 90%	Within 25 miles: 80%
n) Ophthalmology	Within 30 miles: 68%	Within 25 miles: 58%
o) Orthopedic Surgery	Within 30 miles: 67%	Within 25 miles: 58%
p) Otolaryngology	Within 30 miles: 77%	Within 25 miles: 66%
q) Pathology	Within 30 miles: 57%	Within 25 miles: 48%
r) Pediatric (Subspecialties)	Within 30 miles: 33%	Within 25 miles: 28%
s) Physical Medicine and Rehabilitation – Physiatrist	Within 30 miles: 75%	Within 25 miles: 67%
t) Psychiatry	Within 30 miles: 50%	Within 25 miles: 42%
u) Radiology	Within 30 miles: 86%	Within 25 miles: 76%
v) Respiratory/ Pulmonary Medical Services	Within 30 miles: 61%	Within 25 miles: 52%
w) Surgery (General)	Within 30 miles: 91%	Within 25 miles: 83%
x) Surgery (Specialist)	Within 30 miles: 59%	Within 25 miles: 51%
y) Chiropractic	Within 30 miles: 81%	Within 25 miles: 73%
z) Certified nurse practitioner/nurse midwife/physician assistants	Within 30 miles: 97%	Within 25 miles: 95%
aa) Podiatry	Within 30 miles: 64%	Within 25 miles: 52%
ab) Oral and maxillofacial surgery	Within 30 miles: 29%	Within 25 miles: 24%
ac) Occupational, speech and physical therapists	Within 30 miles: 58%	Within 25 miles: 50%
ad) Psychologists, professional counselors and clinical social workers	Within 30 miles: 67%	Within 25 miles: 57%
ae) Audiologist	Within 30 miles: 19%	Within 25 miles: 16%
af) Home health services, including home infusion therapy	Within 30 miles: 3%*	Within 25 miles: 2%
ag) Hospice service	Within 30 miles: 1%*	Within 25 miles: 0%*
ah) Orthodics/prosthetics/DME services	Within 30 miles: 75%	Within 25 miles: 66%

Provider Type	Percentage of Sample Population in Rural Zip Code Areas within Access Standard:	
	Standard A	Standard B
ai) Laboratory, radiology and other diagnostic services	Within 30 miles: 86%	Within 25 miles: 76%
aj) Skilled nursing facilities	Within 30 miles: 80%	Within 25 miles: 69%
ak) Dentists	Within 30 miles: 96%	Within 25 miles: 91%
al) Optometrists	Within 30 miles: 97%	Within 25 miles: 92%
am) Certified diabetes educators and dieticians	Within 30 miles: 9%*	Within 25 miles: 8%*
One Acute Hospital	Within 45 miles: 100%	Within 30 miles: 97%
One Dentist	Within 30 miles: 96%	Within 25 miles: 91%
One Vision Provider	Within 30 miles: 97%	Within 25 miles: 92%
One Retail Pharmacy	Within 25 miles: 100%	Within 20 miles: 100%

Please indicate the name and version of software you used to measure access: Ingenix GeoCoder v3.8.0.0; GeoNetworks v7.8.0.0

*Home Health Services, Hospice Services, Certified Diabetes Educator Services and Dietician Services are provided by organizations that generally have a single central location and then dispatch experienced professionals into the field when services are required. Many of these professionals work out of their homes and travel throughout the regions to provide their necessary services. It is not unusual for a Home Health Agency to be based in Jackson, MS but provide Home Health Services across a large region of the state.

89. Attach as **Exhibit J** to your proposal a summary level access report which indicates the total number of persons in the sample population which do not meet access standards in the above column titled "Standard A".

Exhibit J has been completed and provided for review in Section 6, Required Exhibits.

Exhibit K has been completed and provided for review in Section 6, Required Exhibits.

Provider Network

91.

UnitedHealthcare's proposed network to serve MS CHIP Members became operational in the State of Mississippi on July 1, 1995. Our extensive provider network includes more than 3,000 providers and 85 Mississippi hospitals. We believe the strength of our network lies in the individual, small group contracting model with flexible preferred pricing and not on large, regional or statewide provider organizations.

UnitedHealthcare—by AmeriChoice®, a division of UnitedHealth Group (UHG), referred to as UnitedHealthcare, is the prime contractor for MS CHIP. UnitedHealthcare will include the following sister organizations as network subcontractors: United Behavioral Health (UBH) for mental health services; Spectera, Inc. for vision care services; ACN Group, Inc. for chiropractic, physical therapy, occupational therapy, and speech therapy services; Dental Benefit Providers, Inc. for dental services and Prescription Solutions for pharmacy services.

92. What contractual requirements does your organization have with network providers to hold them accountable for timely scheduling of elective appointments?

UnitedHealthcare has established the following appointment access requirements. These standards are published in the Administrative Guide which is incorporated by reference into our provider contracts.

Appointment Type	Time Frame
Emergency Care	Within 30 minutes typical travel time, 24 hours per day, 7 days per week
Urgent Care (PCP)	Within 24 hours
Routine Patient Care (PCP)	Within 1 week
Well Care (PCP)	Within 1 month

UnitedHealthcare regularly monitors provider compliance with appointment access and wait times. Data sources include but are not limited to:

- Member complaints and appeals
- Member satisfaction survey provider access questions
- Medical records reviews for high-volume PCP and behavioral health providers
- Provider onsite reviews
- Provider profiles that identify Members with excessive emergency room use and few visits over time
- Care manager feedback and reports from 24 hour nurse line indicating consistent access issues.

We actively monitor our provider network to identify issues with individual providers as well as any trends. Initial review occurs at the departmental level, with trended information reported to the Service Quality Improvement Subcommittee and ultimately the Quality Management Community to identify performance improvement opportunities.

Other monitoring methods are specific to certain provider types. For example, we evaluate physical health providers (PCPs, Specialists, Optometrists, etc.) on a quarterly basis through "secret shopper" calls placed to a random sample of 50 PCPs and 50 high volume specialists. Our Personal Care Specialists call each of the sampled providers' offices posing as Members asking for the first available appointment.

Provider Relations staff educate noncompliant providers about contract requirements. Quality Management and Provider Relations staffs develop, implement and monitor corrective action plans to address noncompliance issues. Our Chief Medical Officer follows up with a letter. A provider's unwillingness or inability to meet appointment and wait time standards after receiving a CAP may result in disciplinary actions up to suspension or termination from the network.

93. Do your physician and hospital network contracts have a "continuation of care" clause that says if a physician or hospital cancels or fails to renew its contract that care which began with the network provider will continue to be reimbursed as a network provider?

Yes, our physician and hospital network contracts contain a "continuation of care" clause.

If yes, please outline the specific contractual terms, including the length of time the continuation of care clause would continue to apply following termination of the provider contract.

The following clause contained in our participating provider agreements outlines the continuation of care requirements for specified services:

"**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 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:

Covered Services	Continuation of Care
Inpatient Covered Services	30 days or until discharge, whichever comes first
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 applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As applicable

Any additional continuation of care requirements required under the state contract or regulations will be incorporated into our regulatory appendix."

94. Indicate the standard methods used to communicate provider terminations, additions and address/phone number changes to Members.

PCP Terminations—UnitedHealthcare will provide written notice within 15 days of notice or issuance of termination of a PCP to each Member who received primary care from, or was seen on a regular basis by the terminated PCP. We will generate a letter that explains the situation, provides the new PCP information and explains how to contact us to select a different PCP.

PCP Additions—Members have access to our online provider directories to view updated provider information. Our Member Service Representatives also have access to the online directories in order to provide calling Members with the most up- to-date information. These online directories are updated weekly and are searchable by provider name, location or specialty. Members can also call a Member Service Representative to request to have a paper copy of the directory mailed to them. We update and reprint provider directories annually.

PCP Address/Phone Number Changes—Our Administrative Guide requires providers to notify us of address and phone number changes within ten calendar days of the change. These updates are made weekly to our online directories. Members are encouraged to contact Member Services for updated address and phone numbers if they believe the data they have is incorrect.

95. What plans, if any, do you have for growth in the number of PCPs, specialists and network facilities if you are awarded this contract? Please include target dates for any expansion in the number of network providers.

UnitedHealthcare is fortunate to have a substantial provider network already contracted in the State of Mississippi. We believe that network development and management is a fluid process and upon award will continue supplementing our network with essential community providers, critical access hospitals, public health departments and other safety net providers throughout the state. We have established a date of October 1, 2009 as the date in which we intend to ensure we have a comprehensive network necessary that ensures minimal disruption of existing patterns of care.

96. What percentage of the primary care physicians in your proposed Mississippi provider network currently have closed practices, i.e., are not accepting new patients?

Only 2.8 percent (49 total) of our Primary Care Providers proposed to serve the MS CHIP membership currently have closed panels in the State of Mississippi, or in the bordering cities identified. More than 1,700 Primary Care Providers (97.2 percent) are available to the MS CHIP membership.

97. Complete the following physician reimbursement table. To the extent you are subcontracting or leasing provider networks and reimbursement methodologies vary by network, then please answer this question separately for each subcontracting arrangement.

Name of Network: UnitedHealthcare

	Primary Care Physician	Network Specialist
Predominant reimbursement method, e.g., fee-for-service, discounted fee-for-service, capitation	FFS Fee Schedule	FFS Schedule
Source of Fee Schedule, e.g., HIAA, Medicare, MDR, in-house	Medicare	Medicare
Frequency of updates to reimbursement/fee schedules, e.g., semi-annually, annually	Quarterly	Quarterly
Are there any risk sharing arrangements, e.g., bonus pools, withholds or retroactive payments? If so, list	No	No

Name of Network: United Behavioral Health

	Primary Care Physician	Network Specialist
Predominant reimbursement method, e.g., fee-for-service, discounted fee-for-service, capitation	N/A	FFS Schedule
Source of Fee Schedule, e.g., HIAA, Medicare, MDR, in-house	N/A	In-house
Frequency of updates to reimbursement/fee schedules, e.g., semi-annually, annually	N/A	As needed
Are there any risk sharing arrangements, e.g., bonus pools, withholds or retroactive payments? If so, list	N/A	No

Name of Network: Spectera, Inc.

	Primary Care Physician	Network Specialist
Predominant reimbursement method, e.g., fee-for-service, discounted fee-for-service, capitation	N/A	FFS Schedule*
Source of Fee Schedule, e.g., HIAA, Medicare, MDR, in-house	N/A	In-house
Frequency of updates to reimbursement/fee schedules, e.g., semi-annually, annually	N/A	As needed
Are there any risk sharing arrangements, e.g., bonus pools, withholds or retroactive payments? If so, list	N/A	No

*Providers are paid one flat eye exam reimbursement rate (this can vary depending upon our contracting negotiations) and one flat dispensing fee. Providers utilize an in-house lab where materials are made, and providers dispense these materials.

Name of Network: AGN Group, Inc.

	Primary Care Physician	Network Specialist
Predominant reimbursement method, e.g., fee-for-service, discounted fee-for-service, capitation	N/A	FFS Schedule
Source of Fee Schedule, e.g., HIAA, Medicare, MDR, in-house	N/A	Medicaid
Frequency of updates to reimbursement/fee schedules, e.g., semi-annually, annually	N/A	Quarterly
Are there any risk sharing arrangements, e.g., bonus pools, withholds or retroactive payments? If so, list	N/A	No

Name of Network: Dental Benefit Providers, Inc.

	Primary Care Physician	Network Specialist
Predominant reimbursement method, e.g., fee-for-service, discounted fee-for-service, capitation	N/A	FFS Schedule
Source of Fee Schedule, e.g., HIAA, Medicare, MDR, in-house	N/A	Medicaid
Frequency of updates to reimbursement/fee schedules, e.g., semi-annually, annually	N/A	As needed
Are there any risk sharing arrangements, e.g., bonus pools, withholds or retroactive payments? If so, list	N/A	No

98. [redacted]

A listing of our providers currently under contract has been provided as Exhibit L in Section 6, Required Exhibits.

[redacted]

A listing of our providers with whom we have Letters of Intent has been provided as Exhibit M in Section 6, Required Exhibits.

100. Please complete the following table with regard to your proposed professional provider network in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL and Mobile, AL.

	Number of Providers Currently under Contract		Number of Providers with Letters of Commitment	
Provider Type	Within State of MS	In border cities	Within State of MS	In border cities
Internal Medicine (PCP)	204	1402	60	0
Internal Medicine Subspecialists	–	–	–	–
General/Family Medicine (PCP)	653	649	129	0
Pediatricians (PCP)	238	664	68	0
Pediatrician Specialists:				
Cardiology	9	45	0	0
Craniofacial	0	0	0	0
Hematology/Oncology	0	70	5	0
Nephrology	0	20	0	0
Neonatal Medicine	5	89	9	0
Endocrinology	1	25	0	0
Neurosurgery	0	57	0	0
Orthopedic Surgery	0	7	0	0
Pulmonology	0	25	0	0
Gastroenterology	0	28	0	0
Intensive Critical Care	0	20	0	0
Adolescent Medicine	0	4	0	0
Urology	0	4	0	0

	Number of Providers Currently under Contract		Number of Providers with Letters of Commitment	
Provider Type	Within State of MS	In border cities	Within State of MS	In border cities
Obstetricians/Gynecologists	298	672	27	0
General Surgeons	161	439	49	0
Surgery Subspecialists	236	837	9	0
Dentists	75	342	313	0
Ophthalmologists and Optometrists	404	718	1	0
Audiologist	2	3	1	0
Total Number of Providers	2286	6120	671	0

101. Please complete the following table with respect to your proposed provider network in the State of Mississippi and in the border cities of Memphis, TN; Slidell, LA; New Orleans, LA; Birmingham, AL; and Mobile, AL. If the percentages are unknown, please so indicate.

	% Board Eligible	% Board Certified
Primary Care Physicians	2%	75%
Physician Specialist	4%	72%

102. Please complete the following table regarding your credentialing procedures for physicians. To the extent you are subcontracting or leasing provider networks and the credentialing criteria varies by network then please answer this question separately for each subcontracting arrangement.

Name of Network: UnitedHealthcare

Criteria	Yes/No
Requirement that medical license has never been restricted or revoked?	No
Is board eligible or board certification required?	No
Is valid Drug Enforcement Administration (DEA) certificate required?	Yes
Must physician currently have admitting privileges to at least one community or teaching hospital?	Yes
Are the type and quantity of lawsuits investigated?	Yes
Are references required and checked?	No
Is the physician's status in the National Practitioner Databank checked?	Yes
Is the physician's status on sanctions in Medicare/Medicaid programs checked?	Yes
List any other credentialing requirements for physicians: N/A	

Name of Network: United Behavioral Health

Criteria	Yes/No
Requirement that medical license has never been restricted or revoked?	Yes
Is board eligible or board certification required?	Yes (board certification)
Is valid Drug Enforcement Administration (DEA) certificate required?	Yes
Must physician currently have admitting privileges to at least one community or teaching hospital?	Yes (also require admitting privileges to at least one contracted/network-based facility)
Are the type and quantity of lawsuits investigated?	Yes
Are references required and checked?	No
Is the physician's status in the National Practitioner Databank checked?	Yes
Is the physician's status on sanctions in Medicare/Medicaid programs checked?	Yes

List any other credentialing requirements for physicians: Must meet minimum liability requirements for physicians: N/A

Name of Network: Spectera, Inc. (Ophthalmologists)

Criteria	Yes/No
Requirement that medical license has never been restricted or revoked?	Yes
Is board eligible or board certification required?	Yes
Is valid Drug Enforcement Administration (DEA) certificate required?	Yes
Must physician currently have admitting privileges to at least one community or teaching hospital?	No
Are the type and quantity of lawsuits investigated?	Yes
Are references required and checked?	No
Is the physician's status in the National Practitioner Databank checked?	Yes
Is the physician's status on sanctions in Medicare/Medicaid programs checked?	Yes

List any other credentialing requirements for physicians: N/A

103. How often are physicians re-credentialed? To the extent you are subcontracting or leasing provider networks and the answer to this question varies by network then please answer this question separately for each subcontracting arrangement.

UnitedHealthcare and its sister organizations recredential their network physicians every 36 months in accordance with NCQA guidelines.

104. Complete the following table by indicating your network provider overall average percentage discount off the average prevailing non-network (or non-managed) reasonable and customary charges statewide within Mississippi for the following categories.

Type of Service	Calendar Year 2008	First Three Months of Calendar Year 2009
Physician – non-surgical	13.8%	*See note below
Physician – surgical	25.3%	*See note below
Radiology	18.0%	*See note below
Pathology	37.6%	*See note below
Anesthesiology	11.4%	*See note below
Physician – non-surgical	13.8%	*See note below

What is the source of your prevailing charge data, e.g., Ingenix (formerly HIAA) or internally developed?
The prevailing charge data is developed internally by accessing UnitedHealthcare's data warehouse which includes all claims within our enterprise.

*Due to a variety of contractual claims submission timelines among our providers that affect claims processing, we anticipate data for the first three months of calendar year 2009 will be available at the end of June 2009.

All of the reimbursement information reflected on this document qualifies as commercial and financial information of a proprietary nature and constitutes trade secrets as defined under Mississippi law which are exempt from disclosure pursuant to Section 79-23-1 of the Mississippi Code, and therefore the Bidder requests that this material not be photocopied. Bidder requests, prior to the release of any information, to be notified by the Board of the request for the information to be given sufficient time to seek protection from the appropriate court in the event of a challenge.

Note: the Board reserves the right to request more detailed information regarding provider discount arrangements (e.g., by network, type of provider, type of service) as part of Phase Three of the evaluation process.

105. Complete the following grid regarding your organization's credentialing criteria for the following types of health care providers by checking each column that applies. To the extent you are subcontracting or leasing provider networks, then please answer this question separately for each subcontracting arrangement.

Name of Network: UnitedHealthcare

	No credentialing process for these providers	Providers not part of network	Yes, credentialing process for these providers
Nurse practitioners			X
Occupational and physical therapists			X
Audiologist	X		
Dentist			X
Optometrist			X
Psychologist			X
Professional counselors and clinical social workers			X

Name of Network: United Behavioral Health

	No credentialing process for these providers	Providers not part of network	Yes, credentialing process for these providers
Nurse practitioners		X	
Occupational and physical therapists		X	
Audiologist		X	
Dentist		X	
Optometrist		X	
Psychologist			X
Professional counselors and clinical social workers			X

Name of Network: Spectera, Inc.

	No credentialing process for these providers	Providers not part of network	Yes, credentialing process for these providers
Nurse practitioners		X	
Occupational and physical therapists		X	
Audiologist		X	
Dentist		X	
Optometrist			X
Psychologist		X	
Professional counselors and clinical social workers		X	

Name of Network: AGN Group, Inc.

	No credentialing process for these providers	Providers not part of network	Yes, credentialing process for these providers
Nurse practitioners		X	
Occupational and physical therapists			X
Audiologist		X	
Dentist		X	
Optometrist		X	
Psychologist		X	
Professional counselors and clinical social workers		X	

Name of Network: DentalBenefitProviders,Inc.

	No credentialing process for these providers	Providers not part of network	Yes, credentialing process for these providers
Nurse practitioners		X	
Occupational and physical therapists		X	
Audiologist		X	
Dentist			X
Optometrist		X	
Psychologist		X	
Professional counselors and clinical social workers		X	

A list of those facilities under contract or with whom we have Letters of Intent that are not accredited by JCAHO is shown below. In addition to JCAHO, UnitedHealthcare accepts accreditation from other accreditation organizations as follows:

Facility Type	Accreditations Accepted
Ambulatory Surgery Center	AAAASF, AOA, AAAHC, JCAHO, or CMS or State Agency review or certification
Skilled Nursing Facility	CARF, CHAP, JCAHO, or CMS or State Agency review or certification
Acute Care Hospital	NIAHO, JCAHO, AOA (now referred to as HFAP), AAAHC, or CMS or State Agency review or certification
Psychiatric Facility	COA, CARF and AOA. If a facility is not accredited by one of these agencies, a site visit is completed in accordance with NCQA guidelines prior to contracting the facility.

Name	City	State	Zip Code	Specialty
Tri Lakes Medical Center	Batesville	MS	38606	Psychiatric Facility
A Bridge to Recovery	Ridgeland	MS	39157	Psychiatric Facility
Eastside Mental Health Center	Birmingham	AL	35235	Psychiatric Facility
Gateway Family Counseling	Birmingham	AL	35205	Psychiatric Facility
Mobile Infirmary Medical Center	Mobile	AL	36607	Psychiatric Facility
Capitol Care South Inc	Birmingham	AL	35210	Psychiatric Facility
Addiction Couns & Edu Resources	Slidell	LA	70458	Psychiatric Facility
Youth Truth Inc	Slidell	LA	70461	Psychiatric Facility
Mental Health Resources	Memphis	TN	38119	Psychiatric Facility
Hanover Health & Rehab at Birmingham	Birmingham	AL	35205	Skilled Nursing Facility
Gastroenterology ASC NA	Birmingham	AL	35209	Ambulatory Surgery Center
Birmingham Surgery Center	Birmingham	AL	35209	Ambulatory Surgery Center
Birmingham Nursing & Rehabilitation Center	Birmingham	AL	35214	Skilled Nursing Facility

Name	City	State	Zip Code	Specialty
Birmingham Nursing & Rehabilitation Center	Birmingham	AL	35215	Skilled Nursing Facility
Jefferson Rehab and Health	Birmingham	AL	35217	Skilled Nursing Facility
Mountainview Health Center	Birmingham	AL	35221	Skilled Nursing Facility
Fairview Health and Rehab	Birmingham	AL	35228	Skilled Nursing Facility
HealthSouth Outpatient Care Center	Birmingham	AL	35233	Ambulatory Surgery Center
Kirklin Clinic	Birmingham	AL	35233	Ambulatory Surgery Center
Kirklin Clinic	Birmingham	AL	35233	Ambulatory Surgery Center
Alabama Colon/Rectal Institute	Birmingham	AL	35233	Ambulatory Surgery Center
The Noland Center at Carraway	Birmingham	AL	35234	Skilled Nursing Facility
Gastroenterology ASC NA	Birmingham	AL	35235	Ambulatory Surgery Center
Medplex Outpatient Surgery Center	Birmingham	AL	35244	Ambulatory Surgery Center
Golden LivingCenter – Riverchase	Birmingham	AL	35244	Skilled Nursing Facility
Mary Lewis Skilled Nursing Facility	Birmingham	AL	35249	Skilled Nursing Facility
Crowne Health Care of Mobile	Mobile	AL	36605	Skilled Nursing Facility
HealthSouth Surgicare of Mobile	Mobile	AL	36606	Ambulatory Surgery Center
Cogburn Health & Rehabilitation	Mobile	AL	36607	Skilled Nursing Facility
Specialty Healthcare & Rehabilitation Center	Mobile	AL	36607	Skilled Nursing Facility
Cogburn Health & Rehabilitation – Midtown	Mobile	AL	36607	Skilled Nursing Facility
Dauphin West Surgery Center	Mobile	AL	36608	Ambulatory Surgery Center
HealthSouth Mobile Surgery Center	Mobile	AL	36608	Ambulatory Surgery Center
Springhill Senior Residence	Mobile	AL	36608	Skilled Nursing Facility
Springhill Manor	Mobile	AL	36608	Skilled Nursing Facility
Twin Oaks Nursing Home	Mobile	AL	36617	Skilled Nursing Facility
Lynwood Nursing Home	Mobile	AL	36693	Skilled Nursing Facility
Mobile Nursing and Rehabilitation Center	Mobile	AL	36695	Skilled Nursing Facility
Cogburn Health & Rehab Center West	Mobile	AL	36695	Skilled Nursing Facility
St. Peter Villa	Memphis	TN	38104	Skilled Nursing Facility
High Point Health and Rehab Center	Memphis	TN	38114	Skilled Nursing Facility
Oakville Health Care Center	Memphis	TN	38118	Skilled Nursing Facility
Meca Laser & Surgery Center	Memphis	TN	38119	Ambulatory Surgery Center
Primacy Healthcare & Rehab Center	Memphis	TN	38119	Skilled Nursing Facility
Alliance Private Duty and Home	Memphis	TN	38134	Skilled Nursing Facility
Signature Healthcare of Memphis	Memphis	TN	38134	Skilled Nursing Facility
Spring Gate Rehabilitation Health Care Center	Memphis	TN	38135	Skilled Nursing Facility
Stern Cardiovascular Center	Memphis	TN	38138	Ambulatory Surgery Center
Tri-Lakes Medical Center	Batesville	MS	38606	Acute Care Hospitals
Golden LivingCenter – Batesville	Batesville	MS	38606	Skilled Nursing Facility
Delta Manor (MR)	Clarksdale	MS	38614	Skilled Nursing Facility
Alliance HealthCare System	Holly Springs	MS	38634	Acute Care Hospitals
Holly Springs Health & Rehab	Holly Springs	MS	38635	Skilled Nursing Facility
Quitman County Hospital	Marks	MS	38646	Acute Care Hospitals

Name	City	State	Zip Code	Specialty
Baptist Memorial Hospital North Mississippi – SNF	Oxford	MS	38655	Skilled Nursing Facility
Golden LivingCenter – Ripley	Ripley	MS	38663	Skilled Nursing Facility
Beverly/Southhaven Health Care Center	Southaven	MS	38671	Skilled Nursing Facility
Baptist Progressive Care	Southaven	MS	38671	Skilled Nursing Facility
Golden LivingCenter – Southaven	Southaven	MS	38671	Skilled Nursing Facility
Boliver Health and Rehab Center	Cleveland	MS	38732	Skilled Nursing Facility
Indianola Health & Rhab	Indianola	MS	38751	Skilled Nursing Facility
North Sunflower County Hospital	Ruleville	MS	38771	Acute Care Hospitals
Golden LivingCenter – Eason Blvd.	Tupelo	MS	38804	Skilled Nursing Facility
Golden LivingCenter – Amory	Amory	MS	38821	Skilled Nursing Facility
MS Ca	Corinth	MS	38834	Skilled Nursing Facility
Comerstone Health & Rehab of Corinth	Corinth	MS	38834	Skilled Nursing Facility
Gilmore Chickasaw Heath Service	Okolona	MS	38860	Skilled Nursing Facility
Grenada Health and Rehabilitation	Grenada	MS	38901	Skilled Nursing Facility
Tallahatchie General Hospital	Charleston	MS	38921	Acute Care Hospitals
Greenwood Health and Rehab Center	Greenwood	MS	38930	Skilled Nursing Facility
Yalobusha General Hospital	Water Valley	MS	38965	Acute Care Hospitals
Humphreys County Memorial Hospital	Belzoni	MS	39038	Acute Care Hospitals
Rankin Medical Center	Brandon	MS	39042	Acute Care Hospitals
Canton Manor (MR)	Canton	MS	39046	Skilled Nursing Facility
Leake Memorial Hospital	Carthage	MS	39051	Acute Care Hospitals
Beverly LivingCenter – Carthage	Carthage	MS	39051	Skilled Nursing Facility
Trinity Mission of Clinton	Clinton	MS	39056	Skilled Nursing Facility
Pinehaven	Clinton	MS	39056	Skilled Nursing Facility
Jefferson County Hospital	Fayette	MS	39069	Acute Care Hospitals
Lackey Memorial Hospital	Forest	MS	39074	Acute Care Hospitals
Hardy Wilson Memorial Hospital	Hazlehurst	MS	39083	Acute Care Hospitals
Magee General Hospital	Magee	MS	39111	Acute Care Hospitals
Simpson General Hospital	Mendenhall	MS	39114	Acute Care Hospitals
Scott Regional Hospital	Morton	MS	39117	Acute Care Hospitals
Trace Haven Health & Rehab Center	Natchez	MS	39120	Skilled Nursing Facility
Sharkey-Issaquena Community Hospital	Rolling Fork	MS	39159	Acute Care Hospitals
Sydney House	Vicksburg	MS	39180	Skilled Nursing Facility
Yazoo City Health and Rehab Center	Yazoo City	MS	39194	Skilled Nursing Facility
Disc	Jackson	MS	39232	Ambulatory Surgery Center
Beverly LivingCenter – Meridian	Meridian	MS	39301	Skilled Nursing Facility
Winston Medical Center	Louisville	MS	39339	Acute Care Hospitals
Noxubee County Hospital	Macon	MS	39341	Acute Care Hospitals
Newton Regional Hospital	Newton	MS	39345	Acute Care Hospitals
Neshoba County General Hospital	Philadelphia	MS	39350	Acute Care Hospitals
H. C. Watkins Memorial Hospital	Quitman	MS	39355	Acute Care Hospitals
Laird Hospital	Union	MS	39365	Acute Care Hospitals
Head and Neck Surgery Center	Hattiesburg	MS	39402	Ambulatory Surgery Center
Marion General Hospital	Columbia	MS	39429	Acute Care Hospitals

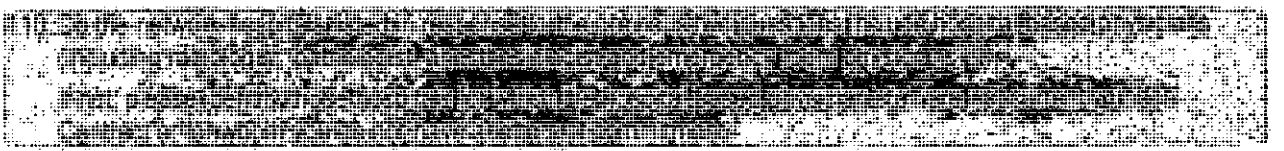
Name	City	State	Zip Code	Specialty
Columbia Health and Rehab Center	Columbia	MS	39429	Skilled Nursing Facility
Greene County Hospital	Leakesville	MS	39451	Acute Care Hospitals
George County Hospital	Lucedale	MS	39452	Acute Care Hospitals
Highland Community Hospital	Picayune	MS	39466	Acute Care Hospitals
Pearl River County Hospital	Poplarville	MS	39470	Acute Care Hospitals
Jefferson Davis Community Hospital	Prentiss	MS	39474	Acute Care Hospitals
Perry County General Hospital	Richton	MS	39476	Acute Care Hospitals
Quest Rehab	Diamondhead	MS	39525	Skilled Nursing Facility
Woodland Village Nursing Center	Diamondhead	MS	39525	Skilled Nursing Facility
Stone County Hospital	Wiggins	MS	39577	Acute Care Hospitals
Golden LivingCenter – Brook Manor	Brookhaven	MS	39601	Skilled Nursing Facility
Countrybrook Living Center	Brookhaven	MS	39601	Skilled Nursing Facility
Lincoln Manor (MR)	Brookhaven	MS	39601	Skilled Nursing Facility
Beacham Memorial Hospital	Magnolia	MS	39652	Acute Care Hospitals
Franklin County Memorial Hospital	Meadville	MS	39653	Acute Care Hospitals
Lawrence County Hospital	Monticello	MS	39654	Acute Care Hospitals
Walthall County General Hospital	Tylertown	MS	39667	Acute Care Hospitals
Golden LivingCenter – Tylertown	Tylertown	MS	39667	Skilled Nursing Facility
Pioneer Community Hospital of Aberdeen	Aberdeen	MS	39730	Acute Care Hospitals
Golden LivingCenter – Eupora	Eupora	MS	39744	Skilled Nursing Facility
Kilmichael Hospital	Kilmichael	MS	39747	Acute Care Hospitals
Rolling Hills	Starkville	MS	39759	Skilled Nursing Facility
Specialty Hospital of New Orleans	New Orleans	LA	70128	Skilled Nursing Facility

107. Please provide the information in the following table:

	Total Number of Facilities Currently under Contract		Total Number of Facilities with Letters of Commitment	
Facility Type	Within State of MS	In border cities	Within State of MS	In border cities
Hospital	109	16	4	0
Other Health Care Facilities (not including hospitals)	38	94	5	0
Total	147	110	9	0

Exhibit N has been completed and is provided for your review as part of Section 6, Required Exhibits.

Exhibit O has been completed and is provided for your review as part of Section 6, Required Exhibits.



Yes, most of the hospitals in our network have participating hospital based provider groups. When UnitedHealthcare contracts with its hospitals, every effort is made during the negotiation process to insert language into our facility agreements that assists us in securing direct agreements with its hospital based providers. UnitedHealthcare is competitive with other payers.

The list below indicates the facilities that do not currently have **all** the hospital based providers at that facility in our current contracted network. Due to the fluid nature of hospital based providers, it is difficult to always maintain an agreement with every group that may practice at a hospital. Additionally, if listed below it may be due to one group that has generated less than five claims a year. Those hospital based groups that are key drivers of cost are continuously approached for negotiation.

State	Hospital
MS	Baptist Hospital
MS	Baptist Hospital Desoto
MS	Baptist Memorial Hospital Desoto
MS	Baptist Memorial Hospital Golden Triangle
MS	Baptist Memorial Hospital No Ms
MS	Biloxi Regional Medical Center
MS	Central Ms Medical Center
MS	Claiborne County Med Center
MS	Forrest General
MS	Garden Park Medical Center
MS	George County Hospital
MS	Gulf Coast Medical Center
MS	Gulfport Memorial Hospital
MS	H.C.Watkins Memorial Hospital
MS	Hancock Medical Center
MS	Hardy Wilson Memorial Hospital
MS	Highland Community Hospital
MS	Jeff Anderson Regional Medical Center
MS	Kings Daughters Hosp
MS	Magee General Hospital
MS	Magnolia Regional Med Center
MS	Natchez Community Hospital
MS	Natchez Regional Med Center
MS	Neshoba County Hospital
MS	North Ms Medical Center
MS	North Oak Regional Med Center
MS	Riley Hospital

State	Hospital
MS	River Oaks Hospital
MS	River Region Medical Center
MS	Rush Foundation Hospital
MS	Scott Regional Hospital
MS	Simpson General Hospital
MS	South Central Regional Med Center
MS	Southwest Mississippi Regional Medical Center
MS	St Dominics Hospital
MS	Southwest Regional Medical Center
MS	Tippah County Hospital
MS	Tri Lakes Medical Center
MS	Walthall County Gen Hospital
MS	Wayne General Hospital
MS	Yalobusha General Hosp
LA	Northshore Regional Medical Ct
LA	Ochsner Baptist Medical Center
LA	Slidell Memorial Hospital
LA	Touro Infirmary
LA	Tulane University Hospital & Clinic
TN	Lebonheur Childrens Medical Center
TN	Regional Medical Center @ Memphis
TN	Saint Francis Hospital
TN	St. Jude Childrens Research Hosp

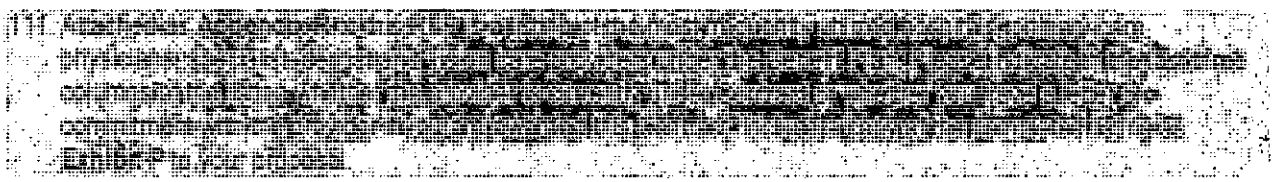


Exhibit P has been completed and is provided for your review as part of Section 6, Required Exhibits.

112. Identify which of the following methods of reimbursement apply to facilities in your network. Also identify the average discount levels (off of billed charges) produced by whatever system of reimbursements you have negotiated.

