DHH - CF - 1
Revised: 2011-06

CONTRACT BETWEEN STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Medical Vendor Administration

CFMS: 733524
DHH: 060470
Agency # 305

AND

UnitedHealthcare of LA, Inc. d/b/a UnitedHealthcare Community Plan

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☒ Social Services

1) **Contractor (Legal Name if Corporation)** UnitedHealthcare of LA, Inc. d/b/a UnitedHealthcare Community Plan	5) **Federal Employer Tax ID# or Social Security #** 72107400800 **(Must be 11 Digits)**
2) **Street Address** 3838 N. Causeway Blvd., Suite 2600	6) **Parish(es) Served** ST
City Metairie **State** LA **Zip Code** 70002	7) **License or Certification #** N/A
3) **Telephone Number** (504) 849-3521	8) Contractor Status Subrecipient: ☐ Yes ☒ No Corporation: ☒ Yes ☐ No For Profit: ☒ Yes ☐ No Publicly Traded: ☒ Yes ☐ No
4) **Mailing Address (if different)**	
City **State** **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**

Contractor will function as a risk-bearing managed care organization (MCO) that provides services to eligible Louisiana Medicaid enrollees as defined in the Louisiana Medicaid State Plan, administrative rules, Medicaid Policy and Procedure manuals, and this contract.

10) **Effective Date** 02-01-2015	11) **Termination Date** 01-31-2018

12) This contract may be terminated by ~~either party~~ DHH upon giving ~~thirty (30)~~ sixty (60) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount** 1,964,731,789

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:
Contractor will be paid upon successful completion of deliverables in the manner outlined in Attachment C.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**First Name** Mary T.C.	**Last Name** Johnson
	Title Deputy Medicaid Director	**Phone Number** 225-342-3426

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

Attachment A: HIPAA Addendum
Attachment B: Statement of Work
Attachment C: Terms of Payment
Attachment D: Rate Certification
Attachment E: Incentive-Based Performance Measures
Attachment F: Member Assignment Methodology
Attachment G: Additional Terms and Conditions
Attachment H: Standard Provisions

Exhibit 1: Board Resolution
Exhibit 2: Multi-Year Letter
Exhibit 3: RFP305PUR-DHHRFP-BH-MCO-2014-MVA
Exhibit 4: Appendices to RFP305PUR-DHHRFP-BH-MCO-2014-MVA
Exhibit 5: Addenda to RFP305PUR-DHHRFP-BH-MCO-2014-MVA
Exhibit 6: Contractor's proposal
Exhibit 7: Contractor's Emergency Preparedness Plan
Exhibit 8: Disclosure of Ownership

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities relevant to this contract. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

8. ~~In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.~~

9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

10. ~~Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.~~

1. ~~All non-third-party-software and source code, records, reports, documents and other material delivered or transmitted to~~ ontractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at ~~ermination or expiration of this contract. All non-third-party software and source code, records, reports, documents, or other~~ ~~aterial related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services~~ ~~ontracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at~~ ~~ermination or expiration of this contract.~~ See Attachment G.

2. Except as otherwise permitted in this Contract or RFP, Contractor shall not enter into any subcontract for work or services ontemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the epartment shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that otwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the urchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required nder this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations escribed herein. This section applies only to subcontracts, statements of work, memoranda of understanding, agreements, or any ortions thereof, which affect Contractor's operations in Louisiana under this contract. Any subcontract, statement of work, emorandum of understanding, agreement, or portion thereof, entered into by Contractor's parent and/or affiliate relating to the perations or administration of that entity, or any of that entity's affiliates or subsidiaries outside Louisiana is not subject to the equirements of this section.

3. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited rom providing such services by the provisions of R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana egislature.

4. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed y the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant o this or previous contracts are not allowable, upon 30 days advance notice to the contractor, the Department shall have the right o set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

5. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability r obligation for payment will develop between the parties until the contract has been approved by required authorities of the epartment; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in ccordance with La. R.S. 39:1502.

6. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of he contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such ppropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total ppropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is o provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the rst fiscal year for which funds are not appropriated.

7. Pursuant to Section 25.1 of the RFP, 305PUR-DHHRFP-BH-MCO-2014-MVA, any alteration, variation, modification, or waiver f provisions of this contract shall be valid only when approved by both parties and reduced to writing, as an amendment duly igned, and approved by both parties and required authorities of the Department; and, if contract exceeds $20,000, approved by he Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost eimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally pproved cost categories.

8. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals r district courts as appropriate.

9. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, opyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, he Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at ontractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or ther allied health providers solely for medical services.

0. ~~Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future ontinuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. or the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and equisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of HH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an pdated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of ntracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such quipment to the Department within 30 days of termination of services.~~

1. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, xpenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, mployees, officers or ~~clients~~ other parties acting on behalf of Contractor, including premises liability and including any claim based n any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides alpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such ersons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being erformed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

UnitedHealthcare of LA, Inc. d/b/a UnitedHealthcare Community Plan

April Golenor 1-14-15

SIGNATURE **DATE**

April Golenor

NAME

CEO, UnitedHealthcare Community Plan

TITLE

SIGNATURE **DATE**

NAME

TITLE

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

SIGNATURE **DATE**

NAME

Secretary, Department of Health and Hospital or Designee

TITLE

Medical Vendor Administration

J. Ruth Kennedy 1-14-15

SIGNATURE **DATE**

J. Ruth Kennedy

NAME

Medicaid Director

TITLE

APPROVED
Office of the Governor
Office of Contractual Review

JAN 30 2015

Pamela Bartfay Rice

DIRECTOR

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment A to the contract.

1. The Louisiana Department of Health and Hospitals ("DHH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of DHH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of DHH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for DHH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
   A. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
   B. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
   C. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
   D. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq.* At the option of DHH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by DHH, in which case contractor shall reimburse DHH for all expenses that DHH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of DHH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to DHH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR § 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.
11. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold DHH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between DHH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between DHH and contractor.
16. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of DHH, whichever occurs first, contractor shall return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

Statement of Work

Goal/Purpose

Contractor will function as a risk-bearing managed care organization (MCO) that provides core benefits and services to eligible Louisiana Medicaid enrollees as defined in the contract, Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals.

Deliverables

The Contractor shall provide all deliverables required in the Request for Proposals issued July 28, 2014, RFP305PUR-DHHRFP-BH-MCO-2014-MVA, which includes all Appendices, Addenda, and responses to written comments.

Performance Measures

The contractor will provide to DHH, or maintain on file, all items that document the completion of deliverables outlined in the contract, including but not limited to:

1) Staffing Requirements
   - Develop and maintain written policies, procedures and job descriptions for each functional area.
   - Provide upon request a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed as required by law.
   - Provide a list of marketing training dates at least fourteen calendar days prior to the date of training.

2) Medical Loss Ratio
   - Provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.

3) Expanded Services/Benefits
   - The MCO shall provide a description of the expanded services/benefits to be offered by the MCO for approval. Additions, deletions or modifications to expanded services/benefits made during the contract period must be submitted to DHH, for approval.

4) Pharmacy Services
   - Submit pharmacy claims information at frequency established by DHH.
   - Submit reporting specific to the pharmacy program, including, but not limited to:
     - Pharmacy help desk performance
     - Prior authorization performance
     - Prior Authorization request turnaround time
     - Number of claims submitted as a 72-hour emergency supply
     - Denials (name of drug, number of requests, number of denials)
     - Pharmacy network access
     - Grievance and appeals
     - Medication therapy management initiatives

5) Provider Network
   - Develop and maintain a provider network development and management plan that must be submitted to DHH at least annually.
   - Maintain written agreements that document the existence of a provider network that is sufficient to provide adequate access to all required services.
   - Submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix TT. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them.

- Provide written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws within 30 days of the signing of the contract.
- Develop and implement network development and management policies.
- Maintain a Provider Directory.
- Maintain and issue a provider handbook within thirty days of the date the contract is signed.
- Conduct provider satisfaction surveys annually.

6) Provider Complaint System
   - Develop and implement a provider dispute and appeal process for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s). This process must be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.
   - Provide the names, phone numbers and e-mail addresses of executives with the authority to require corrective actions to DHH within one week of contract approval, and within 2 business days of any changes.

7) Utilization Management
   - Develop and maintain policies and procedures with defined structures and processes for a Utilization Management program that incorporates Utilization Review and Service Authorization.

8) Quality Assessment and Performance Improvement (QAPI) Plans
   - Form a QAPI Committee.
   - Develop a QAPI Work Plan and submit it to DHH thirty (30) days after the effective date of the contract, and annually thereafter.
   - Submit QAPI reports annually.

9) Clinical and Administrative Performance Measures
   - Report to DHH on administrative measures contained in Appendix J of the RFP on a quarterly basis.
   - Report to DHH on clinical measures contained in Appendix J of the RFP on an annual basis 12 months after services begin.
   - Report to DHH all clinical measures monthly based on HEDIS specifications, ignoring all continuous eligibility requirements for HEDIS in this monthly reporting.
   - Publically report on HEDIS 2016 to NCQA.

10) Performance Improvement Projects (PIPs)
   - Submit a description of each PIP to DHH for approval within three months of the execution of the contract and at the beginning of each contract year thereafter.
   - Perform a minimum of two DHH-approved PIPs in each contract year, including the required three-year PIP and the one-year PIP associated with the contract year
   - Submit project data analysis to DHH monthly.
   - Report to DHH on PIP outcomes on an annual basis.

11) Member and Provider Call Centers
   - Establish and maintain a member call center.
   - Develop and submit to DHH for approval a script to be used during the welcome call.
   - Develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies including but not limited to hurricane-related evacuations. The MCO shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies.
   - Develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette and submit to DHH for review and approval annually.
   - Establish and maintain a provider call center.

- Submit draft training materials for telephone agents.
- Develop a contingency plan for hiring call center staff to address overflow calls and emails.
- Submit telephone and internet activity reports monthly.

12) Member Services

- Develop and maintain a member handbook that adheres to federal requirements in required formats.
- Maintain grievance and appeals logs and submit to DHH monthly.
- Conduct Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys annually.
- Develop and implement a Member Advisory Council Plan.

13) Enrollment

- Maintain a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

14) Marketing and Member Education Materials

- Submit a plan detailing marketing and member education activities within 30 days of contract signature.
- Develop and maintain a welcome newsletter that adheres to federal requirements.
- Submit to DHH for approval all member materials.
- Maintain copies of all member materials including obsolete versions.
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item.

15) Enrollment Website

- Submit website screenshots to DHH for approval.
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item.
- Maintain provider directories.

16) Fraud, Waste, and Abuse Compliance

- Submit plan to DHH within 30 days from the date the contract is signed and annually thereafter.
- Submit fraud and abuse activity report quarterly with an annual summary of activity.
- Attest monthly that a search of websites referenced in Section 15.3.3 of the RFP has been completed.

17) Systems

- Maintain records documenting the exchange all required files with the Medicaid fiscal intermediary.
- Submit encounter data to DHH or its contractor as required.
- Submit refresh plan for review and approval annually.
- Develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.
- Develop a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.
- Enroll at least 75% of all contracted hospitals with an emergency department into the Louisiana Health Information Exchange by December 31, 2015.

18) Claims & Encounters

- Submit weekly encounters to Medicaid fiscal intermediary. Encounters must be submitted within 25 days of payment.
- Submit encounter data on the 25th calendar day of the month to the Medicaid fiscal intermediary.
- Submit claims payment accuracy report monthly.
- Submit claims processing interest payments on weekly encounter file.

- Submit denied claims report weekly.
- Submit weekly transaction records on all prior authorization requests.
- Develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to DHH for approval within thirty (30) days of the date the Contract is signed by the MCO.

19) Financial Reporting
- Submit audited financial statements annually.
- Submit unaudited financial statements quarterly.

20) TPL Reporting
- Report members with third party coverage to DHH on a weekly basis.
- Submit TPL collections on an annual basis.

21) Emergency Management Plan
- Submit annually.

Monitoring
Contract monitoring will be at the direction of the Medicaid Deputy Director for managed care or their designee.

Mary Johnson
Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
Phone: (225) 342-1304
Email: mary.johnson@la.gov

Monitoring activities include:

1) Thorough review and analysis of required work plans and monthly, quarterly and annual reports, as well as review and monitoring of corrective action plans if required of the contractor by DHH;
2) Minimum of weekly status calls between Contractor and DHH Contract Monitor and/or designated Medicaid staff;
3) Face-to-face meetings between Contractor and DHH Contract Monitor and/or designated Medicaid staff as warranted;
4) Solicitation of feedback on Contractor's performance from the Medicaid fiscal intermediary;
5) Annual evaluation through an independent external quality review contractor;
6) Real-time monitoring of member services hotline calls;
7) Investigation of all complaints regarding the Contractor;
8) Monitoring grievances and appeals to determine appropriate resolution;
9) Periodic navigation of contractor website to determine performance;
10) Spot checking to determine that provider listings on contractor website accurately reflects information provided by the providers;
11) Unannounced and scheduled visits to contractor's Louisiana administrative office; and
12) "Secret shopper" calls to Member Services and Provider Services call centers.

Payment: Fixed Rate
See Attachment C for details.

Terms of Payment

Maximum Contract Amount:
The maximum contract amount for each contract year is the product of projected enrollment in the MCO and the projected Per Member Per Month capitation rate. For calculation purposes, the projected Per Member Per Month capitation rate is the statewide composite prior to risk adjustment.