	DRG W/Outlier	DRG No Outlier	Per Diem W/Outlier	Per Diem No Outlier	% Discount Billed Charges	Other _____	Average Discount Level
Acute Inpatient Med/Surg Hospital	Yes	Yes	Yes	Yes	Yes	n/a	60.2%
Hospital Based Surgery Center	No	No	No	No	Yes	OPG Case Rates APC	62.7%
Outpatient Hospital (i.e., x-ray and lab)	No	No	No	No	Yes	Fee Schedule Case Rate APC	64.6%
Hospital Emergency Room	No	No	No	No	No	Case Rate APC	59.6%
Acute Inpatient Mental Health	No	No	No	Yes	No	n/a	52.3%

All of the reimbursement information reflected on this document qualifies as commercial and financial information of a proprietary nature and constitutes trade secrets as defined under Mississippi law which are exempt from disclosure pursuant to Section 79-23-1 of the Mississippi Code, and therefore the Bidder requests that this material not be photocopied. Bidder requests, prior to the release of any information, to be notified by the Board of the request for the information to be given sufficient time to seek protection from the appropriate court in the event of a challenge.

Note: the Board reserves the right to request more detailed information regarding provider discount arrangements (e.g., by network, type of provider, type of service) as part of Phase Three of the evaluation process.

113. Complete the following table by indicating the average percentage discount off of billed charges that apply to hospitals in your network for calendar year 2008 and for the first three months of calendar year 2009.*

	Average for 2008	Average for first 3 months of 2009
Hospital – Inpatient Services	60.0%	*See note below
Hospital – Outpatient Services	63.4%	*See note below

*Due to a variety of contractual claims submission timelines among our providers that affect claims processing, we anticipate data for the first three months of calendar year 2009 will be available at the end of June 2009.

All of the reimbursement information reflected on this document qualifies as commercial and financial information of a proprietary nature and constitutes trade secrets as defined under Mississippi law which are exempt from disclosure pursuant to Section 79-23-1 of the Mississippi Code, and therefore the Bidder requests that this material not be photocopied. Bidder requests, prior to the release of any information, to be notified by the Board of the request for the information to be given sufficient time to seek protection from the appropriate court in the event of a challenge.

Note: the Board reserves the right to request more detailed information regarding provider discount arrangements (e.g., by network, type of provider, type of service) as part of Phase Three of the evaluation process.

Bidder's commercial and financial information is exempt from disclosure because it is a trade secret. Bidder requests that the data not be copied. The Board is requested to notify the Bidder if the data is sought so Bidder can protect it from disclosure.

Services:	Are Services Available Through The Proposed Provider Network? (Y/N)	Total # of Facilities in Mississippi Providing Services	Total # of Facilities in Border Cities Providing Services
Alcohol/chemical dependency	Y	9	12
Ambulatory surgery	Y	39	28
Burn unit/care	Y	1	3
Cardiac care unit	Y	9	20
CT scanner	Y	45	21
Diagnostic radioisotope facility	Y	4	9
Emergency room	Y	71	23
Hemodialysis	Y	21	22
Home health services	Y	90	35
Hospice	Y	8	6
Intensive care unit	Y	33	19
Neonatal intensive care	Y	41	26
Magnetic resonance imaging (MRI)	Y	7	11
Obstetrics	Y	31	11
Occupational therapy	Y	17	16
Open heart surgery	Y	13	16
Pediatric inpatient unit	Y	67	22
Pediatric intensive care	Y	6	8
Physical therapy services	Y	85	312
Psychiatric services	Y	10	23
Rehabilitation (inpatient)	Y	8	12
Rehabilitation (outpatient)	Y	8	12
Skilled nursing home/facility services	Y	48	18
Therapeutic radioisotope facility	Y	5	9
Transplantation – bone marrow	Y	0	2
Transplantation – heart	Y	0	1
Transplantation – kidney	Y	0	4
Trauma center (Level I or II)	Y	0	1

115. For services listed above that are not available in the network, explain the process for providing these services to Members through arrangements with non-participating hospitals.

UnitedHealthcare continually works with both hospitals and providers to ensure needed care is provided and medically necessary services for Members are authorized. Our Medical Management Team reviews all inpatient admissions to non-participating hospitals to evaluate the need for continued care, provides the appropriate authorization as necessary, and documents the admission in our CareOne electronic medical records. Through these electronic medical records and case management records, we identify patterns of utilization in out-of-network hospitals. Our Network Development staff approaches these hospitals for inclusion in the network with the goal of negotiating favorable reimbursement rates. While we strive to negotiate acceptable terms that allow for quality care and successful management of medical costs through effective pricing strategies and facility-based medical cost management initiatives, we are also cognizant that a robust network including key hospitals is critical to our ability to serve our Members, to provide Members with choice, and to grow our membership.

UnitedHealthcare strongly believes that we are successful engaging critical hospitals and hospital systems as participating providers. However we recognize that there are instances where we have to formulate non-participating agreements to ensure access and availability of services to our Members. In these instances, we seek to partner with key non-participating hospitals using many of the same approaches that have proven successful in engaging new providers.

Our approach to successfully engaging hospitals for participation in our network involves planning, dedication of resources, innovative pricing strategies, and enhanced provider servicing. We recognize that the reimbursement rate for hospitals must be competitive on a unit of service basis as the savings from hospitals come from shorter average lengths of stay (ALOS) and reduced admissions due to successful preventive and patient compliance strategies.

UnitedHealthcare has developed and manages to a strategic network development plan that focuses on the key providers and hospital systems necessary to ensure access to quality care for our Members. This plan defines the approaches used to encourage participation of key quality facilities. To execute this plan, we have enhanced our network contracting team, developing a dedicated staff of contracting experts to employ innovative approaches to engaging facilities. Our plan includes a strategic pricing approach that considers the entirety of the network in developing hospital rates. This approach achieves cost effective agreements in some cases to allow for enhanced rates in others. In addition, our plan includes the innovative use of approaches for structuring agreements. These approaches include enhanced payments for hospitals meeting certain performance criteria related to quality of care, patient safety, and cost effective treatment.

UnitedHealthcare's defined network development plan, dedicated contracting resources, and capacity for innovation in pricing, payment, and servicing hospitals distinguishes us from other organizations that have taken more traditional approaches to contracting. In addition, if a hospital in the MS CHIP service area chooses not to contract with us we will work with the hospital and our providers to ensure there are no gaps in our Members' care. We waive prior authorization requirements in some cases, negotiate single case agreements, and extend credentialing periods.

Payment Methodology	Percent
Per diem basis	73%
DRG basis	27%
Discount basis	0%
Other basis (describe other):	N/A

Name of Network: United Behavioral Health

Payment Methodology	Percent
Per diem basis	100%
DRG basis	N/A
Discount basis	N/A
Other basis (describe other):	N/A

Center of Excellence	Address	City, State, Zip Code	Services
Children's Hospital of Alabama	1600 Seventh Avenue, South	Birmingham, AL 35233	Blood/Marrow
Ochsner Medical Center – New Orleans	1514 Jefferson Highway	New Orleans, LA 70121	Kidney; Kidney/Liver; Liver
St. Jude Children's Research Hospital, Inc.	332 N. Lauderdale Street	Memphis, TN 38105	Kidney; Kidney/Liver; Liver
Tulane University Hospital and Clinic	1415 Tulane Avenue	New Orleans, LA 70112	Kidney; Liver
University of Alabama Hospital	619 South 19th Street	Birmingham, AL 35223	Heart; Kidney
University of Tennessee/Methodist Transplant Institute	1265 Union Avenue	Memphis, TN	Kidney; Kidney/Liver; Liver
Forrest General Hospital	6051 U S Highway 49	Hattiesburg, MS	Spine Surgery; Cardiac Care; Cardiac Surgery; Heart Rhythm Disorders
North Mississippi Medical Center	830 South Gloster Street	Tupelo, MS	Cardiac Care; Cardiac Surgery; Heart Rhythm Disorders

118. Explain the process you propose to follow in negotiating discounted fees for services rendered to Members by any non-participating provider. Please include in your response:

i. Are any services subcontracted? If so, list the name of the Subcontractor and the services provided.

We do not maintain subcontracts with "repriced" networks. We conduct negotiations with non-participating providers as necessary to ensure continuity of care or to provide services in geographic areas where we do not have participating providers. If the state identifies a non-participating fee schedule, this reduced rate would be applied as a discount to services rendered by a non-participating provider.

ii. How non-participating providers are identified by the Contractor

Our first step is to approach essential community providers who initially have chosen not to participate. Our second step is to approach competitor networks and lastly, our contracting team will also be alerted if a Member has nominated a provider for participation, or monitor high dollar claim volume. We also identify non-participating providers from claims data, reports on out-of-network authorizations, emergency room utilization and notification by PCPs and our hands-on Care Coordination/Medical Management team who has responsibility for ensuring Members obtain the necessary care from non-participating providers.

iii. The qualifications of the staff utilized to negotiate provider discounts

The staff who is responsible for negotiating provider discounts with non-participating providers are professionals who have proven abilities in negotiating geographically competitive rates while also considering overall unit cost and trend management which produces an affordable and predictable product for our business partners and customers. Other qualifications include:

- A minimum of 2 – 4 years experience working for a health insurer in a network management role handling provider negotiations with accountability for business results
- A broad-scope of financial, reimbursement, and contracting expertise
- In-depth knowledge of the contracting process
- Experience with claims and reimbursement systems
- Ability to systematically analyze problems, draw relevant conclusions and devise appropriate courses of action
- Strong negotiation skills; the ability to gain acceptance from others of a plan or idea and achieve a mutually beneficial outcome
- Bachelors degree in business, health care management or related field, or equivalent experience.

iv. Whether the negotiation of fees occurs before and/or after services are rendered

Under most circumstances, we attempt to negotiate fees with non-participating providers before services are rendered. However, in cases where the patient was admitted to the hospital through the Emergency Room and subsequently required care that was unavailable in our network, we then attempt to negotiate with the provider after services have been rendered.

v. The overall expected percentage discount off of billed charges you expect to achieve

We expect to negotiate a 20 percent discount off of the provider's billed charges.

119. Describe your proposed procedures to assist Members in receiving recommended immunization per Section 8.11 of this RFP.

UnitedHealthcare will work with the Mississippi State Department of Health in matching CHIP enrollment data with immunization records. We will use our Universal Tracking Database™ (UTD) to educate Members on the need to comply with recommended immunization schedules. UTD incorporates submitted claims, allowing near real-time tracking of Member compliance. Our Preventive Services staff will use UTD to check Member compliance with recommended immunizations schedules and will develop lists for each provider showing compliance of their Members. We will provide these lists quarterly as well as on request. As of early 2009, PCPs have received UnitedHealthcare Alerts when Members are overdue for immunizations.

UnitedHealthcare uses a variety of approaches to assist Members in receiving recommended immunizations. We provide information to Members through Member outreach, our quarterly Member Newsletter, mailed reminder notices and automated telephone outreach.

Member Outreach—UnitedHealthcare conducts at least six outreach contacts per year for all Members under 21 and their parents/guardians and will conduct at least one additional contact per quarter to encourage them to make and keep screening appointments. The additional contact per quarter goes beyond minimum requirements for contacting Members who are overdue for screening. The materials used for quarterly contacts may include calendar stickers, bookmarks and postcards. These materials are available online and, upon request, in alternative formats such as audiotape, large print and Spanish. When mail is undeliverable, we attempt to contact the Member via automated phone messaging, mail to the new address obtained from the post office and/or our MS CHIP staff goes to the Member's address. We document these attempts in our UTD. Welcome calls to all new Members contain a message about MS CHIP services. When Members call the Customer Service line, our hold message contains MS CHIP program information, with a prompt allowing Members needing services to transfer directly to our Disease Management and MS CHIP staff. We mail each Member an annual birthday screening reminder that offers transportation and scheduling help and tells the Member how to contact us for help. The Member website will contain content tailored to subpopulations such as African American, Asian and Latino Members, and will allow Members to log on and identify upcoming and missed MS CHIP services.

Member Newsletters—On a quarterly basis, UnitedHealthcare publishes a Member newsletter which will contain specific articles addressing the importance of wellness and how to access services. Newsletters are written at the sixth grade reading level using the Flesch-Kincaid Grade level tool, and will include all MS CHIP requirements including the recommended immunization schedule by the Advisory Committee on Immunization Practices (ACIP). Newsletters are available in English and Spanish. Copies of the Member newsletters are sent to Members as well as placed on the Member portal of our website. Newsletters will be translated for any language group that speaks a common language and constitutes five percent of UnitedHealthcare's membership.

Reminder Notices—We will also send Division approved reminder mailers, in English and Spanish, as a principle outreach tool to notify all Members/caretakers prior to scheduled immunization visits. The notification includes due dates of immunization. If an immunization visit has not taken place a second written notice is sent.

Automated Telephone Outreach—Preprogrammed telephonic messages, in English and Spanish are made to Members identified as needing a specific preventive service, including immunizations. Depending on the Member's status and needs, the messages are tailored as educational, general reminders or specific reminders. Members are tracked to ensure their compliance.

Based on claims data, assessments and PCP collaboration, we determine and are able to target our outreach efforts to those Members who are not current with their immunizations. Our care management staff incorporates all of the above data into CareOne, our care management system, and can set alerts based on the time frames of required immunizations. For pregnant mothers in the population, we begin education initiatives that outline the importance of timely immunizations for their newborn.

Pharmacy Network

Pharmacy Financials – Insured Product

120. What portion of the premium is for pharmacy services?

UnitedHealthcare has budgeted 18 percent of the premium for pharmacy services. Our experience in multiple states with full-risk CHIP and Medicaid programs enables us to be very effective at predicting pharmacy spending according to the population group covered. In addition, our trend for pharmacy cost from 2007 to 2008 in all Medicaid markets was 5.1 percent, significantly lower than the 8.2 percent increase reported in the *2008/2009 Novartis Pharmacy Benefit Report Facts, Figures & Forecasts*.

121. How is this determined?

UnitedHealthcare selects historical cost data for similar populations to obtain costs for a base period, then projects those costs forward into the rating period, using cost trend information. The projected costs are then compared to the overall medical spending to calculate the percentage of rate attributable to pharmacy.

122. Are there any other fees associated with the pharmacy program?

No, there are no other fees associated with the pharmacy program for MS CHIP.

123. If yes, what are they and for what services?

Not applicable because there are no other fees.

124. Are rebates used to offset any portion of the pharmacy premium or cost for other pharmacy programs?

Rebates are included in the overall cost determination. For cost forecasting, we adjust the rebates from the base period costs during the process of converting our base period cost experience to the rating period cost structure. In instances where we reduce our payments to drug manufacturers by the amount of the rebate, we would itemize these payments and rebates and report the result to the Board.

Pharmacy Financials – Self-Insured Product

125. What is the administrative fee for the pharmacy program? If included with medical, please identify what percent of the medical administrative fee is for pharmacy.

The administrative fee for the pharmacy program is 18 percent.

126. Are there any other fees associated with the pharmacy program?

No other fees are associated with the pharmacy program.

127. If yes, what are they and for what services?

Not applicable because there are no other fees.

Pharmacy Network– Insured and Self-Insured Products

128. Do you provide a network of retail pharmacies that contract with you directly?

UnitedHealthcare's Pharmacy Benefits Manager, Prescription Solutions, directly manages contracts with over 61,000 retail chain and independent pharmacies nationwide. Prescriptions Solutions is an affiliated entity within UnitedHealth Group (UHG) and has long-standing relationships with all major national pharmacy chains.

In addition to its established broad national network Prescription Solutions also offers customized or exclusive network solutions, including a Medicare Part D network, a 90-day retail network, and access to long term care pharmacies. Prescription Solutions can discuss specific pharmacy network configurations with the Board during contract negotiation and plan implementation.

129. Are any aspects of your retail pharmacy network under subcontract with another vendor? If yes, with whom and for what services?

UnitedHealthcare's Pharmacy Benefit Manager is Prescription Solutions, an affiliated entity within UHG. Prescription Solutions is NCQA-ready with data to support accreditation and Member satisfaction surveys, and their programs meet or exceed HEDIS requirements.

In addition to Prescription Solutions' vast experience in contracting with and managing pharmacies, they offer technologically advanced systems and efficient procedures that provide superior administrative and claims management support. One leading edge technology that Prescription Solutions uses is the Systems Xcellence (SXC) claims processing system, which they subsequently customized to provide state-of-the-art services. Their capabilities accommodate high-volume adjudication functions and consistently demonstrate the highest levels of precision and accuracy. For the past six years, Prescription Solutions has maintained greater than 99 percent accuracy in the areas of payment and claims processing. The decisive factor in their accuracy is their unique real-time audit system, which evaluates every electronic claim in real time and identifies errors and even potential fraud before the claim is processed—and before the client pays the claim.

130. How do you ensure the quality of services provided by the retail pharmacies that are included in subcontracted arrangement?

UnitedHealthcare is committed to ensuring that its subcontractor, Prescription Solutions, maintains oversight of the quality of services provided by its retail pharmacy network. UnitedHealthcare's subcontractor oversight program begins before a subcontractor is even selected. UnitedHealthcare only selects subcontractors who support us in improving the effectiveness and efficiency of the delivery of medical services and pharmacy services and have a strong reputation for customer service and administrative excellence. We establish an agreement with our subcontractors to govern the operating relationship, which includes a series of mechanisms that give our CEO and executive team the authority to promote quality and adhere to contract compliance among our subcontractors.

UnitedHealthcare develops thorough operating agreements and maintains enforcement of requirements of those agreements, up to and including corrective action plans, sanctions, notices to cure, and subcontract terminations. In addition, we perform Member and provider surveys to gain feedback on the services of our subcontractors. In addition to ongoing oversight and reporting, UnitedHealthcare also performs periodic audits of our subcontractors.

As an affiliated entity within UHG, Prescription Solutions participates in a monthly governance call sponsored by UnitedHealthcare, on which our CEO, executive team and executives from other affiliated Medicaid health plans meet with the CEOs from our sister organizations. Typically, this meeting is attended by executive leaders from our claims operations, Member and provider call center, and provider contracting. National calls allow for collaborative problem solving and sharing of best practices; they allow our leading executives to provide direct feedback on service quality, and ensure that services for our SCHIP and Medicaid programs are prioritized to promote contract/subcontractor compliance.

Prescription Solutions has established sound, reliable relationships with its network pharmacy providers and holds regular meetings and discussions with chain pharmacies and other network partners to assess their network partnerships and identify areas for improvement or development. In addition, Prescription Solutions' Pharmacy Help Desk representatives routinely handle pharmacy support questions and are trained to immediately escalate any pharmacy provider concerns or grievances to our organization's senior management team.

Prescription Solutions' Network Management Department features experienced individuals who are well qualified to support and maintain our network activities and services. All employees associated with pharmacy network operations are certified pharmacy technicians and are strongly attuned to the needs and requirements of the pharmacy provider community. Pharmacy contracts are reviewed on an annual basis. Within the last twelve months, sixteen pharmacies were terminated from the Prescription Solutions network, twelve for fraudulent activity and four for breach of contract.

131. How many retail pharmacies participate in your network?

- Nationally.

UnitedHealthcare's pharmacy network currently totals 61,176 pharmacies nationwide.

- In Mississippi

UnitedHealthcare's pharmacy network in Mississippi currently totals 765 pharmacies.

132. What percent of your network retail pharmacies in Mississippi are open 24 hours?

Two percent of pharmacies are open 24 hours.

133. If not open 24 hours, what percent of your network retail pharmacies in Mississippi offer 24-hour emergency service?

Many independent pharmacies offer 24-hour emergency service, though specific pharmacies in Mississippi that provide emergency service is not captured by Prescription Solutions. UnitedHealthcare's Member Services is available 24 hours day, seven days a week, 365 days a year to help any Member needing emergency assistance and direction to a pharmacy that is open. We fully meet the access standards required by the Board and exceed CMS Medicare Part D standards.

134. Which, if any, retail chains do not participate in your network nationally?

Prescription Solutions has long-standing relationships with all major national pharmacy chains; no major pharmacies or chains are excluded.

135. Which, if any, retail chains do not participate in your network in Mississippi?

Prescription Solutions has long-standing relationships with all major national pharmacy chains; no major pharmacies or chains are excluded.

136. What credentialing criteria must retail pharmacies meet in order to participate in your network?

Prescription Solutions performs credentialing upon our initial evaluation when considering a pharmacy for inclusion in the network. At minimum, the credentialing process requires verification of:

- Pharmacy permit and pharmacist licensure as required by all federal and state pharmacy laws
- Federal Tax ID number
- Current DEA license
- Current MediCal provider number (for California pharmacies only)
- Professional liability insurance and general liability insurance in the minimum amount of $1 million combined single limit to cover the activities and errors and omissions of each of the company pharmacies and their respective personnel
- Ownership and affiliation information
- Business name history
- Most recent inspection data by pharmacy board
- Signed attestation statement related to prior disciplinary actions, convictions, and restrictions.

137. How do you ensure that the retail pharmacies in your network comply with and adhere to your requirements for participation?

Statistics and Reports—UnitedHealthcare requires each subcontractor to submit daily, weekly, and monthly reports and statistics to illustrate their effectiveness. Key indicators used to monitor our subcontractors include pharmacy provider service levels, call center statistics, claims timeliness, and claims accuracy statistics.

Prescription Solutions continually tracks, evaluates, and reports on network pharmacy performance and dispensing practices for our clients, and UnitedHealthcare reviews the results on a regular basis. Pharmacy providers are profiled across multiple performance categories, including:

- Utilization
- Total transactions processed
- Generic substitution performance
- Summary of errors
- Formulary compliance
- Overall provider performance.

Pharmacy performance and profiling reports are tools that can be used to analyze the performance of the pharmacy network and the overall plan effectiveness of individual pharmacies. In addition, we have created several unique reports to provide additional profiling capabilities. These reports provide drill-down capabilities in the area of top therapeutic classes dispensed, and top drugs by ingredient cost prescribed. UnitedHealthcare can provide standard reports on a biweekly, monthly, or quarterly basis depending on the Board's needs.

In addition to ongoing oversight and reporting, we also perform periodic audits of our subcontractors, to verify their staff, policies, and resources are appropriate to meet the agreement requirements. Audit results are reported in our Compliance or Operations Committee meetings, which includes our executive leadership team.

UnitedHealthcare has an established Vendor Management Team to assure all required data, especially encounter data, is received from our subcontractors as scheduled. The team employs validation edits and uses lag reports in this data collection and monitoring process. Once received, third-party data is further evaluated for accuracy and completeness through a stringent verification process that assures files are not duplicates and primary dates of service or claims post dates fall within expected ranges. Additional validation edits include: original input filenames, expected received date, actual received date, insert date, batch load ID, number of claim header and detail records, number of claims accepted into encounter data management system and number of claims failing initial edits.

The team obtains corrections from our subcontractors, also, and ensures completion of reconciliation reports from our finance group and the subcontractor; they participate in the subcontractors' defect management program, too.

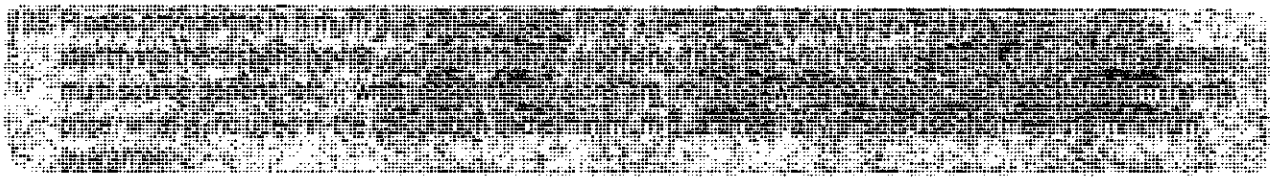
The Vendor Management Team either hosts or attends periodic, at times weekly, calls with our subcontractors to discuss outstanding issues and identified data trends, possible solutions to remediate or prevent problems, and process improvements on both ends.

138. Please provide the minimum guaranteed discount as a percentage off Average Wholesale Price (AWP) for retail for brand name drugs, identifying the dispensing fee, your definition of a brand name drug (e.g., single source brand, multi-source brand, single source generic, etc.), what lesser of provisions are included, what package size is used to determine the price, what is included in the calculation of the minimum guarantee, any offsets used to meet the minimum guarantee.

UnitedHealthcare's minimum guaranteed discount for brand name drugs at retail is Average Wholesale Price (AWP) -16 percent plus $1.50 dispensing fee. The guarantee excludes compound and Direct Member Reimbursement (DMR) claims. A "Brand" is defined as a drug marketed under a proprietary trademark-protected drug and includes both single and multi-source brand drugs. The lesser of provisions include Usual and Customary price (U&C) or copayment. The claims processing is based on the AWP of the product size submitted by the pharmacy.

Guaranteed Aggregate Minimum Pricing—Discounts and dispensing fees set forth above represent the guaranteed aggregate minimum effective rates. Actual rates on a claim-by-claim basis may vary depending on local market conditions. UnitedHealthcare guarantees the following pricing:

- Brand Prescription Drugs: AWP -16% for Brand Prescription Claims (the "Brand Guarantee").
- Generic Prescription Drugs: AWP -74% for Generic Prescription Claims (the "Generic Guarantee").
- Rebates: $9.22 per Brand Prescription Claim Rebate (the "Rebate Guarantee" and, together with the Brand Guarantee and Generic Guarantee, the "Guarantees").
- The Guarantees will be settled annually on a combined basis. Administrator shall have the right to use savings achieved as a result of exceeding any one of the Guarantees to offset amounts owed by Administrator under any of the other Guarantees.



UnitedHealthcare will guarantee a Maximum Allowable Charge (MAC) that is an effective discount of AWP -74 percent plus a $1.50 dispensing fee. The guarantee excludes compound and DMR claims. A "Generic" is identified by its chemical or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

The lesser of provisions include U&C or copayment. The claims processing is based on the AWP of the product size submitted by the pharmacy.

Guaranteed Aggregate Minimum Pricing--Discounts and dispensing fees set forth above represent the guaranteed aggregate minimum effective rates. Actual rates on a claim-by-claim basis may vary depending on local market conditions. UnitedHealthcare guarantees the following pricing:

- Brand Prescription Drugs: AWP -16% for Brand Prescription Claims (the "Brand Guarantee").
- Generic Prescription Drugs: AWP -74% for Generic Prescription Claims (the "Generic Guarantee").
- Rebates: $9.22 per Brand Prescription Claim Rebate (the "Rebate Guarantee" and, together with the Brand Guarantee and Generic Guarantee, the "Guarantees").
- The Guarantees will be settled annually on a combined basis. Administrator shall have the right to use savings achieved as a result of exceeding any one of the Guarantees to offset amounts owed by Administrator under any of the other Guarantees.

140. When is a multi-source generic included on your Maximum Allowable Cost (MAC) list? How often is your list updated?

Prescription Solutions updates the MAC list quarterly, although market dynamics can necessitate adjustments at any time. Adjustment factors include changes in WAC (wholesale acquisition cost), client requests, and network pharmacy concerns.

Pharmacies are notified approximately 30 days prior to the end of a calendar quarter regarding the availability of a new MAC list. MAC changes are loaded into the claims system with a start date that is equal to the first day of the calendar quarter. These MAC prices are valid until the time that another change is made.

A MAC may be implemented any time a generic product becomes available. There may also be circumstances where a MAC is not implemented. Each situation is evaluated on an individual basis and the outcome is dependent upon clinical issues, existing volume of usage, and availability of cost competitive products.

141. How often are MAC prices updated?

Prescription Solutions employs a strategy in calculating MAC that is fair and equitable to pharmacies, other providers, and health plans. We use WAC (wholesale acquisition cost) as the cost basis for all MAC calculations. Approximately one month prior to the start of a new calendar quarter, Prescription Solutions products are reviewed for changes in WAC. Adjustments (increases, decreases, additions, or deletions) are incorporated into the new MAC update.

142. What is your pricing source for (AWP) and how frequently do you update your prices?

Prescription Solutions' AWP source is Facts and Comparisons' Medi-Span Master Drug Database (MDDB). The MDDB file is updated twice weekly.

143. How often do you renegotiate the discounts and dispensing fees with your retail pharmacies?

Our PBM, Prescription Solutions, re-negotiates pharmacy contracts every two years. If, during the course of the contract, the market fluctuates and the result impacts the pharmacy discounts and dispensing fees, their Network Service Department will re-evaluate the pharmacy contract and amend as appropriate.

144. How many specialty pharmacies do you own?

UnitedHealthcare does not own any specialty pharmacies, though our affiliated entity and subcontracted PBM, Prescription Solutions, wholly owns one specialty pharmacy facility. Prescription Solutions currently subcontracts with external vendors for the dispensing of certain specialty medications with limited distribution channels, and provision of home-infusion services. Prescription Solutions ensures full integration of these vendors with their internal systems and processes to minimize any disruption for the Board and MS CHIP Members.

145. How many specialty pharmacies are subcontracted?

While UnitedHealthcare does not subcontract directly with specialty pharmacies, our PBM, Prescription Solutions, maintains subcontracts with specialty pharmacies to augment the specialty pharmacy it owns. To enhance the services and medications available through specialty pharmacies, Prescription Solutions contracts with specialty vendors Accredo and OptionCare, both of which are accredited organizations. They have contracted with Accredo since October 1, 2001, and with OptionCare since August 3, 2001. These companies facilitate delivery of medications with limited or restricted distribution. They also provide advanced home-infusion services and care, including nursing care and training on how to administer injectable medications.

146. Please provide the minimum guaranteed discount as a percentage off AWP at specialty for brand name drugs, identifying the dispensing fee, your definition of a brand name drug (e.g., single source brand, multi-source brand, single source generic, etc.), what lesser of provisions are included, what package size is used for determine the price, what is included in the calculation of the minimum guarantee, any offsets used to meet the minimum guarantee.

UnitedHealthcare's minimum guaranteed discount for brand name specialty drugs is AWP -16 percent; specialty drugs may be available at discounts up to AWP -40 percent, for an effective discount rate of AWP -22 percent depending on utilization. There are no dispensing fees for specialty drugs. A "Brand Name drug" is defined as a drug marketed under a proprietary trademark-protected drug and includes both single and multi-source brand drugs.

Guaranteed Aggregate Minimum Pricing—Discounts and dispensing fees set forth above represent the guaranteed aggregate minimum effective rates. Actual rates on a claim-by-claim basis may vary depending on local market conditions. UnitedHealthcare guarantees the following pricing:

- Brand Prescription Drugs: AWP -16% for Brand Prescription Claims (the "Brand Guarantee").
- Generic Prescription Drugs: AWP -74% for Generic Prescription Claims (the "Generic Guarantee").
- Rebates: $9.22 per Brand Prescription Claim Rebate (the "Rebate Guarantee" and, together with the Brand Guarantee and Generic Guarantee, the "Guarantees").
- The Guarantees will be settled annually on a combined basis. Administrator shall have the right to use savings achieved as a result of exceeding any one of the Guarantees to offset amounts owed by Administrator under any of the other Guarantees.

We are willing to determine MS CHIP's drug utilization mix and estimate the expected discounts that are factored into the overall quote upon receipt of claims data. A minimum of six months of data is required to produce this analysis.

UnitedHealthcare's minimum guaranteed discount for generic specialty drugs is AWP -55 percent; some generic specialty drugs are available at discounts up to AWP -73 percent, for an effective discount rate of AWP -65 percent depending on utilization. There are no dispensing fees for specialty drugs. The claims processing is based on the AWP of the product size submitted by the pharmacy. A "Generic drug" is identified by its chemical or non-proprietary name that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

Guaranteed Aggregate Minimum Pricing—Discounts and dispensing fees set forth above represent the guaranteed aggregate minimum effective rates. Actual rates on a claim-by-claim basis may vary depending on local market conditions. UnitedHealthcare guarantees the following pricing:

- Brand Prescription Drugs: AWP -16% for Brand Prescription Claims (the "Brand Guarantee").
- Generic Prescription Drugs: AWP -74% for Generic Prescription Claims (the "Generic Guarantee").
- Rebates: $9.22 per Brand Prescription Claim Rebate (the "Rebate Guarantee" and, together with the Brand Guarantee and Generic Guarantee, the "Guarantees").
- The Guarantees will be settled annually on a combined basis. Administrator shall have the right to use savings achieved as a result of exceeding any one of the Guarantees to offset amounts owed by Administrator under any of the other Guarantees.

We are willing to determine MS CHIP's drug utilization mix and estimate the expected discounts that are factored into the overall quote upon receipt of claims data. A minimum of six months of data is required to produce this analysis

Pharmacy Network – Self-Insured

148. For what period of time will you guarantee the discounts at retail and specialty?

UnitedHealthcare guarantees the discounts through December 2011, and provides guaranteed discounts annually thereafter.

149. How many Generic Code Numbers (GCNs) are on your MAC list?

Prescription Solutions has 1,543 GPI-based products on the MAC list. Their MAC list is GPI-based, as opposed to GCN-based, which means that the MAC list is based on the product code and not by specific manufacturer. Their MAC list is an open GPI list, enabling Prescription Solutions to split generic drugs into two classes based on different therapeutic indicators.

150. What programs do you have in place to encourage your network pharmacies to dispense generic equivalents whenever possible?

The key programs used to encourage generic dispensing are outlined below and include Mandatory Generic Substitution and Reinforcement and Adherence. The role of a comprehensive generic use program is of critical importance in reducing the escalating drug costs. A long-term strategy of promoting first-line agents over high cost new medications will help control inappropriate prescribing and will yield higher quality and lower costs to plan sponsors.

Our pharmacy benefits manager, Prescription Solutions, is an industry leader in its ability to forecast and control pharmacy trend. UnitedHealthcare has achieved a trend rate of 5.1 percent for 2008 in its Medicaid population, which is substantially below the national average of 8.2 percent (as reported in the 2008/2009 Novartis Pharmacy Benefit Report Facts, Figures & Forecasts). A key aspect of our approach is to provide clients with information and recommend actions with respect to entry of generic drugs to the market. Communicating the cost benefits to prescribers and Members regarding generic drugs optimizes their appropriate utilization and controls costs. In the Medicaid population for 2008, we increased our generic fill rate by 2.6 percent to 81.4 percent.

Mandatory Generic Substitution

UnitedHealthcare's proposed solution to the Board is mandatory generic substitution. Generic substitution policies are supported through benefit plan design structure and system edits. Prescription Solutions can block brand agents if they are multi-source products, thus forcing a switch to the generic product. For example, the edit for the brand drug, Motrin, directs the pharmacist to use the generic Ibuprofen. Another option is to charge the Member a higher copayment for brand products when generics are available, or charge the Member the copayment plus the difference in the cost between the brand and the generic. Plan Sheets are distributed to pharmacists advising them of the mandatory generic substitution policy.

Reinforcement and Adherence

We work closely with Prescription Solution to promote generic drug utilization. Telephonic outreach to targeted prescribers and Members to further support generic utilization begins one month after introduction of a generic drug to market and is ongoing to promote Member adherence to drugs via automated refill reminder calls.

Prescription Solutions also offers a Generic Sampling program—a first-of-its kind—that encourages the use of medically accepted, cost-effective generics, and branded prescription drugs or first-line medications. This program assists in the improvement of physician-prescribing patterns through education on appropriate use and availability of high-quality first-line generic samples. Through appropriate education and availability of office-based samples, physicians are provided with the opportunity to choose quality, medically accepted first-line generics to treat Members successfully instead of the marketing-induced reliance on high-cost, highly used, and often inappropriately prescribed second-line branded drugs. The bottom-line benefits of the Generic Sampling program are two-fold: managing costs and improving quality of care. One of Prescription Solutions' clients realized an average savings of $0.22 PMPM for those pilot groups that successfully participated in the program.

151. What discount applies for specialty drugs when obtained through the retail network?

UnitedHealthcare's goal is to keep all specialty drugs filled within the specialty network for quality and cost effectiveness and therefore the standard network discount would apply. Many specialty drugs require Prior Authorization (PA), and through the PA process, the provider would be advised of the need to use Prescription Solutions' specialty network.

152. What discount applies when prescriptions are sent to a specialty pharmacy?

Brand Name Specialty Drugs: UnitedHealthcare's minimum discount for brand name specialty drugs is AWP -16 percent; specialty drugs may be available at discounts up to AWP -40 percent, for an effective discount rate of AWP -22 percent depending on utilization.

Generic Specialty Drugs: UnitedHealthcare's minimum discount for generic specialty drugs is AWP -55 percent; some generic specialty drugs are available at discounts up to AWP -73 percent, for an effective discount rate of AWP -65 percent depending on utilization.

153. How often do you perform desktop audits on your retail pharmacies?

UnitedHealthcare subcontracts pharmacy audits to Prescription Solutions. Their Real-Time Audit system minimizes the need for conventional onsite audits, desktop audits and traditional audits, which are only conducted when the Real-Time Audit program or the quarterly review of outliers determine the need for an onsite audit. The results of these quality assurance processes indicate exceptional dispensing accuracy rates as follows: In 2007, Prescription Solutions maintained a prescription accuracy percentage of 99.98 percent and as of November, their 2008 year-to-date accuracy percentage was 99.99 percent.

154. What percent of your retail pharmacy network is subject to desktop audit?

One hundred percent of retail pharmacies are subject to desktop audit. Prescription Solutions' actual experience has shown that 17 percent of pharmacies warrant a desktop audit.

155. What areas do you include in your desktop audits?

Desktop audits concentrate on audit reports generated from prior claims. This enables us to investigate the integrity of individual claims that have been submitted by pharmacies and paid on the behalf of its Members, or the Board's MS CHIP Members. Desktop audits include filtering and examining prior claims transactions for the following:

- Usual and Customary Prices
- Average Ingredient Cost
- Amount Paid
- After hour billings
- Quantities >150 percent of Medispan Quantity
- Claims with Day Supply <=31 and Quantity >100
- Refill count>12, or >4 if Days Supply >90
- Duplicate Claims
- Multiple Physicians per Member
- Percentage of Compound Medications
- Percentage of Controlled Medications
- Dispense As Written (DAW) 1
- Reversal Percentage
- Number of Claims per Member
- Dummy DEA Numbers.

Claim transactions are manually reviewed to determine the appropriateness of the criteria listed above. If discrepancies are apparent, a call is placed to the pharmacy to verify the claim transaction. If further validation is required, an auditor may request a copy of the prescription and/or contact the prescribing physician to validate the authenticity and accuracy of the prescription in question.

When inaccurate claims transactions have been identified, the claims are reversed and properly resubmitted by the pharmacist. In some instances, an auditor will reverse and reprocess the claim if the adjudication window is closed.

156. How often do you perform on-site pharmacy audits?

Prescription Solutions' Real-Time Audit system minimizes the need for conventional onsite audits, desktop audits, and traditional audits, which are only conducted when the Real-Time Audit program or the quarterly review of outliers determine the need for an onsite audit.

157. What percent of your retail pharmacy network is subject to on-site audit?

100 percent of retail pharmacies are subject to on-site audit. Prescription Solutions' actual experience has shown that less than 1 percent of pharmacies warrant an on-site audit.

Their Real-Time Audit system minimizes the need for conventional onsite audits, desktop audits and traditional audits, which are only conducted when the Real-Time Audit program or the quarterly review of outliers determine the need for an onsite audit. The results of these quality assurance processes indicate exceptional dispensing accuracy rates as follows: In 2007, Prescription Solutions maintained a prescription accuracy percentage of 99.98 percent and as of November, their 2008 year-to-date accuracy percentage was 99.99 percent.

158. Please describe how you select a retail pharmacy for on-site audit?

Prescription Solutions uses a provider Audit Ranking Program that allows them to focus on pharmacies most likely to be engaged in abusive or fraudulent billing practices. Pharmacies representing fraudulent or aberrant billing patterns are ranked for prioritization. Prescription Solutions will conduct a direct mail audit by sending letters to selected patrons of each subject pharmacy based on this ranking system. The letters explain that an audit is in process and asks the Member to review an enclosed list of selected prescription claims to verify receipt of the listed prescriptions.

Auditors will visit the pharmacies that require more attention than a direct mail audit and providers will be selected for onsite audits based on one or more of the following criteria:

- Client requests onsite visit
- Evidence of wrongdoing in direct mail audit
- Number of complaints
- Qualitative or quantitative outliers.

During an onsite visit, auditors review both randomly selected subsets of paid pharmacy claims and targeted high impact claims. Paid claims will be compared to onsite records such as:

- Hard copy prescription files
- Computer printed daily transaction logs
- Purchase invoices
- Computer files and records
- Third party signature logs.

Within the last twelve months, sixteen pharmacies were terminated from the Prescription Solutions network, twelve for fraudulent activity and four for breach of contract.

159. What procedures are in place to identify potential waste, fraud and abuse?

The onsite audit can lead to an in-depth audit when there is an indication of fraud. While the onsite audit evaluates the pharmacy and determines the presence of fraud, the in-depth audit further investigates and quantifies the full extent of any problems. Pharmacies are permitted to submit documentation to validate discrepancies according to the rules and regulations established by state law. When documentation is not submitted or acceptable, a request is made to recover payment on any undocumented claims. Within the last twelve months, sixteen pharmacies were terminated from the Prescription Solutions network, twelve for fraudulent activity and four for breach of contract.

160. What actions do you take when fraud, waste or abuse is detected?

UnitedHealthcare's Audit team also analyzes monthly prescription data to track and trend any evidence of abuse on a Member or provider level. Should a trend appear, the Audit team further researches to determine the validity of prescriptions. If a Member shows significant evidence towards abuse, the Audit team initializes the lock-in process with Prescription Solutions, wherein a Member is only able to obtain prescriptions from one pharmacy and reducing the probability of further abuse.

Prescription Solutions' Escalation Oversight Committee addresses all cases of potential or actual fraud, waste, and abuse identified in our contracted pharmacy network. This Committee assesses the evidence presented in each case and determines one or more of the following courses of action:

- Termination of the pharmacy's contract
- Restitution of outstanding claims payments
- Civil or criminal prosecution
- Referral to licensing agencies and government authorities, such as Health and Human Services Office of Inspector General (OIG)
- In the Medicare Part D benefit, referral to the Plan Sponsor for additional escalation/handling.

Our Network Audit Department works in coordination with all law enforcement authorities in order to ensure that pharmacies are thoroughly investigated for prosecution when potential fraud is committed against Prescription Solutions or a represented client.

161. Are your criteria for auditing your specialty pharmacy the same as for the retail network? If no, please describe the differences and why they differ.

Prescription Solutions applies the same Real-Time Audit criteria to its mail service and specialty facilities that are applied to retail network providers. As a result, 100 percent of all claims are audited automatically. Because the Real-Time Audit system minimizes the need for conventional onsite audits, traditional audits are only conducted when the Real-Time Audit program or the quarterly review of outliers determine the need for an onsite audit.

162. How often do you audit your specialty pharmacy?

Prescription Solutions applies the same Real-Time Audit criteria to its mail service and specialty facilities that are applied to retail network providers. As a result, 100 percent of all claims are audited automatically. Because the Real-Time Audit system minimizes the need for conventional onsite audits, traditional audits are only conducted when the Real-Time Audit program or the quarterly review of outliers determine the need for an onsite audit.

163. Do you retain any audit recoveries? If yes, please describe and quantify.

Pharmacy claim audit recoveries are usually processed as claims reversals, and are automatically credited to the Board in the billing files on a pass-through basis.

164. What is the minimum per claim rebate at retail that you will guarantee? "Per claim" is defined as each individual paid claim whether brand or generic.

UnitedHealthcare guarantees a rebate of $9.22 for each brand claim at retail. Based on Mississippi SCHIP's generic utilization rate of 58.9 percent in the first three quarters of 2008, we expect that an average rebate across brand and generic will be $3.79 for each claim. Our approach to managing the pharmacy benefit is to drive to the lowest net cost, thereby assuring that the client has optimized appropriate utilization along with cost effective agents. Our strategy to achieve the lowest net cost is to utilize generics wherever possible rather than trying to maximize rebates. We are willing to determine MS CHIP's drug utilization mix and estimate the expected rebates per all claims upon receipt of claims data. A minimum of six months of data is required to produce this analysis.

165. What is the minimum per claim rebate at specialty that you will guarantee? "Per claim" is defined as each individual paid claim whether brand or generic.

Rebates for specialty medications are factored into our overall aggressive AWP discounts per drug. We are willing to determine MS CHIP's drug utilization mix and estimate the expected rebates that are factored into the overall quote upon receipt of claims data. A minimum of six months of data is required to produce this analysis.

Pharmacy Clinical Programs – Insured and Self-Insured Products

166. Are your clinical pharmacists employed by you or subcontracted?

Both UnitedHealthcare and our subcontractor, Prescription Solutions, maintain a pharmacy department. UnitedHealthcare's pharmacy department includes clinical pharmacists, pharmacy technicians and operations management staff.

167. How many clinical pharmacists are on staff?

UnitedHealthcare employs fourteen clinical pharmacists, who collaborate with the pharmacists on staff at Prescription Solutions. Prescription Solutions currently employs 474 pharmacists throughout their organization.

168. What type of specialized training do they receive to enhance their familiarity with government programs and how often do they undergo additional training?

UnitedHealthcare has exclusively served consumers in public sector health care programs for over two decades. The individuals involved in pharmacy services have extensive experience in managing pharmacy programs for Medicaid and SCHIP populations. Our access to the national expertise and extensive resources of our affiliated companies facilitates our ability to adopt best practices for this population.

Pharmacists are required to maintain their licensed status and obtain ongoing continuing education. UnitedHealthcare also provides on-line training courses that are directly related to UnitedHealthcare's business.

169. Please describe in full how your formulary or preferred drug list is determined.

UnitedHealthcare combines clinical expertise and information with a rigorous design process to create the formulary. Our objective is to encourage the use of drug products or therapies that are the most clinically appropriate and cost effective to best serve the health interests of Members. In the following sections, we introduce the team responsible for formulary development, then discuss the process.

Responsibility for Formulary Development

UnitedHealthcare's Pharmacy & Therapeutics (P&T) Committee is responsible for development of the formulary and for making recommendations regarding inclusions and exclusions from the formulary. The P&T committee also develops and recommends policies and procedures for formulary development.

The P&T Committee is chaired by UnitedHealthcare's Vice President for Pharmacy, Jim Hancovsky, R.Ph. The Committee includes the Pharmacy Director, Clinical Pharmacy Coordinator, Medical Director, and at-large committee members who meet the P&T Committee composition guidelines. At-large committee members include active practitioners in family practice, internal medicine, obstetrics/ gynecology, pediatrics, psychiatry, and other practice specialties as needed, based on membership needs.

The P&T Committee also draws on the expertise of ad hoc specialists, such as gastroenterologists, endocrinologist, cardiologist, infectious disease specialists, pulmonologist, and a pharmacoeconomist specialist. Other specialties will be consulted as needed, depending on the therapeutic category of the drug(s) in question. These ad hoc specialists consult with the P&T Committee on relevant specialty topics and attend quarterly P&T committee meetings if a topic of relevance requiring their input is planned.

The P&T Committee meets at least quarterly, and reviews all current policies and procedures as needed, but no less than annually. Formulary additions and deletions occur on an ongoing basis, with every effort made to implement such additions on a standing, quarterly basis.

Policies and Procedures

In developing the formulary for the MS CHIP program, we will assure that it includes a range of drugs in those therapeutic categories and subcategories currently covered, with all subclasses of those categories and subcategories represented. In reviewing new drugs for inclusion in the formulary, our Clinical Pharmacy Coordinator or delegate reviews a Formulary Submission Dossier that includes the following information from the appropriate external expert committees, panels or organizations:

- Product information
- Supporting clinical and economic information that includes identification of all investigators and details of their affiliations, all financial or contractual relations that might affect the independence of the investigators, and all key assumptions
- Impact model report
- Clinical value and overall cost
- Supporting information (bibliography, checklist, and relevant appendices).

When a new drug is considered for the formulary, it is reviewed relative to similar drugs currently included in the formulary. This review process may result in deletion of drug(s) in a particular therapeutic class in an effort to continually promote the most clinically useful and cost-effective agents.

Upon receipt and review of the Formulary Submission Dossier, the Clinical Pharmacy Coordinator or delegate prepares a summary drug review or drug class review document for evaluation by each P&T Committee member, which is distributed in advance of the scheduled P&T Committee Meeting. After review, the committee makes recommendations regarding inclusions and exclusions from the formulary. Medications included in the formulary must demonstrate a clinically significant therapeutic advantage to current formulary agents OR to be new agents with no comparison products available that demonstrate a significant advance in the treatment of the disease state for which they are indicated. Prior authorization may apply to these agents with P&T Committee recommendation.

Use of Generics and Over-the-Counter Medications

The UnitedHealthcare Formulary requires generic substitution on the majority of products when a generic equivalent is available. Generic substitution is a pharmacy action whereby a generic equivalent is dispensed rather than the brand name product. We will identify products on the formulary list that have generic availability. The Maximum Allowable Cost (MAC) list sets a ceiling price for the reimbursement of certain multisource prescription drugs. This price will typically cover the acquisition of most generics, but not branded versions of the same drug. The products selected for inclusion on the MAC list are commonly prescribed and dispensed generic medications.

170. If your formulary is developed through a subcontracted entity, please identify the vendor and what oversight you provide to ensure that the decisions made are based on clinical superiority/equivalence, efficacy and safety, and not rebate return.

We do not subcontract formulary development to another vendor. Our formulary is developed directly by the UnitedHealthcare Pharmacy & Therapeutics Committee and communicated to our pharmacy benefits manager. Decisions regarding the formulary are based on clinical superiority, equivalence, efficacy, and safety, not drug discounts or rebates with manufacturers.

171. Is use of your formulary or preferred drug list mandatory under a fully insured arrangement?

Yes, use of the UnitedHealthcare formulary developed for the MS CHIP program will be mandatory under a fully insured arrangement. This policy helps to ensure that all drugs prescribed under the program are subject to thorough review for clinical effectiveness and appropriate utilization.

172. Is use of your formulary or preferred drug list mandatory in order to meet the minimum discount guarantees?

Yes, use of the UnitedHealthcare formulary for the MS CHIP program will be mandatory to meet the minimum discount guarantees. While the choice of drugs for the formulary is conducted based on clinical effectiveness, our subcontracted Pharmacy Benefits Manager, Prescription Solutions, will negotiate rebates and other discount arrangements with pharmaceutical manufacturers based on expected utilization. Mandatory use of the formulary helps to ensure that utilization is within the expected range. This avoids significant shortfalls that might otherwise occur if prescribers independently selected several different agents within a therapeutic category, and thus allows us to meet the discount volume requirements, maximizing cost-effectiveness for the program.

173. How many formularies or preferred drug lists do you maintain?

UnitedHealthcare maintains a single core formulary for our CHIP programs nationally. However, individual states and programs have needs that are driven by population health characteristics, physician practice patterns and program requirements. We customize the formulary as needed to account for these factors. The process we use to customize the formulary is the same as that used to develop the original base formulary. Thus, we will have a single formulary for the MS CHIP program.

174. How often is your formulary updated?

UnitedHealthcare's P&T Committee reviews the formulary quarterly. These reviews cover both new medications and those presently in the formulary. We address this by completing class reviews concurrently with the new drug reviews. This provides an objective overview of how new products impact the management strategy for the affected class, and evaluates whether current agents in the class are still applicable to current treatment guidelines. Each year, we also compile and present this information to our P&T committee for a comprehensive review and approval of the formulary changes proposed during the previous year. In 2008 the P&T committee reviewed 45 new medications.

UnitedHealthcare also provides coverage for new drugs approved by the FDA within 10 days of their availability in the marketplace via the prior authorization process. New drugs will continue to be available either via inclusion on the formulary or via the prior authorization process, depending upon the results of the final review decision.

175. When and how often do you remove drugs from your formulary or preferred drug list?

UnitedHealthcare's P&T Committee conducts formulary reviews each quarter. Each new drug is reviewed with respect to similar drugs currently included in the formulary. Depending on the review results, the Committee may choose to delete one or more drugs in a particular therapeutic class to continually promote the most clinically useful and cost-effective agents.

Our quarterly schedule promotes stability in the pharmacy program, ensuring that both prescribers and pharmacies can easily track formulary changes. However, whenever the marketplace, new drugs, or Member requirements suggest the need for other drugs, our Prior Authorization process allows use of these drugs, subject to clinical appropriateness. If there are frequent requests for a particular drug through the Prior Authorization process, we will consider this as part of the next quarterly formulary review.

The Committee will recommend deletion of a drug based on thorough review of clinical, pharmacoeconomic, and utilization data. New dosage strengths of current formulary products are also reviewed by the P&T Committee. If a clinical or pharmacoeconomic issue warranting further review is identified, it is brought to the P&T Committee for discussion. The only circumstance where a new dosage form of a current formulary product will not be added to the formulary is following the advisement of the P&T Committee.

Drugs subject to a Class I recall are handled via a separate process. We identify potentially affected Members, based on the last six months of claims history for that Member, and notify both the Member and their physician of the recall. This allows the physician to take appropriate action to find a replacement drug for that Member's condition.

176. When and how often are preferred drugs changed to non-preferred?

UnitedHealthcare's P&T Committee conducts formulary reviews each quarter. Each new drug is reviewed with respect to similar drugs currently included in the formulary. Depending on the review results, the Committee may choose to reclassify one or more drugs in a particular therapeutic class to continually promote the most clinically useful and cost-effective agents.

The Committee will recommend reclassification of a drug based on thorough review of clinical, pharmacoeconomic, and utilization data. New dosage strengths of current formulary products are also reviewed by the P&T Committee. If a clinical or pharmacoeconomic issue warranting further review is identified, it is brought to the P&T Committee for discussion. The only circumstance where a new dosage form of a current formulary product will not be added to the formulary is following the advisement of the P&T Committee.

177. How do you communicate these changes to members?

We communicate formulary changes both directly to Members and through providers, using a variety of media and methods.

Communicating to Members

We communicate formulary information and decisions to our Members in various ways. These include:

- UnitedHealthcare website for the MS CHIP program
- UnitedHealthcare Member Handbook
- UnitedHealthcare Member Letter (affected Members).

NOTE: AmeriChoice has a process in place whereby Member medication history is used to determine if a Member has received a drug which is subject to change. We have developed letters to notify affected Members of the change in formulary status of a drug they have been prescribed. The letter instructs them to contact their physician to obtain a new prescription for an alternative medication.

The website will include a complete listing of our formulary and formulary updates, as well as the prior authorization process and information on how to appeal a decision if a drug is not approved.

Our Member Services representatives are also available Monday through Friday from 8:00 a.m. to 6:00 p.m. to answer any questions or assist Members with any issues they might have.

Communicating to Providers

Because providers are directly involved in face-to-face communications with Members regarding their care and treatment options, it is important for us to ensure that providers have complete and accurate information about the forumulary. Therefore, we use various media to communicate information about the formulary to providers. See the table below for Communicating Formulary Information to Providers.

Medium	Frequency	Description
MS CHIP Provider Manual	Distributed to provider upon joining the network. Current version always available via the UnitedHealthcare website	Provides a complete description of the pharmacy benefit for the program
Pharmacy section of the UnitedHealthcare website	Updated at least quarterly	▪ Includes complete formulary ▪ Link for formulary updates ▪ Description of our Temporary Coverage override processes ▪ "Quick Reference Guide" that contains contact information for our Pharmacy Department.

Medium	Frequency	Description
Provider Letter	Quarterly; mailed to providers and also available via the UnitedHealthcare website	▪ Information on formulary changes ▪ Reminders to physicians to visit our website for complete and up-to-date formulary information, including new P&T Committee decisions ▪ A summary of P&T Committee changes is communicated directly to providers prior to their implementation. These letters also provide the physician with preferred alternatives.
Epocrates	Real-time downloads when PDA is connected to network; reflects most recent weekly update	▪ Web-based formulary application that can be downloaded into a handheld personal digital assistant (PDA) ▪ We provide this functionality in several Medicaid and CHIP markets—it is our intent to deploy this capability across all markets ▪ Includes plan-specific messaging regarding quantity limits, prior authorization requirements, and step therapy ▪ Availability of the formulary on the Epocrates system is promoted in our provider newsletters and by Provider Services representatives.

We also educate our provider services representatives on the formulary and pharmacy prior authorization requirements, so that they may reinforce this message with providers.

UnitedHealthcare coordinates with Prescription Solutions, our Pharmacy Benefits Manager (PBM), to implement formulary changes. This includes system coding and the set-up of edits, which ensures that pharmacies have up-to-date formulary/PDL information. The messaging provided through the claims processing system advises pharmacists of formulary status. When the claims system rejects a claim for the most common non-formulary drugs, the messaging notifies the pharmacist of the formulary alternatives.

Special Notifications for Formulary Deletions

When we delete a drug from the formulary, our pharmacy management notifies prescribers of the changes in writing, at least thirty days prior to the effective date of the change. If the drug to be deleted will not be grandfathered on current users, we send a letter to the affected Members notifying them of the change, at least thirty days prior to implementation.

178. Do you allow customization of your formulary or preferred drug list?

UnitedHealthcare maintains a single core formulary for our CHIP programs nationally. However, we recognize that individual states and programs have needs that are driven by population health characteristics, physician practice patterns and program requirements. Thus, we customize the formulary as needed to account for these factors. The process we use to customize the formulary is the same as that used to develop the original core formulary.

179. What utilization management (UM) programs are included as part of a fully insured program? Please describe each in detail including the drugs or drug categories that are subject to each UM program.

UnitedHealthcare has developed effective utilization management programs and strategies that support the following key principle: Pharmacy benefits comprise one component of overall health care, and all components are interrelated. We manage the pharmacy benefit within that context. That is, we control pharmacy spending, but not at the expense of increasing costs in other health care categories. In fact, sometimes pharmacy costs will need to increase in order to promote health and decrease overall health care costs (for example, when promoting compliance related to asthma controller medications, HIV medication regimens, etc.). The most important aspect of managing pharmacy services is promoting the appropriate utilization and cost-effective mix of drugs needed to elevate our membership's overall health status.

With this guiding principle in mind, we have developed a proven approach, which we continually monitor for effectiveness and revise as necessary to enhance our success. Key aspects of our approach are summarized below.

Prior Authorization and Exceptions Process for Non-preferred Drugs

UnitedHealthcare's Prior Authorization program assesses medication appropriateness, safety and/or efficacy. Established guidelines may require prior use of other formulary and/or cost-effective medications.

UnitedHealthcare's prior authorization procedure enhances formulary/PDL compliance, facilitates appropriate prescribing, and promotes high-quality cost- effective pharmaceutical care. All requests for authorization of non-formulary medications must be initiated by providers prescribing the medications. We issue decisions within 24 hours of receipt and track our performance in meeting this time frame. Our actual average review time is considerably shorter, at approximately 4 hours. To request an authorization for the use of a medication that is non-formulary the prescribing physician must fax or phone a prior authorization request to UnitedHealthcare's Pharmacy team that includes the following information:

- Patient's name
- UnitedHealthcare Plan ID number
- The requested drug, dose and frequency desired
- Documentation of which formulary drugs have been tried to treat the Member's condition
- Documentation of any adverse reactions the Member experienced when using formulary drugs
- Other relevant clinical information, which substantiates the need for an exception to the formulary/PDL.

We evaluate the request based on medical necessity, taking into account the availability of alternative formulary agents that can effectively treat the stated condition. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. A UnitedHealthcare pharmacy services representative (PSR), in consultation with a Pharmacist, reviews all prior authorization requests. The pharmacist or PSR may approve or deny a request.

Exceptions in an Emergent Situation

In emergency situations, if the retail pharmacist cannot speak with the prescribing physician immediately and determines that there is an immediate need for an exception the pharmacists have the authority to initiate an override for a one-time five-day supply of a newly prescribed, non-formulary medication at the point of sale without contacting UnitedHealthcare. We receive a daily report itemizing all overrides that authorized a five-day supply of medication on the previous day, allowing us to monitor emergency fills and to contact the pharmacy and/or physician as needed to facilitate prior authorization request and review.

Prior Authorization Decision Processes

A UnitedHealthcare certified pharmacy technician (CPhT) documents the request in the prior authorization clinical management system. If the request does not meet the guidelines for approval, it is referred to a clinical pharmacist for review. The clinical pharmacist or CPhT may approve or deny a request. We operate a "peer-to-peer" process, through which physicians may confer with our Pharmacy Director and/or Chief Medical Officer by telephone if they are not in agreement with a prior authorization decision and wish to discuss their concerns.

When a prior authorization request is approved, we enter an authorization into the pharmacy claims processing system and notify the requesting physician. In the event that requests are denied, we notify requesting physicians and Members via telephone or facsimile with a brief explanation of the denial. We issue Pharmacy Denial Notices—a written confirmation of the denial—within 24 hours of the denial decision and mail the notice the next business day to the Member. If the physician's office has a secure fax line, the Pharmacy Denial Notice is faxed within one hour of the time the request is finalized. The Denial Notice clearly indicates the reason(s) for the denial as well as the right and process to file a grievance.

Continuity of Care

In emergent situations, we offer a temporary, five-day continuation of care supply of medication. When pharmacists initiate a temporary coverage override (TCO) by entering an electronic code for a continuation of care supply, the system automatically generates a customized TCO letter. The letter includes information on the alternative medications for the non-preferred/prior authorized agent(s) and how to request a prior authorization for the specific non-preferred/prior authorized medication through the Member's physician provider, if appropriate.

Paperless Workflow

In 2009, UnitedHealthcare, in coordination with our PBM, Prescription Solutions, is moving to a paperless workflow system that will improve efficiencies in our prior authorization process and increase reviewer productivity. The system, targeted for implementation prior to third quarter 2009, is a web-based application that will allow for remote access (in other words, physician review can be accomplished off-site). For instance, the system will intake, print, and time stamp faxes; assign workloads; generate denial letters; and document approval and denial decisions. The system will also include look-up capabilities related to medication history, eligibility status, and prior authorization status. Finally, the system will have reporting components that allow users to schedule, build and customize reports. We also are exploring the development of a web-based prior authorization system, which would further facilitate the prior authorization process for physicians. This solution would likely involve a provider portal, to which prescribers could log in using a secure password, enabling on-line prior authorization requests.

Development of Prior Authorization Criteria

The approval criteria for all drugs requiring prior authorization are developed by UnitedHealthcare's P&T Committee and are based on information from the FDA and manufacturers, medical literature, actively practicing consultant physicians and appropriate external organizations.

UnitedHealthcare monitors utilization of high-dollar medications, along with treatment guidelines for conditions requiring specific treatment algorithms. UnitedHealthcare's Clinical Coordinator or delegate identifies areas (either drugs or disease states) that require greater oversight by the plan due to misuse or abuse and compiles and reviews relevant data, which may include information on new drugs and existing treatment guidelines (for example, whether it is a first-line or second-line therapy). Based on this research, the Clinical Coordinator develops clinical criteria relating to the following:

- Clinical information required to support the request, for example., diagnosis, lab work, list of medications previously used for this indication including dose, duration and outcome
- Formulary alternatives appropriate as first-line therapy
- Appropriate length of therapy for initial treatment, re-treatment, etc.

Once developed, the prior authorization criteria are then forwarded to the P&T Committee, which reviews them for appropriateness. Upon P&T approval, the guidelines are sent for peer review by practicing physicians in the relevant specialty who does not participate in the P&T Committee.

Step Therapy

Our Step Therapy program assesses medication appropriateness, safety and/or efficacy and provides incentives to reduce costs when medically appropriate. Prescription Solutions claims system utilizes a Point-of-sale edit that allows claims for medications to pay if the system recognizes a precursor medication in the Member's fill history.

Data Analysis and Reporting to Support Utilization Management

We work with Prescription Solutions, our contracted PBM, to develop a comprehensive set of periodic and ad hoc pharmacy reports. Prescription Solutions provides UnitedHealthcare with claims data to generate quarterly reports that contain high-level utilization and financial information, and monthly and ad hoc reports that target provider prescribing patterns and Member utilization patterns. We utilize pharmacy claims data to internally generate pharmacy reports via a dedicated pharmacy analytics team. Our medical management and pharmacy team review these utilization reports to ensure that the formulary is appropriately applied, identify unusual utilization patterns, identify utilization of generic prescriptions, including new generics, analyze the cost of generic claims versus brand name drugs, analyze spend and utilization between generic drugs and brand name drugs, and evaluate step therapy opportunities for appropriate utilization of the pharmacy spend.

Efficient Medication Dosing (EMD)

In addition to securing competitive, reasonable rates for the drugs on the Unison preferred drug list, the UnitedHealthcare clinical pharmacy staff develops and maintains dose optimization parameters for many drugs. The purpose of these parameters is to ensure the drug is prescribed and dispensed consistently with the dosage and administration guidelines approved by the United States Food and Drug Administration (FDA). For example, many drugs have a release mechanism in the formulation and/or a pharmacokinetic profile which permit them to be given once daily. Thus, the therapeutic levels of the drug can be maintained with a single daily dose. In most instances, there is no additional benefit for the patient to take the drug two or three or more times per day. However, there may be significant differences in the cost of taking a 30mg tablet once daily versus taking a 10mg tablet three times a day. Therefore, the Unison clinical pharmacy staff establishes maximum daily quantity edits (example of a dose optimization parameter) to ensure the specific drugs are taken at a frequency that is consistent with the approved use of the drug. Such edits support the appropriate use of the drugs and also ensure the drug is dispensed in the most cost-effective manner.

Coordination of Benefits (COB)

UnitedHealthcare can actively manage pharmacy coordination of benefits both prospectively at the Point of Sale (POS) and retrospectively through recovery from the primary payer after initial payment by UnitedHealthcare. The prospective POS process is the most efficient as it allows the plan to actively direct the pharmacy to the primary insurer first and then bill the balance co-pay/coinsurance to UnitedHealthcare with no disruption to the Member. UnitedHealthcare's PBM vendor facilitates processing of COB claims online using NCPDP standard protocols. Once the existence of primary insurance pharmacy coverage is validated, the Member's eligibility record is flagged to indicate other insurance (OI) pharmacy coverage. This information is then transmitted as part of the daily eligibility feeds to Prescription Solutions, and the Member record is tagged in the pharmacy claim processing system. This flag in the PBM system prompts the processing system to reject all primary claims for this Member and sends a message to the pharmacy indicating the existence of other insurance.

180. Will the State of Mississippi have the option to decline any of these programs under a fully insured arrangement?

Yes, UnitedHealthcare is open to discussing any of our utilization management programs as to the appropriateness for implementation.

181. If yes, which ones and what will be the impact or implications?

UnitedHealthcare looks forward to working with the Board to review past utilization in depth and recommend appropriate solutions and cost implications of each utilization management program. We can work with the Board to determine the implications should the Board elected to decline any of the programs. A complete analysis of a minimum of six months of pharmacy claims data would be required.

182. What drug utilization review programs are included in a fully insured arrangement? Please describe each in detail.

UnitedHealthcare and Prescription Solutions offer vast expertise in developing and implementing clinical programs that address all aspects of utilization management, including cost control, medication adherence, medication safety, appropriate prescribing, prevention of drug interactions, and more.

The objective of UnitedHealthcare's Drug Utilization Review (DUR) Program is to assure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results. Our DUR activities also serve to enhance the quality of patient care by educating prescribers, pharmacists and Members on the appropriateness of care provided to our Members. Our DUR program consists of three major components, as follows: prospective DUR, retrospective DUR, and P&T Committee. Each component is described below.

Prospective DUR

UnitedHealthcare's prospective DUR is largely carried out by UnitedHealthcare's PBM, Prescription Solutions. Our prospective DUR process is fully integrated with our PBM's electronic claims system. Using evidence-based guidelines and literature, we have developed a comprehensive library of criteria (or edits) that are used to evaluate and flag claims at the point of sale, before the Member receives the medication. Before dispensing a prescription drug, our prospective DUR program sends the pharmacist a real-time message, allowing the pharmacist to counsel the patient at the point of service and consult with the prescribing provider, when available.

Our prospective DUR program has developed multiple algorithms for comparing submitted prescription data with pre-determined evidence-based guidelines to identify any potential drug issues or critical medication interactions. We also ensure comparison of prescription data with the Member's profile data and prescription history to further refine messaging based on the Member's specific condition or needs.

For example, when the pharmacist enters the claim into the processing system, the system will:

- Scan the Member's claim history for potential drug interactions
- Compare the days supply provided on the current prescription claim, and any previous prescription claims on the Member's history
- Examine the Member's claim history to identify duplicate therapy
- Run the prescription against a database of dosage parameters designed to detect inappropriate medication dosing (subtherapeutic or excessive dose)
- Check for under utilization of maintenance drugs to detect non-compliance
- Profile specific drugs to determine if a dosing change is indicated after a specified period of time
- Review the Member's history to infer a state of health and compare that health state to the prescribed drug (this is how the edit system screens for drug/ pregnancy contraindications and drug/disease contraindications/interactions)
- Screen the Member's profile records (if completed by the Member) for drug allergies and potential cross sensitivities
- Review the prescribed drug and identify contraindications in drug therapy based upon Member's age.

To support this process, the Prescription Solutions database stores the patient's entire claims paid history for at least one year, without regard to the pharmacy used. Based on the specific messaging or criteria programmed in the system, the dispensing pharmacist may receive a hard reject of the prescription; or, the pharmacist may receive a "soft" warning that will prompt interaction and discussion with the Member to determine appropriateness of the medication being requested. Key system-based edits include quantity limits, step therapy, and prior authorization. All of these prospective utilization management tools adhere to the Department's contractual requirements.

Physician Education and Awareness

UnitedHealthcare publishes a provider newsletter on a regular basis, which includes articles on the use of the formulary and sound prescribing practices. In addition, UnitedHealthcare pharmacists contact physicians as necessary on current drug use information and provide consultation with health plan physicians upon request.

Educational mailings are complemented with information on newly added formulary alternatives and new FDA approvals, drug indications and interactions, and dosage forms and strengths.

Quantity Limits

Quantity limit edits are fully integrated with our electronic claims system and offer the ability to:

- Control minimum/maximum quantity dispensed per prescription and reject claims if criteria are not met
- Prevent over- and under- utilization of prescribed medication, incorrect dosage or duration of drug therapy and clinical abuse/misuse.

Member Education

We strive to ensure that Members are well informed before they begin any drug regimen. To assist with Member awareness and education, we have developed a complete library of Member Q&A materials that address common drug issues and questions, such as:

- Take as Directed
- Influenza Vaccine Information
- Generic Medication Effectiveness
- Understanding Your Heart Medicines
- Look-Alike Drugs
- Antibiotic Use.

We work with our clients to ensure appropriate dissemination of these educational materials, which we provide at no additional cost.

Retrospective DUR

The objective of the retrospective DUR program is to ensure that UnitedHealthcare Members receive appropriate drug therapy. The program can identify exceptional or potentially inappropriate therapy and prescribing practices of physicians by collecting, tabulating, and analyzing data from our point-of-service claims processing system. In a continuous improvement loop, issues identified through retrospective DUR feed the prospective review processes described above.