Contract Year	Projected Member Months	Projected Per Member Per Month Capitation Rate	Maximum Contract Amount
Contract year 1 - February 1, 2015 to January 31, 2016	2,007,023	$302.90	$607,927,267
Contract year 2 - February 1, 2016 to January 31, 2017	2,156,211	$310.90	$670,366,000
Contract year 3 - February 1, 2017 to January 31, 2018	2,161,943	$317.51	$686,438,522
3-Year Total			$1,964,731,789

DHH reserves the right to adjust Per Member Per Month capitation rates in the following instances:

1. Changes to core benefits and services included in the capitation rates;
2. Changes to Medicaid population groups eligible to enroll in an MCO;
3. Legislative appropriations and budgetary constraints; or
4. Changes in federal requirements.

Terms of Payment:

1. DHH shall make monthly risk-adjusted capitation rate payments for each member enrolled into the MCO. Capitation rates are developed in accordance with 42 CFR 438.6 and are actuarially sound.

2. MCO agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.

3. DHH reserves the right to defer remittance of the monthly capitation rate payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

4. The monthly risk-adjusted capitation rate payment shall be based on the total number of Medicaid eligibles assigned to the MCO as of the last working day of the previous month and paid in the weekly payment cycle nearest the 15th calendar day of the month.

5. In addition to the monthly capitated rate, DHH shall provide MCOs a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs.

6. If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the MCO's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall make an annual payment to the MCO in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by

DHH (and its contracted actuary) as an adjustment to each MCO's capitation rates for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

Effective Date of Enrollment

MCO enrollment for members in a given month will be effective at 12:01AM on the first calendar day of the month of Medicaid eligibility not to exceed 12 months of retroactive eligibility.

Withhold of Capitation Rate

As outlined in detail in Section 5.3 of the RFP, a withhold of a portion of the monthly capitation rate payment shall be applied to provide an incentive for MCO compliance with the requirements of this contract. The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments.

Attachment D

MERCER

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Ms. Mary Johnson
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Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

August 29, 2014

Subject: Louisiana Bayou Health Program – Full Risk-Bearing Managed Care Organization Rate Development and Actuarial Certification for the Period February 1, 2015 through January 31, 2016

Dear Ms. Johnson:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of February 1, 2015 through January 31, 2016.

The Bayou Health program began February 1, 2012, and operated under two separate managed care paradigms for the first three years of the program. The Bayou Health Prepaid program operated under an at-risk capitated arrangement, and the Shared Savings program was an enhanced Primary Care Case Management (ePCCM) program. Effective February 1, 2015, Bayou Health will begin operating as an at-risk capitated program only.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses,

marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology

Overview

Capitation rate ranges for the Bayou Health program were developed in accordance with rate-setting guidelines established by CMS. For rate range development for the Bayou Health managed care organizations (MCOs), Mercer used calendar year 2013 (CY13) Medicaid FFS medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by DHH and the Prepaid and Shared Savings plans for consistency and reasonableness and determined that the data are appropriate for the purpose of setting capitation rates for the MCO program. The data certification shown in Appendix G has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.

Adjustments were made to the selected base data to match the covered populations and Bayou Health benefit packages for rating year 2015 (RY15). Additional adjustments were then applied to the base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Provision for incurred-but-not-reported (IBNR) claims.
- Financial adjustments to encounter data for underreporting.
- Trend factors to forecast the expenditures and utilization to the contract period.
- Changes in benefits covered by managed care.
- Addition of new populations to the Bayou Health program.
- Opportunities for managed care efficiencies.
- Administration and underwriting profit/risk/contingency loading.

In addition to these adjustments, DHH takes two additional steps in the matching of payment to risk:

- Application of maternity supplemental (kick) payments.
- Application of risk-adjusted regional rates.

The resulting rate ranges for each individual rate cell were net of Graduate Medical Education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Mercer removed GME amounts in the FFS and Shared Savings data to be consistent with DHH's intention to continue paying GME amounts directly to the teaching hospitals. Encounter data does not include GME payments and therefore no adjustment is required.

Bayou Health Populations

Covered Populations

In general, the Bayou Health program includes individuals classified as Supplemental Security Income (SSI), Family and Children, Breast and Cervical Cancer, and LaCHIP Affordable Plan (LAP) as mandatory or voluntary opt-out populations. Voluntary opt-in populations include Home- and Community-Based Services (HCBS) Waiver participants and Chisholm Class Members (CCM).

Chisholm Class Members

Effective February 1, 2015, members of Louisiana's Chisholm class will be permitted to participate in Bayou Health on a voluntary opt-in basis. Previously, membership in the Chisholm class would make a recipient ineligible for Bayou Health.

Chisholm refers to a class action lawsuit (*Chisholm v. Hood*) filed in 1997. Chisholm class members are defined as all current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now or will in the future be placed on the Office of Citizens with Developmental Disabilities' Request for Services Registry.

LaHIPP Population

Effective February 1, 2015, Bayou Health will include individuals covered by the Louisiana's Health Insurance Premium Payment (LaHIPP) Program. This program pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job and someone in the family is enrolled in Medicaid. The program also covers out of pocket expenses incurred by the enrollee (Medicaid is the secondary payer). Premiums will continue to be paid by DHH, but out of pocket expenses incurred by the enrollee will be the responsibility of the MCO. LaHIPP is not a category of eligibility. Enrollees in this program are eligible under the other categories of aid (COA) and their experience are included in the applicable COA and Rate Cell combination for purposes of developing the capitation rate range.

Excluded Populations

The following individuals are excluded from participation in the Bayou Health program:

- Medicare-Medicaid Dual Eligible Beneficiaries
- Qualified Medicare Beneficiaries (QMB) (only where State only pays Medicare premiums)
- Specified Low-income Medicare Beneficiaries (SLMB) (where State only pays Medicare premiums)
- Medically Needy Spend-Down Individuals
- Individuals residing in Long-term Care Facilities (Nursing Home, Intermediate Care Facility/Developmentally Disabled (ICF/DD))
- Individuals enrolled in the Program for All-inclusive Care for the Elderly (PACE)
- Individuals only eligible for Family Planning services
- Individuals enrolled in the Greater New Orleans Community Health Connection (GNOCHC) Demonstration waiver

Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.

Rate Category Groupings

Rates will vary by the major categories of eligibility. Furthermore, where appropriate, the rates within a particular category of eligibility are subdivided into different age bands to reflect differences in risk due to age. In addition, due to the high cost associated with pregnancies, DHH will pay a maternity kickpayment to the MCOs for each delivery that takes place. Table 1 shows a list of the different rate cells for each eligibility category including the maternity kickpayments.

Table 1: Rate Category Groupings

COA Description	Rate Cell Description
SSI	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
Family and Children	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
Breast and Cervical Cancer (BCC)	BCC, All Ages

LAP	LAP, All Ages
HCBS	Child, 0-18 Years of Age
	Adult, 19+ Years of Age
CCM	CCM, All Ages
Maternity Kickpayment	Maternity Kickpayment
Early Elective Delivery Kickpayment	EED Kickpayment

Region Groupings

For rating purposes, Louisiana has been split into four different regions. Table 2 lists the associated parishes for each of the four regions.

Table 2: Region Groupings

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson , Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana
South Central	Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Lasalle, Rapides, St. Landry, St. Martin, Vermilion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Tensas, Union, Webster, and West Carroll

Bayou Health Services

Covered Services

Appendix C lists the services that the Bayou Health MCOs must provide. The MCOs also have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective alternative services) as long as the contractually-required Medicaid services are covered. Costs of alternative services are expected to be funded through savings on the contractually-required services for which these services are a cost-effective substitute.

New Services

Effective February 1, 2015, DHH has decided to incorporate services covered historically by FFS in the Bayou Health program. The following services were previously excluded from the Bayou Health program and now are included:

- Hospice services
- Personal care services for ages 0-20

Additionally, non-emergency medical transportation (NEMT) will be the responsibility of the Bayou Health MCO, even if the service the recipient is being transported to is not a Bayou Health-covered service. Previously, NEMT to non-covered services would have been FFS.

Behavioral Health Mixed Services Protocol

In the Request for Proposals (RFP) issued by the State for the Bayou Health program to be effective February 1, 2015, Behavioral Health services are divided into two levels: basic and specialized. Basic Behavioral Health services will be the responsibility of Bayou Health MCOs. Basic services include:

- General hospital inpatient services, including acute detoxification
- General hospital emergency room (ER) services, including acute detoxification
- Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) encounters that do not include any service by a specialized behavioral health professional
- Professional services, excluding services provided by specialized behavioral health professionals
- Prescribed drugs prescribed by any professional that is not a specialized behavioral health professional

Specialized behavioral health services will be identified primarily based on provider type. Any service provided by behavioral health specialists, as well as behavioral health facilities are considered specialized behavioral health.

Excluded Services

Bayou Health MCOs are not responsible for providing acute care services and other Medicaid services not identified in Appendix C, including the following services:

- Applied Behavioral Analysis

- Dental services with the exception of Early and Periodic Screening & Diagnostic Treatment (EPSDT) varnishes provided in a primary care setting
- ICF/DD services
- Personal Care services for those ages 21 and older
- Nursing Facility services
- School-based Individualized Education Plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures including school nurses
- HCBS Waiver services
- Specialized Behavioral Health,
- Targeted Case Management services
- Services provided through DHH's Early-Steps Program

Data Adjustments

IBNR Claims

Completion factors were developed to incorporate consideration for any outstanding claims liability.

To establish the completion factors for the Shared Savings/Legacy Medicaid FFS data, claims were grouped into three COA and seven main completion service categories. All remaining service categories were grouped into the other service category. Completion category mapping is provided in Appendix C. Note that the BCC and CCM populations utilized SSI completion factors and the LAP population utilized Family and Children completion factors, as these populations are expected to exhibit similar completion patterns. Appendix D-1 summarizes the completion factors adjustment that was applied to the Shared Savings/Legacy Medicaid FFS data.

Encounter claim completion factors, developed separately for each Prepaid plan, were compared to completion factors provided by the Prepaid plan actuaries and summarized by completion category of service. Appendix D-2 summarizes the completion factors adjustment that was applied to the Prepaid encounter data.

Under-reporting

Under-reporting adjustments were developed by comparing encounter data from the Medicaid management information system (MMIS) to financial information provided by the Prepaid plans. This adjustment was computed and applied on a plan basis resulting in an overall adjustment of 3.7%. Note this adjustment does not apply to the Shared Savings claims nor Legacy Medicaid/FFS data.

Third-Party Liabilities
All claims are reported net of third party liability, therefore no adjustment is required.

Fraud and Abuse Recoveries
DHH provided data related to fraud and abuse recoveries on the Shared Savings and Legacy FFS. The total adjustment applied was -0.1%. Prepaid plans included fraud and abuse recoveries in their financial reports. These recoveries were included in the development of the underreporting adjustment.

Co-payments
Copays are only applicable to prescription drugs. Pharmacy claims are reported net of any co-payments so no additional adjustment is necessary.

DSH Payments
DSH payments are made outside of the MMIS system and have not been included in the capitation rates.

Fee Schedule Adjustments
Fee Changes
These capitation rates reflect changes in made by DHH to the fee schedules used in the FFS program. The first of these changes, effective February 1, 2013, was a 1% cut in fees paid to non-rural, non-state hospitals. This 1% cut also applied to physician services, except for procedure codes affected by Section 1202 of the Affordable Care Act, when performed by a physician eligible for the enhanced payment rate. Fee changes also include estimation of cost settlements and reflect the most up to date cost settlement percentages for each facility. For most non-rural facilities, the cost settlement percentage is 66.46% however some facilities are settled at different amounts. Rural facilities are cost settled at 110%.

Hospital Privatization
During 2013 nine state hospitals privatized. As a result of this privatization, they no longer are paid for services based on the state hospital fee schedule, but rather on the non-state, non-rural fee schedule. Similarly, reimbursement for cost-based services for these hospitals is now based on the 66.46% cost settlement percentage for non-state, non-rural hospitals, rather than the 90% cost-settlement percentage applicable to state hospitals. Two additional state hospitals are closing. The utilization in these facilities was assumed to be absorbed by other facilities in the regions and claims were adjusted accordingly.

Tables 3 summarizes the overall fee schedule adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 3: Fee Schedule Adjustment

Prepaid Fee Schedule Adjustment	
COA Description	**Rate Impact**
SSI	0.8%
Family & Children	0.6%
BCC	-1.6%
LAP	1.3%
HCBS	0.0%
CCM	0.0%
Maternity Kickpayment	1.7%
EED Kickpayment	1.7%
Total	**0.7%**

Shared Savings/FFS Fee Schedule Adjustment	
COA Description	**Rate Impact**
SSI	-1.8%
Family & Children	-1.6%
BCC	-5.9%
LAP	-0.7%
HCBS	-0.1%
CCM	-1.1%
Maternity Kickpayment	-0.6%
EED Kickpayment	-0.6%
Total	**-1.5%**

ACA PCP

Under Section 1202 of the Affordable Care Act (ACA), state Medicaid programs were required to increase payments to primary care providers (PCPs) in 2013 and 2014. This requirement expires on December 31, 2014. As a result, 2013 Bayou Health encounter and FFS claims were adjusted to reflect the decrease in PCP payment rates between 2013 and 2015. The reduction, applied at the COA level is based on adjusting the provider fee schedule from the enhanced ACA rate to the Medicaid rate set by DHH. Prepaid encounter data was adjusted based on submissions by the plans, and following discussions with them to identify the necessary adjustments to their experience. Table 4 summarizes the overall adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 4: ACA PCP Adjustment

Prepaid Encounter ACA PCP Carve-Out	
COA Description	Rate Impact
SSI	-1.3%
Family & Children	-3.9%
BCC	-0.7%
LAP	-4.4%
HCBS	0.0%
CCM	0.0%
Maternity Kickpayment	0.0%
EED Kickpayment	0.0%
Total	**-2.5%**

Shared Savings/FFS ACA PCP Carve-Out	
COA Description	Rate Impact
SSI	-1.5%
Family & Children	-4.7%
BCC	-0.7%
LAP	-5.2%
HCBS	-0.7%
CCM	-0.9%
Maternity Kickpayment	0.0%
EED Kickpayment	0.0%
Total	**-3.1%**

Program Changes

Act 312

Effective January 1, 2014, Act 312 requires that when medications are restricted for use by an MCO by a step therapy or fail first protocol, the prescribing physician shall be provided with and have access to a clear and convenient process to expeditiously request an override of such restriction from the MCO. The MCO is required to grant the override under certain conditions. Mercer reviewed this new requirement and estimated the impact of this change to be an increase of approximately 3% of pharmacy costs.