Drug claims data are categorized according to frequency of prescription, cost, side effects, physician education opportunities, patient risk for hospitalization, controlled substance, and inappropriate utilization. UnitedHealthcare, in coordination with Prescription Solutions, reviews and analyzes drug utilization patterns on a daily basis with attention to patterns of fraud, misuse, abuse, and inappropriate or unnecessary care. Fraud and abuse is detected through the edits for controlled substance abuse, excessive utilization, and excessive drug dosing. All prescription drug claims are reviewed quarterly to establish utilization profiles for patients, pharmacies and physicians. Interventions, which may occur by mail, telephone or a face-to-face encounter, take place only after a clinical pharmacist has reviewed the prescribing information and UnitedHealthcare has approved the intervention plan.

We also use these data for our focused drug classification interventions or targeted DURs. As we identify potentially adverse patterns, we work with our PBM to implement existing or new interventions that may yield improved outcomes and cost savings. Selected programs are implemented, and Prescription Solutions provides reporting on a pre- and post-intervention basis to demonstrate program effectiveness and identify opportunities for repeat intervention as warranted.

Retrospective DURs are performed using UnitedHealthcare claim data spanning time frames of 3 to 6 months. In all of the DURs, identified physicians are sent the following information: a letter describing the DUR, patient profiles of affected Member(s), educational material associated with the DUR including appropriate clinical guidelines and recommendations, patient education materials, and a provider response form. Results are recorded from the returned forms and reported at the following P&T meeting.

P&T Oversight

OBRA 90 assigns three primary activities to the P&T Committee. These include but are not limited to: the application of predetermined standards, retrospective DUR and ongoing interventions with pharmacists and physicians on issues identified through the DUR process. The P&T Committee is ideally suited to serve in this function and is responsible for review of DUR activities.

Strategies for Improving Performance

We continually strive to evaluate and improve our programs to achieve better results, both in terms of quality and cost outcomes. Our core improvement strategies include enhancing and updating program components as necessary based on regulatory requirements, new evidence from medical literature and national guidelines, our P&T Committee's recommendations, provider feedback, and outcomes analyses from previous years. During 2009, UnitedHealthcare will implement the following specific strategies as part of our effort to continually improve performance:

- We will review the most commonly reported therapeutic duplication issues identified through the retrospective drug utilization review program and evaluate the potential of moving the edits to the prospective drug utilization review program, in an effort to take a proactive, preventive approach to avoiding these problems.
- We will conduct a routine review of hospital admissions to identify those that are related to drug therapy. Based upon the information identified in these reviews, we will review the associated prescription claims history to identify potential patterns that will help us to initiate preventive measures.

We provide several examples of drug utilization programs that have been successful in the table below:

Program Name	Program Description	Outcomes/Evidence of Success
Asthma DUR: Use of Appropriate Medications for People With Asthma	This DUR was designed to improve the quality of asthma therapy and decrease overall cost of care for this disease state by enhancing physician awareness of the NAEPP guidelines for appropriate pharmacotherapeutic management of asthma. Specifically, the intent of this DUR was to achieve these goals by identifying patients with a diagnosis of persistent asthma who have not been appropriately treated with a long-term control medication and to inform PCPs of their patients who have been identified by the plan as asthmatics, and may benefit from the addition of a long-term control medication.	The success of this medication review was assessed via monthly tracking of Members who have fills of long-term control of medications according to HEDIS standards. Calculated HEDIS % increased from 57.05 to 77.87 over a 4-month period.

Program Name	Program Description	Outcomes/Evidence of Success
Controlled Substance (CS) DUR: Excessive CS Utilization	This DUR was designed to identify plan Members who are receiving excessive prescriptions for controlled substances or are engaging in drug seeking behavior, utilizing multiple physicians and/or multiple pharmacies. Members were identified if they received more than 12 CS Rxs (DEA schedule II-IV) in a 3-month time frame OR if they received at least 6 CS Rxs in a 3-month time frame utilizing 3 or more physicians. Physicians were also informed of potential acetaminophen or aspirin over-utilization in combination products. Reports were generated and the identified Members were ranked by the total number of CS prescriptions, the number of physicians writing CS prescriptions and by the number of pharmacies used to fill CS prescriptions.	UnitedHealthcare's lock-in program is a direct reflection of this review's success. Currently, UnitedHealthcare has 119 enrollees in this restricted access program. These Members receive all care through specific providers who coordinate care.
Antidepressant Medication Management	Over a rolling six-month period, we identified selected patients who have had gaps in their antidepressant medications for longer than allowable periods as defined by HEDIS measurements. We have sent mailings to these patients' physicians asking them to review the enclosed medication profiles for these patients and recommending they discuss with these patients the importance of medication adherence in the treatment of depression. The mailings also include talking points for discussion with their patients.	This DUR was completed for the first 6 months of data for 2008. It is scheduled to run first quarter of 2009 for the last 6months of 2008 data and will be run every 6 months thereafter. Outcomes will be tracked for medication adherence through 2009 and beyond.

We have integrated some of our core quality assurance and utilization management programs with our CMS-approved Medication Therapy Management program (MTMP) to create a library of interventions that are appropriate for SCHIP populations. The table below provides descriptions for a sampling of available retrospective programs. (* Generic names have been provided for all drugs.)

Program Name	Program Description	Targeted Medications*
Polypharmacy Program	This program is a physician-based intervention that aims to reduce unnecessary use of pharmaceuticals and heath care burden caused by inappropriate use. The program uses pharmacy claims data to identify Members whose pharmacy profile contains a drug or a combination of drugs that are in one or more polypharmacy categories during a defined three-month identification period. Program components include provider letter, provider-specific reports listing patients with polypharmacy issues, and provider educational materials on polypharmacy (for example, Medication Appropriateness Evaluation tool).	Various medications based on multiple references (for example, Applied Therapeutics by Koda-Kimble, Beers' criteria, The Medical Letter, JAMA)

Program Name	Program Description	Targeted Medications*
Appropriate Use of Controlled Substances Program	This program is a provider-based initiative designed to promote optimal pharmacologic therapy for the management of patients with pain and to minimize the occurrence of drug abuse, diversion, and inappropriate use in patients utilizing opioid analgesics. In addition, the program aims to educate providers regarding the appropriate use of opioid analgesics, as outlined in guidelines and policies from the American Pain Society, World Health Organization, and Federation of State Medical Boards. This program targets physicians who have prescribed an opioid analgesic to a patient that may require evaluation, as determined by analysis of prescription claims. Targeted prescribers receive individual reports for each patient that details the opioid utilization that triggered the intervention mailing. Prescribers are encouraged to return a response form to confirm appropriate use and follow-up, or the specific action that will be taken if a change in treatment is deemed appropriate. Educational materials regarding the use of opioid analgesics for the management of pain are also included in the mailing.	Long-acting and short-acting narcotic analgesics (for example, morphine, meperidine, oxycodone, and combination products)
Refill Reminder Program	This program is a Member-based intervention that targets Medication Therapy Management (MTM) program enrollees who have been identified as non-adherent with select oral maintenance medications The objectives of this program are to promote patient awareness of the importance of medication adherence, improve adherence of commonly prescribed maintenance medications, and reduce the number of missed (or delinquent) fills of maintenance medications. The identified Members receive HIPAA-compliant refill reminder calls from a messaging and communications vendor contracted with Prescription Solutions to provide this service.	Various therapeutic areas (for example, antidepressants, statins, antidiabetic agents, antiasthma agents, cardiovascular agents)

In addition, we can integrate the following clinical programs to achieve greater control over drug costs and encourage appropriate medication utilization. The table below provides standard clinical programs. (* Generic names have been provided for all drugs.)

Program Name	Program Description	Targeted Medications*
Generics Program	This program is specifically designed to promote appropriate use of lower cost, high-quality, and first-line generic medications. Key components of our multi-faceted, clinical campaign to enhance generic utilization include: General educational outreach to prescribers and Members to increase their awareness of the availability of generic products Targeted communication to prescribers and Members to alert them of cost savings opportunity via provider-specific reports and Member letters Telephonic outreach to targeted prescribers and Members to further promote generic utilization. Automated refill reminder calls to promote Member adherence to therapy	Including, but not limited to, statins (for example, atorvastatin, rosuvastatin), PPIs (for example, esomeprazole, pantoprazole), and SSRIs (for example, sertraline, escitalopram).
Migraine Prophylaxis Program	This program is designed to increase physician awareness of current recommendations from the United States Headache Consortium (USHC) regarding migraine prevention therapy and to optimize the use of migraine prophylactic agents in patients who frequently utilize triptans. Program components include a provider letter, educational materials for the provider and Member, and a provider-specific report listing Members under the provider's care who might benefit from migraine prophylactic therapy.	Sumatriptan, naratriptan, almotriptan, frovatriptan, rizatriptan, eletriptan, zolmitriptan, NSAIDs (for example, ibuprofen, naproxen), tricyclic antidepressants (for example, amitriptyline, nortriptyline), beta-blockers (for example, propranolol, atenolol, metoprolol), calcium channel blockers (for example, verapamil, diltiazem), divalproex sodium, and cyproheptadine.
Diabetes Programs	We administer several diabetes programs that focus on this disease state in relation to use of statins, use of ACEI/ARB drugs, screening for microalbuminuria, and management of Syndrome X. Program objectives include promoting appropriate management of diabetes and increasing physician and patient awareness of related health conditions.	Lovastatin, simvastatin, niacin ER/lovastatin, ezetimibe/simvastatin, captopril, benazepril, enalapril, ramipril, quinapril, fosinapril, moexipril, lisinopril, valsartan, olmesartan
Asthma Intervention Program	This program is designed to improve quality of life and self-management skills of Members with asthma and to reduce asthma related costs. The program targets Members with poorly controlled asthma as indicated by their asthma prescription utilization pattern and asthma related medical claims data. The components of this program include educational materials for Members and their prescribers and provider-specific reports identifying their patients who are classified as high risk or who are not meeting HEDIS criteria for appropriate asthma medication use.	Short-acting beta agonists (for example, albuterol, metaproterenol, isoproterenol), inhaled corticosteroids (for example, beclometasone, flunisolide, fluticasone), and other asthma medications (for example, salmeterol, zafirlukast, cromolyn)

Evidence of Program Success

Savings related to our DUR programs can vary greatly depending on client program selections, Member utilization, and physician prescribing habits. Below we provide examples of our most recent client savings related to three of our key DUR programs that target senior populations.

Polypharmacy Program

This provider intervention is designed to promote safe and appropriate medication use among Members by addressing providers of Members with polypharmacy cases. These include inappropriate "duplicate" therapies and drug-disease interactions. Key components of the program include provider introductory letter, provider education material and provider report of each identified Member and polypharmacy incident.

An illustration of the effectiveness of our polypharmacy program is in the adult Medicare Part D population. Results from 2007 included:

- 45.8 percent of 526,039 intervened upon PDP Members resolved at least one polypharmacy issue during the measurement period. Member resolution rates were as follow: 36.8 percent for duplicate therapy, 46.1 percent for drug-disease interaction, and 34.9 percent for cascading therapy. Following the intervention, mean costs for targeted polypharmacy medications per Member decreased by $99.38.
- 47.2 percent of 27,216 intervened upon MAPD Members in one client resolved at least one polypharmacy issue during the measurement period. Following the intervention, mean costs for targeted polypharmacy medications per Member decreased by $88.71.

Narcotic Drug Utilization Review

The narcotic drug utilization review proved effective when it was implemented for an adult Medicare Part D population. Results from 2007 included:

- 73.5 percent of 13,861 intervened upon PDP Members resolved at least one incident of potentially inappropriate narcotic use during the measurement period. Member resolution rates were as follow: 49.2 percent for meperidine utilization, 22.4 percent for chronic nasal butorphanol, 30.2 percent for use of ≥ 2 long-acting opioid, 83.9 percent for multiple prescribers for same opioid, and 77.3 percent for multiple pharmacies for same opioid. Following the intervention, mean costs for opioid analgesic medications per Member decreased by $20.11.
- 82.1 percent of 290 intervened upon MAPD Members in one client resolved at least one incident of potentially inappropriate narcotic use during the measurement period. Member resolution rates were as follow: 57.1 percent for meperidine utilization, 66.7 percent for chronic nasal butorphanol, 31.0 percent for use of ≥ 2 long-acting opioid, 91.4 percent for multiple prescribers for same opioid, and 87.2 percent for multiple pharmacies for same opioid. Following the intervention, mean costs for opioid analgesic medications per Member decreased by $44.48.

Strategies for Improving Performance

We continually strive to evaluate and improve our programs to achieve better results, both in terms of quality and cost outcomes. Our core improvement strategies include enhancing and updating program components as necessary based on state or CMS requirements, new evidence from medical literature and national guidelines, our P&T Committee's recommendations, provider feedback, and outcomes analyses from previous years.

For example, we may take steps to broaden or limit the scope of a particular program when our outcomes studies indicate either the need to target a larger or smaller Member population based on a Member's likelihood to respond to the intervention.

183. How is prescription drug data used to enhance care and health management? Please describe in detail.

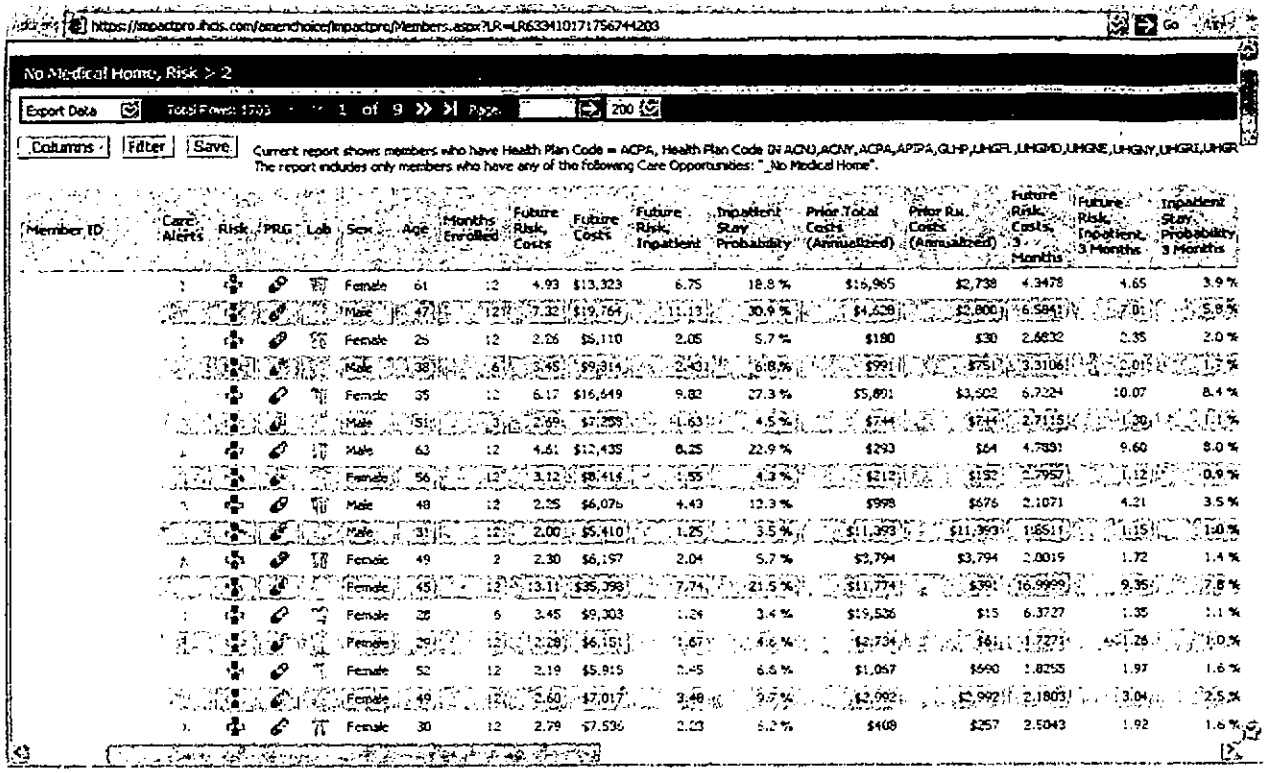
We work with Prescription Solutions, our subcontracted PBM, to develop a comprehensive set of periodic and ad hoc pharmacy reports. Prescription Solutions provides UnitedHealthcare with claims data to generate quarterly reports that contain high-level utilization and financial information, and monthly and ad hoc reports that target provider prescribing patterns and Member utilization patterns. We use pharmacy claims data to internally generate pharmacy reports via a dedicated pharmacy analytics team. Our medical management and pharmacy team review these utilization reports to ensure that the formulary is appropriately applied, identify unusual utilization patterns, identify utilization of generic prescriptions, including new generics, analyze the cost of generic claims versus brand name drugs, analyze spend and utilization between generic drugs and brand name drugs, and evaluate step therapy opportunities for appropriate utilization of the pharmacy spend.

Strategic Management Analytic Reporting Tool (SMART)—SMART is a robust data warehousing and decision support tool used for analytics and enhanced reporting. Our SMART Data Warehouse is an analytics system for enhanced reporting for predictive care models, episodes of care, claims lag, utilization, unit costs, provider profiling, Member retention and other analytical capabilities. It is a multi-dimensional data warehouse that collects information from the various operational systems on a daily, weekly and monthly basis; depending on the data source. Information stored in this warehouse includes geographic, line of business, service category, product data; Member and provider demographics, provider contracts; revenue capitation data by rate cell; claims/encounters for each service category; appeals; service authorizations by day, diagnosis and level of care; actuarial reserving completion factors; and disease management categorizations and risk stratification scores by Member.

Impact Pro—We use this predictive modeling software to stratify Members at risk for future admissions based on diagnosis codes. Impact Pro supports our case and disease management strategies. Claims, laboratory, pharmacy, and Member demographic data are entered into Impact Pro, through which we conduct a comprehensive risk assessment. Impact Pro then assigns a risk score to each Member. Based on these risk scores and our interaction with the Member, our case management team determines if the Member requires case management.

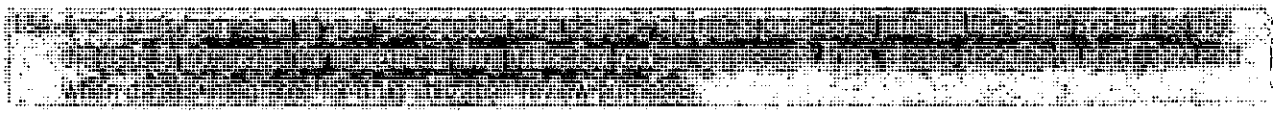
CareOne—CareOne is used by our care managers to manage the Member's care and identify Members in need of case or disease management services. After we identify Members in need of case management, our care managers use CareOne to view both Member claims data, assessment results, and case notes. Care managers can then reference our Impact Pro system for additional information on a Member's care history, risk profile and clinical indicators. UnitedHealthcare has access to a large number of ad hoc internal current data reports to promote daily intervention and proactive Care Management Intervention. Below is one of over 30 major reports available from our Impact Pro software. This report identifies all Members currently enrolled who do not have a medical home and have a risk factor of two or greater for encounter/costs/utilization.

Inpatient Case Managers can quickly identify those Members admitted who do not have a medical home and see their future health risk score, which can be compared to the current risk score in column. Taken together, they offer a snapshot of that Member's future prognosis as well as the need and intensity of case management intervention required. In addition to the daily census, we produce a daily listing of outlier patients, which serves as a focal point for care management to assess discharge planning and needs.



Pharmacy data feeds into 'Smart' and CareOne databases are available for utilization management and interventions. Our Pharmacy department monitors utilization patterns to assure appropriate use and manage the drug program, (Prior Authorization, Step Therapy and Quantity limits). Data is also generated that can be used to identify patients for possible case management. For example, a prenatal vitamin Rx report can be generated monthly and provided to case management to assure that individuals are enrolled in prenatal care programs.

Pharmacy Clinical Programs – Self-Insured Products



Prescription Solutions and UnitedHealthcare fully integrate retail and mail service specialty drug operations with utilization review and reporting in order to achieve optimum efficiency and excellent customer service. For example, the same information files are used for eligibility with all retail and mail claims for adjudication in real time. This level of integration ensures that all drug interactions and critical issues are preempted proactively. Since the mail service and retail programs use the same Member information from the same database, the potential adverse interactions are negated.

- Following are some of the benefits of our integrated online claims processing system:
- Drug utilization review edits are applied across all claims
- Integrated Member claim history profiles are available
- Consistent interventions are applied in both retail and mail service settings
- Integrated billing and reporting to create simplified data management and efficient program administration
- Consistent claims auditing processes to ensure high quality service level.

185. Are there additional fees for drug utilization management programs when prescription drug services are self-funded? If yes, please describe in full and quantify.

Yes. The standard utilization management (UM) programs are $0.03 per Member per month. Additional programs can be provided at cost of $0.05 per Member per month for each selected program.

Pharmacy Account Management and Reporting – Insured and Self-Insured Products

186. Will you provide a clinical pharmacist who is dedicated to the Board for this program?

UnitedHealthcare will maintain a single point of contact for the MS CHIP program. A pharmacist will be assigned to monitor the MS CHIP program and interface with the Board. We maintain our own pharmacy department to monitor and manage our Membership. These include clinical pharmacist, pharmacy technicians and operations management staff.

187. If no, how do you propose to manage prescription drug utilization and recommend changes to enhance quality and savings opportunities? Please describe in full.

UnitedHealthcare's lead pharmacy pharmacist will be the Board's one point of contact on pharmacy matters, and will manage Prescription Solutions and interface with the P&T committee. Our pharmacy department will be fully engaged with Prescription Solutions to manage the relationship and advise the Board regarding enhancements to its prescription drug program.

188. How often will you provide detailed reports on the prescription drug program?

UnitedHealthcare will provide the required standard prescription drug reports on a quarterly and annual basis as specified in Section 11.4.1 of the RFP. These reports are identified in the table below (see our response to Question 189). We and our PBM monitor activity monthly and will provide more frequent reports if requested of the Board.

In addition to the required reports, the Board may obtain detailed prescription drug information at any time by using the Online Reporting Tool, a web-based ad hoc reporting and decision-analysis tool. This tool will be furnished free of charge.

189. Please describe in full what reports will be provided and when.

UnitedHealthcare will provide the standard reports as requested by the RFP, and will also offer a comprehensive package of off-the-shelf reports in addition to the required reports. The table below describes the required reports.

Report	Description	Frequency
Prescription drug utilization	Utilization data by prescription drug, including: ▪ Number of prescriptions ▪ Single source, multisource, generic ▪ Total charges ▪ Ineligible charges ▪ Paid charges Other data elements will be included as agreed between UnitedHealthcare and the Board.	Quarterly for the most recently-completed calendar quarter; will be completed within 30 calendar days of the end of the prior quarter. Each quarter will include cumulative year-to-date totals.
Prescription drug utilization by provider	Separate reports for network and non-participating providers, including: ▪ Number of prescriptions ▪ Single source, multisource, generic ▪ Total charges ▪ Ineligible charges ▪ Paid charges Other data elements will be included as agreed between UnitedHealthcare and the Board.	Quarterly for the most recently-completed calendar quarter; will be completed within 30 calendar days of the end of the prior quarter. Each quarter will include cumulative year-to-date totals.

Report	Description	Frequency
Prescription claims and top 25 drugs	Prescription claims data by therapeutic category, including: ▪ Number of claims paid by category ▪ Dollars paid by category Top 25 drugs, including: ▪ Number of claims by drug ▪ Dollars paid by drug Top 25 drug list sorted from highest to lowest dollars paid. Other data elements will be included as agreed between UnitedHealthcare and the Board.	Quarterly for the most recently-completed calendar quarter; will be completed within 30 calendar days of the end of the prior quarter. Each quarter will include cumulative year-to-date totals. Separately, provide federal fiscal year-end report.

Other Standard Reports

UnitedHealthcare offers the Board additional standard reports that are based on those available in the core reporting package of Prescription Solutions, our pharmacy benefits management subcontractor. These include a combination of general and complex reports that measure drug cost and utilization information at the plan, group, pharmacy, prescriber, and Member level. With the assistance of Prescription Solutions' client management team, UnitedHealthcare can help the Board identify benchmark statistics, discover trends that may warrant intervention, and forecast potential savings.

Report Types and Titles

We can provide the Board with the following standard reports on a monthly, quarterly and annual basis. We can also accommodate ad hoc reporting as needed, though such requests may be best served through use of the Online Reporting Tool, which we will furnish to the Board at no charge.

- Brand and Generic Utilization Summary
- Customer Service Statistics
- Days Supply
- Direct Member Reimbursement
- Direct Member Utilization
- Drug Utilization and Cost
- Formulary Compliance
- Generic Utilization
- Group Utilization Summary
- Mail Service Utilization
- Member Prior Authorization Detail
- Pharmacy Provider Utilization Summary
- Prescription Solutions Customer Service Statistics
- Top 5 Therapeutic Classes by Ingredient Cost
- Top 10 High Cost Drugs by Ingredient Cost
- Top 30 Members by Ingredient Cost
- Top 30 Pharmacies by Ingredient Cost
- Top 30 Prescribers by Ingredient Cost
- Total Transactions Processed
- Utilization Summary.

Quarterly management reports, which organize raw data into actionable information, will be reviewed with the Board. An Executive Summary will also be provided to the Board, which provides a platform to analyze census information, plan averages, ingredient costs, generic fill rates, and client statistics; it is also used to recommend future plan designs.

Annual reports will also be provided to the Board in the form of an Executive Summary and will include comprehensive statistical management details that provide the Board with data necessary to accurately forecast and manage the pharmacy benefit for MS CHIP. In addition, we use the data to carefully review critical areas such as trends in formulary compliance and utilization management. These analyses allow our management team to propose and implement cost-saving measures that can further reduce overall healthcare expenditures.

Reporting and Clinical Management Programs

In addition to the reports described above, UnitedHealthcare runs a variety of different reports on pharmacy data to assist with clinical management programs. For example, we analyze overall pharmacy over and under-utilization, trends, and prescribing patterns, and produce specific reports such as: the top 100 drugs, top 100 Members' utilization and the top 100 prescribers; therapeutic class report; prenatal vitamin report; anti-hemophilia medication and HIV/AIDS therapy reports. Pharmacy data is also integrated into our data warehouse and Impact Pro reports to risk stratify and identify Members for case and disease management. These analyses occur weekly. Our Medical Directors and Pharmacy Director meet weekly to monitor and evaluate all pharmacy utilization reports and discuss any required interventions with our Chief Medical Officer and senior management team.

190. Will on-line reporting be provided? Please describe in detail.

Yes, UnitedHealthcare will provide the Board with an Online Reporting Tool, a sophisticated web-based reporting and decision-analysis tool that enables the Board to generate reports at its convenience.

UnitedHealthcare will grant a single-user access to the Board for the Online Reporting Tool. Our pharmacy staff will conduct training for the Board on the appropriate use of the tool and interpretation of the data. All technical questions regarding use of the tool and interpretation of the data should be directed to the UnitedHealthcare Clinical Pharmacist. The designated Board user must also respect appropriate confidentiality and HIPAA regulations in use of the reported data.

Our sophisticated Online Reporting Tool serves as an on-demand report resource and effective decision-support system. This Web-based, interactive tool provides instant access to a broad range of plan metrics and performance data. Through this tool, Unison can graph, print, and download online reports to a Microsoft Excel spreadsheet. The Online Reporting Tool can even calculate potential cost savings if Members were to switch from a high cost medication to a medically equivalent low cost alternative.

The tool displays report options in the following categories:

- Shared Reports: Reports available for everyone's use
- My Reports: Reports available only to the requesting client
- Create Reports: Includes wizards to create reports
- History List: Includes recently run reports.

Some of the features and benefits of the Tool include:

- Internet-based information delivery: Access information from anywhere in the world using Internet Explorer® or Netscape® Web browser and an Internet connection.
- Convenient user interface: Our user-friendly interface facilitates easy navigation by dividing site functionality into five site sections: Shared Reports (shows reports available to a group of users), My Reports (shows reports available to the specific use), Create Reports, History List, and Preferences.
- Extensive portfolio of pre-defined, flexible report wizards: Choose from over 20 pre-defined report wizards.
- Graph information on your browser display: Visualize information to spot trends and exceptions quickly.

- Download your reports directly to Microsoft Excel®: Use Excel® to further manipulate and analyze your data.
- Drill up, down, across and through report data: A robust multidimensional data model enables users to drill in virtually any direction.
- Secure Data transmission: Firewall, filter and encryption technology protects the integrity and confidentiality of your data.
- Customized reporting: Custom report builder makes it easy for users to focus on data that is important to their business.
- High-speed parallel processing database: Complex queries and reports are returned to the desktop in minutes.

Data Elements

The reporting tool captures and reports on multiple data elements that can be displayed under various categories, including plan, drug, Member, pharmacy, medical group, primary care provider, and prescriber categories. Standard data elements include those shown in the table below.

Available Data Elements		
Approved Amount Due	Dosage Form	Plan Drug Status
Approved Copayment Amount	Drug Administration Route	Prescriber ID
Approved Dispensing Fee	Drug Unit of Dose/Unit of Use	Prescriber Name
Approved Ingredient Cost	Gender	Prescription/OTC Indicator
Approved Patient Pay Amount	Generic Indicator Information	Primary Prescriber ID
Approved Sales Tax	GPI Information	Prior Authorization Number
Care Facility Information	Gross Amount Due	Prior Authorization Reason Code
Claim Counter	Member Date of Birth	Refills
Claim Number	Member ID	Reimbursement Flag
Claim Sequence Number	Member Name	Relationship Code
Client	Metric Quantity NABP Number	SBM Ingredient Cost
Cost Type	NDC Information	Specialty Code
Customer Location	New Refill Code	Submitted Date
DAW	Paid Amount Due	Submitted Prescription Number
Days Supply	Person Code	Tax
Dispensing Fee	Pharmacy Address	TCD Claim Status
	Pharmacy ID	U&C
	Pharmacy Name	Zip Code

Many of these elements can be displayed on an aggregate basis, including per Member per month (PMPM), Per Utilizing Member Per Month (PUMPM), Per Member Per Year (PMPY).

Standard Online Reports

We offer a standard catalog of reports that the Board can use to analyze various performance and utilization data elements. The tool also includes a user-friendly report wizard that offers a step-by-step process for generating specialized report templates that can be saved and reused.

Some of our standard, pre-designed online reports include:

- Drug Detail
- Member Detail
- Pharmacy Detail
- Medical Group Detail
- PCP Detail

- Prescriber Detail
- Top Cost Effective Alternatives (shows potential cost savings for generic drugs)
- Top Medical Groups
- Top PCPs
- Top Prescribers
- Top Drugs
- Top Members
- Top Pharmacies
- General Performance Statistics
- General Client Comparison
- General Medical Group Utilization Summary
- General Formulary Management.

Book-of-business and Benchmark Data

Through the online tool, users can easily generate specific benchmark reports that compare performance and utilization across plan, drug, Member, pharmacy, medical group, primary care provider, and prescriber categories. These reports can help identify specific patterns or trends within certain categories on an aggregate or individual basis. For example, benchmark reports can assist with identifying outlier prescribing patterns across all medical groups or within one specific medical group.

This benchmark reporting capability is available only for the MS CHIP-specific plan data. The Board cannot access data for other UnitedHealthcare plans via our online tool. However, we do provide book-of-business reports through our standard quarterly and annual reporting packages, which are delivered by the account management team. We are also willing to accommodate ad hoc requests for book-of-business comparison statistics. We can tailor these reports to include clients that are similar to the MS CHIP plan in terms of size, location, Member demographics, and other key factors.

Report Formats

Our tool supports various report views and options for printing and saving reports. Users can hide fields or toggle between grid and graphic report displays or select a combination view. A pivot function that switches views between a row or column display is also available. Users can also select page divisions that break up reports into meaningful sections and choose preferred header titles and colors. All reports are formatted for easy export to a plain text or Excel format. This export function allows users to further manipulate data and create customized charts and graphical displays.

Technical Requirements

Users of the Online Reporting Tool must have the appropriate permissions to access their own computer network(s) and the internet. The following table outlines the minimum and recommended requirements to run the Online Reporting Tool:

Hardware Requirements	Minimum	Recommended
Processor (CPU) speed	333 megahertz (MHz)	500 MHz or higher
Random Access Memory (RAM)	32 megabytes (MB)	128 MB or greater
Internet access	(High-speed access recommended for best results)	High-speed access (cable, digital subscriber line (DSL))
Operating system	Microsoft (MS) Windows 98	MS Windows 2000 or later
Office Software	MS Office 97	MS Office 2000 or later

Hardware Requirements	Minimum	Recommended
Internet browser	Standard browser that supports the following: ▪ Hypertext markup language (HTML) capabilities ▪ 128-bit encryption (SSL) ▪ Forms compatibility ▪ Cookie enablement	MS Internet Explorer 6.0 or later

Access and Security

We protect the confidentiality of the data warehoused in our Online Reporting Tool by using advanced firewall, filter, and 128-bit encryption technology. We also apply stringent user ID and password policies that facilitate secure access by authorized users. We can restrict access type (read only versus write access) for specific users based on client input and requirements. Internally, we apply similar restrictions by providing access only to those employees who need access to client data in order to perform their job duties.

191. If yes, will the Board be able to develop ad hoc reports from the on-line system? Please describe.

Yes, the Board can conduct on-demand business information analysis and reporting using the Online Reporting Tool. It is a flexible, state-of-the-art reporting system that the Board can use to access data and generate ad hoc reports. Using a Web interface, the Board will be able to view and download accurate and easy-to-comprehend information on:

- Overall utilization data in a summarized format
- Provider-specific utilization information
- Trend information
- Recommendations to improve performance
- Forecasting drug expenses to develop strategies to control costs.

The tool is an ad hoc decision support system that provides instant web access to deliver reliable data for managing the utilization of pharmacy products and services. The Board can graph, print, and download these reports to a Microsoft Excel spreadsheet. The Online Reporting Tool can even calculate potential cost savings if Members were to switch from a high-cost medication to a medically equivalent low-cost alternative. This tool has provided most clients with the ability to customize their reports with little need for additional customization work by Prescription Solutions.

192. How often is the data updated or refreshed in the on-line reporting system?

Prescription Solutions maintains up to 36 months of historical Member data in the Online Reporting Tool data warehouse. Additionally, Prescription Solutions loads and updates claims information for this tool on a daily basis to ensure that the Board will have timely access to Member utilization information.

193. How often will your clinical pharmacist/account manager meet with the Board to discuss the prescription program?

Our Clinical Pharmacist and Account Manager will meet with the Board quarterly to review the prescription drug program. This will include, but not be limited to, reviews of utilization, prior authorization activity, rebate programs, formulary and clinical agents, MAC pricing, prospective and retrospective DUR, and so on. The meetings will also be used to discuss proposed program improvements, action items, assignments, and timelines.

Other meetings may be conducted as needed to discuss items of an urgent nature; for example, benefit design changes, emerging clinical issues with specific drugs, and so on.

194. Are there any fees for the on-line reporting program? If yes, please describe and quantify.

There are no additional fees for the web-based Online Reporting Tool.

If customized reports are required that cannot be produced by the Online Reporting Tool, we will negotiate additional costs, which will depend on the complexity of the custom requirements. Custom programming services are available at $150 per hour.

Provider Services

195. Indicate the days of the week and hours of the day your proposed provider service department and telephone lines will be open and staffed with live personnel.

Our office will be open and staffed with trained personnel, including a Manager of Provider Services and Provider Service Representatives (PSRs), Monday through Friday from 8:00 a.m. until 5:00 p.m. CST. We will maintain a distinct team of PSRs in our call center to respond to MS CHIP providers. PSRs are available from 8 a.m. to 6 p.m. CST. After normal business hours, providers have access to UnitedHealthcare's interactive voice response (IVR) system. The IVR is a toll-free voice portal that gives providers access to claims, benefits and eligibility, credentialing and appeals and grievances.