Early Elective Deliveries (EED)

Beginning February 2015, facility and delivering physician costs for early elective deliveries will not be covered under the Bayou Health program. These deliveries will trigger a reduced kickpayment to the MCO. Mercer identified the average facility and delivering physician costs included in the maternity kick payment by region and removed those costs to create the EED Kickpayment. Table 5 shows the adjustments and resulting EED Kickpayments.

Table 5: Early Elective Delivery Rate Reduction

Early Elective Delivery Rate Reduction			
Region Description	Reduction (%)	Reduction - Low	Reduction - High
Gulf	-34.3	$ (3,706.64)	$ (3,862.49)
Capital	-43.3	$ (2,831.28)	$ (2,950.33)
South Central	-41.2	$ (2,918.12)	$ (3,040.81)
North	-38.0	$ (3,170.62)	$ (3,303.94)
Total	**-38.9**	**$ (3,169.67)**	**$ (3,302.95)**

Retro-active Eligibility Adjustment

Beginning in February 2015 members granted retroactive eligibility will be capitated retroactively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in a MCO. The MCO selected by these members will then receive the appropriate number of capitation months, and will be liable for all claims incurred during this retroactive eligibility period. In order to account for the inability of MCOs to manage these retro-active claims, an adjustment factor has been applied to the capitation rates. Mercer did not apply any savings adjustments to the retro-active period claims in the development of these factors. Table 6 summarizes the overall adjustment by rate cell for retro-active eligibility.

Table 6: Retro-Active Eligibility Adjustment

Retro-Active Eligibility Adjustment		
COA Description	**Rate Cell Description**	**Adjustment (%)**
SSI	0-2 Months	0.0
SSI	3-11 Months	0.0
SSI	Child 1-18	0.0
SSI	Adult 19+	0.5
Family & Children	0-2 Months	0.0
Family & Children	3-11 Months	0.0
Family & Children	Child 1-18	0.0
Family & Children	Adult 19+	1.7
BCC	BCC, All Ages	7.5
LAP	LAP, All Ages	0.0
HCBS	Child 0-18	0.0
HCBS	Adult 19+	0.0
CCM	CCM, All Ages	0.0
Maternity Kickpayment	Maternity Kickpayment	0.0
EED Kickpayment	EED Kickpayment	0.0
Total		**0.7**

Rating Adjustments

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for each of the three data sources incorporated in the capitation rates: Prepaid encounters, Shared Savings, and FFS. Trends were selected based on Louisiana experience, as well as national trend information. Trends by population are shown in Appendix E.

Managed Care Adjustments

For those populations and services that had previously been excluded from Bayou Health, Mercer adjusted the capitation rates to reflect areas for managed care efficiency. Managed Care is able to generate savings by:

- Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the ER or hospitalization.
- Using alternatives to the ER for conditions that are non-emergent in nature.
- Increasing access and providing member education.
- Minimizing duplication of services.
- Hospital discharge planning to ensure a smooth transition from facility-based care to community resources and minimize readmissions.

Managed care savings factors were applied to the HCBS and Chisholm class COA. Additionally, durable medical equipment (DME) and NEMT costs for Shared Savings enrollees were adjusted as part of this rate setting, as these services were excluded from Bayou Health Shared Savings. Appendix F summarizes the managed care savings adjustments that were applied to the Shared Savings/Legacy Medicaid FFS data.

Shared Savings Rx claims

Under the Bayou Health Shared Savings program, plans had limited ability to manage prescription drug costs. In order to use the Shared Savings experience to set capitated rates, adjustments were needed to account for generic dispense rate (GDR) differences between the Prepaid and Shared Savings experience. For the Prepaid program, GDR was approximately 84%, compared to approximately 77% for Shared Savings and FFS. Mercer assumed the change in GDR would be zero the first month the rates are in effect, increasing evenly over the next 3 months until an 84% GDR is achieved in May 2015. This results in prescription drug savings of 11% to 13%.

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of $150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU)-specific cost-to-charge ratio (CCR). DHH makes payments to a maximum of $10 million, annually. As payment of outlier liability is the responsibility of Bayou Health MCOs, this additional $10 million was built into the rates based on the distribution by rate cell observed in State Fiscal Year (SFY)11 and SFY12. Outliers added an average cost of $0.93 per member per month (PMPM) to the base data used in rate setting.

Graduate Medical Education

DHH will be making payments for GME outside of the capitation rates. Therefore, Mercer made adjustments to exclude GME payments from the capitation.

Data Smoothing

For certain rate cells, there were not enough member months (MMs) within each region to produce a statistically credible rate. For these rate cells, Mercer calculated a statewide capitation rate. Affected rate cells include:

- SSI newborns 0-1 years of age
- BCC, All Ages
- LAP, All Ages
- HCBS, All Ages
- CCM, All Ages

Voluntary Opt-In Adjustments

It is unclear at this time if there will be a material difference in the risk profile of the Opt-in population from the historical FFS population. Therefore, Mercer made no adjustments for selection risk in the development of the HCBS and CCM rates.

Non-Medical Expense Load

The actuarially sound capitation rate ranges developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed historical Prepaid plan expense data and relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each member month, which reflects program requirements, such as state-mandated staffing. Added to this is a variable administrative amount, based on claims volume. For pharmacy, 2% of claims cost was targeted, while 6.1% was targeted for medical. Maternity kickpayment rate cells have only the variable medical administrative load. The total administrative cost is estimated to be between $21.33 and $22.86 PMPM

Additionally, provision has been made in these rates for a 2% risk margin, as well as Louisiana's 2.25% premium tax.

Risk Adjustment

Risk adjustment will be applied to the rates in Attachment A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Bayou Health MCOs according to the relative risk of their enrolled members. Actuarially sound risk adjustment protocols have been developed so as to be appropriate to rates that have been developed by underlying age and gender cells.

Federal Health Insurer Fee

Section 9010 of the ACA established a health insurance provider fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize in actuarially sound capitation rates.

At the time of this certification, many aspects of the calculation and application of this fee are not yet determined and/or finalized. These fees will be calculated and become payable sometime during the third quarter of 2016. As these fees are not yet defined by insurer and by market place, no adjustment has been made in the rate range development for the Bayou Health program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced in 2016.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Attachment A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Bayou Health MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Bayou Health MCOs for any purpose. Mercer recommends that any Bayou Health MCO considering contracting with the DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the DHH.

This certification letter assumes the reader is familiar with the Bayou Health Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3358.

Sincerely,

Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Appendix A: Bayou Health Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	291	$21,714.18	$23,187.74
Gulf	SSI	3-11 Months	1,790	$4,268.75	$4,554.33
Gulf	SSI	Child 1-18	122,394	$315.40	$338.01
Gulf	SSI	Adult 19+	276,704	$744.61	$794.63
Gulf	Family & Children	0-2 Months	43,180	$1,247.14	$1,333.03
Gulf	Family & Children	3-11 Months	104,549	$209.39	$225.60
Gulf	Family & Children	Child 1-18	2,053,265	$100.88	$108.38
Gulf	Family & Children	Adult 19+	374,005	$243.76	$260.34
Gulf	BCC	BCC, All Ages	3,702	$1,558.12	$1,682.05
Gulf	LAP	LAP, All Ages	9,457	$130.97	$140.95
Gulf	HCBS	Child 0-18	6,826	$1,436.85	$1,562.34
Gulf	HCBS	Adult 19+	21,296	$471.84	$514.04
Gulf	CCM	CCM, All Ages	15,710	$766.57	$841.00
Gulf	Maternity Kickpayment	Maternity Kickpayment	10,993	$5,645.11	$5,882.47
Gulf	EED Kickpayment	EED Kickpayment	N/A	$1,938.47	$2,019.98
Capital	SSI	0-2 Months	168	$21,714.18	$23,187.74
Capital	SSI	3-11 Months	1,491	$4,268.75	$4,554.33
Capital	SSI	Child 1-18	89,519	$350.07	$375.54
Capital	SSI	Adult 19+	210,439	$828.40	$884.04
Capital	Family & Children	0-2 Months	38,789	$1,269.87	$1,358.14
Capital	Family & Children	3-11 Months	94,611	$234.54	$252.93
Capital	Family & Children	Child 1-18	1,863,396	$108.21	$116.37
Capital	Family & Children	Adult 19+	268,984	$284.36	$303.49
Capital	BCC	BCC, All Ages	3,946	$1,558.12	$1,682.05

Capital	LAP	LAP, All Ages	10,487	$130.97	$140.95
Capital	HCBS	Child 0-18	7,164	$1,436.85	$1,562.34
Capital	HCBS	Adult 19+	21,638	$471.84	$514.04
Capital	CCM	CCM, All Ages	15,831	$766.57	$841.00
Capital	Maternity Kickpayment	Maternity Kickpayment	9,776	$4,993.41	$5,203.37
Capital	EED Kickpayment	EED Kickpayment	N/A	$2,162.13	$2,253.04
South Central	SSI	0-2 Months	217	$21,714.18	$23,187.74
South Central	SSI	3-11 Months	1,692	$4,268.75	$4,554.33
South Central	SSI	Child 1-18	91,728	$366.85	$392.21
South Central	SSI	Adult 19+	247,354	$753.10	$803.99
South Central	Family & Children	0-2 Months	43,502	$1,362.72	$1,457.24
South Central	Family & Children	3-11 Months	104,512	$238.42	$256.64
South Central	Family & Children	Child 1-18	2,038,315	$116.59	$125.16
South Central	Family & Children	Adult 19+	285,454	$271.50	$289.77
South Central	BCC	BCC, All Ages	2,893	$1,558.12	$1,682.05
South Central	LAP	LAP, All Ages	12,222	$130.97	$140.95
South Central	HCBS	Child 0-18	6,665	$1,436.85	$1,562.34
South Central	HCBS	Adult 19+	23,110	$471.84	$514.04
South Central	CCM	CCM, All Ages	16,556	$766.57	$841.00
South Central	Maternity Kickpayment	Maternity Kickpayment	10,509	$4,964.46	$5,173.20
South Central	EED Kickpayment	EED Kickpayment	N/A	$2,046.35	$2,132.39
North	SSI	0-2 Months	239	$21,714.18	$23,187.74
North	SSI	3-11 Months	1,678	$4,268.75	$4,554.33
North	SSI	Child 1-18	100,260	$318.45	$340.17
North	SSI	Adult 19+	212,259	$706.03	$754.16
North	Family & Children	0-2 Months	32,253	$1,387.94	$1,484.93
North	Family & Children	3-11 Months	80,214	$226.40	$243.68
North	Family & Children	Child 1-18	1,587,962	$102.79	$110.29
North	Family & Children	Adult 19+	213,631	$253.70	$271.21
North	BCC	BCC, All Ages	2,395	$1,558.12	$1,682.05
North	LAP	LAP, All Ages	6,545	$130.97	$140.95

North	HCBS	Child 0-18	4,164	$1,436.85	$1,562.34
North	HCBS	Adult 19+	17,320	$471.84	$514.04
North	CCM	CCM, All Ages	16,472	$766.57	$841.00
North	Maternity Kickpayment	Maternity Kickpayment	8,136	$5,110.00	$5,324.86
North	EED Kickpayment	EED Kickpayment	N/A	$1,939.38	$2,020.92

Appendix B: Bayou Health Eligibility Designation

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI (Aged, Blind and Disabled)				
Acute Care Hospitals (LOS > 30 days)	●			
BPL (Walker vs. Bayer)	●			
Disability Medicaid	●			
Disabled Adult Child	●			
Disabled Widow/Widower (DW/W)	●			
Early Widow/Widowers	●			
Family Opportunity Program*	●		●	
Former SSI*	●		●	
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	●			
PICKLE	●			
Provisional Medicaid	●			
Section 4913 Children	●			
SGA Disabled W/W/DS	●			
SSI (Supplemental Security Income)*	●		●	
SSI Conversion	●			
Tuberculosis (TB)	●			
SSI (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
Foster Care IV-E - Suspended SSI			●	
SSI (Supplemental Security Income)			●	
TANF (Families and Children, LIFC)				
CHAMP Child	●			
CHAMP Pregnant Woman (to 133% of FPIG)	●			
CHAMP Pregnant Woman Expansion (to 185%	●			

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
FPIG)				
Deemed Eligible	●			
ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	●			
Grant Review	●			
LaCHIP Phase 1	●			
LaCHIP Phase 2	●			
LaCHIP Phase 3	●			
LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	●			
LIFC - Unemployed Parent / CHAMP	●			
LIFC Basic	●			
PAP - Prohibited AFDC Provisions	●			
Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	●			
Regular MNP (Medically Needy Program)	●			
Transitional Medicaid	●			
FCC (Families and Children)				
Former Foster Care children	●			
Youth Aging Out of Foster Care (Chaffee Option)	●			
FCC (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
CHAMP Child			●	
CHAMP Pregnant Woman (to 133% of FPIG)			●	
IV-E Foster Care			●	
LaCHIP Phase 1			●	
OYD - V Category Child			●	
Regular Foster Care Child			●	

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
YAP (Young Adult Program)			●	
YAP/OYD			●	
BCC (Families and Children)				
Breast and/or Cervical Cancer	●			
LAP (Families and Children)				
LaCHIP Affordable Plan	●			
HCBS Waiver				
ADHC (Adult Day Health Services Waiver)		●		
Children's Waiver - Louisiana Children's Choice		●		
Community Choice Waiver		●		
New Opportunities Waiver - SSI		●		
New Opportunities Waiver Fund		●		
New Opportunities Waiver, non-SSI		●		
Residential Options Waiver - non-SSI		●		
Residential Options Waiver - SSI		●		
SSI Children's Waiver - Louisiana Children's Choice		●		
SSI Community Choice Waiver		●		
SSI New Opportunities Waiver Fund		●		
SSI/ADHC		●		
Supports Waiver		●		
Supports Waiver SSI		●		
CCM				
Chisholm Class Members**		●		
LaHIPP				
Louisiana's Health Insurance Premium Payment Program***	●	●	●	●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
Excluded				
CHAMP Presumptive Eligibility				●
CSOC				●
DD Waiver				●
Denied SSI Prior Period				●
Disabled Adults authorized for special hurricane Katrina assistance				●
EDA Waiver				●
Family Planning, New eligibility / Non LaMOM				●
Family Planning, Previous LAMOMs eligibility				●
Family Planning/Take Charge Transition				●
Forced Benefits				●
GNOCHC Adult Parent				●
GNOCHC Childless Adult				●
HPE B/CC				●
HPE Children under age 19				●
HPE Family Planning				●
HPE Former Foster Care				●
HPE LaCHIP				●
HPE LaCHIP Unborn				●
HPE Parent/Caretaker Relative				●
HPE Pregnant Woman				●
LBHP - Adult 1915(i)				●
LTC (Long-Term Care)				●
LTC Co-Insurance				●
LTC MNP/Transfer of Resources				●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
LTC Payment Denial/Late Admission Packet				●
LTC Spend-Down MNP				●
LTC Spend-Down MNP (Income > Facility Fee)				●
OCS Child Under Age 18 (State Funded)				●
OYD (Office of Youth Development)				●
PACE SSI				●
PACE SSI-related				●
PCA Waiver				●
Private ICF/DD				●
Private ICF/DD Spendown Medically Needy Program				●
Private ICF/DD Spendown Medically Needy Program/Income Over Facility Fee				●
Public ICF/DD				●
Public ICF/DD Spendown Medically Needy Program				●
QI-1 (Qualified Individual - 1)				●
QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)				●
QMB (Qualified Medicare Beneficiary)				●
SLMB (Specified Low-Income Medicare Beneficiary)				●
Spend-Down Medically Needy Program				●
Spendown Denial of Payment/Late Packet				●
SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic				●
SSI DD Waiver				●
SSI Payment Denial/Late Admission				●
SSI PCA Waiver				●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI Transfer of Resource(s)/LTC				●
SSI/EDA Waiver				●
SSI/LTC				●
SSI/Private ICF/DD				●
SSI/Public ICF/DD				●
State Retirees				●
Terminated SSI Prior Period				●
Transfer of Resource(s)/LTC				●

* Children under 19 years of age who are automatically enrolled into Bayou Health, but may voluntarily disenroll.
** Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are *Chisholm* Class Members.
*** LaHIPP is not a category of eligibility. Eligibility designation for LaHIPP enrollees will vary according to the qualifying category of eligibility.

Appendix C: Bayou Health Covered Services

Medicaid Category of Service	Units of Measurement	Completion Category of Service
Inpatient Hospital	Days	Inpatient
Outpatient Hospital	Claims	Outpatient
Primary Care Physician	Visits	Physician
Specialty Care Physician	Visits	Physician
FQHC/RHC	Visits	Physician
EPSDT	Visits	Physician
Certified Nurse Practitioners/Clinical Nurse	Claims	Physician
Lab/Radiology	Units	Other
Home Health	Visits	Other
Emergency Transportation	Units	Transportation
NEMT	Units	Transportation
Rehabilitation Services (occupational therapy {OT}, physical therapy {PT}, speech therapy {ST})	Visits	Other
DME	Units	Other
Clinic	Claims	Physician
Family Planning	Visits	Physician
Other	Units	Other
Prescribed Drugs	Scripts	Prescribed Drugs
ER	Visits	Outpatient
Basic Behavioral Health	Claims	Physician
Hospice*	Admits	Inpatient
Personal Care Services (Age 0-20)*	Units	Physician

* Services that were previously excluded from the Bayou Health program and now are included.

Appendix D-1: Shared Savings/FFS IBNR Adjustment

Category of Service Description	COA Description						
	SSI	Family & Children	BCC	LAP	HCBS	CCM	Maternity Kickpayment
	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Inpatient Hospital	4.6	6.1	4.6	6.1	2.6	4.6	N/A
Outpatient Hospital	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Primary Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Specialty Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
FQHC/RHC	3.8	2.4	3.8	2.4	3.9	3.8	N/A
EPSDT	3.8	2.5	0.0	2.4	3.9	3.8	N/A
Certified Nurse Practitioners/Clinical Nurse	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Lab/Radiology	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Home Health	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Emergency Transportation	2.4	3.8	2.4	3.8	1.3	2.4	N/A
NEMT	2.4	3.8	2.4	3.8	1.3	2.4	N/A
Rehabilitation Services (OT, PT, ST)	3.3	3.0	0.0	3.0	1.5	3.3	N/A
DME	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Clinic	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Family Planning	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Other	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	0.0	0.0	N/A
Emergency Room	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Basic Behavioral Health	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Hospice	4.6	6.1	4.6	0.0	2.6	4.6	N/A
Personal Care Services	3.8	2.6	0.0	0.0	3.9	3.8	N/A
Total	**2.2**	**2.3**	**2.4**	**1.7**	**1.6**	**2.6**	**4.0**

Appendix D-2: Prepaid IBNR Adjustment

Category of Service Description	COA Description						
	SSI	Family & Children	BCC	LAP	HCBS	CCM	Maternity Kickpayment
	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Inpatient Hospital	2.0	6.9	1.7	9.7	N/A	N/A	N/A
Outpatient Hospital	2.4	3.0	2.6	2.6	N/A	N/A	N/A
Primary Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
Specialty Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
FQHC/RHC	2.9	3.0	2.9	3.0	N/A	N/A	N/A
EPSDT	2.9	3.0	2.4	3.0	N/A	N/A	N/A
Certified Nurse Practitioners/Clinical Nurse	2.8	3.0	2.8	3.1	N/A	N/A	N/A
Lab/Radiology	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Home Health	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Emergency Transportation	3.1	2.3	3.1	2.3	N/A	N/A	N/A
NEMT	1.3	1.5	1.6	2.4	N/A	N/A	N/A
Rehabilitation Services (OT, PT, ST)	1.1	0.0	0.5	0.0	N/A	N/A	N/A
DME	1.0	0.0	1.1	0.0	N/A	N/A	N/A
Clinic	2.5	3.1	2.7	2.9	N/A	N/A	N/A
Family Planning	2.8	3.0	2.8	2.8	N/A	N/A	N/A
Other	1.3	0.0	1.5	0.0	N/A	N/A	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	N/A	N/A	N/A
Emergency Room	2.3	2.9	2.4	2.6	N/A	N/A	N/A
Basic Behavioral Health	2.9	3.0	2.8	3.0	N/A	N/A	N/A
Hospice	4.6	6.1	4.6	0.0	N/A	N/A	N/A
Personal Care Services	3.8	2.4	0.0	0.0	N/A	N/A	N/A
Total	**1.4**	**2.9**	**1.9**	**2.2**	**N/A**	**N/A**	**2.1**

Appendix E: Trend

Category of Service Description	SSI/BCC		Family & Children/LAP		HCBS/CCM	
	Low PMPM (%)	High PMPM (%)	Low PMPM (%)	High PMPM (%)	Low PMPM (%)	High PMPM (%)
Inpatient Hospital	0.0	3.0	0.0	3.0	1.0	3.0
Outpatient Hospital	2.0	7.1	3.0	8.2	3.5	8.7
Primary Care Physician	2.0	7.1	2.0	7.1	2.0	6.1
Specialty Care Physician	2.0	7.1	2.0	7.1	2.0	6.1
FQHC/RHC	3.0	7.1	3.0	7.1	3.0	7.1
EPSDT	2.0	7.1	2.0	7.1	2.0	6.1
Certified Nurse Practitioners/Clinical Nurse	2.0	7.1	2.0	7.1	2.0	6.1
Lab/Radiology	2.0	4.0	2.0	4.0	2.0	4.0
Home Health	2.0	4.0	2.0	4.0	2.0	4.0
Emergency Transportation	2.0	4.0	2.0	4.0	1.0	4.0
NEMT	2.0	4.0	2.0	4.0	1.0	4.0
Rehabilitation Services (OT, PT, ST)	2.0	4.0	2.0	4.0	2.0	4.0
DME	2.0	4.0	2.0	4.0	2.0	4.0
Clinic	2.0	7.1	2.0	7.1	2.0	6.1
Family Planning	2.0	7.1	2.0	7.1	2.0	6.1
Other	2.0	4.0	2.0	4.0	2.0	4.0
Prescribed Drugs	5.4	7.2	5.4	7.2	2.0	3.0
Emergency Room	1.0	4.0	1.0	3.0	3.5	8.7
Basic Behavioral Health	2.0	7.1	2.0	7.1	2.0	6.1
Hospice	2.0	4.0	2.0	4.0	2.0	4.0
Personal Care Services	2.0	4.0	2.0	4.0	2.0	6.1
Total	**2.7**	**5.7**	**2.6**	**5.7**	**2.0**	**4.6**

Appendix F: Managed Care Savings

	HCBS Waiver/CCM*		Shared Savings**	
Category of Service Description	**Low PMPM (%)**	**High PMPM (%)**	**Low PMPM (%)**	**High PMPM (%)**
Inpatient Hospital	-11.6	-5.5	0.0	0.0
Outpatient Hospital	-9.1	-4.7	0.0	0.0
Primary Care Physician	7.6	12.4	0.0	0.0
Specialty Care Physician	-12.5	-8.2	0.0	0.0
FQHC/RHC	0.0	4.5	0.0	0.0
EPSDT	5.0	7.0	0.0	0.0
Certified Nurse Practitioners/Clinical Nurse	7.6	12.4	0.0	0.0
Lab/Radiology	-10.0	-3.1	0.0	0.0
Home Health	0.0	2.0	0.0	0.0
Emergency Transportation	-5.0	-0.6	0.0	0.0
NEMT	0.0	4.5	0.0	7.1
Rehabilitation Services (OT, PT, ST)	-5.0	-0.6	0.0	0.0
DME	-10.0	-5.6	-20.0	-13.3
Clinic	-10.0	-5.6	0.0	0.0
Family Planning	0.0	4.5	0.0	0.0
Other	0.0	4.5	0.0	0.0
Prescribed Drugs	-10.4	-10.4	0.0	0.0
Emergency Room	-8.1	-3.7	0.0	0.0
Basic Behavioral Health	0.0	2.0	0.0	0.0
Hospice	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	-10.0	-5.0
Total	**-8.3**	**-4.8**	**-5.2**	**-4.1**

*Previously unmanaged populations utilizing Legacy Medicaid/FFS claims.
**Covered services previously not covered under the Shared Savings program.
***Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and Managed Care savings are not applied.

Appendix G: Data Reliance Attestation

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 27, 2014

Mr. Jaredd Simons, ASA, MAAA
Senior Associate
Mercer Government Human Services
3560 Lenox Road, Suite 2400
Atlanta, GA 30326

Subject: Capitation Rate Range Certification for the Bayou Health Prepaid Program – Implementation Year (February 1, 2015 – January 31, 2016)

Dear Jaredd:

I, Jen Steele, Medicaid Deputy Director and Chief Financial Officer, for the State of Louisiana's Department of Health and Hospitals (DHH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the February 1, 2015 – January 31, 2016 Prepaid rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes calendar year (CY) 2013 fee-for-service (FFS) data files, MCO submitted encounter data, and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems (MMIS).

Mercer relied on DHH and its fiscal agent for the collection and processing of the FFS data, encounter data, and other information used in setting these capitation rates. Mercer did not audit the data, but did assess the data for reasonableness as documented in the rate certification letter.

Jen Steele
Signature

8/27/14
Date

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-9245 • Fax #: 225/342-9598 • www.MakingMedicaidBetter.com
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Incentive-Based Performance Measures
Targets for Improvement

Identifier	Measure	Measure Description	Target Population	Condition	Target for Improvement
PTB $$	Initiation of Injectable Progesterone Therapy in Women with Previous Pre-Term Births	The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.	Children's and Maternal Health	Perinatal and Reproductive Health	**20.00**
NQF #0471 (CSEC) $$	Cesarean Rate for Low-Risk First Birth Women	The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).	Children's and Maternal Health	Perinatal and Reproductive Health	**26.47**
(AWC) $$	Adolescent Well Care Visit	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement Year	Children's Health	Utilization	**40.69**
NQF # 0108 $$	Follow-up Care for Children Prescribed ADHD Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Children's Health	Behavioral Health	**Initiation 42.07** **C&M 48.49**
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	Chronic Disease	HIV	**54.34**
NQF #0272 (PQI 1) $$	Diabetes Short Term Complications Rate	Number of discharges for diabetes short term complications per 100,000 Medicaid enrollees age 18 and older.	Chronic Disease	Diabetes	**17.15**
NQF # 1517 (PPC) $$	Postpartum Care (PPC Submeasure)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Maternal Health	Perinatal and Reproductive Health	**63.12**
(AMB) $$	Ambulatory Care	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	Population Health	Utilization	**ED Visits 68.37**

Bayou Health Enrollment-- MCO Assignment Methodology
2015-2018 Contract Period

All existing Bayou Health members as of November 1, 2014 will be given the option to select the plan of their choice during open enrollment (November 13, 2014 – January 20, 2015). If a member does not actively select a health plan, DHH will seek to preserve the continuity of care for the member by maintaining existing patient/provider relationships, as well as the continuation of care coordination provided by the incumbent health plans as detailed below.