Our automated IVR system routes incoming calls to recorded announcements, options that are available using a touch-tone phone and to the next available representative. To maximize efficiency and get providers information they need quickly, we customize the call scheme to enable the provider to choose topics including eligibility issues, benefit questions, authorization or claim status. We then efficiently route the call to an experienced PSR who expertly responds to the call.

UnitedHealthcare has proven monitoring and reporting processes that will ensure responsiveness to providers calling the provider service center. Our provider call center management team uses a series of training and monitoring applications to aid in auditing our call response rate. We generate specialized reports on a daily basis to identify peak call times and quantify PSR productivity. Call auditing provides the information necessary to determine if staff scheduling requires an adjustment during peak hours, if we identify the need to hire additional staff, or if specific PSRs require additional training. Because Member and provider service representatives are cross-trained, supervisors are also able to temporarily assign service representatives to the greatest area of need.

UnitedHealthcare will generate our Customer Care Daily MIS telephone system report daily. This report provides daily, week-to-date and month-to-date information and statistics on call availability, answering speed, on-hold time and abandonment rates for the MS CHIP program. Our experience and record show that we will easily accommodate the MS CHIP RFP requirements of 90 percent answer rate within 30 seconds, 3-minute maximum hold time and less than 5 percent abandonment rate. We will provide the State with reports that track the daily availability of telephone service, the monthly telephone average speed of answer (ASA), the monthly average on-hold time and the average monthly abandonment rates. In addition, we will supply quarter-end and year-end telephone system reports no later than the last day of the month following the reporting period.

Our experience and success with call center operations, indicated by the statistics presented in the table below, ensure that we will answer at least 90 percent of MS CHIP program Member calls within 30 seconds, with less than three minute hold times and an average abandonment rate less than 5 percent. The table below demonstrates our expertise in responding to large call volumes.

Month	Total Calls	Live Answered Calls	ASA	On-Hold	Abandon Rate
MS CHIP Requirement			<30 seconds	<3 min.	≤5%
Feb 2008	46417	45225	17	0	3%
Mar 2008	51493	50204	21	0	3%
Apr 2008	50009	48728	19	0	3%
May 2008	47531	46096	23	0	3%
Jun 2008	44045	43127	16	0	2%
Jul 2008	41454	40360	20	0	3%
Aug 2008	41148	39512	29	0	4%
Sep 2008	41676	39283	42	0	6%*
Oct 2008	41891	40562	24	0	3%
Nov 2008	35997	35032	18	0	3%
Dec 2008	40603	39169	23	0	4%
Jan 2009	49824	47883	30	0	4%
Total/Average	**532088**	**515181**	**24**	**0**	**3%**

*In September 2008, Hurricane Ike devastated Houston and our call center was without power.

197. How do you plan to educate providers regarding your policies and procedures for CHIP?

The UnitedHealthcare provider education and training program is built on 27 years of experience with providers and multi-state Medicaid managed care programs and includes the follow training components:

- Provider training sessions
- Provider forums
- Provider manual
- Provider website
- Provider newsletters and fax blasts.

Our provider education, training, and communications program covers multiple topics and uses various channels to give CHIP policy and procedure information to providers. In this section, we cover the following:

- Topics covered in provider education, training, and communications
- Provider Training Sessions
- Department and Staff Roles and Responsibilities
- Provider Education and Communications Tools.

Topics Covered in Provider Education, Training, and Communications

UnitedHealthcare has a strong provider education and training program that begins when the provider first contracts to join our network and provides ongoing general and targeted education and training. We ensure that all providers understand contract requirements and plan processes related to the MS CHIP program, including but not limited to:

- MS CHIP benefits, exclusions and limitations
- Integration of physical/behavioral health
- Emergency services not requiring authorization
- Services coordinated by MS CHIP or affiliates
- MS CHIP coding and reporting requirements
- Member rights and responsibilities
- UnitedHealthcare network requirements
- Member enrollment/eligibility verification procedures
- Access and availability requirements; including ED diversion
- Timely provision of prenatal care
- MS CHIP services
- Coordination with CM program and specialty DM and CM programs (for example Healthy First Steps, Personal Care Model)
- HIPAA compliance expectations and protocols
- Level of care guidelines
- MS CHIP coding requirements
- Treatment/medical record documentation

- Transportation access
- Specialty, behavioral health, ancillary, hospital network
- Web based tools clinical tools and evidenced based medicine
- Referral management and preauthorization procedures
- How to read the UnitedHealthcare explanation of payment
- Claims mailing address/EDI submission requirements
- TPL/Coordination of benefits process and requirements
- Provider disputes and claims appeal process
- Complaints and Appeals and process including emergency appeals
- Web-based services for provider claims inquiry/appeals
- Provider rights and responsibilities
- Fraud/abuse prevention and obligations to allow State access
- Prohibition to balance bill Members
- requirements
- PCP selection procedures
- Cultural competence
- Key contacts for UnitedHealthcare
- Provider billing requirements/claims processes
- HIPAA coding requirements
- UnitedHealthcare payor identification number and use of NPI
- Proper completion of billing forms
- Timely filing requirements for submission of claims
- Submission process for corrected claims
- Coordination with PBM re: authorization and payment
- Medical home model
- Requirements for language interpretation/translation
- Special needs accommodation
- State access to financial, clinical & administrative records
- Quality management participation & improvement initiatives.

Provider Training Sessions

Our ongoing training team is led by experienced Provider Relations Managers (PRM) and supported by network development, operations and clinical staff (including the CMO). We educate and train every provider within 30 days of contract effective date through educational mailings, on-site provider visits and group training. PRMs will assess each provider's training needs at the time of contracting and may conduct in-person training if needed. To assess training needs, we will coordinate with all key provider associations along with our Quality Management Committee (QMC). PRMs will review weekly reports from our provider contract management database to contact providers not yet trained to ensure they get the required training.

Group trainings will be used for new providers and continuing education. Within the first 90 days of contract implementation, UnitedHealthcare will schedule group trainings for providers and their billing staff. This training will be at different times of day, in multiple locations throughout the region to be within a 60 minute drive of all contracted providers and in locations that will generate high local participation. PCPs, high volume specialists and hospitals will receive on-site orientations based on volume of Member contact.

Through provider complaints, staff feedback, trended claims data, associations and advisory councils, UnitedHealthcare identifies common topics or opportunities for retraining as well as specific providers for focused retaining. We monitor to ensure effectiveness and provide additional education when we identify common issues of interest. We send mailings and fax blasts 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.

Department and Staff Roles and Responsibilities

Role of the Provider Services Department

The Provider Services Department will mail our transition of care policy to all contracted providers 30 days prior to implementation. The letter and policy will be also posted on the web portal and we will send providers a UnitedHealthcare Alert reminding them of the policy and instructing them to logon to the portal for important information about ensuring continuity of Members' care. We will also conduct in-person education. Our Disease and Care Managers will individually contact all key provider groups to educate them about transition of care for critical populations, such as those requiring private duty nursing (PDN). We will cover our transition policy and processes during provider orientation group trainings prior to implementation.

UnitedHealthcare Provider Services Management (PRM) staff will visit key primary care sites each week to cover the topics listed above as well as emerging billing trends, key initiatives and the provider report card. At these visits, we meet with the PCP to identify any issues or problems that require attention or improvement, and develop appropriate action plans. After implementation, we will meet at least quarterly with our large providers and hospital systems, and will make quarterly presentations for smaller providers, to ensure that providers understand the new program and how to participate. In addition, we will reach out to our providers to assess performance by placing a minimum of 10 – 20 random outbound calls per week to providers in three provider categories:

- Provider
- Hospital
- Ancillary.

PSRs will enter the results into an Access database and sort by provider type, county and call center rating. Managers and supervisors will send task reminders out to the PSRs when follow-up is needed. Managers and supervisors will monitor task completion and the outcome of the call.

We also hold quarterly Joint Operating Committee meetings with key facilities to resolve billing issues and offer real time training and feedback.

Role of the Medical Director

Our Medical Directors are an essential component of provider education. First, our Medical Directors will meet with key physicians on a quarterly basis to review provider scorecards. Second, when issues are raised regarding a deficiency in provider compliance with policies, the Medical Director will review and may lead the efforts to educate provider or office staff along with the Provider Relationship Manager. Finally, our Quality Management structure is built around the involvement of network physicians and will serve as an on-going opportunity for identifying trends or challenges in the practice environment that may be improved with education and training.

Provider Education and Communications Tools

Provider Manual

Another key component of UnitedHealthcare's provider education is our Provider manual. Within 30 days of contract award, we will update this draft and post it to our provider website for distribution to all MS CHIP providers. The manual includes information about the MS CHIP program benefits and our policies and procedures, as well as information regarding payment terms and utilization review.

Provider Newsletter and Service Bulletins

We will also include training and educational information in our quarterly provider newsletter. The newsletters contain any 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. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements.

UnitedHealthcare will also use facsimile service bulletins (fax blasts) to distribute urgent information that impacts the entire network. We will e-mail service bulletins to providers' offices that have electronic communication capabilities. The service bulletins are also listed on the website and recapped in the Provider Newsletter.

Provider Portal

UnitedHealthcare promotes the use of web-based functionality among its provider population. Our web-based provider portal supports our MS CHIP providers through many innovative features and tools and is integrated with our key systems. Our interactive website enables providers to electronically determine Member eligibility, submit claims and ascertain the status of claims. UnitedHealthcare also offers an internet-based prior authorization system, iExchange, which allows providers who have internet access the ability to request their medical prior authorizations online rather than telephonically. The provider website will contain an online version of the Provider Manual, the Provider Directory, the Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as cultural competency information, newsletters, recent fax service bulletins and other provider information. We will also post notifications regarding changes in laws, regulations and subcontract requirements.

Through our Provider Portal, providers can view their provider profiles, check Member eligibility, submit claims and check claims status, request claim adjustments, view claim trends and view summary data. 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.

198. Are there any requirements listed in Sections 9.1 or 9.3 of this RFP regarding provider services which your organization is not able to agree to or accept? If so, please identify those items and explain.

No, we will meet or exceed all requirements in Section 9 of this RFP, and are not requesting any exceptions. UnitedHealthcare has 27 years of experience providing excellent service to its providers in 22 states. This experience, as well as our proven policies and processes ensure comprehensive and compliant service delivery to our CHIP providers in Mississippi.

199. Section 9.2 of this RFP lists desired features to be included in a provider manual. Are there any desired features which you do not envision incorporating into your provider manuals? If so, please identify which ones.

No, our Provider Manuals will meet or exceed all requirements stipulated in Section 9.2 of the RFP. UnitedHealthcare will produce and distribute a fully compliant Provider Manual that incorporates all features listed in the MS CHIP RFP. Our Provider Services staff has developed, distributed and maintained comprehensive provider manuals to providers in 22 states.

We will distribute a provider manual to each network provider which will include an overview of the program, toll free number to our provider services hotline, a removable quick reference guide and a list of additional provider resources and incentives. Our provider manual will be available online and will include the following:

- An introduction to the MS CHIP benefits plan
- UnitedHealthcare's organization and administrative structure
- A description of all covered medical services, excluded medical services and benefit limitations
- Billing and encounter submission instructions, including specifics form, field, code requirements and payment terms
- HIPAA EDI-compliant electronic claims submission instructions
- Performance expectations, including UM and QA criteria and process
- Utilization review

- Emergency room utilization information and guidelines
- Paper and electronic claims filing procedures
- Key UnitedHealthcare contacts and telephone numbers
- Prior authorization requirements, including referrals and use of non-participating providers
- Complaint and grievance/appeal instructions
- Quality improvement programs
- Grievance/Appeal procedures.

200. List the top three most common complaints by your network providers and indicate any quality improvement actions you have taken as a result of provider complaints.

The top three complaints by our network providers and UnitedHealthcare's targeted improvement activities are discussed in the following table.

Complaint	Action	Office Responsible
▪ Claims/Billing	▪ Educate provider on plan policies and procedures regarding claims and billing through face-to-face interaction and distribution of targeted printed material	▪ PSR in collaboration with Claims Manager
▪ Authorization Process	▪ Increase provider education with emphasis on authorization policies and procedures ▪ For trended complaints, conduct root cause analysis and communicate results back to providers	▪ PSR in collaboration with Medical Director
▪ PCP Change	▪ Increase provider education with emphasis on PCP selection through provider visits and distribution of targeted printed material ▪ Strengthen provider/Member communication through PSR outreach	▪ PSR

We address all our provider complaints through increased provider communications and education, as well as evaluation of our provider processes. If call center trends or provider satisfaction survey results indicate specific problem areas, we implement Targeted Improvement Plans to address the issue. In addition, we increase our regular visits to provider offices and add identified problem areas to our training materials and activities. We use our Joint Operating Committee forum and our provider Town Meetings to resolve problems and communicate new policies and procedures to providers. Our health plan management team, including our Provider Services Manager, Claims Manager and Director of Operations, develop action plans to address provider complaints.

201. Does your organization conduct provider satisfaction surveys? If so, in your most recent survey what percentage of providers was dissatisfied overall?

Annually, UnitedHealthcare conducts large scale, ongoing assessments of provider satisfaction as part of our continuous quality improvement efforts. Our Provider Satisfaction Surveys and Targeted Improvement Plans ensure thorough assessment and promotion of provider satisfaction. Our most recent survey showed 27.7 percent of our providers reporting dissatisfaction, and our Targeted Improvement Plans are addressing any issues. We share survey results with our executive team and staff, and ensure that the results are communicated and acted upon throughout the organization. In response to the survey results, we create and execute specific work plans to address areas rated as primary and secondary improvement targets. To improve the value of the provider survey and to expedite the resolution of issues, we will encourage (but not require) providers to identify themselves in their response. Identification will allow us to follow-up directly with providers to address their concerns and improve our relationships and performance.

Objectivity is our utmost concern in the survey process. UnitedHealthcare works with Survey Research Solutions, a product of our sister company, Ingenix, and the Center for Study Services (CSS) to conduct our annual provider satisfaction survey(s). We survey primary care physicians (PCPs) and high volume specialists. CSS draws the survey samples of eligible physicians working within UnitedHealthcare's networks from lists provided by Ingenix. The survey protocol includes a pre-survey notification letter addressed to the practice manager of the physician, followed by two mailings of a cover letter and questionnaire to all physicians in the sample. There is typically a four-week interval between the initial survey mailing and the replacement survey mailing. In some areas, our provider relations team hand delivers the replacement survey to non-responding physicians.

Survey results from all UnitedHealthcare health plans are aggregated annually and reported to our National Quality Management Oversight Committee (NQMOC). The results are compared by health plan year over year and also in comparison to other UnitedHealthcare plans across the country. The survey results include key strengths, secondary strengths, key improvement targets and secondary improvement targets.

For 2008 UnitedHealthcare's key strengths included:

- The utilization review process
- Clinical appropriateness of the utilization review decisions
- Assistance provided by care management staff in facilitating treatment coordination.
- Ease of prior authorization process
- Timeliness of claims payment process
- Accuracy of claims payment process
- Assistance provided by the provider service center or 1-800 provider help line
- Disease management and health education programs for your patients
- Care management programs provided for your patients
- Care management program for your Medicare patients.

For 2009 our key improvement targets include:

- Coordination of care with the behavioral health specialist
- Exchange of information with the behavioral health specialist is timely
- Range of choices in the formulary
- Ease of the pharmaceutical pre-authorization process
- Timeliness of claims dispute process.

Through the NQMOC our national clinical leadership works with each health plan to identify and implement improvement action(s) with national impact. In addition, each health plan's Service Quality Improvement Subcommittee (SQIS) reviews their data, using year to year results as well as other plan results as benchmarks and identifies actions for improvement specific to their provider network. The SQIS may establish interdisciplinary work groups to partner with plan physician advisory committees to discover the most effective approaches to solving provider satisfaction issues. Annual survey results are also published in the provider newsletter and our provider relations representatives follow up with individual providers to assure satisfaction.

Utilization Management

UnitedHealthcare has managed utilization in compliance with state and federal regulations across the nation in various Medicaid programs for over 25 years. Our utilization management program, based on our national experience and tailored to comply with all Mississippi SCHIP requirements, evaluates the appropriateness, medical necessity, efficiency and efficacy of health care services and procedures. It also evaluates appropriateness of facility or location of services using established criteria or guidelines. Our program ensures that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope and places significant emphasis on maintaining compliance with Mississippi SCHIP requirements.

UnitedHealthcare's Utilization Management (UM) Program, under the direction of the Chief Medical Officer, is designed to employ a comprehensive approach to health care. The goal of the UM Program is to manage the medical care of our Members by effectively utilizing existing resources while assuring that quality care is delivered. Medical necessity of services is determined by severity of illness, intensity of service and appropriateness of level of care. We emphasize coordinating the Member's transition through the full continuum of care. UnitedHealthcare works collaboratively with its Members, practitioners, and other health care providers to promote a seamless delivery of health care services. UnitedHealthcare's UM Program integrates the medical benefits package as well as coordinating the behavioral health and pharmacy benefits according to state contract requirements, reimbursement structure, Member and practitioner education, and quality management to monitor cost and quality of services to its Members.

202. With regard to the proposed entity and office that will be performing utilization management services (excluding nurse triage services) for CHIP, provide the following:

UnitedHealthcare of Mississippi's health plan management services, including all utilization management, are performed by UnitedHealthcare Services, Inc. (UHS). UHS organizes employees into the following segments relevant to the MS CHIP contract: UnitedHealthcare for all medical services and United Behavioral Health (UBH) for behavioral services.

Full name of entity:

Medical UM: UnitedHealthcare, Inc.

Behavioral health UM: United Behavioral Health

Location(s):

Medical UM: Houston, Texas (precertification) Nashville, Tennessee (concurrent review, second level review, case management)

Behavioral health UM: Atlanta, Georgia

Years in operation:

Medical UM: 4 years

Behavioral health UM: 27 years

Days & hours of operation:

Medical UM: Monday through Friday, 8:00 a.m. to 5:00 p.m. CST

Behavioral health UM: 24 hours a day, 7 days a week

Staffing

	# of	Avg. Yrs. Experience in UM
Non-licensed intake coordinators	24	2
RNs	149	6
LVNs/LPNs		
Behavioral health counselors	17[1]	5
MDs/DOs	11[2]	6+
Other: Social Workers	40	2

[1] Two of the 17 behavioral health counselors are licensed as RNs.
[2] Includes behavioral health medical director, etc.

Average UM employee turnover for most recently available months: Medical UM: 16%; Behavioral Health UM: 4%

Total # of covered lives for whom UM services are being performed: Medical UM: 530,000; Behavioral Health UM: 450,000

Total # of covered lives located in Mississippi for whom UM services are being performed: 180,000

UnitedHealthcare's utilization management services are provided through our sister UnitedHealth Group (UHG) company, UHS. UHS is appropriately licensed in Mississippi as a Private Review Agent and operates in accordance with all requirements of Section 41-83-1 through Section 41-83-29 of the Mississippi Code.

UnitedHealthcare has been providing efficient and effective utilization management services for CHIP programs since 2000. We currently provide CHIP services in 17 states. This experience, together with our proven policies and processes ensure our successful administration of all preferred features listed in Section 4.15 and other UnitedHealthcare best practices for utilization management.

We are committed to providing a fair and timely process for resolving Member grievances and appeals. UnitedHealthcare is proposing as both a fully-insured and self-insured entity for the MS CHIP bid. As a fully insured proposer and the entity conducting UM for MS CHIP services, we agree to adhere to the grievance and appeals procedures outlined in Section 5 of the RFP.

UnitedHealthcare, as a self-insured proposer and the entity conducting UM for MS CHIP services, agrees to fully comply with or exceed the procedures outlined in Section 6 of the RFP.

UM Telephone System

UM staff is available via a toll free number 7:00 a.m. to 6:00 p.m. local time throughout the service area Monday through Friday. Our automated IVR system routes incoming calls to the next available UM clinician through a menu option accessed using keys on a touch-tone phone. After hours and on weekends, callers receive a message to call back during normal business hours. Members can contact us after hours through the nurse triage line, which is available 24 hours a day, 7 days a week. Providers may also fax their authorization requests to the call center 24 hours a day, 7 days a week or use our web-based prior authorization system, iExchange.

Telephone System Productivity Reports

Our Virtual Call Center telephone system generates routine daily, weekly, monthly and annual reports on call availability, answering speed, on-hold time and abandonment rates. We confirm that our system can produce reports specific to MS CHIP and easily accommodate the MS CHIP RFP requirements of 90 percent answer rate within 30 seconds, 3-minute maximum hold time, and less than 5 percent abandonment rate. We will provide the Board with reports that track the daily availability of telephone service, the monthly telephone answering speed, the monthly average on-hold time, and the average monthly abandonment rates. In addition, we will supply quarter-end and year-end telephone system reports no later than the last day of the month following the reporting period.

Determining and Maintaining Sufficiency of Incoming Lines

Our call center currently has the capacity to expand call volume for several years without adding additional incoming lines. Annually we project call volume based on historical data on the number and duration of calls, and monitor performance on a monthly basis We have proven monitoring and reporting processes that will ensure responsiveness to providers calling the UM unit. Our highly skilled call center management team uses a series of training and monitoring applications to aid in auditing our call response rate. We generate specialized reports on a daily basis to identify peak call times and quantify staff productivity. Call auditing provides the information necessary to determine if staff scheduling requires an adjustment during peak hours, if we need to hire additional staff, or if specific PSRs require additional training. Because Member and provider service representatives are cross-trained, supervisors are also able to temporarily assign service representatives to the greatest area of need.

We use the Goal Lengths of Stay in Milliman USA Healthcare Management Guidelines to estimate the length of stay for a hospital admission. These guidelines are integrated into CareOne, our health management system. Milliman's Goal Length of Stay information provides a snapshot of the recovery times possible in the most efficient healthcare delivery systems across the nation and does not vary by state or geographic area. These target lengths of stay cover the entire spectrum of medical and surgical services. Most importantly, the Care Guidelines provide clinical indicators of when it is appropriate to transition a patient to the next level of care.

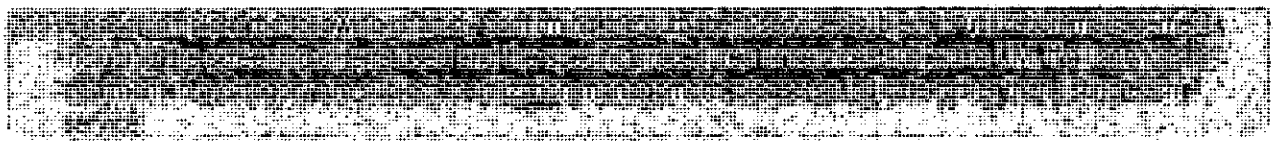
When applying the guidelines, our UM reviewers always evaluate the individual circumstances of each patient in the context of the attending healthcare professional's clinical judgment in determining treatment patterns and goal lengths of stay. Our national Executive Medical Policy Committee, the National Quality Management Oversight Committee and the health plan's Utilization Management Committee review guidelines annually. We use inter-rater reliability studies, chart audits and medical director reviews to ensure appropriate application of these guidelines.

Behavioral Health

Behavioral Health Level of Care Guidelines are internally developed and based upon nationally accepted standard clinical practice guidelines derived primarily from the American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), and the American Society of Addiction Medicine (ASAM). Level of Care Guidelines inform utilization management determinations by standardizing utilization management decisions regarding the most appropriate and available level of care needed to treat a Member's presenting problems, given his or her symptoms and levels of functioning.

We apply guidelines based on Members' individual needs and circumstances, and take into account variables such as whether the Member's benefit plans include a particular level of care, unique nature of the Member's presenting problems, Member's history of treatment, Member's ability to utilize treatment at a particular level of care, Member's age developmental level, Member's social circumstances, resources, risk factors, and barriers to care.

The flexibility of our behavioral health Level of Care Guidelines allows us to manage care according to regional variations. This approach considers the availability of facility-based treatment programs across the continuum of care, as well as guidelines that are in effect in a given state. In conducting reviews and determining the most appropriate level of care, behavioral health Care Advocates consider the geographic accessibility of local services and match the Member with the resources that are most clinically appropriate.



We use nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including Milliman USA Healthcare Management Guidelines; Apollo Medical Review criteria; and CMS policy guidelines. Milliman is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best-practices care templates, and key milestones for the best possible treatment and recovery.

Behavioral Health UM guidelines are internally developed and based upon nationally accepted standard clinical practice guidelines derived primarily from the APA, AACAP, and the ASAM. The UBH Level of Care Guidelines inform utilization management determinations by standardizing utilization management decisions regarding the most appropriate and available level of care needed to treat a Member's presenting problems, given his or her symptoms and levels of functioning.

We review all criteria annually and made them available to network practitioners (subject to specified license and copyright requirements).

Service	Are services subject to UM? If, yes, indicate the primary source for the written screening criteria used	To the extent UM only applies to specific procedures or services, please list
Surgery	Yes, Milliman	All outpatient surgeries except office-based procedures by network providers
Diagnostic services	Yes, Milliman	MRI, MRA, and PET Scans (ambulatory and non-emergency)
Durable medical equipment	Yes, Milliman	> $500 per item
Corrective appliances/prosthetics	Yes, Milliman	> $500 per item
Home health, private duty nursing and home infusion therapy services	Yes. Milliman	All
Mental health and substance abuse outpatient visits	Yes, UBH Level of Care Guidelines for Outpatient Treatment	All

Service	Are services subject to UM? If, yes, indicate the primary source for the written screening criteria used	To the extent UM only applies to specific procedures or services, please list
Hospice home care	Yes, Milliman	All
Occupational and physical therapy	Yes, Milliman	After 6th visit
Manipulative therapy	Yes, Milliman	All
Physician specialty care visits	Yes, Milliman	Non-contracted providers
Other, please list:		
Speech Therapy	Yes, Milliman	After 6th Visit

210. Indicate your procedure if no written screening criteria or length of stay guidelines exist for a particular diagnosis, case or service?

In instances where national criteria do not exist, the Medical Director makes the medical decision based on clinical judgment specific to that case. We also contract with a company that has a panel of subject matter experts (SMEs) in subspecialty area that support our Medical Directors, when the case falls outside the scope of their practice experience. Typically we will authorize treatment if any of the following apply:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will or is reasonably expected to, reduce or ameliorate the mental, physical, or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

We also develop state-specific criteria to address benefits or services not addressed by our existing criteria. For example, we developed private duty nursing criteria in Tennessee. To develop criteria, we will do the following:

- survey specialists and medical societies
- perform literature search
- consult the State Medical Director
- draft guidelines and approve through the Quality Management Committee.

211. Are clinical indicators and the criteria upon which the UM firm's approval or denial was based routinely documented in the case file?

Yes, UnitedHealthcare's clinical management system, CareOne has the capability to store clinical criteria and indicators used in authorization determination in the case file. When reviewing authorization requests our clinical UM reviewers can access online criteria and copy the relevant criteria into the case notes where it is stored permanently as part of the case file. If the Medical Director denies an authorization, CareOne imbeds the clinical criteria in into the denial letter. We train clinical UM reviewers on documentation requirements and monitor the process through monthly audits of nurse and behavioral health reviewers, and quarterly reviews of Medical Directors' decisions and case notes. The CareOne system is presently being deployed in the two newest regions in TN and has been functioning in Middle Region; the system now covers 500,000 members in TN.

212. What is the process for assigning precertification, continued stay review and case management cases to physicians for review? What percent of precertification cases typically require physician involvement?

When, after consideration of all unique Member characteristics, the case does not meet established clinical criteria, the nurse refers the case to a Medical Director for further review and consideration. For behavioral health cases, the clinical reviewer refers the case to the behavioral health Medical Director or a Peer Reviewer. Medical Directors/Peer Reviewers may consult with the requesting provider as appropriate. To refer the case, the reviewer documents the information into the case record on CareOne, our clinical management system, and routes the case to the physician review queue. If the authorization is for expedited review, the reviewer also calls the Medical Director to provide an alert that a particular case needs escalation. The reviewing practitioner retrieves the case from the queue and uses clinical guidelines, best practice models and judgment to approve or deny the request. When reviewing the case, the reviewing practitioner takes into consideration factors such as individualized circumstances, psychosocial issues, accepted practice patterns, evidence-based studies and the local health care delivery system characteristics. After making a determination, the Medical Director enters the information into the clinical system and routes the case back to the nurse in the form of a task.

The Medical Director conducts rounds to review inpatient stays that are close to or over LOS guidelines and help with discharge planning and CM cases. These rounds, attended by nurse and behavioral health reviewers, occur 3-5 times per week depending on inpatient census and market.

Percent of Precertification Cases Typically Requiring Physician Involvement

Clinical reviewers refer all cases that do not meet criteria to a physician for final decision on authorization. The percentage of cases referred to the Medical Director or other physician reviewer varies depending on how long our UM program has been in place for the local providers. Through ongoing training and interactions with our UM team, providers become more familiar with utilization requirements and criteria over time. As a result, the number of requests for services that require physician review will decrease over the first few years of a contract. On an average, the percentage of precertification cases referred for physician review averages approximately 25 percent.

213. What criteria are used to identify cases for case management?

As previously stated, we use retrospective and prospective methods to ensure potential high-risk Members are identified as early as possible. To identify Members who meet criteria for disease and care management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated, mini health risk assessment. In addition, we also review with authorization requests, hospital and ER use, Rx data and referrals from providers, Members and their family/caregivers as well as UnitedHealthcare clinical staff. Individuals identified for possible care management go through a more in-depth, scored comprehensive assessment and are routed to the appropriate DM or CM program based on the outcome of that scoring.

Retrospective Risk Modeling—UnitedHealthcare uses a risk scoring and stratification system within Impact Pro, our multi-dimensional, episode-based predictive modeling tool. Impact Pro enables care managers to identify need, stratify Member risk and coordinate services with Members and providers. It is designed to identify a cohort of Members who specifically have multiple chronic diseases and supports enhanced care management by targeting the highest risk Members and gaps in care. Impact Pro compiles information from multiple sources including claims, laboratory and pharmacy data, and uses it to predict future risk for intensive care services. Our care management department evaluates the information and identifies individuals with the highest level of risk for further assessment.

Prospective Identification—UnitedHealthcare uses numerous data sources to identify Members with a diagnosis for which we have a disease management program as well as those whose utilization reflects high-risk and/or complex conditions. These data sources include but are not limited to:

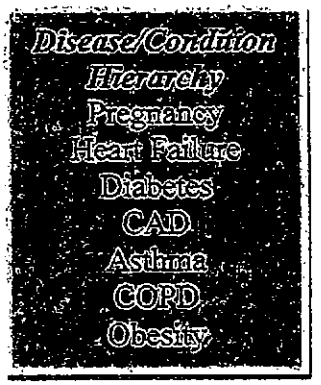
- Short health risk assessments conducted during new Member welcome calls
- Member reported health needs in calls made to our Member Service Department
- Pharmacy and lab data indicating the incidence of a specific condition (for example, insulin or inhalers)

- Emergency room utilization reports, hospital inpatient census reports, authorization requests and transitional care coordination requests
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare clinical staff referrals.

Risk Stratification—All identified Members complete a health risk assessment that scores them into risk categories. Based on the actionable population and aid categories of each health plan and state program, we determine the specific Impact Pro threshold for each care and disease management level. Generally, we use the following HRA score and Impact Pro results to stratify Members into three care management levels and assign to the appropriately qualified staff.

If a list is used, please provide a copy of the list. When and how is case management initiated?

We do not simply rely on a list of diagnoses to identify cases. UnitedHealthcare's approach to care management takes into account the holistic health status of the individual, irrespective of the illnesses or conditions that occur simultaneously. Our Personal Care Model ensures that with this holistic approach, each condition is adequately addressed through personalized interventions.



The typical high risk Medicaid Member has multiple co-morbid conditions. These conditions occur simultaneously, often with each condition linked to the other(s). Behavioral, social and environmental factors add to the complexity of the Member's health needs and increase risk levels. For such Members, a single-condition care management program is not effective. In recognition of the multiple co-morbidities, UnitedHealthcare uses a patient-centric case management model to assess and track determinates of health and well-being across all conditions which may be present. Our model addresses medical, behavioral, social and environment factors simultaneously through a holistic care plan with established timelines/priorities for activities that maximize quality outcomes and cost benefit.

To ensure that each Member is linked to the care manager with the right expertise, our PCM includes a hierarchy of conditions that ranks the impact of conditions by inherent severity (see text box). For example, pregnancy is the highest ordered condition followed by certain behavioral diagnosis. We use this hierarchy to ensure that the care or disease manager with the right level of clinical expertise is assigned to the Member. For further clinical support, that disease or care manager has access to clinical protocols for all of our DM programs as well as access to other care/disease manager experts in other areas, clinical supervisors, and the medical director.

Once a Member has been identified, the Care Manager will contact the Member's parent or caregiver via a telephone call and may send program and health education materials to the Member. The accompanying letter informs the Member's parent or caregiver how to use the care management services, how the Member became eligible to participate in the program and how to opt out if they do not wish to participate. During the call, the Care Manager administers a more detailed health assessment to determine gaps in care to be used in development of a plan of care. Working with the Member, the Member' s parent or caregiver and primary care physician, the Care Manager develops a Member-centric plan of care with interventions that support self-management/self-efficacy and Member education. The plan of care's interventions also ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the Member is connected with available and appropriate community support groups, for example, nutrition programs or caregiver support services. The Care Manager continues to monitor the Member's progress, adjusting the plan of care as necessary to meet the Member's needs and desires until the Member reaches the plan goals and the case is closed.

214. Does the entity proposed to perform UM have any experience case managing for a SCHIP population? If yes, describe the experience.

UnitedHealthcare provides case management for CHIP programs in 17 states through our Care Management (CM) program. Our CM program is guided by the principles of our Personal Care Model, which we developed to address the needs of medically underserved and low-income populations. The Personal Care Model emphasizes the whole individual, including environment, background and culture. Our approach achieves optimal outcomes through:

- Member-driven process of coordinated care—physical, behavioral, social and environmental
- Population based, predictive modeling to understand and address health risks
- Multi-disciplinary team to meet diverse needs
- Evidence-based best practices
- Physician-directed management that instills clear accountability for medical home responsibilities
- Online and interactive medical practice support
- Culturally appropriate online and interactive self-help tools for Members
- Engagement with community supports such as local health departments, rural health clinics, Federally Qualified Health Centers (FQHCs), Mississippi Faith Based Coalition and other organizations.

Through our extensive experience in operating CM Programs, we have learned the importance of focusing our efforts on those Members who are most at risk and able to benefit from personal intervention. Using Impact Pro, our multi-dimensional, episode-based predictive modeling tool, we identify and stratify Members' risk and assign Members into service categories based on risk and intensity of needs using risk stratification algorithms. Members in care management receive a supplemental condition-specific assessment, a *Comprehensive Personal Care Plan* intensive care coordination and outreach, and ongoing follow-up as clinically appropriate. The care manager consults with our multidisciplinary team to ensure the right care is provided to improve quality of life and outcomes.

We employ a number of strategies to contact these Members as soon as possible after enrollment. Once a Member agrees to enroll in the CM Program, the Care Manager performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of Members.

Our CM program is supported by UnitedHealthcare's integrated clinical system; *CareOne* which includes basic and comprehensive supplemental assessments (for example, Health and Functional Assessments), facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools. *CareOne* serves as the framework within which to share clinical information across clinical domains and departments and to serve as the health plan's virtual medical record, tracking clinical information longitudinally. *CareOne* can produce reports that can be shared with providers to aid in their decision making.