A. Members in Incumbent CCN-P Plan

1. Member may make a proactive choice to select the plan of their choice.
2. If the member does not make a proactive choice, they will remain in their current plan.

B. Members in Incumbent CCN-S Plan

1. Member may make a proactive choice to select the plan of their choice.
2. If the member does not make a proactive choice:
    a. Members of the Community Health Solutions CCN-S Plan will be assigned to the Louisiana Healthcare Connections (LHC) MCO plan if their current PCP is in network with LHC.
    b. Members of the United Healthcare (UHC) CCN-S Plan will be assigned to the United Healthcare MCO if their current PCP is in network with the UHC MCO.
    c. If a CCN-S member's PCP is not in network with one of the successors identified above, the member will be assigned randomly to an MCO in which the PCP participates.
    d. If the PCP is not contracted with any MCOs, they will be randomly assigned to one of the five MCOs in accordance with the procedure described in paragraph E below.

C. **New** Members Enrolled in Louisiana Medicaid Between 12/30 /14 and 1/ 29 /15

1. New members will be given the opportunity to proactively select a plan of their choice during the application process.
2. If the new member does not make a proactive choice:
    a. If a family member has an existing MCO relationship, the new member will be assigned to that MCO.
    b. If there is no family member relationship but the member has had a Medicaid PCP visit in the past 6 months, the member will be assigned randomly to an MCO in which the PCP participates.
    c. If the member has neither an existing MCO relationship nor recent PCP visit, the member will be assigned to the new MCO entrant.

D. **New** Members Enrolled in Louisiana Medicaid On or After 1/30/2015 Through 1/ 29/2016

1. New members will be given the opportunity to proactively select a plan of their choice during the application process.
2. If the new member does not make a proactive choice:
    a. If a family member has an existing MCO relationship, the new member will be assigned to that MCO.
    b. If there is no family member relationship but the member has had a Medicaid PCP visit in the past 6 months, the member will be assigned randomly to an MCO in which the PCP participates.
    c. If the member has neither an existing MCO relationship nor recent PCP visit, the member will be randomly assigned to one of the five MCOs in accordance with the procedure described in paragraph E below.

E. Random Assignment Procedure

When members are randomly assigned on or after 1/21/2015 through 1/29/2016, the new MCO entrant will receive 2 members for each 1 member that each of the other four MCOs receives. (Two out every six new members). All random assignments on or after 1/30/2016 will be distributed without preference to the new MCO entrant.

F. DHH reserves the right to end the preference for the new MCO entrant (see paragraphs C.2.c and E above) if its enrollment exceeds 80,000 members.

***Auto-assignments** on any basis other than family member in MCO will not be made to an MCO whose membership share is at or above 40% of the total membership.*

During the 2014-2015 open enrollment, all members will be given through April 29, 2015 to change plans without cause.

Bayou Health Enrollment-- MCO Assignment Methodology
2015-2018 Contract Period

All existing Bayou Health members as of November 1, 2014 will be given the option to select the plan of their choice during open enrollment (November 13, 2014 – January 20, 2015). If a member does not actively select a health plan, DHH will seek to preserve the continuity of care for the member by maintaining existing patient/provider relationships, as well as the continuation of care coordination provided by the incumbent health plans as detailed below.

A. Members in Incumbent CCN-P Plan
1. Member may make a proactive choice to select the plan of their choice.
2. If the member does not make a proactive choice, they will remain in their current plan.

B. Members in Incumbent CCN-S Plan
1. Member may make a proactive choice to select the plan of their choice.
2. If the member does not make a proactive choice:
    a. Members of the Community Health Solutions CCN-S Plan will be assigned to the Louisiana Healthcare Connections (LHC) MCO plan if their current PCP is in network with LHC.
    b. Members of the United Healthcare (UHC) CCN-S Plan will be assigned to the United Healthcare MCO if their current PCP is in network with the UHC MCO.
    c. If a CCN-S member's PCP is not in network with one of the successors identified above, the member will be assigned randomly to an MCO in which the PCP participates.
    d. If the PCP is not contracted with any MCOs, they will be randomly assigned to one of the five MCOs in accordance with the procedure described in paragraph E below.

C. **New** Members Enrolled in Louisiana Medicaid Between 12/30 /14 and 1/ 29 /15
1. New members will be given the opportunity to proactively select a plan of their choice during the application process.
2. If the new member does not make a proactive choice:
    a. If a family member has an existing MCO relationship, the new member will be assigned to that MCO.
    b. If there is no family member relationship but the member has had a Medicaid PCP visit in the past 6 months, the member will be assigned randomly to an MCO in which the PCP participates.
    c. If the member has neither an existing MCO relationship nor recent PCP visit, the member will be assigned to the new MCO entrant.

D. **New** Members Enrolled in Louisiana Medicaid On or After 1/30/2015 Through 1/ 29/2016
1. New members will be given the opportunity to proactively select a plan of their choice during the application process.
2. If the new member does not make a proactive choice:
    a. If a family member has an existing MCO relationship, the new member will be assigned to that MCO.
    b. If there is no family member relationship but the member has had a Medicaid PCP visit in the past 6 months, the member will be assigned randomly to an MCO in which the PCP participates.
    c. If the member has neither an existing MCO relationship nor recent PCP visit, the member will be randomly assigned to one of the five MCOs in accordance with the procedure described in paragraph E below.

E. Random Assignment Procedure

When members are randomly assigned on or after 1/21/2015 through 1/29/2016, the new MCO entrant will receive 2 members for each 1 member that each of the other four MCOs receives. (Two out every six new members). All random assignments on or after 1/30/2016 will be distributed without preference to the new MCO entrant.

F. DHH reserves the right to end the preference for the new MCO entrant (see paragraphs C.2.c and E above) if its enrollment exceeds 80,000 members.

***Auto-assignments** on any basis other than family member in MCO will not be made to an MCO whose membership share is at or above 40% of the total membership.*

During the 2014-2015 open enrollment, all members will be given through April 29, 2015 to change plans without cause.

Additional Terms and Conditions

The following changes shall be made to the RFP language as incorporated into the contract. Corrections are struck through and additions are underlined.

Document/Location	Existing language	Revised Language
CF-1 Page 1, Line 12	Add new language	The contract may be terminated by the contractor only if DHH fails, without reason as determined by DHH, to remit appropriate PMPM payment within 120 days of the date the payment was due.
CF-1 Page 3, Paragraph 11	Replace existing language	Third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code related to this contract and/or obtained or prepared by Contractor exclusively in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract, except for any materials, information, processes, programs, and payments that are owned by, are licensed to, or are proprietary to, Contractor, including any modifications or enhancement thereto, which shall remain the property of Contractor. All records, reports, and documents related to this Contract shall be provided to DHH upon request.
RFP Section 2.6.1.3	2.6.1.3 The initial amount of the bond shall be equal to fifty (50) million dollars. The initial bond must be submitted to DHH with the original signed contract.	2.6.1.3 The initial amount of the bond shall be equal to fifty (50) million dollars. The initial bond must be submitted to DHH ~~with the original signed contract~~within 10 days of contract approval by the Office of Contractual Review.
RFP Section 5.15	Addition of new section	5.15. Health Insurance Provider Fee (HIPF) Reimbursement If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the MCO's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall, upon the MCO satisfying completion of the requirements below, make an annual payment to the MCO in each calendar year payment is due to the

		IRS (the "Fee Year"). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each MCO's capitation rates for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year. 5.15.1. The MCO shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements: 5.15.1.1. Provide DHH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified by DHH each year. The MCO shall provide DHH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing. 5.15.1.2. Provide DHH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline to be identified by DHH each year (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing. 5.15.1.3. If the MCO's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The MCO will indicate for DHH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, if applicable, beginning with Data Year 2014. 5.15.1.3.1. The MCO shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606. 5.15.1.3.2. If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, the MCO shall submit the calculations and methodology for the

		amount excluded. 5.15.1.4. Provide DHH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline to be identified by DHH each year. 5.15.1.5. Provide DHH with the final calculation of the Annual Fee as determined by the IRS by the deadline to be identified by DHH each year. 5.15.1.6. Provide DHH with the corporate income tax rates – federal and state (if applicable) -- by the deadlines to be identified by DHH each year. and include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606 5.15.2.For covered entities subject to the HIPF, DHH will perform the following steps to evaluate and calculate the HIPF percentage based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by DHH. 5.15.2.1. Review each submitted document and notify the Contractor of any questions. 5.15.2.2. DHH will check the reasonableness of the MCO's Louisiana-specific Medicaid/CHIP premium revenue included on the MCO's Form 8963/supplemental delineation. This reasonableness check will include, but may not be limited to comparing the MCO's reported Louisiana-specific Medicaid/CHIP premium revenue to DHH's capitation payment records. 5.15.2.3. DHH and its actuary will calculate revised Data Year capitation rates and rate ranges to account for the Louisiana portion (specific to this contract) of the Contractor's HIPF obligation per the IRS HIPF final fee calculation notice (as noted in 5.17.1.5. above). To calculate the capitation payment adjustment, the DHH will: 5.15.2.3.1. Calculate the HIPF obligation as a percentage of the total data year premiums subject to the HIPF (this total will include all of the first $25 million and 50% of the next $25 million of premium deducted by the IRS). This is the "HIPF%", which is unique to each MCO that is subject to the HIPF. 5.15.2.3.2. Calculate Figure A. Figure A

		is the total premium revenue for coverage in the Data Year from item 5.17.1.2. above. The Figure A amount has no provision for the HIPF obligation. 5.15.2.3.3. Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are excludable under Section 9010 of the Patient Protection and Affordable Care Act of 2010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation. 5.15.2.3.4. Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and applicable taxes. DHH will use the following formula to calculate Figure C. If the Contractor has not provided satisfactory documentation of federal income tax obligations under section 5.17.1.5., then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the Contractor has not provided satisfactory documentation of corporate net income tax obligations under section 5.17.1.6. or if state income taxes are not applicable, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The Louisiana Department of Insurance has determined that state premium tax is not applicable to the HIPF payment; as such, no consideration for premium tax will be made. If in the future, however, the applicability of premium tax to the HIPF payments changes, the formula will be modified accordingly. Figure B 1 – (HIPF% / (1 – AvgSIT% – AvgFIT% x (1 – AvgSIT%))) 5.15.2.3.5. Calculate Figure D. DHH will calculate Figure D by subtracting Figure B from Figure C. This is the final HIPF adjustment amount that will serve as the basis for DHH payment to the impacted contractors. 5.15.2.3.6. DHH will compare Figure D with Figure B to calculate the percentage adjustment to the Data Year capitation rates and rate ranges for submission to CMS for approval. 5.15.3. DHH (and its contract actuary) will compute the change in capitation revenue that is due to the higher

		capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the MCO. 5.15.4. In accordance with a schedule to be provided by DHH each contract year, DHH will make a payment to the MCO that is based on the final Annual Fee amount provided by the IRS and calculated by DHH (and its contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if DHH determines that that the reporting requirements under this section have been satisfied. 5.15.5. The MCO shall advise DHH if payment of the final fee payment is less than the amount invoiced by the IRS. 5.15.6. The MCO shall reimburse DHH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the MCO, at any time and for any reason, by the IRS. 5.15.7. DHH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee. 5.15.8. Payment by DHH is intended to put the MCO in the same position as the MCO would have been in had the MCO's health insurance providers fee tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates. The obligation outlined in this section shall survive the termination of the contract.
RFP Section 5.3.2	5.3.2. The capitation rate payment withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments	5.3.2. The capitation rate payment withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments and the Full Medicaid Payment (FMP) component of the monthly capitation rate payment.
RFP Section 6.1.4	6.1.4 The MCO shall provide core benefits and services to Medicaid members. The core benefits and services	6.1.4 The MCO shall provide core benefits and services to Medicaid members. The core benefits and services

	that shall be provided to members are: • . . . • Pharmacy Services (Outpatient prescription medicines dispensed except those prescribed by a specialized behavioral health provider). . . .	that shall be provided to members are: • . . . • Pharmacy Services (Outpatient prescription medicines dispensed ~~except those prescribed by a specialized behavioral health provider~~). . . .
RFP Section 6.2	6.2. Eye Care and Vision Services The MCO shall provide coverage of vision services that are performed by a licensed ophthalmologist or optometrist, conform to accepted methods of screening, diagnosis and treatment of eye ailments or visual impairments/conditions for members. Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21. The MCO shall not require a referral for in-network providers.	6.2. Eye Care and Vision Services The MCO shall provide coverage of vision services that are performed by a licensed ophthalmologist or optometrist, conform to accepted methods of screening, diagnosis and treatment of eye ailments or visual impairments/conditions for members. Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21. The MCO shall not require a referral for in-network providers. <u>The MCO's requirements for provision and authorization of services within the scope of licensure for optometrists cannot be more stringent than those requirements for participating ophthalmologists.</u>
RFP Section 7.15.1.8.	7.15.1.8.The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50. Ingredient costs of medications must be updated at least weekly.	7.15.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • Pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50; • <u>Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by DHH;</u> • <u>Update</u> ingredient costs of medications at least weekly; • <u>Make drug pricing list available to pharmacies for review; and</u> • <u>Afford individual pharmacies a chance to appeal inadequate reimbursement.</u>
RFP Section 8.4.2	8.4.2 The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following: . . .	8.4.2 The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, state laws, regulations <u>and the court ordered requirements of Chisholm v. Kliebert and Wells v. Kliebert</u> for initial and continuing authorization of services that include, but are not limited to, the following: . . .
RFP Section 9.8.6.	9.8.6.1 The MCO shall deny payment to providers for deliveries occurring before	9.8.6.1 The MCO shall deny payment to providers for deliveries occurring before

	39 weeks without a medical indication noted in LEERS in accordance with Louisiana Medicaid Program policy.	39 weeks without a medical indication. ~~noted in LEERS in accordance with Louisiana Medicaid Program policy~~. MCO will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks.
RFP Section 11.1.1	11.1.1. In order to minimize member disruptions, the initial contract enrollment period and annual open enrollment will be aligned with the contract start date. In subsequent years, the annual open enrollment will be in conducted in accordance with Section 11.7.	11.1.1. In order to minimize member disruptions, the initial contract enrollment period and annual open enrollment will be aligned with the contract start date. In subsequent years, the annual open enrollment will be in conducted in accordance with Section ~~11.7~~11.8.
RFP Section 11.3.1	11.3.1. DHH will auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its enrollment capacity limit or as a result of DHH-initiated sanctions. As specified in Section 11.7, members who fail to select a new MCO during their annual open enrollment period will remain enrolled with their existing MCO. These members will not be subject to the automatic assignment process.	11.3.1. DHH will auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its enrollment capacity limit or as a result of DHH-initiated sanctions. As specified in Section ~~11.7~~11.8, members who fail to select a new MCO during their annual open enrollment period will remain enrolled with their existing MCO. These members will not be subject to the automatic assignment process.
RFP Section 11.10.2	11.10.2 Effective Date of Enrollment The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker. In general, a member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid. Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in an MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO being notified of the person's enrollment. Therefore, enrollment of individuals in the MCO may occur without prior notice to the MCO or enrollee. The MCO shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of enrollment/eligibility.	11.10.2 Effective Date of Enrollment ~~The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker. In general, a member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid.~~ ~~Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in an MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO being notified of the person's enrollment. Therefore, enrollment of individuals in the MCO may occur without prior notice to the MCO or enrollee.~~ ~~The MCO shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of~~

	DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's date of MCO enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, providers shall submit claims directly to the Medicaid Fiscal Intermediary for payment. Except for applicable Medicaid cost sharing, the MCO shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.	~~enrollment/eligibility.~~ ~~DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's date of MCO enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, providers shall submit claims directly to the Medicaid Fiscal Intermediary for payment.~~ - ~~Except for applicable Medicaid cost sharing, the MCO shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.~~ The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker. A member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid, subject to the following limitation. Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled in an MCO. However, retroactive enrollment in an MCO is limited to 12 months. In cases of retroactive eligibility, the effective date of MCO enrollment may occur prior to either the individual or the MCO being notified of the person's MCO enrollment. The MCO shall not be liable for the cost of any covered services prior to the effective date of MCO enrollment, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of MCO enrollment. - DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's MCO enrollment. Claims for dates of service prior to the effective date of MCO enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary for payment. Except for applicable Medicaid cost sharing, the MCO shall ensure that

		members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.
RFP Section 14.2.3	14.2.3. The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the MCO and annually thereafter, and prior to implementation of revisions.	14.2.3. The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH ~~within thirty (30) days from the date the Contract with DHH is signed by the MCO~~ thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions.
RFP Section 15.7.2	15.7.2. The MCO has the exclusive right of review and recovery for 356 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.	15.7.2. The MCO has the exclusive right of review and recovery for ~~356~~ 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.
RFP Section 17.2.2	17.2.2 Rejected Claims 17.2.2.1 The MCO may reject claims because of missing or incomplete information. The original claim must be returned to the provider accompanied by a reject letter. 17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system. 17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. As required by La. R.S. 46:460.71, the letter shall contain at a minimum the following information: • The patient or member name; • The MCO claim number; • The date of each service; • The patient account number assigned by the provider;	17.2.2 Rejected Claims 17.2.2.1 The MCO may reject claims because of missing or incomplete information. The original claim must be returned to the provider accompanied by a reject letter. 17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system. 17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. As required by La. R.S. 46:460.71, the letter shall contain ~~at a minimum the following information~~: • The patient or member name; • The MCO claim number; • The date of each service; • The patient account number assigned by the provider;

	• CPT codes for each procedure, including the amount allowed and any modifiers and units; • The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles; • Identification of the MCO on whose behalf the payment would be made; and • If the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code.	• Total billed charges; • CPT codes for each procedure, including the amount allowed and any modifiers and units; • The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles; • Identification of the MCO on whose behalf the payment would be made, i.e., the MCO's name; and • If the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code. • The date the letter was generated; and • Defects or reasons for rejection.
RFP Section 17.11.2.1	17.11.2.1. The MCO shall, at its own expense, be required to submit to an annual independent Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Control (SOC) Type II audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance.	17.11.2.1.The MCO shall, at its own expense, be required to submit to an annual independent Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Control (SOC) Type II audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance. The audit period must be 12 consecutive months with no breaks between subsequent audit periods.
RFP Section 18.12 (Addition of new section)		18.12 Court Ordered Reporting The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the Wells v. Kliebert and Chisholm v. Kliebert cases in the manner determined by DHH.
RFP Section 19.5	19.5. DHH will assess the performance of the selected MCOs prior to and after the begin date for operations. DHH will complete readiness reviews of MCOs prior to implementation. This includes evaluation of all MCOs' program components including IT, administrative services and medical management. Each readiness review will be performed on site at the MCO's Louisiana administrative offices. Refer to Appendix JJ, **Transition**	19.5. DHH will assess the performance of the selected MCOs prior to and after the begin date for operations. DHH will complete readiness reviews of MCOs prior to implementation. This includes evaluation of all MCOs' program components including IT, administrative services and medical management. Each readiness review for entities that did not contract with DHH as a prepaid entity will be performed on site at the MCO's

	Period Requirements.	Louisiana administrative offices. Refer to Appendix JJ, **Transition Period Requirements.** Readiness reviews for entities that were previously contracted with DHH to serve as prepaid entities will be conducted via desk audit.
RFP Section 19.7	19.7. DHH will conduct on-site readiness reviews prior to member enrollment under this contract and as an ongoing activity during the Contract period. The MCO's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of MCO performance. These focus areas may include, but are not limited to the following . . .	19.7. DHH will conduct on-site readiness reviews for entities that did not contract with DHH previously as prepaid entities prior to member enrollment under this contract and as an ongoing activity during the Contract period. The MCO's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of MCO performance. These focus areas may include, but are not limited to the following . . .
RFP Section 25.1	Numbering correction.	This section should be numbered 25.3, and all sections thereafter have been updated accordingly.
RFP Section 25.7	25.7. Subject to Section 25.30 of the RFP, the MCO and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern."	25.7. Subject to Section ~~25.30~~ 25.29 of the RFP, the MCO and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern."
RFP Glossary	Add a new term	**Basic Behavioral Health Services -** Mental health and substance abuse services which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities.
RFP Glossary	**Behavioral Health Services (BHS)** – Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized mental health services shall include, but not be limited to, services specifically defined in state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a behavioral disorder.	**Specialized Behavioral Health Services ~~(BHS)~~** ~~– Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized~~ Mental health services and substance abuse services that ~~shall~~ include, but ~~is~~ are not ~~be~~ limited to, services specifically defined in the state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider. ~~to those enrollees with a primary diagnosis of a behavioral disorder~~

Standard Provisions

Entire Agreement Clause

This contract, together with the RFP and addenda issued thereto by the Department, the proposal submitted by the Contractor in response to the Department's RFP, and any exhibits specifically incorporated herein by reference, constitute the entire agreement between the parties with respect to the subject matter.

Order of Precedence

In the event of any inconsistent or incompatible provisions, this signed agreement (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal.

Exhibit 1

ASSISTANT SECRETARY'S CERTIFICATE

I, Michelle M. Huntley, the undersigned, hereby certify as follows:

1. That I am an Assistant Secretary of UnitedHealthcare of Louisiana, Inc., a Louisiana corporation (hereinafter the "Corporation").

2. That the Board of Directors of the Corporation adopted the UnitedHealth Group Delegation of Binding Authority Policy and associated guidelines, schedules and supplemental materials (collectively referred to as the "Policy").

3. That the Board of Directors of the Corporation has, and at the time of the adoption of the Policy had, full power and lawful authority to adopt the Policy and to confer the powers thereby granted.

4. That pursuant to the duly adopted Policy, April Golenor has authority to sign documents on behalf of the Corporation, including entering into any contracts with the Louisiana Department of Health and Hospitals on behalf of the Corporation.

IN WITNESS WHEREOF, I have hereunto set my hand this 12th day of January 2015.

Michelle M. Huntley
Assistant Secretary
UnitedHealthcare of Louisiana, Inc.

THIS CORPORATION HAS
NO CORPORATE SEAL

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

Exhibit 2

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

January 9, 2015

Ms. Pamela Bartfay Rice, Esq.
Interim Director, Professional Contracts
DOA-Office of State Procurement
P.O. Box 94095
Baton Rouge, Louisiana 70804-9095

RE: Request for Multi-Year Contract

Dear Ms. Rice:

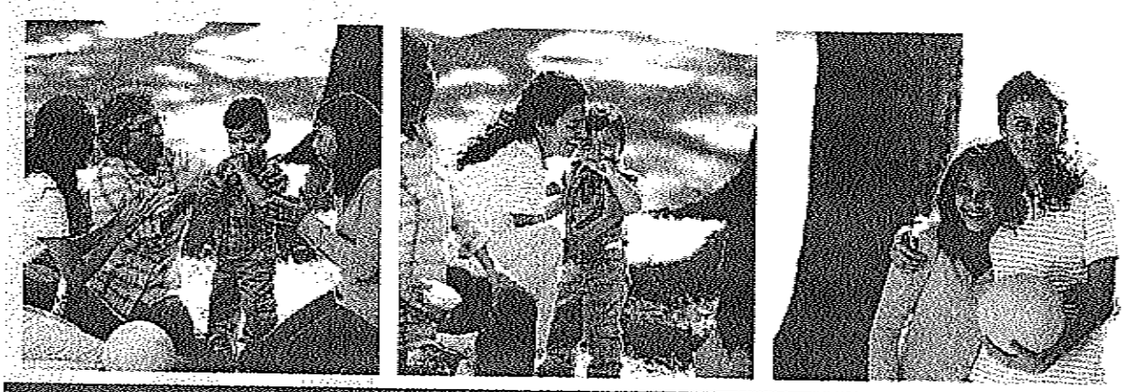
The Department of Health and Hospitals' Bureau of Health Services Financing seeks to enter into a three-year contract with UnitedHealthcare of Louisiana, Inc. (hereinafter referred to as "United") to function as one of the Bayou Health managed care organizations. United was selected pursuant to the request for proposal issued July 28, 2014 (RFP # 305PUR-DHHRFP-BH-MCO-2014-MVA). The department understands that payment for subsequent fiscal years shall be subject to the availability of funds.

We appreciate your assistance in this matter and we hope that you will give this contract your favorable consideration and approval.

Should you need further information, please contact Stacy Guidry via telephone at (337) 857-6115 or via e-mail at stacy.guidry@la.gov.

Sincerely,

Mary T.C. Johnson
Medicaid Deputy Director



UnitedHealthcare Community Plan of Louisiana, Inc. Emergency Management, Business Continuity and Disaster Recovery Plan

3838 N. Causeway Blvd., Ste. 2600
Metairie, LA 70002

UnitedHealthcare®
Community Plan

UnitedHealthcare
Community Plan

UnitedHealthcare Community Plan of Louisiana, Inc.

Emergency Management, Business Continuity and Disaster Recovery Plan PDF Table of Contents

Contains Confidential Commercial/Financial and Other Protected Information
Exempt from State or Federal Law or Regulation, including the Freedom of Information Act (FOIA), 5 U.S.C. §552.

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan of Louisiana

Emergency Management, Business Continuity and Disaster Recovery Plan

December 2014

Table of Contents

SECTION I – ENTERPRISE RESILIENCY & RESPONSE OVERVIEW

Background

The purpose of UnitedHealth Group's Enterprise Resiliency & Response Program (the Program) is to help prevent and/or mitigate the impact of events that could disrupt UnitedHealth Group business by containing the impact within a predictable and predetermined period of time. Effective business continuity planning establishes the basis from which business processes and operations, including service to customers, are resumed.

UnitedHealth Group has business contingency planning preventative controls, contingency resources, and procedures administered by a formal internal management organization. UnitedHealth Group has developed a contingency process that minimizes customer impact from disrupted service in a disaster while aiding compliance to published regulatory guidelines.

This document focuses on the components of our program that minimize service disruptions to members and customers. More information on the other program components can be found in UnitedHealth Group's Customer Overview document.