A key component of our care management programs for CHIP Members is ensuring access to all needed services for children with special health care needs (CSHCN). In addition to our CSCHCN programs, we have implemented a number of innovative case management initiatives for providing services to children, including an in home nursing pay for performance program in Pennsylvania, collaboration with school-based services in Maryland, and coordination of benefits for a Child Rehabilitative Services (CRS) in Arizona. These programs are described in our response to Question 218.

215. Will prior authorization or case management requirements apply to certain types of outpatient prescription drug therapies such as growth hormones?

Yes, UnitedHealthcare will impose prior authorization requirements for certain types of outpatient prescription drug therapies.

(a) Drug Therapies Requiring Prior Authorization

UnitedHealthcare requires prior authorization for the drug therapies shown in the table below.

Therapeutic Category	Therapeutic Subcategory	Drugs Requiring Prior Authorization
Anti-Infectives	Antivirals	Ribavirin (ex. Rebetol, Copegus)
	Antifungals	Fluconazole, Itraconazole, Vancocin
Antineoplastic & Immunosuppressant Drugs	N/A	Lupron, Hycamtin, Revlimid, Sutent, Tykerb
Autonomic & CNS Drugs, Neurology & Psych	Narcotics	Fentanyl Transdermal, OxyContin
	Narcotic Antagonists	Suboxone
	Anticonvulsants	Gabitril, Lamotrigine, Levetiracetam, Topamax, Trileptal, Zonisamide
	Miscellaneous Neurological Therapy	Copaxone, Xenazine
	Miscellaneous Antidepressants	Bupropion SR, Cymbalta, Effexor XR
	SSRI's	Citalopram (2nd to age edit)
Autonomic & CNS Drugs, Neurology & Psych	Miscellaneous Psychotherapeutic Agents	Adderall XR, Amphetamine Salt Combination (2nd to age edit only), Methylphenidate (2nd to age edit only), Methylphenidate Sustained Release (2nd to age edit only), Dextroamphetamine (2nd to age edit only), Dextroamphetamine Sustained Release (2nd to age edit only)
Cardiovascular, Hypertension & Lipids	Adrenergic Antagonists & Related Drugs	Catapres-TTS
Dermatologicals/Topical Therapy	Therapy For Acne	Tretinoin Cream (2nd to age edit only), Isotretinoin
	Antipsoriatic/Antiseborrheic	Calcipotriene (Dovonex)
	Miscellaneous Dermatologicals	Elidel
Endocrine/Diabetes	Miscellaneous Hormones	Androderm, Testim
	Miscellaneous Agents	Kuvan, Sensipar
	Diabetes Therapy	Insulin Pens / Cartridges
Gastroenterology	Proton Pump Inhibitors (PPI's)	Pantoprazole / Protonix
Immunology, Vaccines &	Erythroid Stimulants	Aranesp, Epogen, Procrit

Therapeutic Category	Therapeutic Subcategory	Drugs Requiring Prior Authorization
Biotechnology	Myeloid Stimulants	Leukine, Neulasta, Neupogen
	Interferons	Rebetron, Alferon-N, Roferon-A, Avonex, Betaseron, Copaxone, Peg-Intron, Pegasys, Intron A, Actimmune
	Growth Hormones	Humatrope, Norditropin, Nutropin / Nutropin AQ, Serostim, Tev-Tropin
	Interleukins	Neumega
Musculoskeletal & Rheumatology	Miscellaneous Rheumatological Agents	Leflunomide, Enbrel, Kineret, Humira
Respiratory, Allergy, Cough & Cold	Miscellaneous Pulmonary Agents	Singulair, Revatio, Pulmozyme
Diagnostics & Miscellaneous Agents	N/A	Increlex, Chantix

In addition, UnitedHealthcare imposes Step Therapy requirements for various therapeutic agents. These are listed in the table below.

Therapeutic Category	Therapeutic Subcategory	Drugs Requiring Prior Authorization
Autonomic & CNS Drugs, Neurology & Psych	Muscle Relaxants & Antispasmodic Agents	Enablex, Oxybutynin Sustained Release, Oxytrol
	Hypnotic Agents	Zaleplon, Zolpidem
Cardiovascular, Hypertension & Lipids	Angiotensin II Receptor Blockers (ARB's)	Benicar / Benicar HCT, Cozaar / Hyzaar, Diovan / Diovan HCT
	Lipid/Cholesterol Lowering Agents	Antara, Fenofibrate, Triglide, Vytorin
Ear, Nose, & Throat Medications	Otic Steroid/Antibiotic	Ciprodex
Endocrine/Diabetes	Oral Hypoglycemic Agents	Actos, ActoPlus Met, Avandamet, Avandaryl, Avandia, Janumet, Januvia
Ophthalmology	Miscellaneous Ophthalmologics	Optivar
Respiratory, Allergy, Cough & Cold	Antihistamines	Fexofenadine
	Beta Agonists	Xopenex Nebs
	Inhaled Corticosteroids	Advair Diskus / Advair HFA

Name and Location of Entity Performing Prior Authorization

UnitedHealthcare will use two facilities for pharmacy Prior Authorization activities. One is in Houston, TX; the other in Pittsburgh, PA. Both are UnitedHealthcare facilities, not subcontractors. Using two facilities for Prior Authorization provides a number of benefits to the Board, including redundancy in the event of a systems outage or disaster, as well as rollover coverage in times of high demand.

Process for Obtaining Prior Authorization

UnitedHealthcare has a comprehensive, in-house process for conducting Prior Authorization of drug therapies. In the following sections, we discuss:

- The Prior Authorization process (overview)
- Exceptions for emergent situations
- Decision processes in prior authorization
- Ensuring continuity of care
- Developing prior authorization criteria.

Prior Authorization and Exceptions Process for Non-preferred Drugs

UnitedHealthcare's Prior Authorization program assesses medication appropriateness, safety and/or efficacy. Established guidelines may require prior use of other formulary and/or cost-effective medications.

UnitedHealthcare's prior authorization procedure enhances formulary/PDL compliance, facilitates appropriate prescribing, and promotes high-quality cost- effective pharmaceutical care. All requests for authorization of non-formulary medications must be initiated by providers prescribing the medications. We issue decisions within 24 hours of receipt and track our performance in meeting this time frame. Our actual average review time is considerably shorter, at approximately 4 hours. To request an authorization for the use of a medication that is non-formulary the prescribing physician must fax or phone a prior authorization request to UnitedHealthcare's Pharmacy team that includes the following information:

- Patient's name
- UnitedHealthcare Plan ID number
- The requested drug, dose and frequency desired
- Documentation of which formulary drugs have been tried to treat the Member's condition
- Documentation of any adverse reactions the Member experienced when using formulary drugs
- Other relevant clinical information, which substantiates the need for an exception to the formulary/PDL.

We evaluate the request based on medical necessity, taking into account the availability of alternative formulary agents that can effectively treat the stated condition. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. A UnitedHealthcare pharmacy services representative (PSR), in consultation with a Pharmacist, reviews all prior authorization requests. The pharmacist or PSR may approve or deny a request.

Exceptions in an Emergent Situation

In emergency situations, the retail pharmacist may not be able to speak with the prescribing physician immediately. If the pharmacist determines that there is an immediate need for an exception, the pharmacist has the authority to initiate an override for a one-time 5-day supply of a newly prescribed, non-formulary medication at the point of sale without contacting UnitedHealthcare. We receive a daily report itemizing all overrides that authorized a 5-day supply of medication on the previous day, allowing us to monitor emergency fills and to contact the pharmacy and/or physician as needed to facilitate prior authorization request and review.

Prior Authorization Decision Processes

A UnitedHealthcare certified pharmacy technician (CPhT) documents the request in the prior authorization clinical management system. If the request does not meet the guidelines for approval, it is referred to a clinical pharmacist for review. The clinical pharmacist or CPhT may approve or deny a request. We operate a "peer-to-peer" process, through which physicians may confer with our Pharmacy Director and/or Chief Medical Officer by telephone if they are not in agreement with a prior authorization decision and wish to discuss their concerns.

When a prior authorization request is approved, we enter an authorization into the pharmacy claims processing system and notify the requesting physician. In the event that requests are denied, we notify requesting physicians and Members via telephone or facsimile with a brief explanation of the denial. We issue Pharmacy Denial Notices—a written confirmation of the denial—within 24 hours of the denial decision and mail the notice the next business day to the Member. If the physician's office has a secure fax line, the Pharmacy Denial Notice is faxed within one hour of the time the request is finalized. The Denial Notice clearly indicates the reason(s) for the denial as well as the right and process to file a grievance.

Continuity of Care

In emergent situations, we offer a temporary, 5-day continuation of care supply of medication. When pharmacists initiate a temporary coverage override (TCO) by entering an electronic code for a continuation of care supply, the system automatically generates a customized TCO letter. The letter includes information on the alternative medications for the non-preferred/prior authorized agent(s) and how to request a prior authorization for the specific non-preferred/prior authorized medication through the Member's physician provider, if appropriate.

Development of Prior Authorization Criteria

The approval criteria for all drugs requiring prior authorization are developed by UnitedHealthcare's P&T Committee and are based on information from the FDA and manufacturers, medical literature, actively practicing consultant physicians and appropriate external organizations.

UnitedHealthcare monitors utilization of high-dollar medications, along with treatment guidelines for conditions requiring specific treatment algorithms. UnitedHealthcare's Clinical Coordinator or delegate identifies areas (either drugs or disease states) that require greater oversight by the plan due to misuse or abuse and compiles and reviews relevant data, which may include information on new drugs and existing treatment guidelines (for example, whether it is a first-line or second-line therapy). Based on this research, the Clinical Coordinator develops clinical criteria relating to the following:

- Clinical information required to support the request, for example., diagnosis, lab work, list of medications previously used for this indication including dose, duration and outcome
- Formulary alternatives appropriate as first-line therapy
- Appropriate length of therapy for initial treatment, re-treatment, etc.

Once developed, the prior authorization criteria are then forwarded to the P&T Committee, which reviews them for appropriateness. Upon P&T approval, the guidelines are sent for peer review by practicing physicians in the relevant specialty who does not participate in the P&T Committee.

Step Therapy

Our Step Therapy program assesses medication appropriateness, safety and/or efficacy and provides incentives to reduce costs when medically appropriate. Our subcontractor, Prescription Solutions, has a point-of-sale edit in their claims system that allows claims for medications to pay if the system recognizes a precursor medication in the Member's fill history.

216. Please explain the methods you will use to control cost and utilization for residential treatment and partial day treatment of mental health disorders?

We seek to provide the right behavioral services in the right location at the right time. As such, we believe that many Members can often be fully engaged in their plan of recovery without accessing more restrictive levels of care such as residential treatment (RTC) and partial day hospital (PHP). We believe that RTC and PHP continue to have their place in a full continuum of care that includes both traditional and community-based services. When either of these services provides the most appropriate level of care and place of service, we work with the local provider community to ensure that care meets the guidelines put forth in our proprietary level of care guidelines. These guidelines are reviewed at least annually with input from both internal and external subject matter experts such that they reflect the most current thinking regarding both these levels of care. Behavioral health Care Advocates and Physician Reviewers work to ensure that Members in higher levels of care such as RTC and PHP are given the support and tools they need to meet goals for discharge to a lower, less restrictive level of care.

Community-based alternative programs such as psychosocial rehabilitation and illness management and recovery provide alternatives and flexibility to more traditional RTC and PHP programs. We are committed to continue expanding community-based services for MS CHIP to support children and adolescents in meeting their resiliency goals and working their individual plans of recovery. Our behavioral health subcontractor, affiliated UHG business United Behavioral Health, will build a full array of community–based services including crisis intervention, respite care, Assertive Community Treatment (ACT) , psychosocial rehabilitation and peer run services to best support MS CHIP Members and provide the most cost-effective, clinically driven care.

A core component of UBH's service delivery system in Mississippi will be the network of community mental health centers. (CMHCs) With their significant degree of familiarity with this population, CMHCs are ideally positioned to provide an array of services that provide effective community-based treatment to MS CHIP children and adolescents. In addition to access to child/adolescent psychiatrists, CMHCs provide case management, Assertive Community treatment, psychosocial rehabilitation, illness management and recovery and other Member-focused services in the least restrictive environment. UBH will work to leverage successful CMHC-based services in one part of Mississippi to develop similar services in other parts of the state, such that clinically sound programs are accessible to all MS CHIP Members. Partnering with the CMHC community, UBH will work to ensure that cost effective treatment alternatives that emphasize principals of recovery and resiliency are available throughout the MS CHIP service area to provide safe, cost effective and clinically sound diversion alternatives to traditional hospital and office based services. We have already begun meeting with local consumer organizations and CMHCs, including:

- MS NAMI
- MS Families as Allies for Children's Mental Health – Federation of Families MS Chapter
- Hinds Behavioral Health Services (Jackson region 9 CMHC)

In addition, we monitor utilization by contract for each of these levels of care on a monthly basis and trends quarterly. Metrics here include, but are not limited to:

- Admits/1000
- Days/1000
- Average length of stay (ALOS)
- Readmission with 30, 90, 180 days.

We compare utilization trends against similar products within the behavioral health book of business as well as externally validated norms, when available. Goals/goal ranges are set against which to compare utilization in any given period and, in combination with volume metrics from other levels of care as well as on a standalone basis, we assess issues of either over-or under-utilization.

By using community-based alternatives to RTC and PHP and by monitoring both individual cases closely using proprietary level of care guidelines, aggregate data and comparing trended utilization both to similar books of business as well as externally validated benchmarks, we believe that we a offer a well-positioned solution to control both cost of care as well as offer quality utilization for MS CHIP Members.

217. Is any aspect of the case management program subcontracted? If so, list the name of the subcontractor and the services provided.

At the present time, UnitedHealthcare provides all aspects of our case management program and does not subcontract with any organization to provide services. We are however, evaluating numerous opportunities to engage Mississippi community-based entities to provide in-home care management training in support of new mothers. Our staff will work with these community-based entities such as Alpha-Maxx to conduct in-home post-discharge management of high-risk mothers and babies. In addition, our program will follow all NICU graduates until their first birthday. Our goal is to provide the new mother:

- Responses to her concerns about such issues as breastfeeding, contraception, tobacco use, shaken baby syndrome, domestic violence and post-partum depression
- Information on local community resources such as WIC, parenting classes and new mother support classes
- Assistance with scheduling her post-partum and well-baby visits.

218. Do you anticipate the need to make any changes to your case management program to better address the needs of the CHIP population? If so, please explain.

CHIP has developed and refined our approach to providing case management for the CHIP population over the past nine years managing their care. As noted earlier, our Personal Care Model programs are designed to meet the needs of medically underserved and low-income populations. Within the PCM, we have established child-oriented tools and procedures where appropriate. For example, our clinical team uses a specialized Pediatric Health Risk Assessment (PHRA) as the initial means of assessing children who have been identified for case management. Another example is our targeted program for CSHCN, which is staffed by pediatric specialists who work with the Members, families, and providers to ensure that these children receive coordinated services to meet all their health care needs.

We also provide high risk pregnancy management and discharge planning for NICU-admitted babies through our Healthy First Steps (HFS) program. HFS nurses conduct in-home post-discharge management of high-risk mothers and babies. Our first of life program within HFS provides newborns, including NICU graduates, with ongoing medical needs. Those with certain family resource or psychosocial needs are provided care management to age one. The HFS care managers assist with newborn educational needs as well as assistance accessing all MS CHIP services.

In addition to our core PCM services, we have initiated a number of activities and programs to meet the specific needs for our state customers and will do the same for Mississippi. Examples of some of UnitedHealthcare's innovative case management initiatives for children in other state programs include the following:

In -Home Nursing Pay for Performance Program—Our Pennsylvania health plan initiated an innovative pay for performance program for providers of in home nursing services for children to increase availability of staff while monitoring quality of care and flexibility for Members and their families. The providers receive incentives to improve ongoing coverage of home care cases: Incentive payments are based on the achievement of the pre-defined benchmark identified by the homecare agencies as an opportunity to improve their service to our Members. The incentives address weekend reimbursement, full coverage and quality improvement. In addition to providing incentives, the health plan hires, educates and deploys an experienced pediatric nurse for each agency to act as liaison to providers/families. The Liaison's responsibilities include oversight of the initiatives and managing the financial incentives. A UnitedHealthcare team comprised of the Pediatric Medical Director, Manager of Pediatrics, Shift Care Coordinator and Clinical Liaison evaluates indicators and outcomes.

Maryland School Based Health Center Program—Our Maryland health plan established a program for co-management of care for students enrolled in Maryland's HealthChoice program and in a school based health center (SBHC). In this program, we reimburse SBHCs for the same types of services that would be provided in an office by a primary care provider (PCP). We also developed a communications protocol in conjunction with SBHCs that includes care coordination/ co-management protocols. The SBHCs agree to participate in our QI program activities, follow established practice guidelines, and meet our standards for medical record keeping. The benefits of a co-management model of care between a PCP and SBHC is that there is an increased likelihood of accessing quality health and mental health services in a setting that is easily accessible and where both students and their families are familiar and comfortable.

Child Rehabilitative Services—In Arizona, the UnitedHealthcare's health plan has a contract to provide carved out Child Rehabilitative Services (CRS) for 25,000 eligibles. CRS maximizes the quality of life and improves services for children who have chronic and disabling or potentially disabling health conditions. We transformed fragmented services into a single statewide, seamless service delivery system with maximized accessibility through a broadened statewide network, coordinated chronic care management and innovation through modern technology such as telemedicine. Because primary benefits were provided by separate health plans, we established mechanisms with the other Acute Care plans to coordinate care management of their CRS-eligible Members; work with their claims departments to ensure that CRS claims did not adjudicate as Acute Care claims or vice versa; and to gather historical patient data to better assess and manage each CRS participant.

Referral Process

219. How do you propose to handle services not provided in-network?

PCPs are generally responsible for initiating and coordinating referrals of Members for medically necessary services beyond the scope of their practice. PCPs monitor the progress of referred Members' care and ensure that Members are returned to their care as soon as medically appropriate. We require prior authorization of all out of network referrals. The request is generally processed like any other authorization request. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the Medical Director for review and determination. Out of network referrals are generally approved for, but not limited, to the following circumstances:

- Continuity of care issues exist
- Necessary services are not available in network.

Out of network referrals are monitored on an individual basis and trends related to individual physicians or geographical locations are reported to Network Provider Services to assess root causes for action planning. Services that require prior authorization include the following:

Emergency Department services provided in an out-of network hospital do not require prior authorization; however, hospitals must notify UnitedHealthcare within one business day after an emergency inpatient admission.

Nurse Triage Service

220. With regard to the proposed entity and office that will be performing nurse triage services, provide the following:

Full name of entity

UnitedHealthcare will subcontract with NurseLine℠, an affiliated United HealthGroup entity, to perform nurse triage services. NurseLine is a market leader in symptom support and health care information. Through a single point of contact, 24 hours a day, 365 days a year, NurseLine helps direct individuals to appropriate care resources to drive improved outcomes. NurseLine supports 6.5 million public sector lives.

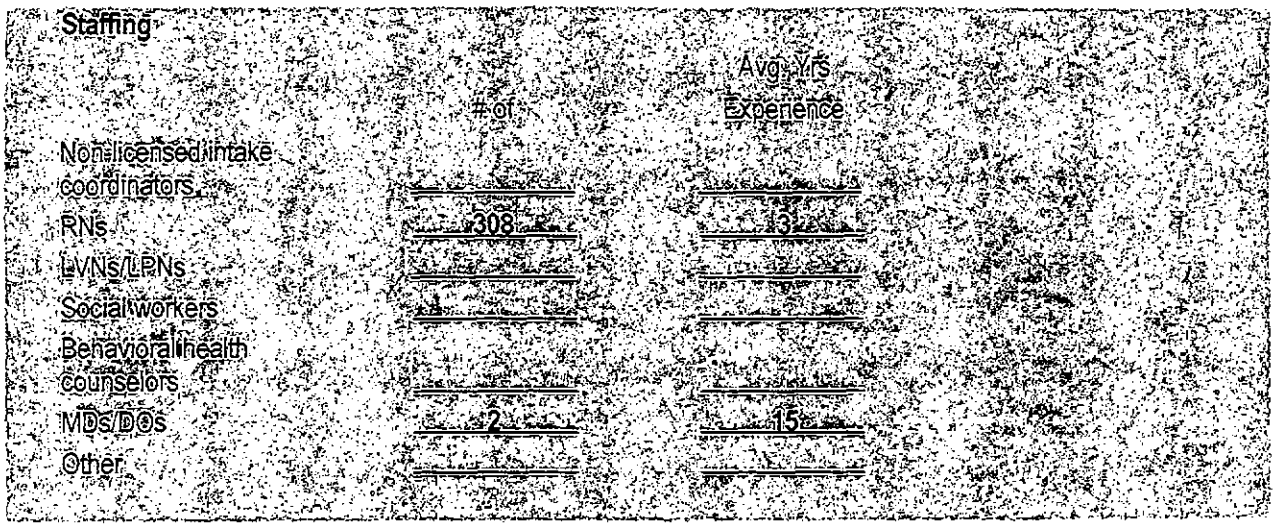
Location(s)

Eight inbound Care Solution Centers are located throughout the country in:

- Albany, New York
- Buffalo, New York
- Charleston, West Virginia
- Cyprus, California
- Dayton, Ohio
- Bloomington, Minnesota
- Plano, Texas
- San Antonio, Texas*.

Years in operation

NurseLine has been in operation for 29 years.



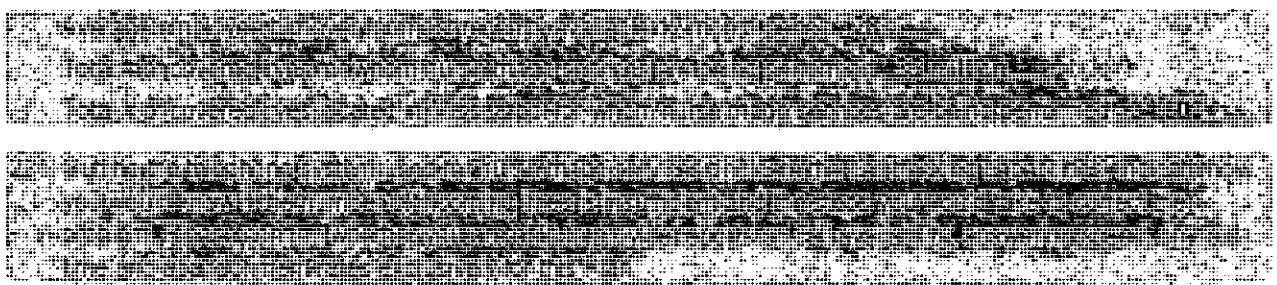
Staffing	# of	Avg. Yrs Experience
Non-licensed intake coordinators		
RNs	308	3
LVNs/LPNs		
Social workers		
Behavioral health counselors		
MDs/DOs	2	15
Other		

*Our San Antonio, Texas Call Center is the call center we would propose for the State of Mississippi's NurseLine program. Existing staff is already in place to offer culturally competent services to CHIP beneficiaries. While we recognize that CHIP programs have similarities, we know that MS CHIP) will have unique nuances, and we will offer training specific to this program. This approach ensures we will deliver sensitive and relevant services to meet the needs of Mississippi membership.

The San Antonio staff undergoes Medicaid and CHIP immersion training sessions, and nurses on this team includes ones that are highly skilled, trained, and understanding of the needs of those enrolled in CHIP programs.

Recent survey findings show that:

- Over 95 percent of respondents were satisfied or very satisfied with our services overall.
- Over 90 percent of respondents felt the nurse's recommended action plan was effective and over 70 percent indicated that their overall health and well being have improved because of using our services.
- 90 percent of respondents indicated that they would be more likely to select a health care plan that included our services.



Our flexible telephone system is configured and monitored to manage high call volumes with minimal delays. We currently manage over 4000 calls per day.

During client implementation, we collect call volume, average talk time, average handle time, and busy hour data, if available, in order to determine whether current capacities are adequate or need to be supplemented with additional network resources. Network monitoring is conducted on an ongoing basis to ensure network blockages do not occur.

In addition, prior to peak season, we analyze each new program to estimate anticipated call volumes in order to determine if additional network capacity is required to meet the additional volumes. If so, additional capacity is ordered, tested and put into production prior to call volume escalation.

Call Tracking

We will provide reports through NurseLine exclusively for the MS CHIP program that capture call availability, answering speed, and abandonment rates. We will not report against hold times since Members are not placed on hold. NurseLine reports provide timely and relevant trend analysis, a record of quality improvement activities, and measures the ways the program benefits an organization. Data provided in these reports not only reflect the value of the program, but also can help customers understand and manage participants' health trends and formulate specific organizational strategies and decisions.

NurseLine data collection processes are fully automated. Demographic data about callers, as well as the reason for the call, topics discussed, and recommendations delivered are collected online by the nurses during their discussions with callers. Quality measurements such as speed of answer and satisfaction rates are also included in the report. Aggregate results are analyzed and reported back to the To the UnitedHealthcare of Mississippi clinical team.

Standard Reports

Standard reports include monthly or quarterly delivery of program performance, outcomes, and usage trends. The standard reports include a variety of content and media options, including the following:

- **Utilization report:** Our utilization report begins with a five-page, executive-style summary report, including service delivery details, most frequent topics discussed, issue resolution trends, and detailed utilization information. The balance of the report includes program usage detail including monthly usage figures, trending of usage rates, and a detailed listing of all topics discussed with participants.
- **Outcomes report**: Participant survey results, demonstrating caller health and well-being, health decision making, willingness to select a particular benefits package option, and satisfaction levels as a result of their experience with us.

Quarterly or monthly reports will be provided that address call availability, answering speed, and abandonment rates exclusively for the MS CHIP program.

Yes, our nurse triage subcontractor, NurseLine, can perform and administer all of the program requirements outlined in Section 4.16.

223. What qualifications and/or experience do you require of the personnel who interact with Members using your nurse triage program?

All NurseLine registered nurses have a minimum of three years of recent clinical experience in emergency room nursing, pediatrics, geriatrics, obstetrics, critical care or urgent care clinic nursing or medical/surgical nursing. In addition, our nurses are trained to be effective listeners, communicators, and good problem-solvers, as well as empathetic to the individual's condition. Our clinical training is composed of four key components and prepares the staff to deliver the highest level of quality care:

- Core curriculum training
- Continuing education (ongoing)
- Client-specific training (as required)
- Quality improvement training (ongoing).

A new registered nurse in the training and on-boarding phase has 100 percent of his or her calls and call records monitored and reviewed. As the nurse gains competency and experience in handling these calls, he/she is advanced to the next level of monitoring.

224. What percent of your medical triage protocol necessitates:

	%
Staff to rely on past experience and training	10%
Staff to follow written computerized criteria	10%
Staff to ask specific questions on an algorithm directed toward prompt clinical assessment/triage	80%
Other: (Describe)	
Total	**100%**

225. What percent of your program contains computerized logic structured so that the most medically sensitive issues are addressed first? Provide an example.

NurseLine nurses use nationally accepted evidence-based guidelines and contents that tie together clinical (for example, safety, efficacy, effectiveness), humanistic (for example, quality of life, Member satisfaction) and cost-effective outcomes. Using our own guidelines allows us to tune dispositions to the needs of our customers as they include services like convenience care (Minute Clinics, on-site services, etc.). It also allows nurses to respond quickly to provide support for issues like disease outbreaks or medication recalls, by adding a new guideline within hours, rather than waiting weeks for a vendor to update a purchased system.

Our guidelines serve as the primary tool to delineate the nurse's thought processes to provide credible, consistent, and accurate information to a caller. This is accomplished through a series of intuitive, step-by-step prompts and screens, which are supported by the clinical guidelines referred to above. Please see our Pediatric Guidelines Sample provided as Attachment 225 in Section 7, Appendix of Other Materials. Additional resources may include audio library topics and medical director-approved Internet resources, as well as local and national resources.

226. Is the software logic used to conduct services internally developed or purchased? If you purchase the software logic what is the name of the software used?

The software is internally developed. NurseLine℠ clinical guidelines are an advanced adult and pediatric triage system developed to support the practice of telephonic nursing. This unique set of guidelines represents a comprehensive body of knowledge designed to offer the specificity of an algorithmic approach with the flexibility of a guideline. NurseLine is a business of a larger UHG entity, OptumHealth. OptumHealth's clinical services are fully accredited through the American Accreditation HealthCare Commission/URAC.

A team of registered nurse specialists with a broad medical knowledge base and experience, research, develop and review the adult and pediatric triage and health education content. Current medical textbooks, scientific journals, on-line searches and other clinical gold standard references are used to assure it's evidenced based and scientifically accurate. The guidelines are also crosschecked with medical management guidelines (Preference, Knowledge Library, Milliman & Robertson, etc.) to assure that the clinical content is appropriate.

Guideline development and review is an ongoing process with every topic, both adult and pediatric, going through the review process at least annually.

NurseLine is supported by a review process which involves the department manager coordinating with a medical review physician consultants and Sr. Medical Director These consultants make up an expert panel of over forty board-certified generalist and specialist physicians in the areas of family practice, internal medicine, emergency medicine, cardiology, OB/GYN, etc. Physician review and approval is required before the guidelines are available on-line for the nurse.

The medical content team, which supports NurseLine, has the ability to respond to emergent community needs. The day following September 11, 2001, the team developed an educational topic on bioterrorism with chemical agent data. The content was coordinated with two national medical director's offices, the CDC, local and regional health departments, a variety of medical/governmental Web sites, as well as the director of the Center for Infectious Disease Research and Policy. The content was monitored daily and continuously updated. More recently, we developed a health education and symptom triage guideline for the SARS outbreak. Through these processes, the clinical content department strives to provide the nurses with the most up-to-date, accurate and thorough medical information available.

227. Do triage tools prompt the nurses to direct the Member to the network providers?

Yes, NurseLine referrals to network providers is a key part of the service to callers. Access to current accurate UnitedHealthcare network providers is critical in triage and routine referral scenarios. It is a cornerstone of the NurseLine service.

The NurseLine role is to help people find the right care, at the right time, at the right place, with the right provider. Thus, talking with Members about their choices for service location is part of each NurseLine conversation. The program can capture Member considerations that influence service locations.

Since NurseLine services are proposed through a sister UHG business, NurseLine nurses also bring the additional knowledge of the company and network and can help direct CHIP families to service locations most likely to help them address their needs.

With each conversation in non-emergency situations, the nurse reminds the callers that it is their responsibility to verify that the physician and/or facility are a participating provider in their plan at the time of service delivery.

NurseLine offer a full range of opportunities for successful program communications. We recognize that the introduction or redesign of health care benefits often result in the need for transition communication materials. Communications solutions are designed to promote the available services and drive utilization among eligible users and their families. Traditional Member communications tools are used, along with custom solutions to help clients achieve these goals. NurseLine's in-house capabilities are extensive, including communications consultants, editorial and design resources, and state-of-the-art printing and distribution partners. Some of the Member communication programs include:

- **Brochures**—To promote our integrated services, brochures containing product descriptions and often durables (magnet and wallet card) provide the Member with information on the services available and reasons to call. The brochure, magnet, and wallet card are all imprinted with a program toll-free number, so the number is readily available to each individual.
- **Postcards**—Use of postcards offers a great deal of customization flexibility at no additional cost. Topics are selected based on your population's needs and interests, such as high medical cost drivers. Postcards also include information on the services available and reasons to call.
- **Tip sheets**—One-page sheets offer at-a-glance information designed to inform and reinforce use of NurseLine services. Topics include a wide range of health issues such as healthy aging, nutrition, chronic conditions, health care consumerism, men's, women's and children's health, and much more. Promotional tip sheets focusing on the value of services also are available. Each sheet includes the client's toll-free number and a URL as applicable.
- **E-mail message**—NurseLine commonly provide electronic e-mail messages promoting services, including the toll-free number and a URL as applicable. Our standard e-mail program frequency is monthly.
- **Promotional/health text**—Promotional text describes services and is developed in coordination with monthly health promotion topics. These pieces can be used as articles in client communication vehicles or as letters.

Among other items, we have found that direct mail campaigns can be effective when properly focused and targeted to the needs of our health plan customers and their membership. Incorporation of the NurseLine telephone number into other plan communications or Member materials, such as Explanation of Benefits documents, is also effective in reinforcing the availability of our program as a resource. This often works best when coordinated with the health plans community liaisons and their Member services departments.

In addition, based on current behavioral health experience and utilization trends, we have had success in segmenting and targeting messages to include topics such as depression management and the importance of psychosocial supports for users of behavioral health benefits.

On an ongoing basis, we are committed to working with the State to determine the high cost drivers and the needs and preferences of the membership. Utilization of program services and the reasons for usage are monitored to determine the effectiveness of communications activity. This information is used to establish a customized communication plan. This plan can include direct mail pieces. The mail pieces can include customized, State of Mississippi-branded tip sheets, letters, postcards and newsletter articles. These mail pieces will include specific monthly topics driving participants to relevant programs and services

229. How do you identify and refer callers who may be appropriate for case management or disease management?

NurseLine integrates well with other plan resources, such as case and disease management. Our nurses serve as a key navigational hub, guiding Members to a wide range of other programs including case and disease management, mental health assistance, wellness services and community based programs that help Members achieve their goals for better health.

Our nurses receive extensive training in telephone triage before performing these responsibilities. Without visual and tactile assessment, the telephonic nurse is limited to auditory, verbal and emotional cues. We rely upon the training and sensitivity of these experienced registered nurses to understand not only what the caller is saying, but also to be attuned to the emotional state of the caller and the apparent ability of the caller to understand the information being discussed. It is the combination of a qualified triage nurse and medically approved user-friendly guidelines that make telephone triage successful.

- Triage guidelines are symptom and condition-based, allowing the nurse to provide a caller with the appropriate level of care and treatment, as well as providing self-care information. We have over 320 guidelines for triaging adults and pediatrics.
- Condition and health education is intended to educate the caller on a wide variety of disease and medical health topics, diagnoses, tests, treatments, medications, prevention, and self-care, as well as assist clients with difficult decisions about treatment options for serious conditions. Close to 400 topics are used to deliver this service.

We understand that deploying comprehensive solutions relies heavily on the ability to seamlessly integrate benefits and services for all participants. We have designed our programs with an "open architecture," allowing us to integrate with current or future partners, both clinically and technically. These capabilities have enabled us to integrate the services of more than 120 external programs, including over 50 health plans and third-party program providers, into our clients' customized service offerings during the past four years.

In partnering with these external organizations to provide a seamless and integrated service offering, we develop an integration strategy during program implementation that would focus on:

- Identification of health plan services offerings for your Members, and the appropriate contact information for each
- Working with your health plan partner(s) to identify preferred communication channels (that is, warm transfer, fax transmission, or secure messaging)
- Information requirements to support a seamless participant experience

We can accept data from health plans and eligibility vendors via dynamic data exchange, utilization management systems, and health risk appraisals. We welcome the opportunity to further discuss your specific requirements.

In a study of a recent 12-month period, 28 percent of calls (53 percent of triage calls) from Members presented a referral opportunity—more than 80,000 in all. Referrals were made to more than 50 different internal and external programs. This includes referrals to internal programs like case and disease management, complex condition support and behavioral health programs. We also made referrals to external disease management programs from well known vendors, and external behavioral health and wellness organizations.

230. Does your program provide for the nurse to re-contact a patient, indeemed necessary, to follow up regarding the course of action recommended?

Yes. Our administrative system contains an automated reminder system that prompts nurses to place follow-up calls at a time and number preferred by the participant.