Mission Statement

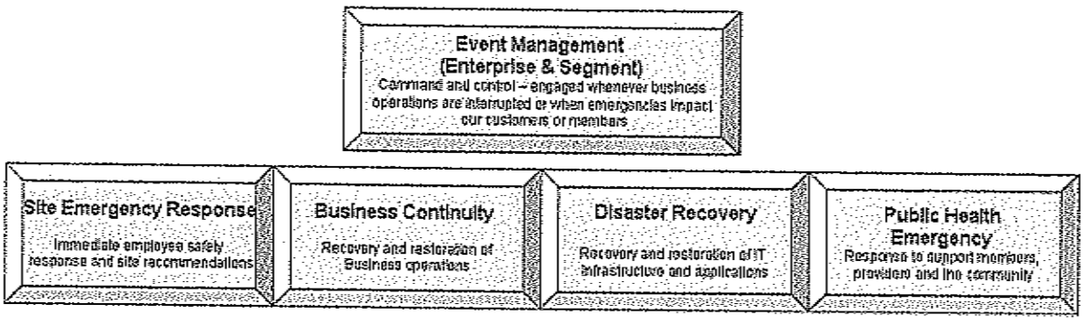
The mission of the Program is to:

- Provide for the safety of our employees in the event of a business disruption or disaster
- Demonstrate our consumer-focus and service excellence when our customers and members are vulnerable after a crisis
- Minimize service disruptions
- Meet customer and other stakeholder expectations
- Preserve customer information
- Protect and preserve UnitedHealth Group's organizational assets, including people, process, technology and information
- Comply with laws and regulations regarding the continuity of operations
- Enhance UnitedHealth Group's competitive position, market share and reputation

This mission can only be achieved through management and control of business impact and risk; therefore, the program focuses on designated critical operations and business continuity safeguards are based on the business impact of the business segment's critical operations, sites, assets, and their inherent vulnerabilities.

The Layered Program Model

The layered Program model is focused on ensuring consistency between the organization's event management, site emergency response, business continuity, disaster recovery and public health emergency planning efforts. These layers are interrelated and work together to provide maximum protection and risk mitigation.



Event Management Strategy

UnitedHealth Group Event Management is the management organization (i.e., event management team) and communication process utilized to facilitate a timely response to major events affecting our personnel, business operations, and site locations, with the goal of avoiding or minimizing damage to the organization's profitability, reputation and ability to operate.

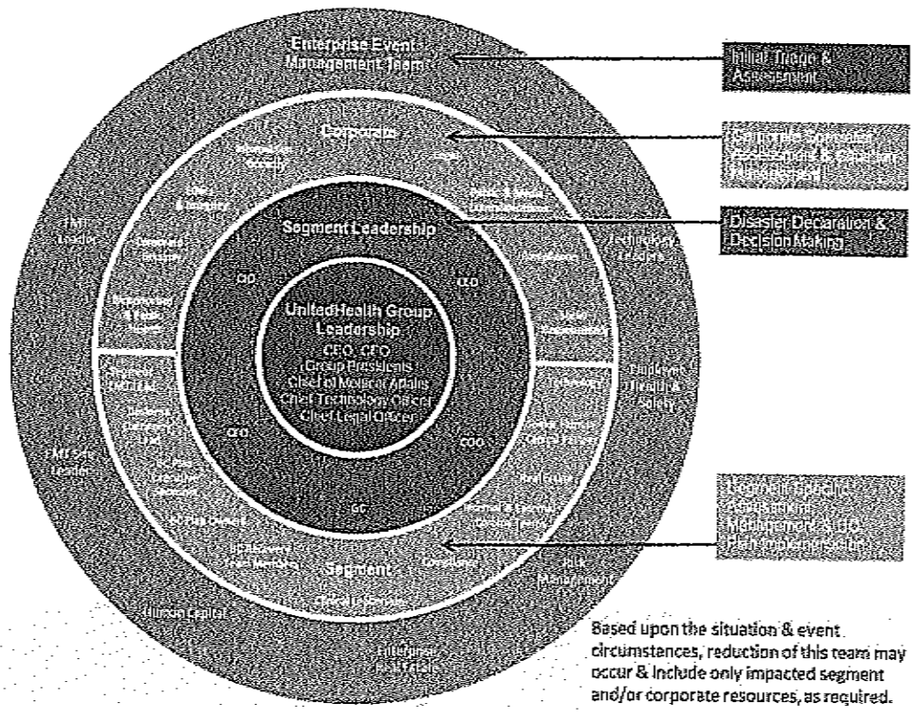
The event management team is collectively responsible for managing the situation and making the critical decisions that drive remediation and coordination with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization. The event management team also supports execution on the event management decisions and provides central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.

Event Management Team

The primary purpose of the event management team is to provide a consistent and reliable approach for communication and engagement between all required parties necessary to manage a major event. Subject matter experts, both at the corporate and segment level, continue to manage actions within their functional teams, however, will leverage the event management team as a forum to more quickly and reliably engage, communicate and make decisions between teams.

The event management team:

- Consists of corporate and segment leadership with responsibility for event communication and response execution.
- Engages required executive leadership necessary to respond to the event.
- Executes on the decisions made by executive leadership and provide central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.
- Determines the strategy for how an event will be managed effectively and efficiently through to resolution. Responsible for facilitating the critical decisions that drive the remediation and coordination efforts with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization.
- Comprised of the following functional leaders or appropriate alternatives, as required:



SECTION II – SITE EMERGENCY RESPONSE

Site Emergency Response Strategy

To support and facilitate a coordinated and controlled building occupant response in an emergency, UnitedHealth Group policy requires all offices with over 10 employees have a site emergency response plan. These plans focus on the immediate site needs during an emergency, such as employee evacuation and public services engagement. The company's emergency response team is often the first responder to a situation and help ensure that employees remain safe, sheltered and their basic life/safety needs are met.

The emergency response plans are used in conjunction with the event management process. These plans focus on the immediate site needs during an emergency, such as employee evacuation and public services engagement.

Site Emergency Response Planning

To help ensure consistency and effectiveness, the site emergency response plans are developed using standard tools and templates. The following provides a high-level description of each of the sections contained within the individual site plans:

- Purpose – The purpose of the Emergency Response Plan.
- Location Information – Information pertaining to the physical location including address and contact numbers.
- Emergency Contact Information – A list of key phone numbers including emergency services, Facilities Management and Security, where applicable.
- Site Emergency Response Team Roles and Responsibilities – Specific roles and responsibilities as defined including Event Management Team Site Lead, and Emergency Response Team Site Lead.
- Emergencies that may Result in Business Interruption or Office Closing – Procedures to engage the Event Management Team.
- One Breath Situations – Procedures to engage Human Capital, where applicable.
- Medical Emergencies – Specific procedures to respond to medical emergencies including location and contents of first aid supplies.
- Fire(s) – Specific procedures pertaining to fires within the building including building alarm sounds, high rise procedures (where applicable), evacuation maps and post evacuation assembly areas.
- Severe Weather – Specific procedures to respond to severe weather events including monitoring/notification procedures and areas to shelter-in-place.
- Additional Hazard-Specific Procedures - if applicable, including but not limited to: Criminal, Terroristic or Violent Behavior; Bomb Threats; Civil Demonstrations; and Hazardous Materials Exposures or Release.

Lifecycle Maintenance

Change Management and Update Process

In order to maintain an effective Program, site emergency response plans are updated annually and monitored for compliance by the Risk Management and Safety organization.

Testing

The site emergency response plans are tested at a minimum annually for UnitedHealthcare Community Plan Louisiana office located at 3838 N. Causeway Blvd., Ste. 2600, Metairie, LA and the health plan's additional offices located in Baton Rouge at 8550 United Plaza Blvd, Suite 703 through drill techniques including fire, severe weather and/or earthquake. Drills may include tabletop (practical or simulated exercise), structured walk-through (functional), and/or large or full-scale (live or real-life exercise).

SECTION III – LOUISIANA BUSINESS CONTINUITY AND DISASTER RECOVERY

Key Contacts

During disasters, we encourage members and providers to use the toll-free numbers we have already provided to them to help ensure their calls are routed appropriately. We recognize that in the confusion of evacuation and the aftermath of a disaster, people may not have these numbers readily at hand, so we have created single entry points into our customer care organization, which we publish in press releases associated with our event response.

Member Services			
Toll-free number:	866-675-1607	Website:	www.myuhc.com
Provider Services			
Toll-free number:	866-675-1607	Website:	www.unitedhealthcareonline.com www.uhccommunityplan.com
Provider Verification Outreach			
Toll-free number:	877-369-1302		

Member Education and Communications

Community Outreach

The UnitedHealthcare Community Plan provides regular ongoing outreach to both members and providers using a variety of methods, and will use establish communication methods to ensure pre-hurricane communications reach our intended audiences. We will send out general hurricane

preparedness communications based on content developed by FEMA, the American Red Cross, and State of Louisiana (www.getagameplan.org) as a starting point, and ensure the material is framed appropriately for the member and provider considerations. Emergency Preparedness and hurricane preparedness education will be provided to members through a member newsletter in June of each year. Additionally, emergency preparedness post-cards will be mailed to members. Over the entire year, emergency preparedness materials will be provided in new member orientations and other community events.

Frequency	Method of communication	Description of member materials	Contents
Spring and/or Summer	Member Newsletter	Emergency Preparedness article	Instructions on how to prepare for a hurricane or other disasters.
Annually in June	UHC Member and Provider Website Portal	Emergency Preparedness readiness points	Key contact numbers for members to reach UHC resources, a reminder to bring their medical ID cards in an evacuation, and other emergency preparations those members can make around medical needs, supplies, and medications.
Ongoing	Community Meetings	Emergency Preparedness Member Brochure In-Person Presentation Important Information Magnets	Key contact numbers for members to reach UHC resources, and emergency preparations those members can make. Magnets include Primary Care Provider (PCP) number, nurse line #, and other important contact information.
Annually ongoing	Community Plan Website, myuhc.com member website	Emergency Preparedness Reminders	Member focused information such as the member newsletter content and various relevant emergency preparedness information (i.e. Red Cross, FEMA, State of Louisiana, etc.)
At time of event	Outbound Calls	Emergency	Actions to take to remain

		notification and reminder	safe.
At time of event	Community Call Tree	Outreach to Community Partners	Member Services FAQ that will be shared with community partners.

Outbound Member Calls

UnitedHealthcare Community Plan will provide a list of members with special healthcare needs to the UnitedHealthcare Community Plan member outreach center. The member outreach center will immediately begin contacting members to determine their medical status as it relates to the emergency event. As the member outreach center makes contact with the members, they will document each member's medical status and needs. Special needs members will be assigned to a Case Manager who will work with members to facilitate their evacuation plan and identify alternate evacuation destinations. UnitedHealthcare Community Plan will provide to the Case Managers the Louisiana State command center contacts, so the Case Managers can identify alternate evacuation destinations should members need to evacuate from their homes.

Member Services Call Center Information

Bayou Health members can contact UnitedHealthcare Community Plan during an emergency by calling 866-675-1607. UnitedHealthcare Member Services will have a Frequently Asked Questions (FAQ) document that contains information and guidance about the medical emergency exceptions and preparations that UnitedHealthcare Community Plan receives from State of Louisiana Department of Health and Hospitals (DHH) at time of event (Sample FAQs from State are attached). Member Services will reference the FAQ when communicating with members to ensure adequate care of members in an emergency situation.

Members Services has operational resiliency to handle a surge in member calls. Member Services can route calls to trained resources to handle additional volumes, and can provide basic training to alternate Member Services agents at time of event if needed. Member Services can be made available 24X7 in a crisis situation, if needed.

Member Access to Medical Records

Members and providers may need access to medical records if providers' offices are closed or destroyed. UnitedHealthcare Community Plan retains claims history and can release the information to the member's provider after the member gives legal consent. Members can make the initial request for claims history by calling Member Services. After making the request, members can obtain and sign release forms at their provider's office. Providers will need to fax the signed release forms to Member Services at which time the claims history can be released to

the provider. Members Services can also place pre-scripted messaging on the Interactive Voice Response system about access to medical records.

Member Notifications and Access to Alternate Health Care Services

UnitedHealthcare Community Plan can assist members when their current provider is not available or has moved to an alternate address temporarily. If the member is evacuating in-state, Members Services can provide the member with information about alternate Louisiana Medicaid approved providers. If the member is evacuating out-of-state, Member Services will receive direction from UnitedHealthcare Community Plan leadership based on DHH's provision of an alternate list of approved providers and any guidance on exceptions or allowances. DHH informed UHC that there would be an expedited credentialing process creating an alternative list.

Members temporary address changes can be captured by Member Services. If members are moving out-of-state temporarily, members may use UnitedHealthcare Community Plan's existing network if those providers are approved by DHH to deliver Louisiana Medicaid services.

If a member's regular provider closes their office and the member does not relocate or temporarily relocates in the affected area, Member Services can offer a list of alternate providers to the member that are located in the member's area. If all local providers close their offices and evacuate, members will be directed to local emergency rooms and alternate care facilities. Member Services will advise members to contact the alternate providers office to confirm that they are open. If requested by a member, Member Services can perform an outbound call to the alternate provider's office to determine if they are open.

Additionally, UnitedHealthcare Community Plan's toll free NurseLine is available for Louisiana members and is listed on their member ID card. As part of the community outreach program, members will be reminded of where to find the NurseLine phone number located on their member ID card, and the services that are provided by NurseLine.

Member Complaints and Inquiries

Member complaints and inquiries will be handled through the UnitedHealthcare Members Services. Member Services will capture the complaints and inquiries, and determine where to forward the issues and questions based on the subject matter. Some complaints and inquiries can be resolved directly by Member Services who will work to resolve all complaints and inquiries. Specific issues related to authorization of care that cannot be resolved will be forwarded to the UnitedHealthcare Grievance and Appeals unit.

Member Transportation

For special needs members, Case Managers will assist members by referring them to a transportation provider who provides transportation services such as parish emergency services,

assistance from friends and/or family, etc. Providing member transportation is not contracted with UnitedHealthcare Community Plan.