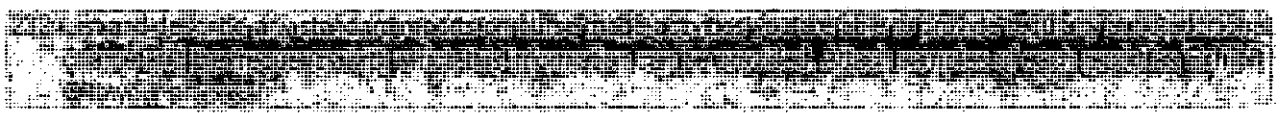
If yes, describe those types of situations where this might occur.

Our nurses have some latitude in determining when a follow up call would be appropriate. They are typically used when a caller seems unclear about their care plan, is hesitant to comply with a care plan, or when additional reinforcement would be appreciated by the participant.

231. How do you assure that information pertinent to a patient's on-going care is communicated to that patient's attending physician or the UM department? Explain how you secure the patient's consent to accomplish this communication.

NurseLine uses our Daily Activity Report (DAR) when notification services are required for triage calls. This report can be expanded to all calls—including program referrals. It can also help identify callers more inclined to use more intense health care resources, including emergency rooms. Many customers use the DAR to allow timely follow up by case managers or others involved in clinical management. This process can also be used to provide notification to primary physicians, for an additional per call fee.

Consent is not generally required to provide this information to a plan administrator for medical management use. Their provider notification process includes an avenue for allowing callers to opt-out if they do not want their physician to be notified of their call.



Standard reports include monthly or quarterly delivery of program performance, outcomes, and usage trends. The standard reports include a variety of content and media options, including the following:

- **Utilization report**—Our utilization report begins with an executive summary report overview within the first four pages, including service delivery details, most frequent topics discussed, issue resolution trends, and detailed utilization information. The balance of the report includes program usage detail for clients who are interested in the deeper details, including monthly usage figures, trending of usage rates, and a detailed listing of all topics discussed with participants.
- **Outcomes report**—Participant survey results, demonstrating caller health and well-being, health decision making, willingness to select a particular benefits package option, and satisfaction levels as a result of their experience with us.

The above reports may be delivered via e-mail as an Adobe® PDF file or on paper and are sent within 30 days following the last day of the reporting period. Standard report production is automated. Samples of these reports have been provided as Exhibit Q in Section 6, Required Exhibits.

Member Services

233. With regard to the office that is proposed to provide Member service functions for the CHIP Plan, provide the following:

Location(s)

UnitedHealthcare—by AmeriChoice (UnitedHealthcare) will have a fully-functional Member Services office in Mississippi no later than 30 days prior to contract go-live. We are currently working to identify facilities for our Mississippi Member Services office. We will we use our Kingsport, TN call center to provide support to our MS CHIP Members until our permanent office is operational, and for overflow call support as needed. Our Virtual Call Center (VCC) telephony solution, including call sequencers and seamless data management, combined with our Mississippi-based Member Services operation will ensure comprehensive service coverage for our Members from the start. Please refer to UnitedHealthcare's MS CHIP Implementation Plan for specific dates and activities, provided as Attachment 246 in Section 7, Appendix of Other Materials.

Years in operation

UnitedHealthcare has operated fully compliant Member Services offices for 27 years in 22 states, serving over 2.3 million Members. We will leverage this experience and our proven Member Services processes to ensure timely and effective service delivery for our MS CHIP Members.

Days & hours of operation

UnitedHealthcare MS CHIP offices will be staffed and open during normal business hours 8:00 a.m. to 5:00 p.m. CST., Monday through Friday. Our Member Service Representatives in our call center will be available to answer Member calls Monday through Friday from 8:00 a.m. to 6:00 p.m. CST. In addition, our interactive voice response (IVR) telephone system is available to Members 24 hours a day, 7 days a week, and our nurse triage hotline is available through our IVR for health-related issues.

Staffing:

	# of	Avg. Yrs Experience	Annual Turnover Rate (%)
Member service representatives	485	2	<28%
Supervisors	27	5	<28%
Managers	5	10	<28%
Other	N/A	N/A	N/A

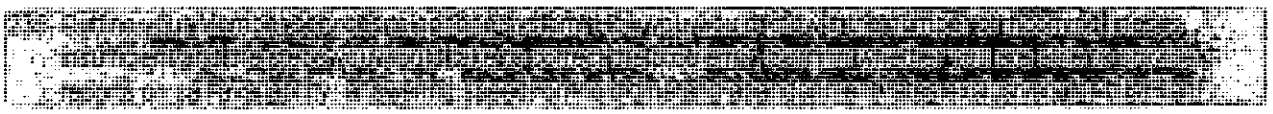
Annual claim volume: 18,971,384 (on Facets system)

# of plans presently administering: 13 (by AmeriChoice on Facets system)

UnitedHealthcare will staff our Mississippi Member Services office with 10 MSRs and one Member Services Supervisor. Our Kingsport, TN office staff, presented above, will support our Mississippi office throughout the contract.

234. Indicate the days of the week and hours of the day your proposed Member services telephone lines will be open and staffed with live personnel.

UnitedHealthcare's MS CHIP telephone lies will be available to answer Member questions with live personnel during normal business hours Monday through Friday from 8:00 a.m. to 6:00 p.m. After hours and weekends, Members can access information via our 24 hours a day, 7 days a week IVR phone system. For health-related issues, our Members can access our nurse triage hotline through our IVR system. Our IVR system will be available to MS CHIP Members no later than January 1, 2010 and will include information on accessing the Member website.



UnitedHealthcare will monitor and record all call information through our VCC technology, and will use the results to ensure an adequate number of lines for the MS CHIP call center. The VCC system allows for an extremely high service availability and will capture data and generate reports on call availability, answering speed, on-hold time and abandonment rates for the MS CHIP program. If we identify any deficiencies in capacity in our Mississippi call center, we will immediately install additional lines, and calls can be transferred to another call center in the event of a high influx of calls. Any other call-handling deficiencies identified by our system reports or audit processes will be corrected through training and other processes identified below.

UnitedHealthcare has extensive experience in providing 24 hours a day, 7 days a week support to our Members. We will provide our Mississippi Members with outstanding service using our NurseLine. NurseLine is an always-available network extender that supports Members in a variety of medical situations, from advice about a particular problem, to guidance on how to prevent a problem, to triage and support in a medical emergency. NurseLine value-added services are geared to deliver the following outcomes:

- Higher and more targeted levels of participation in disease management, quality improvement and wellness
- Increased Member satisfaction through the promotion of wellness, health literacy and 24 hours a day, 7 days a week access to help
- Health care decision support for people in remote rural areas where transportation challenges are common
- Reduction of emergency room use through timely and appropriate handling of medical concerns, including referrals to PCPs, specialists and urgent care (as appropriate).

Our NurseLine value-added services include quarterly utilization reporting and daily activity reports focusing on triage and referrals. Interpretation services are available for non-English speaking Members.

Standards for Rates of Response

UnitedHealthcare monitors MSRs' performance using the VCC system, which captures data that includes answered calls, abandonment rates and average length of call. Supervisors routinely monitor queues to ensure targets are met and to identify and respond to potential issues. Supervisors review performance results hourly and daily and meet each morning with MSRs to review the previous day's results. They also review weekly performance in staff meetings and report results monthly on business segment scorecards. Supervisors use load balancing analytics to balance workload and employ a variety of variable staffing techniques in order to accommodate anticipated volume. The following table demonstrates our success in managing large call volumes.

Month	Total Calls	Live Answered Calls	ASA	On-Hold Time	Abandon Rate
MS CHIP Requirement			<30 seconds	< 3 min.	≤5%
Feb 2008	46417	45225	17	0	3%
Mar 2008	51493	50204	21	0	3%
Apr 2008	50009	48728	19	0	3%
May 2008	47531	46096	23	0	3%
Jun 2008	44045	43127	16	0	2%
Jul 2008	41454	40360	20	0	3%
Aug 2008	41148	39512	29	0	4%
Sep 2008	41676	39283	42	0	6%*
Oct 2008	41891	40562	24	0	3%
Nov 2008	35997	35032	18	0	3%
Dec 2008	40603	39169	23	0	4%
Jan 2009	49824	47883	30	0	4%
Total/Average	**532088**	**515181**	**24**	**0**	**3%**

*In September 2008, Hurricane Ike devastated Houston and our call center was without power.

UnitedHealthcare will generate our Customer Care Daily MIS Report telephone system report daily. This report provides daily, week-to-date and month-to-date information and statistics on call availability, answering speed, on-hold time and abandonment rates for the MS CHIP program. Our experience and record show that we will easily accommodate the MS CHIP RFP requirements. We will provide the State with reports that track the daily availability of telephone service, the monthly telephone answering speed, the monthly average on-hold time and the average monthly abandonment rates. In addition, we will supply quarter-end and year-end telephone system reports no later than the last day of the month following the reporting period.

Our experience and success with call center operations, indicated by the statistics presented in the table below, ensure that we will answer at least 90 percent of MS CHIP program Member calls within 30 seconds, with less than three minute hold times and an average abandonment rate less than 5 percent.

	Reporting Period: 2/08 – 1/09 Actual	Goal
Average number of calls completed per hour per Member Service Representative in an average week	8-10 calls per hour	NA
Length of time a Member is on hold before speaking to a Member Service Representative	24 seconds average	< 30 seconds
Overall abandonment rate	3% average	< 5%

237. How do you propose to ensure that new Members understand the benefits and access requirements of the Plan?

Our experience shows that educating new members must be a multi-faceted approach using written materials, telephonic outreach, in person meetings with groups at convenient community locations and person to person conversations if necessary. Each of these channels will reach some of our membership and even our providers will play a critical role in rounding out our efforts to ensure that our members know how to use their benefits.

Welcome Kit, Welcome Call and Member Orientation

UnitedHealthcare provides each new Member a New Member Welcome Kit within 5 business days of receipt of enrollment data for the Member. The New Member Welcome Kit indicates the Member's first effective date of enrollment. We use first class mail delivery services for the New Member Welcome Kit. The Kit includes a Welcome Letter, a MS CHIP Member identification card, UnitedHealthcare's Provider Network Directory, the UnitedHealthcare Member Handbook and a brochure on Advanced Directives. The Provider Directory includes names, telephone numbers and information identifying any providers who are not accepting new patients. The Provider Directory includes specific information on primary care physicians, specialists and hospitals, identifying any restrictions that could impact the Member's freedom of choice among network providers. All of the material in the New Member Welcome Kit will be updated on an annual basis and a copy of the revised packet will be forwarded to the Board for review.

The following information is included in the New Member Welcome Kit packet:

- General information about the basic features of care coordination, which populations are excluded from enrollment and which are subject to mandatory enrollment and the responsibilities of UnitedHealthcare for coordination of a Member's care
- Specific information about UnitedHealthcare and the MS CHIP Program, including covered services, names, locations, telephone numbers of and the identification of providers and pharmacies in UnitedHealthcare's network that are not accepting new patients
- Covered services that are available through UnitedHealthcare but are not covered under MS CHIP , including information on how and where Members may obtain these benefits
- The amount, duration and scope of covered health and pharmacy services available in sufficient detail to ensure that Members understand the benefits to which they are entitled
- Procedures for obtaining covered health and pharmacy services
- The extent to which and how Members may obtain covered health services including family planning services, from out-of-network providers
- How and the extent to which after-hours and emergency coverage are provided including:
  - What constitutes an emergency medical condition, emergency services and post-stabilization services, with reference to the definitions in 42 CFR Section 438.114(a)
  - The fact that prior authorization is not required for emergency services
  - The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered
  - Members have a right to use any hospital or other setting for emergency care
  - The post-stabilization care services rules set forth at 42 CFR Section 422.113(c)
  - UnitedHealthcare's policy on referrals for specialty care and for other covered health and pharmacy services not furnished by the Member's primary care provider.

In addition, our Member Service staff will place a **Welcome Call** to all new Members with a telephone number listed in their initial enrollment information. These scripted calls include providing the Member with information on all covered health and pharmacy services. The MSR will offer to assist the Member with scheduling an initial appointment with the Member's primary care provider. Any questions the Member may have about covered services, providers and pharmacies available to the Member will also be addressed by the MSR.

A sample of the New Member Welcome Kit and its contents has been provided as Attachments 237(1) through 237(4) in Section 7, Appendix of Other Materials.

New Member Orientations

UnitedHealthcare has begun developing relationships with over 50 community-based organizations (CBOs), faith-based organizations, advocacy groups, and schools in Mississippi to discuss the MS CHIP program and Member education activities. All organizations contacted have expressed interest in working with UnitedHealthcare to ensure coverage and education for our Members. These groups will continue to be an integral part of our Member Services education and service delivery and for new members are potential sites for **New Member Orientations**. These **New Member Orientations** will be used as additional venues for reaching our members and will particularly effective during the initial implementation phase of the transition from the current vendor.

Face-to-face and Provider Support

Our local Member Services office will be available if Members desire a face-to-face personal orientation meeting with a MSR. Our MSRs will utilize UnitedHealthcare's proven approach to assisting Members with covered benefits and access requirements in Mississippi. We will leverage our experience to provide useful and easy to understand orientation and informational materials and services that will quickly and efficiently give Members the information they need. Our communication approach is designed to ensure appropriate provision of covered services without regard to payor source, race, color, creed, gender, religion, age, national origin (including those with limited English proficiency), ancestry, marital status, sexual orientation, or physical or mental disability, except where medically indicated. Our Member communications create a comfort level with the delivery system, empower Members to self-manage their conditions and promote an understanding of the importance of preventive care.

Finally, we will educate our providers with information about the transitions happening for our members. FQHCS, rural health clinics, local health departments and other provider venues will display information and many will allow us to set up orientation sessions to help their staff answer questions and educate members about he transition and help new members understand their benefits.

UnitedHealthcare has a comprehensive Member education and outreach approach, which includes the following:

- Comprehensive Coverage of Topics of Interest to Members
- Written Member Materials
- Use of Healthcare Informatics to Track Member Compliance
- Outreach Contacts for All Members.

These are described in the following sections.

Comprehensive Coverage of Topics of Interest to Members

Our MS CHIP educational materials and activities will include:

- Prenatal care
- Immunizations and preventive services
- AIDS and HIV
- Accessing network health services

- Leading causes of hospitalization
- Appropriate emergency room use
- Compliant, grievance and appeals processes Asthma and diabetes self-care
- Lifestyle choices and ways to promote good health
- Family planning
- Disease management services.

Written Member Materials

A core element of our Member education effort is our cadre of written materials, many of which are designed to help Members access care within a complex delivery system. These materials include the UnitedHealthcare Member Handbook and other elements of the Welcome Kit, along with brochures on the following topics:

- Adult Checkups
- Child Immunizations
- Diabetes Care
- Domestic Violence
- Flu
- Lead Screening
- Nutrition
- Pregnancy/Newborns
- Special Needs Provider rights and responsibilities
- Asthma
- Cholesterol
- Dental Care
- Family Planning
- Heart and Blood Pressure
- Mammogram
- Pap Smears
- Smoking Cessation Services for people with visual impairments.

Written Member materials are created in a minimum 12-point font, in an easily readable style. UnitedHealthcare ensures that all information is presented at a sixth-grade reading level. Draft written Member materials are reviewed for reading sixth-grade English using the Flesch-Kincaid Grade Level tool. Upon request, UnitedHealthcare makes alternative formats available for Members who have visual impairments. Materials requiring approval are submitted to the Board for review and before printing. Member materials are supplemented with health-related educational brochures developed by national organizations recognized by the Board. Before using these educational materials, UnitedHealthcare reviews the materials to ensure (1) services are covered by the MS CHIP program, (2) the information is accurate and (3) the information is culturally sensitive.

UnitedHealthcare will produce written Member materials in English and Spanish. In addition, UnitedHealthcare will translate written materials including the Member Handbook when 200 Members, or 10 percent of total UnitedHealthcare program membership if less than 200 Members, is non-English speaking and speaks a common language. Members are notified through the Member Handbook, in the appropriate language, that they may request information in Arabic, Cantonese, Mandarin, Romanian, Russian, Somali and Vietnamese. Materials will be provided in these languages and others as needed, including alternative formats for visually impaired Members. We use a translation vendor for translation of materials and provide certificates of authenticity upon completion of each translation.

Member Handbook

UnitedHealthcare's Member Handbook explains how to navigate our health plan and access the care Members need to remain healthy or treat a medical condition. We distribute the handbook to Members within 5 business days of receiving Member enrollment information and distribute revised handbooks when changes occur or upon request. Our Member website prominently displays a link to our Member Handbook. UnitedHealthcare's procedural information follows the current National Committee for Quality Assurance (NCQA) requirements. The Member Handbook will cover all of the sections required in the RFP, including:

- MS CHIP benefits and scope of coverage, including Member responsibilities, cost-sharing and, co-payment and out-of-pocket maximums
- A complete description of covered services, service limitations, exclusions and UnitedHealthcare liabilities.
- Access to services, including appropriate utilization, self-referral and referral requirements for non-participating providers
- Emergency and urgent medical care access and utilization
- Member Services description and contact information
- NurseLine nurse triage toll-free hotline
- Reference information to any health-care specific information not included in the handbook
- Complaint, grievance and appeal procedures, including information on independent review rights
- Preventive health guidelines and preventive care
- Coordination of benefits and third-party liability
- Advance directives
- Managed care plan overview.

Provider Directory

UnitedHealthcare MS CHIP Members will receive a provider directory in their New Member Welcome Kit that lists names, locations and telephone numbers of PCPs, specialists, hospitals and other providers. The directory also includes information on providers who are not currently accepting new patients and information on restrictions that could impact the enrollee's freedom of choice among network providers.

Provider directories are also available on our website. The directories are updated weekly and are searchable by provider name, location or specialty. Members can also call Member Services to request that a MSR mail a copy to them. If our provider network changes, we will update and reprint directories and mail them to all Members within the first quarter of each year.

Member Identification Cards

UnitedHealthcare commits to providing MS CHIP Members with Member Identification (ID) cards within 5 business days of receipt of enrollment data from DOM. Our streamlined process for the production and distribution of Member ID cards provides us with the opportunity to serve Members in an expeditious manner and decrease interruption of service for Members who are at high risk.

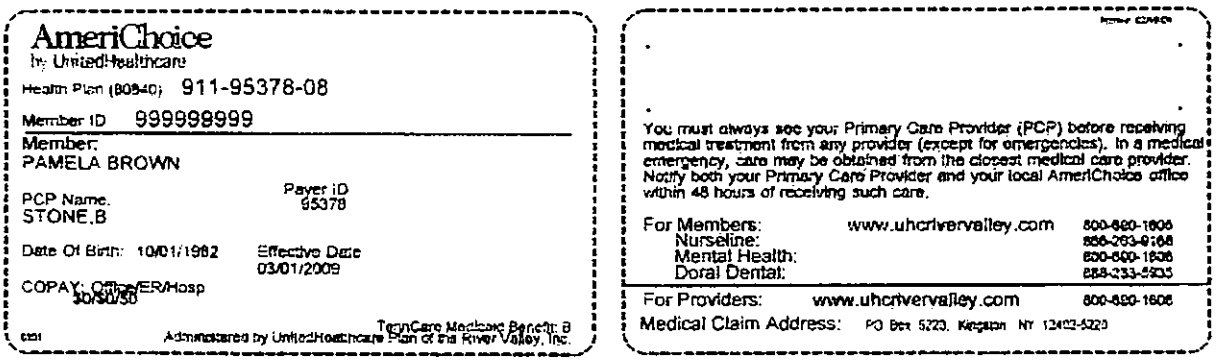
UnitedHealthcare's core transaction system is Facets, a Windows-based managed care information system that provides eligibility, enrollment, claims processing and reporting capabilities to fulfill the Plan's information system requirements.

Upon receipt of the monthly enrollment report from the Division of Medicaid (DOM), UnitedHealthcare enrollment coordinators transfer Member and provider data into Facets. Enrollment coordinators perform a quality check to verify Members' selection of a Primary Care Provider (PCP). Members who have not indicated a medical home are assigned a PCP within the DOM's access parameters using their home zip code and, where appropriate, by specialty and grouping by family.

Enrollment coordinators transmit information to a Member ID file nightly. The data is encrypted and securely transmitted to the vendor. On days three and four following receipt of the 834 files from DOM, the vendor will produce and mail the ID card to the Member via first class or priority mail. MS CHIP Member ID cards will closely mirror the ID cards UnitedHealthcare issues to its commercial clients and will include:

- Member name and Member identification number
- Effective date of coverage
- Name of the Benefit Plan
- Toll-free nurse triage/nurse triage telephone number and that the service is available 24 hours a day, 7 days a week
- Telephone number for Member services (if different)
- Telephone number for providers to verify eligibility
- Instruction on obtaining prior authorization for use of non-participating providers, including telephone number to call
- Instructions on what to do in an emergency
- Copayment requirements.

The figure below presents a sample of our ID card and will be modified as needed to meet the requirements of the MS CHIP Members' ID card.



Use of Healthcare Informatics to Track Member Compliance

UnitedHealthcare will use our Universal Tracking Database™ (UTD) to educate Members on Member responsibilities and compliance. UTD incorporates submitted claims, allowing near real-time tracking of Member compliance. Preventive Services staff use UTD to check Member compliance with MS CHIP services and to develop lists for each provider showing compliance of their Members. We will provide these lists quarterly as well as on request. As of early 2009, PCPs will receive UnitedHealthcare Alerts when Members are overdue for immunizations, giving birth, or screenings or have received no services for a year.

Outreach Contacts for All Members

UnitedHealthcare conducts at least six outreach contacts per year for all Members under 21 and their parents/guardians and will conduct at least one additional contact per quarter to encourage them to make and keep screening appointments. The additional contact per quarter goes beyond minimum requirements for contacting Members who are overdue for screening. The materials used for quarterly contacts may include calendar stickers, bookmarks and postcards. These materials are available online and, upon request, in alternative formats such as audiotape, large print and Spanish. When mail is undeliverable, we attempt to contact the Member via automated phone messaging (see TeleVox, below), mail to the new address obtained from the post office and/ or our MS CHIP staff go to the Member's address. We document these attempts in our UTD. Welcome calls to all new Members contain a message about MS CHIP services. When Members call the Customer Service line, our hold message contains MS CHIP program information, with a prompt allowing Members needing services to transfer directly to our Disease Management and MS CHIP staff. We mail each Member an annual birthday screening reminder that offers

transportation and scheduling help and tells the Member how to contact us for help. The Member website will contain content tailored to subpopulations such as African American, Asian and Latino Members, and will allow Members to log on and identify upcoming and missed MS CHIP services.

Our Member website includes a CHIP Handbook which explains all CHIP policies and services to our Members. In addition to the website and our mailings and phone contacts, UnitedHealthcare will use innovative, non-traditional approaches to ensure comprehensive delivery and provide exceptional education to priority or hard-to-reach Members. We will use in-person outreach from individuals within the community and specialty case/disease management programs. UnitedHealthcare will partner with community leaders, faith based organizations and advocacy groups to reach Members and potential Members. We have had discussions with many groups such as the Boys and Girls Clubs of Central Mississippi, who are enthusiastic about working with us to deliver health education and benefit information to the communities that they serve.

UnitedHealthcare has already met with over 50 community-based organizations (CBOs), faith-based organizations, advocacy groups, and schools in Mississippi to discuss the MS CHIP program. All organizations contacted have expressed interest in working with UnitedHealthcare to ensure compliant, comprehensive coverage for our Members. We will continue to work with these groups to ensure that our educational programs are specific to the MS CHIP population.

Special Populations

In rural areas, we will work on outreach strategies with county health departments and FQHCs. We will institute a quarterly teen newsletter which provides immunization reminders, screenings in high schools with numerous noncompliant Members, intensive phone outreach and screening incentives for teens. Our Be Wise Immunize program mails immunization reminders according to CDC recommendations to all families. Healthy First Steps, our program for early pregnancy identification and care management for at-risk pregnant Members, provides MS CHIP information to expectant mothers upon program entry and during the post-partum period. The program holds Baby Showers to educate high-risk pregnant Members about MS CHIP, offering nominal-value gifts such as diapers. We are partnering with local authorities for expert advice on outreach to deaf and hearing impaired Members and parents/guardians.

National (Outbound) Call Center (NCC)

UnitedHealthcare currently uses the NCC for health educator coaching calls for Members in our disease management programs. Our Medicaid-focused service center will complement Televox (automated message system described below) with a personal phone call to support MS CHIP and HEDIS initiatives and help Members address compliance challenges.

Televox

Televox delivers recorded outbound calls and can be tailored to subpopulations, such as those overdue for screenings, those who have received no services, or teenagers. We currently use it to increase breast cancer screening rates and to contact Members for whom we have received undelivered mail.

Community and Faith-Based Outreach

UnitedHealthcare will conduct in-person outreach tailored to specific communities in Mississippi. The UnitedHealthcare Partners in Care (PIC) Program will hire Health Advocates from the local and faith-based communities to conduct outreach at churches, community events and other local sites. Their community integration will help them reach Members who otherwise may not respond to MS CHIP outreach. We will provide enhanced Care Management and MS CHIP outreach activities for newborns to age one and to other families with children up to age 21. Activities will include MS CHIP education via mailings and pre/post-partum phone contacts.

Well Child Inc (WCI)

This best practice approach provides wellness services from a nurse practitioner to high risk Members in schools. WCI performs outreach and in-school screenings at selected schools. To encourage participation, we give the school a gift card in an amount equal to $5.00 for every screening performed on our Members at their school. WCI will link Members back to the medical home, provide scheduling help for children with positive screens and track referred Members to ensure appointments are kept. WCI will notify the PCP and UnitedHealthcare when Members miss appointments.

240. How often does your organization conduct general member satisfaction surveys? What characteristics listed below describe the member satisfaction survey tool currently used? Check only one.

[X] Use the NCQA member health survey instrument
[ ] In-house proprietary instrument
[ ] Other nationally used instrument. Indicate name:
[ ] Other:

UnitedHealthcare performs annual Member surveys to gain standardized Member feedback. This approach includes the CAHPS survey. Annually, a NCQA-certified CAHPS vendor conducts a Member satisfaction survey, CAHPS, following HEDIS technical specifications. UnitedHealthcare uses the CAHPS survey to understand Member satisfaction levels with service, access and availability, UM and other operations and correlates results to Member complaints and appeals. Upon completion, the Service Quality Improvement Subcommittee (SQIS) analyzes the results, compares UnitedHealthcare's performance to other UnitedHealthcare plan performance as well as national and regional data where available. The SQIS identifies barriers to optimal performance, improvement opportunities and designs, develops and implements improvement initiatives to improve Member satisfaction. UnitedHealthcare uses the Member satisfaction survey results to track overall performance year-to-year.

UnitedHealthcare will conduct an annual Member satisfaction survey for the MS CHIP population and will tabulate and report the results to the Board exclusively for MS CHIP Members. We will report Member satisfaction survey results to the Board no later than March 31st following the end of the contract year.

241. Indicate the percentage of members who responded during the last completed survey that they were at least "satisfied" with your organization.

In UnitedHealthcare's February 2009 post-call Member survey, 90.67 percent of our Members indicated overall satisfaction with our services.

242. List the top three most common complaints by members and indicate any quality improvement actions you have taken as a result of Member complaints.

The top three complaints by our Members and UnitedHealthcare targeted improvement activities are discussed in the following table.

Complaint	Action	Responsible Office
▪ Dissatisfaction with Formulary	▪ Reinforce Member understanding of plan parameters, benefit structure, and plan policies and procedures through Member contact and distribution of targeted printed material ▪ Strengthen Member/provider communication ▪ Analyze patterns/trends of specific drug coverage dissatisfaction	▪ Member Services (MSR) ▪ PBM and Medical Director

Complaint	Action	Responsible Office
■ Medical Necessity (related to ER)	■ Increase Member education with emphasis on emergency room use and reimbursement parameters procedures through Member contact and distribution of targeted printed material ■ Strengthen Member/provider communication through PSR outreach	■ Member Services (MSR) ■ MSR and PSR
■ Provider Balance Billing Member	■ Increase provider education on contract terms ■ Communicate plan policies and procedures regarding billing through distribution of targeted printed material	■ Member Services (MSR), Provider Services (PSR) and Network Management ■ Provider Services (PSR)

We address Member complaints through increased Member communications and education, as well as evaluation of our Member processes. If call center trends or satisfaction survey results indicate specific problem areas, we implement Targeted Improvement Plans to address the issue. In addition, we increase our regular interactions with Members and community organizations and add identified problem areas to our training materials and activities.

243. What percentage of all claims appealed within your organization proceeded to the final level of appeal?

UnitedHealthcare ensures rapid resolution of all claims appeals through one level of claims appeal. MSRs and our Claims department work together to ensure that we review all appealed claims and communicate resolution to the Member within 30 days of receipt. When a claim is appealed, our MSRs work with the Member to ensure that they understand all benefits and payment parameters of the plan and communicate the result of the claims review. The MSRs also ensure, through telephone communications and the Member Handbook, that the Member understands their right to appeal an adverse determination to the applicable State regulatory body.

UnitedHealthcare does not currently refer adverse determination claims appeals to an independent review organization. As stated in the Member Handbook, Members can contact the applicable State regulatory agency for an adverse determination on a claim.

245. What communication capabilities are available to accommodate special populations, including non-English speaking, hearing and/or visually impaired?

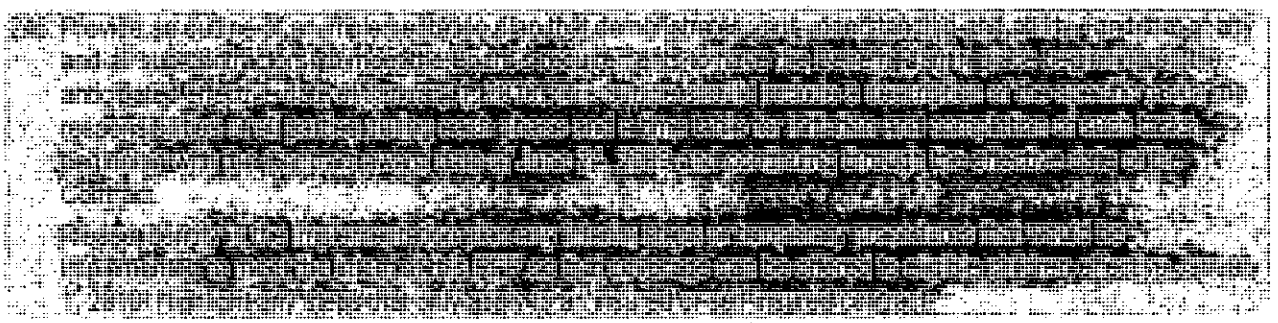
UnitedHealthcare will provide translation services for our telephone lines and Member/provider interactions and produce written Member materials in any language when 200 Members, or 10 percent of total UnitedHealthcare program membership if less than 200 Members is non-English speaking and speaks a common language.

MSRs receive training specific to cultural sensitivity, with a special focus on how to respond to calls from Members who have Limited English Proficiency (LEP). UnitedHealthcare employs bi-lingual MSRs to assist Members with LEP and our phone line prioritizes call routing to Spanish-speaking MSRs with a single button option. For languages other than Spanish and English, we provide translation through the Language Line, which provides translation capabilities in over 170 languages using interpreters trained in medical terminology. The MSR transfers the caller seamlessly to a translator and remains on the call through resolution.

MSRs receive training on handling calls from Members with hearing impairments. Members with hearing impairments have access to MSRs by using the toll-free relay line listed in our Member materials. The Telecommunications Device for the Deaf (TDD) operator conducts a three-way call with the MSR and the Member. All Member materials explain how to access communications services for Members with Limited English Proficiency and for those who have hearing impairments.

MSRs taking calls from Members who are facing barriers due to a visual impairment offer these Members several options. The MSR will initially offer to assist the Member verbally with their needs, that is, providing answers to their questions from the Member handbook or provider directory. At the Member's request, UnitedHealthcare provides alternate formats, including audio tapes, large print or Braille of written materials.

Implementation



UnitedHealthcare has a proven, reliable, repeatable approach to ensure timely integration of multiple functions to create a smooth transition for Members and providers who are part of the MS Chip program. In the past 15 months, UnitedHealthcare has successfully implemented two new Regions in TN covering over 300,000 Members, a statewide Children's Rehabilitative Services contract covering over 20,000 AZ children, a new health plan in CT and an expansion into new counties in FL. These effective implementations have been achieved by using a replicable process and a dedicated team of experienced Project Managers who organize and manage the implementation process on a full time basis. In addition to the people, our focus on continuous improvement has led to a very comprehensive project management tool that ensures that each functional team (clinical, technology, operations, etc.) can simultaneously achieve the milestones within their units yet stay connected on those active interdependencies across multiple functions.

Our Process

Our approach is based upon a cross functional executive steering committee that meets regularly (at least weekly) to address progress toward milestones and to encourage rapid resolution of issues or barriers. Each functional sub team also meets as needed to achieve the objectives of the project. Each team reports progress and challenges and the resources of the organization are directed to ensure that key milestones are met. Our accomplishments in the past 15 months attest to the effectiveness of this process.

At each stage we are in constant with our customer—the Board and the staff assigned to this project. We are fully transparent on our progress and welcome close coordination as there are many dependencies that are required, especially regarding approval and data interfaces. Our experience in 22 states makes us confident that we can work effectively in the implementation to meet our mutual constituents' needs.

Our Implementation Plan

Our implementation plan is updated with each new project to reflect new program requirements and our lessons learned from previous projects. Our implementation plan has been developed in collaboration with all functional areas. Interdependencies are identified with all predecessors clearly marked. For convenience, UnitedHealthcare is providing an overview report in advance of the implementation plan so that the critical paths are clear.

Schedules for All Deliverables

UnitedHealthcare has extensive experience in working through client approval processes and we look forward to working with the Board throughout our implementation process.

The UnitedHealthcare process includes a post 'go live' phase where the dedicated team remains focused to resolve any issues immediately.

Our implementation work plan has been provided as Attachment 246 in Section 7, Appendix of Other Materials.

Attachment C

Performance Standards and Liquidated Damages

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
1. Nurse Triage Telephone Hotline In accordance with **Section 4.16** of this RFP, telephone lines are operational twenty-four (24) hours per day, seven (7) days a week.	In accordance with **Section 11.4.2** (a) of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
2. Nurse Triage Telephone Hotline In accordance with **Section 4.16 (g)** of this RFP, 80% of all telephone calls answered within 30 seconds.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average telephone answering speed for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly answering speed achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
3. Nurse Triage Telephone Hotline In accordance with **Section 4.16 (g)** of this RFP, the maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	its designee. All reports are due by the last day of the month following the close of the reporting period.	DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	
4. Nurse Triage Telephone Hotline In accordance with **Section 4.16 (g)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete or inaccurate
5. Member Services Telephone Line In accordance with **Section 10.1** of this RFP, telephone lines are operational 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
		performance standard.	
6. Member Services Telephone Line In accordance with **Section 10.2 (d)** of this RFP, 80% of all telephone calls answered within 30 seconds.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average telephone answering speed for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly answering speed achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
7. Member Services Telephone Line In accordance with **Section 10.2 (d)** of this RFP, the maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
8. Member Services Telephone Line In accordance with **Section 10.2 (d)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. DOM will use the	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	required report is late, incomplete or inaccurate
9. Utilization Management Telephone Line In accordance with **Section 4.15.2 (j)** of this RFP, telephone lines are operational 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$500 for each day full telephone service is not operational In addition, $500 for each calendar day a required report is late, incomplete or inaccurate
10. Utilization Management Telephone Line In accordance with **Section 4.15.2 (k)** of this RFP, 80% of all telephone calls answered within 30 seconds.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average telephone answering speed for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly answering speed achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day a required report is late, incomplete or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
		that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	
11. Utilization Management Telephone Line In accordance with **Section 4.15.2 (k)** of this RFP, maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
12. Utilization Management Telephone Line In accordance with **Section 4.15.2 (k)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
13. Provider Services Telephone Line In accordance with **Section 9.1** of this RFP,	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM	Contractor's compliance will be evaluated at the end of each Contract	$500 for each day full telephone service is not operational

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
telephone lines are operational 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.	calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the availability of the telephone service for each day in the Contract year. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end (12 month) report from the Contractor. Liquidated damages will be assessed for each day the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate
14. Provider Services Telephone Line In accordance with **Section 9.3 (h)** of this RFP, 80% of all telephone calls answered within 30 seconds.	Contractor is required to provide DOM calendar quarter-end reports and a Contract year end report of the automated telephone system, which documents the telephone answering speed for each calendar quarter in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the reporting period the Contractor was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point below the performance requirement for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
15. Provider Services Telephone Line In accordance with **Section 9.3 (h)** of this RFP, maximum length of time a caller is placed on hold not to exceed three (3) minutes.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports a contract year-end (12 month) report of the automated telephone system, which documents the on-hold time for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. Contractor is required to provide DOM a report following the end of each calendar year quarter	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly on-hold time achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for	$2,500 for each full 30 second increment in which the average on hold time is greater than 3 minutes for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	of the automated telephone system, which documents the on-hold time. DOM will use this report to monitor the performance of the Contractor. All reports are due by the last day of the month following the close of the reporting period.	each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/or failed to meet the reporting requirements for the performance standard.	
16. Provider Services Telephone Line In accordance with **Section 9.3 (h)** of this RFP, an average abandonment rate of no greater than 5%.	In accordance with **Section 11.4.2 (a)** of this RFP, the Contractor is required to provide DOM calendar quarter-end reports and a Contract year-end (12 month) report of the automated telephone system, which documents the average abandonment rate for each calendar month in the reporting period. Performance may also be monitored by random checks of phone availability by DOM or its designee. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall average monthly abandonment rate achieved in each calendar quarter. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each calendar quarter in the Contract year that the Contractor was not in compliance with the performance standard and/ or failed to meet the reporting requirements for the performance standard.	$2,500 for each full percentage point the average abandonment rate is above 5% for each calendar quarter In addition, $500 for each calendar day any required report is late, incomplete, or inaccurate
17. Grievance Resolution by Contractor The Contractor resolves all Grievances within the time frames specified in **Section 5** of this RFP.	In accordance with **Section 11.4.2 (b)** of this RFP, the Contractor is required to provide DOM with a Contract year-end (12-month) which documents the length of time in which Grievances are resolved. Performance may also be monitored by random checks the Grievance Register by DOM or its designee.	Contractor's compliance will be evaluated at the end of each Contract year, based on the number of Grievances during the Contract year, which were not resolved within the time periods specified in **Section 5** of this RFP. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed for each Grievance not resolved within the time periods specified in **Section 5** of this and/ or failed to meet the reporting	$2,500 per incidence of non-compliance In addition, $500 for each calendar day a required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
		requirements for the performance standard.	
18. Claims Processing Turnaround Time 90% of all claims to be completely processed within 30 calendar days after they are received For the purposes of this standard: ➢ A claim is a request for payment of a plan benefit by a member or provider (includes adjustments) ➢ A claim is deemed to have been received when it has been time-stamped by the Contractor ➢ Processing of a claim will be completed when it has been approved for payment, rejected or denied. ➢ The time that elapses between the time a claim is pended due to a request for additional information from an outside party and the time that the additional information is received may be deducted from the turnaround time provided the amount of time deducted does not exceed 14 calendar days per claim.	Contractor is required to provide DOM calendar quarter-end system generated reports and a Contract year-end system-generated report documenting the average claims turnaround time for the reporting period exclusively for the CHIP Plan. All reports are due by the last day of the month following the close of the reporting period. DOM reserves the right to confirm the accuracy of the Contractor's internal reports by conducting a statistically valid independent audit of the Contractor's claims operations using a qualified firm, of its own choosing, who is experienced in claims auditing. DOM will pay the expense of the independent auditing firm. The results of the independent audit will determine the Contractor's liability for liquidated damages, if any.	Contractor's compliance will be evaluated at the end of each Contract year, based on the average claims processing turnaround time for the Contract year. DOM will use the calendar quarter-end reports to monitor the Contract's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if the overall average annual claims turnaround time for the Contract year under review was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	**Average Annual Turnaround Time** **Per Member Fee** Less than 90% but greater than 85% of all claims are processed within 30 calendar days $2.00 85% or less of all claims are processed within30 calendar days $4.00 The total dollar amount of the liquidated damages shall be determined by multiplying the applicable per Member fee by the total number of enrolled members as of the last month of the measurement period. In addition, $1,000 for each calendar day any required report is late, incomplete or inaccurate.
19. Claims: Financial Accuracy (Dollar Value) 99% of claims dollars submitted for payment will be accurately processed and paid. Regardless of whether or not these standards of performance are satisfied, the Contractor is to adjust the paid claims component of its renewal rates by the amount of any overpayments that are discovered in the previous experience period upon which the renewal rates are based.	The total absolute value of all overpayments and underpayments are subtracted from the dollar amount audited and then divided by the total paid dollars audited to determine the level of payment accuracy. Depending on the sampling methodology used, the result may be statistically adjusted to reflect the entire population of claims for the audited period. Payments caused by the failure to provide adequate information that are corrected upon submission of the missing information, shall not be counted as errors for the purpose of determining financial accuracy performance. Contractor is required to provide DOM copies of internal audit reports at the end of each	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall financial accuracy for the Contract year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if the overall financial accuracy for the Contract year under review was not in compliance with the performance	**Financial Accuracy** **Per Member Fee** Less than 99%, but greater than 97% $2.00 97%, or less $4.00 The total dollar amount of the liquidated damages shall be determined by multiplying the applicable per Member fee by the total number of enrolled members as of the last month of the measurement period. In addition, $1,000 for each calendar day any required report is late, incomplete or inaccurate.

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	calendar quarter and a Contract (12 month) audit report, exclusively for the CHIP Plan, which includes the total dollar value of the claims audited, the total dollar value of claims in error and a detailed listing of each overpayment and underpayment, with an explanation of the error. All reports are due by the last day of the month following the close of the reporting period. DOM reserves the right to confirm the accuracy of the Contractor's internal reports by conducting a statistically valid independent audit of the Contractor's claims operations using a qualified firm, of its own choosing, who is experienced in claims auditing. DOM will pay the expense of the independent auditing firm. The results of the audit will determine the Contractor's liability for Liquidated damages, if any.	standard and/or for failure to meet the reporting requirements for the performance standard.	
20. Claims: Processing Accuracy (Number of Claims) 95% of all claims will be processed accurately. Accurate processing includes payment amounts; appropriate communication to the provider; payment issued to proper party; appropriate investigation of third party liability, and absence of data entry errors, which may affect current or future benefit determinations and management reports.	Every claim that has a processing error shall be subtracted from the total number of claims audited and divided by total number of claims audited to determine the percentage of claim processing accuracy. Errors are not to be weighted. Contractor is required to provide DOM with a Contract year-end (12 month) administrative internal audit report, exclusively for CHIP, which includes the total number of the claims audited, the total number of claims in error and a detailed listing of the errors found, with an explanation of the error. The Contract year-end report will be the basis upon which liquidated damages are determined. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year, based on the overall processing accuracy for the Contract year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if claims processing accuracy for the year under review was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	**Processing Accuracy** **Per Member Fee** Less than 95%, but greater than 93.5% $2.00 93.5%, or less $4.00 The total dollar amount of the liquidated damages shall be determined by multiplying the applicable per member fee by the total number of enrolled members as of the last month of the measurement period. In addition, $1,000 for each calendar day any required report is late, incomplete, or inaccurate.

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	DOM reserves the right to confirm the accuracy of the Contractor's internal reports by conducting a statistically valid independent audit of the Contractor's claims operations using a qualified firm, of its own choosing, who is experienced in claims auditing. DOM will pay the expense of the independent auditing firm. The results of the audit will determine the Contractor's liability for Liquidated damages, if any.		
21. Network Access At the end of first twelve (12) months following the Contract effective date, and for each twelve (12) month period thereafter 85% of members are within the required access parameters. The access standards for primary care physicians, acute hospitals, and retail pharmacies are specified in **Section 8.10.2 (a),** (c) and (e) of this RFP.	To be measured by access reports produced by the Contractor, DOM, or its designee (to be determined at the discretion of DOM, but no less than annually), using GeoAccess or similar software. If the Contractor is producing the access report information, the results must be provided to DOM within 45 days following the end of each calendar quarter and Contract year. The match is to be conducted separately for each provider type for urban/suburban zip code areas and for rural zip code areas. The term urban/suburban area is defined as a zip code with a population density of 1,000 or more persons per square mile and a rural area is defined as a zip code with a population density of less than 1,000 or more persons per square mile. The mapping or methodology used to measure distance must be based on actual driving distance The elements used to measure member access is as follows: ➢ The five digit zip code census of covered members as of the end of the measurement period; and ➢ The five-digit zip code census of the provider network (using the address of their practice locations) under contract as of the end of the measurement period.	Contractor's compliance will be evaluated at the end of each Contract year. DOM will use the calendar quarter-end reports to monitor the Contractor's performance. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor. Liquidated damages will be assessed if the access for the Contract year-end under review for any provider type was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	$5,000 for each full percentage below the performance standard for each provider type each Contract year In addition, $500.00 for each calendar day any required report is late, incomplete, or inaccurate

Performance Standard	Measurement, Source of Information and Required Reports	Assessment	Liquidated Damages for Failure to Meet Performance Standard
	Note: PCPs with closed practices, who are not serving any CHIP members are to be excluded from the PCP provider match.		
22. Transfer of Data to the State's Information Management Vendor (IMV) Within fifteen (15) calendar days following the end of each calendar quarter, the Contractor must transfer to the State's IMV enrollment and claims data, including outpatient prescription drug claims activity, by member ID number in a file format to be specified by the State.	Contractor is to provide written verification each calendar quarter to DOM as to the date on which the data transfer occurred and a Contract year-end report documenting the date each calendar quarter the required data was transfer by the Contractor to the IMV. In addition, performance may also be measured based on documented receipt date of the data by the State's IMV.	Contractor's compliance will be evaluated at the end of each Contract year. The assessment period will begin after DOM's receipt of the required Contract year-end report from the Contractor or upon inception of an independent audit, if such an audit is conducted. Liquidated damages will be assessed if the overall claims processing accuracy for the Contract year under review was not in compliance with the performance standard and/or for failure to meet the reporting requirements for the performance standard.	$1,000 per calendar day for each day the required data is late, incomplete, or inaccurate
23. Reporting Requirements In accordance with **Section 11.4** of this RFP, the Contractor is to produce and provide DOM with reports. The final reporting format and elements are to be agreed upon between DOM and the Contractor following Contract award.	Board's date-stamp of receipt. All reports are due by the last day of the month following the close of the reporting period.	Contractor's compliance will be evaluated at the end of each Contract year. Liquidated damages will be assessed for failure to meet the reporting requirements for the performance standard.	$500 for each calendar day a required report is late, incomplete, or inaccurate

Attachment D
Policy (#POL.I.12.MSCHIP)

Children's Health Insurance Program (CHIP) Policy

UnitedHealthcare Insurance Company

450 Columbus Boulevard

Hartford, Connecticut 06115-0450

1-800-357-1371

This Policy is entered into by and between UnitedHealthcare Insurance Company ("UHC") and the "Policyholder", as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

We agree to provide benefits for Covered Services as set forth in this Policy, including the Benefit Plan attached as Exhibit 2 and the Letter of Understanding attached as Exhibit 3, subject to the terms, conditions, exclusions, and limitations of this Policy. The Policyholder's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to benefits for Covered Services between the Policyholder and UHC. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to benefits for Covered Services between the Policyholder and us.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

[Signature of authorized company officer]

[Title of authorized company officer]

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in the attached Benefit Plan attached as Exhibit 2.

Benefit Plan - The benefits for Covered Services and the provisions for the Mississippi Children's Health Insurance Program as described in the Member Handbook attached as Exhibit 2.

Children's Health Insurance Program (CHIP) - The Children's Health Insurance Program authorized by Section 41-86-1 et seq. of the Mississippi Code and Title XXI of the Social Security Act, and administered by the Mississippi Department of Medicaid.

Member - An individual who is eligible to receive CHIP benefits as determined by the Mississippi Division of Medicaid and enrolled in the CHIP program.

Article 2: Benefits

Members are entitled to benefits for Covered Services subject to the terms, conditions, limitations and exclusions set forth in the Benefit Plan. The Benefit Plan attached as Exhibit 2 describes the Covered Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage under the Benefit Plan.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable on behalf of Members are specified in Exhibit 1 of this Policy or in any attached Notice of Change. The monthly premium will be calculated based on terms and conditions outlined in the Letter of Understanding attached as Exhibit 3. Exhibit 1 of this Policy and the Letter of Understanding attached as Exhibit 3 describe the way in which the premiums are calculated, the timing and process for invoicing, and payments and how adjustments in Members and premiums are made.

3.2 Grace Period

A grace period of 15 days will be granted for the payment of any premium not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates. The grace period will be extended for up to 30 days if there is a delay in the Policyholder receiving the federal or state allotment for program funds. The Policyholder shall remain fully liable for payment of the premium due during the original and any extended grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due premium remains unpaid.

Article 4: Eligibility and Enrollment

Member eligibility and the effective date for eligibility will be determined in accordance with the process conducted by the Policyholder by which children are determined to be eligible for the Children's Health Insurance Program.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all benefits for Covered Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. Upon the expiration of the grace period; or

B. On the date specified for termination under the terms and conditions of the Letter of Understanding attached as Exhibit 3.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Policyholder is and will remain liable to us for the payment of any and all premiums which are unpaid at the time of termination, except if termination is the result of the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including Exhibits 1, the Benefit Plan attached as Exhibit 2, the Letter of Understanding attached as Exhibit 3, the application of the Policyholder, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties.

6.2 Dispute Resolution

The parties will work together in good faith to resolve any disputes pertaining to or arising out of this Policy. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, the parties will submit the dispute to non-binding mediation at a location and with a mediator acceptable to both parties, with costs shared equally between the parties.

Venue for any legal action pertaining to or arising out of this Policy shall be in the First Judicial District, Hinds County, Mississippi.

6.3 Time Limit on Certain Defenses

No statement made by the Policyholder, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

This Policy may be modified, altered, or changed only by written agreement signed by us and the Policyholder. The parties agree to renegotiate the terms of the Policy if Federal and/or State revisions of any applicable laws or regulations make changes in this Policy necessary.

6.5 Relationship Between Parties

The relationships between us and network providers, and relationships between us and the Policyholder, are solely contractual relationships between independent contractors. Network providers and the Policyholder are not our agents or employees, nor are we or any of our employees an agent or employee of network providers or the Policyholder.

The relationship between a network provider and any Member is that of provider and patient. The network provider is solely responsible for the services provided by it to any Member.

The Policyholder is solely responsible for eligibility determinations (including termination of a Member's coverage) and for the timely payment of the Premium.

6.6 Examination of Members

In the event of a question or dispute concerning benefits for Covered Services, we may reasonably require that a health care provider, acceptable to us, examine the Member at our expense.

6.8 Continuation Coverage

There is no continuation of coverage available under this Policy or under federal or state law, for Members who no longer meet eligibility requirements for the Benefit Plan or when this Policy terminates.

6.9 Certification of Coverage Forms

As required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), we will produce certification of coverage forms for Members who lose coverage under this Policy. The Policyholder will provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Policyholder provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

Exhibit 1

1. Parties. The parties to this Policy are UnitedHealthcare Insurance Company (United) and the Mississippi Division of Medicaid (DOM). DOM is responsible for making all payments to United. United will provide health insurance coverage to children under the Mississippi Children's Health Insurance Program.

2. Effective Date of this Policy. The effective date of this Policy is 12:01 a.m. on January 1, 2013 in the time zone of the Policyholder's location.

3. Effective Date for Members. The effective date of coverage for Members who are eligible on the effective date of the Policy is January 1, 2013.

   For a Member who becomes eligible after the effective date of the Policy, his or her effective date of coverage will be the date established by DOM.

4. Place of Issuance. We are delivering this Policy in the State of Mississippi. The laws of the State of Mississippi are the laws that govern this Policy.

5. Monthly Premiums. The premium rate payable on behalf of each member for the period of January 1, 2013 through December 31, 2013 is $XX.XX per month of coverage. The full monthly premium is payable for any month in which a Member is enrolled in the program, even if eligibility is for only a portion of the month. United will provide the Policyholder and the DOM with monthly invoices, which shall be payable to United by DOM within thirty (30) days of receipt. Terms and conditions for monthly premium determination, member eligibility, invoicing, payment and payment adjustments shall be in accordance with the Letter of Understanding attached to this Policy as Exhibit 3.

   Annual premium adjustments shall be made in accordance with the Letter of Understanding attached to this Policy as Exhibit 3. Changes to premium rates will be attached to this Policy by means of a Notice of Change to this Exhibit 1.

6. Notice. Any notice sent to us under this Policy must be sent by certified mail and addressed to:

President
UnitedHealthcare Community Plany

795 Woodlands Parkway, Ste. 301
Ridgeland, MS 39157

Any notice sent to the Policyholder under this Policy must be sent by certified mail and addressed to:

Executive Director
Division of Medicaid
Walter Sillers Building, Suite 1000
550 High Street
Jackson, Mississippi 39201-1399

Attachment E

Prior-Authorization Program Requirements

UnitedHealthcare®

A UnitedHealth Group Company

Services that Require Prior Authorization

Cosmetic and Reconstructive Surgery
Dental Major Services • Crowns • Periodontal Procedures Oral Surgery Procedures (excluding extractions) • Accidental Injury Benefits • TMJ Coverage Benefit
Durable Medical Equipment and Supplies > $500 Per Item
Prosthetics and Orthotics > $500 Per Item
Home Health Care Services • Medication or infusion • Therapy services provided in home • All other
Hospice Services – Inpatient and Outpatient
Hospital Services – Acute Inpatient* • Prescheduled procedures – excluding maternity
Hospital Services – Sub-acute Inpatient • Rehabilitation and skilled nursing facility
Hysterectomy
MRI, MRA and PET Scans
Non-contracted Provider Services (hospital and professional)
Occupational Therapy -performed in an outpatient facility after the initial evaluation and six visits
Pharmacy - injectables high cost and non formulary drugs/prescriptions
Physical Therapy – performed in an outpatient facility after the initial evaluation and six visits
Skilled Nursing Facility Services
Speech Therapy – performed in an outpatient facility after the initial evaluation and six visits
Transplantation Evaluations
Transportation – non-emergent
Behavioral Health and Substance Abuse - Ambulatory • Intensive Outpatient • Outpatient Detoxification and Rehabilitation • Psychological and Neuropsychological Testing • Applied Behavioral Analysis • Electro Convulsive Therapy
Hospital Services – Behavioral Health and Substance Abuse* • Inpatient • Detoxification • Rehabilitation • Partial hospitalization • Residential treatment facility
*Emergency admissions do not require prior authorization

Services that Require Prior Authorization

Prior Authorization

Cosmetic Surgery
Dental Major Services
• Crowns (excluding D2930 prefabricated stainless steel crowns-primary tooth and D2933 prefabricated stainless steel crown with resin window-anterior teeth only)
• Periodontal Procedures
• Oral Surgery Procedures (excluding extractions)
• Accidental Injury Benefits
• TMJ Coverage Benefit
Durable Medical Equipment and Supplies > $500 Per Item
Prosthetics and Orthotics > $500 Per Item
Home Health Care Services
• Medication or infusion
• Therapy services provided in home
• All other
Hospice Services – Inpatient and Outpatient
Hospital Services *
• Inpatient Admissions (emergency admissions do not require prior authorization)
Hospital Services – Sub-acute Inpatient
• Rehabilitation and skilled nursing facility
MRI, MRA and PET Scans
Non-contracted Provider Services (hospital and professional)
Occupational Therapy -performed in an outpatient facility after the initial evaluation and six visits
Pharmacy - injectables high cost and non formulary drugs/prescriptions
Physical Therapy – performed in an outpatient facility after the initial evaluation and six visits
Skilled Nursing Facility Services
Speech Therapy – performed in an outpatient facility after the initial evaluation and six visits
Transplantation Evaluations
Transportation – non-emergent
Behavioral Health and Substance Abuse - Ambulatory
• Intensive Outpatient
• Outpatient Detoxification and Rehabilitation
• Psychological and Neuropsychological Testing
• Applied Behavioral Analysis
• Electro Convulsive Therapy
Hospital Services – Behavioral Health and Substance Abuse*
• Inpatient
• Detoxification
• Rehabilitation
• Partial hospitalization
• Residential treatment facility
*Emergency admissions do not require prior authorization

Attachment F
Business Associate Statement

Business Associate Agreement

This Business Associate Agreement ("Agreement") is entered into between Mississippi Division of Medicaid, a State Agency ("DOM") and UnitedHealthcare Insurance Company, a corporation qualified to do business in Mississippi ("Business Associate").

I. RECITALS

a. DOM is a State Agency that acts both as an employer and as a health plan for public benefit with a principal place of business at 550 High Street, Suite 1000, Jackson, MS 39201.

b. Business Associate is a corporation qualified to do business in Mississippi that will act to perform health care program services for DOM with a principal place of business at 795 Woodlands Parkway, Suite 301, Ridgeland, MS 39157.

c. DOM, as a Covered Entity defined herein under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is required to enter into this Agreement to obtain satisfactory assurances that Business Associate, a Business Associate under HIPAA, will appropriately safeguard all Protected Health Information ("PHI") as defined herein, disclosed, created or received by Business Associate on behalf of, DOM.

d. DOM desires to engage Business Associate to perform certain functions for, or on behalf of, DOM involving the disclosure of PHI by DOM to Business Associate, or the creation or use of PHI by Business Associate on behalf of DOM, and Business Associate desires to perform such functions, as set forth in the contracts or agreements which involve the exchange of information, and wholly incorporated herein.

e. The terms used in this Agreement shall have the same meaning as those terms in the Privacy Rule.

In consideration of the mutual promises below and the exchange of information pursuant to this agreement and in order to comply with all legal requirements for the protection of this information, the parties therefore agree as follows:

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.
b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure

of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to DOM any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of DOM agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
f. Business Associate agrees to provide access, at the request of DOM, and in the time and manner determined by DOM, to Protected Health Information in a Designated Record Set, to DOM or, as directed by DOM, to an Individual in order to meet the requirements under 45 CFR § 164.524.
g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that DOM directs or agrees to pursuant to 45 CFR § 164.526 at the request of DOM or an Individual.
h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, and available to DOM, or to the Secretary of the Department of Health and Human Service, in a time and manner designated by the Secretary, for purposes of the Secretary determining DOM's compliance with the Privacy Rule.
i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for DOM to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
j. Business Associate agrees to provide to DOM or an Individual, an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

General Use and Disclosure Provisions

Refer to underlying agreements and contracts:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, DOM as specified in the service agreements and contracts, provided that such use or disclosure would not violate the Privacy Rule if done by DOM or the minimum necessary policies and procedures of DOM.

IV. OBLIGATIONS OF DOM

a. Provisions for DOM to Inform Business Associate of Privacy Practices and Restrictions

i. DOM shall notify Business Associate of any limitation(s), as set forth in the Notice of Privacy Practices attached hereto as Exhibit "A" and wholly incorporated herein, in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

ii. DOM shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

iii. DOM shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that DOM has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

b. Permissible Requests by DOM

DOM shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by DOM.

V. TERM AND TERMINATION

a. Term. The Term of this Agreement shall be effective as of the effective date of the agreements and contracts entered into between DOM and Business Associate, and shall terminate when all of the Protected Health Information provided by DOM to Business Associate, or created or received by Business Associate on behalf of DOM, is destroyed. If it is infeasible to destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon DOM's knowledge of a material breach by Business Associate, DOM shall, at its discretion, either:

i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the associated Contracts or Agreements. If Business Associate does not cure the breach or end the violation within the time specified by DOM; or

ii. Immediately terminate this Agreement and the associated Contracts or Agreements if Business Associate has breached a material term of this Agreement and cure is not possible; and

iii. In either event, DOM shall report the violation to the Secretary of Health and Human Services as required.

c. Effect of Termination.
   i. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall destroy all Protected Health Information received from DOM, or created or received by Business Associate on behalf of DOM. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
   ii. In the event that Business Associate determines that destroying the Protected Health Information is infeasible, Business Associate shall provide to DOM notification of the conditions that make destruction infeasible. Upon notification in writing that destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VI. MISCELLANEOUS

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement as is necessary to effectively comply with the terms of any agreements or contracts, or for DOM to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. Such modifications signed by the parties shall be attached to and become part of this Agreement.
c. Survival. The respective rights and obligations of Business Associate under the Section, "Effect of Termination" of this Agreement shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DOM to comply with the Privacy Rule.
e. Indemnification. Business Associate will indemnify and hold harmless DOM to this Agreement from and against all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in conjunction with:
   i. Any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the party under this Agreement; and
   ii. Any claims, demands, awards, judgments, actions and proceedings made by any person or organization arising out of or in any way connected with the performance of the Business Associate under this Agreement.
f. Business Associate's Compliance with HIPAA. DOM makes no warranty or representation that compliance by Business Associate with this

Agreement, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

g. Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and may be either personally delivered or sent by registered or certified mail in the United States Postal Service, Return Receipt Requested, postage prepaid, addressed to each party at the addresses which follow or to such other addresses as the parties may hereinafter designate in writing:

DOM:	**Office of the Governor** **Division of Medicaid** **550 High Street, Suite 1000** **Jackson, MS. 39201**
Business Associate:	**President** **UnitedHealthcare Community Plan** **795 Woodlands Parkway, Suite 301** **Ridgeland, MS 39157**

Any such notice shall be deemed to have been given, if mailed as provided herein, as of the date mailed.

h. Change in Law. In the event that there are subsequent changes or clarifications of statutes, regulations or rules relating to Agreement, DOM shall notify Business Associate of any actions it reasonably deems are necessary to comply with such changes, and Business Associate promptly shall take such actions. In the event that there shall be a change in the federal or state laws, rules or regulations, or any interpretation or any such law, rule, regulation or general instructions which may render any of the material terms of this Agreement unlawful or unenforceable, or materially affects the financial arrangement contained in this Agreement, Business Associate may, by providing advanced written notice, propose an amendment to this Agreement addressing such issues.

i. Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.

j. Counterparts. This Agreement may be executed in counterparts, any of which is considered to be an original agreement.

k. Governing Law. This Agreement shall be construed broadly to implement and comply with the requirements relating to the HIPAA laws and regulations. All other aspects of this Agreement shall be governed under the laws of the State of Mississippi.

l. Assignment/Subcontracting. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Except as otherwise provided in

the Contract and any proposal or RFP related thereto and agreed upon between the parties, Business Associate may not assign or subcontract the rights or obligations under this Agreement without the express written consent of DOM. DOM may assign its rights and obligations under this Agreement to any successor or affiliated entity.

m. Entire Agreement. This Agreement contains the entire agreement between parties and supersedes all prior discussions, negotiations and services for like services.

n. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than DOM, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

o. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any agents, affiliates, subsidiaries, subcontractors or employees assisting Business Associate in the fulfillment of its obligations under this Agreement, available to DOM, at no cost to DOM, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DOM, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where Business Associate or its agents, affiliates, subsidiaries, subcontractors or employees are a named adverse party.

IN WITNESS WHEREOF, the parties hereto have duly executed this agreement to be effective on the date first herein written.

DOM

By: _____

Name: David J. Dziela
Title: Executive Director
Date: 1/9/13

BUSINESS ASSOCIATE

United Healthcare

By: _____

Name: Jocelyn C. Carter
Title: President
Date: 1/7/13

EXHIBIT "A"

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Office of the Governor, Division of Medicaid (known as DOM) must by law keep your health information private and give you notice of its legal duties and privacy practices for your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at DOM, please contact:

Division of Medicaid
Privacy Officer
550 High Street, Suite 1000
Jackson, MS 39201
(601) 359-6050
(800) 421-2408

Effective Date of This Notice: April 14, 2003

I. How DOM May Use or Disclose Your Health Information

DOM gets health information from you and stores it in files and on a computer. This is part of your Medicaid record. The Medicaid record belongs to DOM, but the information in the medical record belongs to you. DOM keeps your health information private. The law lets DOM use or disclose your health information for the following purposes:

1. Treatment. DOM will get or keep information about you regarding your health care treatment and options. Although DOM does not give the treatment directly to you, DOM will get some medical history and coded information about your health and treatment. DOM does use and keep this specific health information to make sure proper payment of benefits, and many times that the best benefits have been given to you within Medicaid guidelines. This use or disclosure by DOM does not mean that your health providers are not responsible to provide the best care. You and your provider must decide together what care is best for you. *Example: DOM will get your medical information from your provider, who will send billing information to Medicaid for care they provide to you. DOM will then review the billing and treatment information to make sure it was correct, based on standards, and DOM will pay your provider for the services that you are eligible for at pre-set rates.*

2. Payment. DOM does get information about you and will use and disclose information about you to health care providers, business associates, and other covered entities in order to send and get payments for services you get from providers. *Example: Your doctor will send certain health and private information about you to DOM or a DOM business associate, who will in turn check to be sure you were eligible for benefits and will send payment directly to the health care provider for the services you got if you were eligible for such.*

3. Regular Health Care Operations. DOM does some contracts with business associates to handle your personally identifiable health information. These business associates will often prepare reports, data and information for use and disclosure throughout DOM and to any others allowed by law. Also, DOM will use and disclose your information as the law allows to conduct an assessment of Medicaid systems and training. *Example: DOM does plan for future Medicaid services by conducting needs assessments. Also, DOM does conduct medical reviews or administrative proceedings to check quality control of services available.*

4.. Information provided to you. DOM does let individuals request an opportunity to see the health information about themselves.

5. Notification and communication with family. We may disclose your health information to tell a family member, your personal representative or another person responsible for your care about where you are, your general condition or if you die. If you are able and can agree or object, DOM will give you a chance to object prior to making this notification. If you are unable or cannot agree or object, our health professionals will use their best judgment in telling your family and others.

6. Required by law. As required by law, we may use and disclose your health information.

7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

10. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

11. Deceased person information. We may disclose your health information to coroners, medical examiners, and funeral directors.

12. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

13. Research. We may disclose your health information to researchers doing research that has been approved by a DOM approved Privacy Board.

14. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military, national security, correctional institutions and government benefits purposes.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

17. Marketing. We may contact you to remind you of appointments or to give you information about other treatments or health-related benefits and services that may be of interest to you.

II. When DOM May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, DOM will not use or disclose your health information without your written authorization. If you do authorize DOM to use or disclose your health information for another purpose, you may take back your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to ask for restrictions on certain uses and disclosures of your health information. DOM does not have to agree to the restriction that you ask for.

2. You have the right to get your health information through a reasonable alternative means or at an alternative location. You must present a DOM form which tells your specific request. There may be charges to get this information. You will be told in advance.

3. You have the right to see and copy your health information. There may be fees and charges for the time it takes to copy, prepare, supervise, and mail the information you ask for.

4. You have a right to request that DOM change your health information that is not correct or not complete. DOM does not have to change your health information and will give you information about DOM not changing the information. You will be told how you can disagree with the denial.

5. You have a right to get a list of disclosures of your health information made by DOM, except that DOM does not have to include disclosures for: 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you), and 16 (certain government functions) of Section I of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices and can get this Notice in another format.

IV. Changes to this Notice of Privacy Practices

DOM reserves the right to change this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it keeps, including information that was created or received prior to the date of such change. Until such change is made, DOM must by law comply with this Notice. Upon a material change of this Notice, DOM will send a new Notice with the changes and effective date of change to each current beneficiary.

V. Complaints

Complaints about this Notice of Privacy Practices or how DOM handles your health information should be sent to:

Division of Medicaid
Privacy Officer
550 High Street, Suite 1000
Jackson, MS 39201

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.

For instructions on how to obtain this information in either Braille or a non-English speaking format, please contact your local Division of Medicaid Office for details.

Attachment G
Reports

	Report	Frequency[1]
1.	Claims Lag-All	Monthly, Federal Fiscal Year-End
2.	Claims Lag-Dental	Monthly
3.	Claims Lag-Medical-Inpatient-Behavioral Health	Monthly
4.	Claims Lag-Medical-Inpatient-Physical Health	Monthly
5.	Claims Lag-Medical-Outpatient-Behavioral Health	Monthly
6.	Claims Lag-Medical-Outpatient-Physical Health	Monthly
7.	Claims Lag-Medical-Physician-Behavioral Health	Monthly
8.	Claims Lag-Medical-Physician-Physical Health	Monthly
9.	Claims Lag-Vision	Monthly
10.	Member Utilization-Vision	Monthly
11.	Diagnosis Classification-Inpatient, Outpatient and Physician	Monthly, Federal Fiscal Year-End
12.	Fraud and Abuse	Monthly
13.	Member and Provider Services Call Metrics	Quarterly, Contract Year-End
14.	Claims Financial Accuracy-All	Quarterly, Contract Year-End
15.	Claims Financial Accuracy-Dental	Quarterly
16.	Claims Processing Accuracy-All	Quarterly, Contract Year-End
17.	Claims Processing Accuracy-Dental	Quarterly
18.	Claims Processing Turnaround Time	Quarterly, Contract Year-End
19.	Grievance Resolution	Quarterly, Contract Year-End
20.	Utilization Management Telephone	Quarterly, Contract Year-End
21.	Executive Management (Summary and Detail)	Quarterly, Federal

		Fiscal Year-End
22.	High Amount Claimant-$75,000	Quarterly
23.	CHIP Program Activity Report	Quarterly, Federal Fiscal Year-End
24.	Case Management Activity	Quarterly
25.	Disease Management Activity	Quarterly
26.	Medical Claims and Financial Accuracy by Audit Type	Quarterly
27.	Nurse Triage-Inbound and Outbound, Person Entered, Encounter Types, and Member Redirection/Outcomes	Quarterly
28.	PBM Financial Summary	Quarterly
29.	Population Language	Quarterly
30.	Prescription Drug Utilization	Quarterly, Federal Fiscal Year-End
31.	Prescription Drug Utilization-In Network	Quarterly, Federal Fiscal Year-End
32.	Top 100 Drug Classes by Occurrences	Quarterly
33.	Top 100 Drug Classes by Payments	Quarterly
34.	Top 50 Drugs by Occurrences	Quarterly
35.	Top 50 Drugs by Payments	Quarterly
36.	Geo Access	Quarterly, Contract Year-End
37.	Immunizations	Contract Year-End
38.	Prescription Claims Paid by Therapeutic Categories	Quarterly, Federal Fiscal Year-End
39.	Claims Financial Accuracy-Pharmacy	Quarterly
40.	Claims Financial Accuracy-Vision	Quarterly
41.	Claims Financial Accuracy-Medical	Quarterly
42.	Claims Processing Accuracy-Pharmacy	Quarterly

43.	Claims Processing Accuracy-Vision	Quarterly
44.	Claims Processing Accuracy-Medical	Quarterly
45.	Nurse Line	Quarterly
46.	Claims Lag-Pharmacy	Monthly
47.	Out of Pocket Maximum	Contract Year-End
48.	Annual Experience Accounting	Contract Year-End, Fiscal Year-End
49.	Maternity Claims	Monthly