Provider Education and Communications

Provider Communications

On a monthly basis, UnitedHealthcare Community Plan sends a Network Bulletin to all providers in a region, and a newsletter to the Louisiana State Medical Association. A quarterly newsletter is sent to providers that includes on an annual basis emergency preparedness instructions for providers, and emergency preparedness tips that providers can give to their members. UnitedHealthcare Community Plan will also make available to the providers the emergency preparedness member materials, which they can distribute at their offices. Member materials may contain information such as the Federally Qualified Health Centers and Rural Health Clinics addresses and phone numbers where Bayou Health members can receive medical care at time of event. Additionally, emergency preparedness information will be posted on the UnitedHealthcare Provider Portal. In the emergency preparedness materials for providers, providers will be instructed to call Provider Services to report the status of their practice at time of event.

Provider Practice Closures

When providers close or relocate their offices or practice, they are expected to contact Provider Verification Outreach and report the status of their practice. The change in the status of their practice will be made available to Provider Services and Member Services so they can provide referrals to members for alternate providers whose offices are still open. This will also be communicated in UnitedHealthcare Community Plan's providers in the education newsletter. Proactively, UHC will be targeting outreach to the largest and most critical providers upon imminent storm threat to obtain critical information related to closures and evacuation contingencies from providers for our call center teams.

Members Access to Medical Records

UnitedHealthcare Community Plan retains claims history and can release the information to the member's provider after the member gives legal consent. Members can make the initial request for claims history by calling Member Services. After making the request, members can attain and sign release forms at their provider's office. Providers will need to fax the signed release forms into Member Services at which time the claims history can be released to the provider.

Provider Services

Louisiana Medicaid providers can contact UnitedHealthcare Community Plan during an emergency by calling 866-675-1607. UnitedHealthcare Provider Services will have a Frequently Asked Questions (FAQ) document that contains information and guidance about the medical emergency exceptions and preparations that UnitedHealthcare Community Plan receives from DHH at time of event. Provider Services will reference the FAQ when communicating with providers to ensure adequate care of members in an emergency situation.

Provider Services has operational resiliency to handle a surge in provider calls. Provider Services can route calls to trained resources to handle additional volumes, and can provide basic training to alternate Provider Services agents at time of event if needed. Provider Services can be made available 24X7 in a crisis situation, if needed. UnitedHealthcare Community Plan will rely on DHH to provide input on the provider call script.

Providers Refer Members to Services

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) addresses and phone numbers will be posted on the UnitedHealthcare Community Plan website and myuhc.com, so members will have access to information about where to seek medical care in an emergency. Providers can also contact Providers Services to get information about where they can refer their members for services.

Provider Complaints and Inquiries

Providers can call UHC Provider Services to request help with questions and issues. Provider Services will work to resolve complaints and inquiries, and will escalate unresolved issues to local Provider Advocates as appropriate to assure a resolution.

Provider Claims Payments

Processing claims payments correctly and efficiently is an important part of the service we deliver to Louisiana Medicaid providers, which is why we have ensured our claims processing operations are resilient, and our claims platforms have robust recovery capabilities.

Should operational issue arise with claim payments, our providers are instructed to call UHC Provider Services to report issues, and we will work with them to resolve their complaints, and escalate any unresolved issues to local Provider Advocates to ensure a resolution.

Provision of Services

Using appropriate methods to ensure UnitedHealthcare Community Plan is in compliance with HIPAA requirements regarding Protected Health Information and Personally Identifiable

Information, UnitedHealthcare Community Plan will inform DHH of how the needs of members with special healthcare needs are being met.

Member Services and Provider Services

UnitedHealthcare Community Plan will provide Member and Provider Services for DHH members in Louisiana. These services will be fully redundant with load balancing and offload capability between United Health primary sites operating in Richardson and Houston, Texas. Additionally, the Houston site has a generator supporting local network and telephony.

Enrollment and Billing

Enrollment and Billing are fully redundant with load balancing and offload capability between sites operating in Illinois, Minnesota, and Wisconsin.

Claim Processing and Member Verifications

UnitedHealthcare Community Plan will perform claims processing for DHH members including member and provider verification, and member authorization matching for services that require authorizations. Claim Operations for members are located in Wisconsin. Claim Operations will make changes to processing based on the exceptions and exemptions as determined and directed by Louisiana DHH at time of event. Based on the impact of the event and DHH direction, processes could be amended to waive authorizations, and/or pay out-of-state providers. Claim Operations has emergency procedures for adjusting to changes in the business that are affected by emergencies. The claim operations are fully redundant with offloading and offload capacity between other multiple United Health sites.

Medical Management Teams - Identification of Members with Special Healthcare Needs

UnitedHealthcare Community Plan will identify members with special healthcare needs by using the State's historical claims data, performing member outreach calls, reviewing member data to identify members by risk ranking, and recording referrals that come into Member Services. Special needs members are defined as members that are: homebound, live alone, in need of transportation, on assisted devices (i.e., oxygen, ventilators, pumps, suction equipment, etc.), in their third trimester for identified high-risk pregnancy, being assessed for or have received transplants, on dialysis, or receiving chemotherapy.

Using the criteria above UnitedHealthcare Community Plan will run reports to delineate members with special needs, and then outreach to them to determine their needs at time of event. The order of contacting the special needs members will be prioritized based on the severity and fragility of their medical condition and the type of event.

UnitedHealthcare Community Plan member outbound call services will outreach to special needs members, review the special needs checklist with each member, and will document the

members' needs for follow-up by their Case Managers. The Case Managers will assist members with implementing their transition plans and remind members to bring their medical ID cards, medical equipment and supplies, and medications in an evacuation. Case Managers will prioritize the order of contact for high-risk members first.

Medical Management Teams - Care Plans

Case Managers will work with members with special needs prior to an emergency to assist them with developing a care plan for at the time of event that will arrange for continuity of care. The Care plans will include an explanation of how their medical needs will be met at time of event. If UnitedHealthcare Community Plan is made aware that a member is receiving hospice services, our Case Managers will assist the members in locating an alternate hospice agency to provide their care in another service area if they were forced to evacuate for a disaster. Hospice care is not contracted with UnitedHealthcare Community Plan.

Replacement of Durable Medical Equipment

UnitedHealthcare Community Plan will encourage members to take all required equipment, medications, and medical supplies with them when they evacuate. For members who need replacement of Durable Medical Equipment (DME), UnitedHealthcare Community Plan will collaborate with DHH on providing replacement of DME. DHH will issue an emergency directive on the process to replace DME. UnitedHealthcare Community Plan will rely on DHH to provide the procedure to replace DME. After DHH coordinates replacement of DME, UnitedHealth Community Plan Case Managers will follow-up with their members to determine if they received the replacement DME, and assist members that did not receive their DME. Providing DME is not contracted with UnitedHealthcare Community Plan.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

UnitedHealthcare Community Plan will assist and direct members and providers to work with DHH, if members or providers are requesting EPSDT services that are currently not on a fee schedule but are medically necessary from out-of-network or out-of-state providers. If UnitedHealthcare Community Plan receives a request that requires prior authorization, UnitedHealthcare Community Plan will review the service for medical necessity and direct the provider to contact DHH if they are not already a Louisiana Medicaid Provider. If the member is trying to receive services out-of-state, UnitedHealthcare Community Plan will work with the member to identify a provider that is a Louisiana Medicaid Provider. UnitedHealthcare Community Plan will also direct members to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

Special Needs Member Transportation during Disaster

For members with special needs, Case Managers will assist members by referring them to a transportation provider who will provide them with transportation service such as utilizing parish emergency services, assistance from friends and/or family, etc. Providing member transportation is not contracted with UnitedHealthcare Community Plan.

Medical and Pharmaceutical Supplies

Member questions and requests about event-related rules on medical and pharmaceutical supplies will be directed back to the DHH. If DHH waives early refill limitations on prescription drugs, Case Managers will notify members with special needs of the changes in the pharmaceutical requirements and provide information on how they may obtain early refills prior to the event. UnitedHealthcare Community Plan will rely on DHH to provide the procedure to waivers. Providing medical and pharmaceutical supplies is not contracted with UnitedHealthcare Community Plan.

Relationships with Other Health Care Entities

UnitedHealthcare Community Plan recommends that DHH consider a unified solution for all members and health insurance plans by DHH developing the "Memorandums of Understanding" (MOUs) with providers. The providers are primarily all Medicaid providers and may or may not be contracted with the health plans. MOUs between the providers and DHH would have a greater opportunity to deliver the results that that DHH desires. Central coordination of agreements with dialysis facilities, alternate primary care providers (i.e., FQHCs & RHCs), home health agencies and hospitals will ensure consistent and reliable care of Bayou Health members, and consistent and reliable engagement and communication between the providers and the health plans. These types of providers would treat our special needs members, and assume care provided by other providers in the evacuation areas so that care coordination and member special care needs would not be impacted.

Prior Authorizations

DHH may temporarily modify medical benefits and Prior Authorization requirements to assist members preparing for or responding to the disaster in order to ease access to healthcare. UnitedHealthcare Community Plan will accommodate DHH changes with regards to the contractual responsibilities of UnitedHealth Community Plan and given that DHH has financial responsibility for those changes.

Out-of-Network or Out-of-State Providers

Prepaid Health Plans – Alternate Providers

UnitedHealthcare Community Plan is contracting with Primary Care Physicians in all 3 Geographic Service Areas defined by DHH, so additional Memorandums of Understanding (MOU's) are not required to ensure access to Primary Care Provider (PCP) services for evacuated members. UnitedHealthcare Community Plan will rely on DHH to provide an expedited credentialing process for out-of-state providers so that UnitedHealthcare Community Plan can direct members to approved providers and the providers in turn can receive payment from DHH for services provided.

As the relative size of PCP practices in northern parishes may make it difficult to support this need, we believe that a better approach is to ensure that hospitals are available for use by displaced providers. We anticipate that all Louisiana hospitals with DHH contracts will allow evacuated providers the opportunity to provide services to Bayou Health members during a disaster once any restrictions on such practices are waived by DHH.

Out-of-Service Area for Members, Prior Authorization and Referrals

UnitedHealthcare Community Plan leaders will collaborate with DHH on the timing and changes in prior authorization and referral requirements given that DHH has financial responsibility for those changes. UnitedHealthcare Clinical Services will assess the change in requirements from the State of Louisiana and FEMA, and make changes to their prior authorization and referral processes based on Federal and State direction. Changes could be made such as waiving prior authorization by degree, by parish, within a date range, etc. Changes in requirements are distributed to the UnitedHealthcare business leads and staff for responding to providers seeking services for Louisiana members. Claims pre-processing changes will follow whatever changes are made for prior authorization and referrals. Providers that do not have a Louisiana Medicaid Provider ID number issued by the State of Louisiana, and those that do not have one will be directed to the State of Louisiana.

Operational Readiness

Business Continuity/Disaster Recovery Plan Activation

Potential disruptions to business operations, or events, are reported into our 24X7 command center. At that time, UnitedHealth Group's Event Management Team (EMT) tier one members will be paged to convene in our virtual command center. The tier one team members will triage the situation to determine whether there has been an event that requires activation of the partial or full EMT. All mandatory EMT participants must respond within 15 minutes or we begin notification to alternate participants.

If an incident occurs that impacts our operations in Louisiana, the Event Management Team will mobilize and triage the situation with local leaders and corporate teams. The time between when

a threat is reported and the BC-DR is activated depends on the event or situation; however our goal is to triage the situation within 15 minutes, and to have the appropriate recovery teams assembled and briefed within 30 minutes after the situation has occurred.

If the event has impacted critical technology, IT Disaster Recovery leaders may activate the DR command center as required to further assess technology impact and prepare for activation of the applicable Disaster Recovery Plans.

UnitedHealth Group has two approaches to managing technology interruptions that impact continuation of business operations. Technology interruptions are categorized as either operations incidents or disaster recovery incidents. The former is managed through implementation of the UnitedHealth Group Incident Management Process and Policy (attached). The latter is managed through the United Command Center High Priority Incident Management Process (attached). One of both incident management processes could be implemented depending on each scenario listed below.

Activation of our Business Continuity plans is authorized by the Event Management Team, and is done to minimize the impact of events that cause business disruption. Activation of our Disaster Recovery plans requires a formal Disaster Declaration by UnitedHealth Group IT executives.

For Disaster Declaration purposes, a disaster is an event of such magnitude that it threatens the ability of an organization to provide critical business functions and/or services for an extended period of time, including the possibility of causing unacceptable interruption in the Segment/Site's essential business processes. Examples of a disaster include: a full outage of a primary production data center, where the hardware and/or infrastructure is unusable and recovery is not immediate; or a partial outage of a primary production data center that impacts critical primary IT infrastructure for an extended period of time.

Should we need to implement our disaster recovery plans following a Disaster Declaration, then the Enterprise Disaster Recovery team lead would use the master recovery schedule to define the restoration priorities for critical infrastructure and applications; and mobilize the UnitedHealth Group IT infrastructure and application teams that are responsible for restoring the applications and data. The top priority is the infrastructure layers used by all applications, followed by critical applications based on their DR Recovery Time Objective (RTO). The master recovery schedule and disaster recovery plans are tested annually with the teams who are responsible for the recovery.

If a disaster has not been declared, the recovery from a systems disruption would be handled as an operational incident, and standard IT Service Management processes would be followed.

Business Continuity Readiness

The business continuity plan is part of the overall program designed and structured to respond to disaster events, restore critical business function processes, and resume normal business function operations in a prioritized manner. The business continuity plan focuses on critical business functions and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of operations and assets. These worst-case scenarios cover impacts from all types of disasters, both natural and man-made (e.g., hurricanes, floods, fires, terrorism attacks, and disease pandemics).

The following scenarios are provided as planning and recovery objectives:

- Loss of Facility - Complete interruption of facilities without access to its equipment, local data and content. The interruption may impact a single site or multiple sites in a geographic region. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

- Loss of Critical Resources - Complete interruption with 100% loss of personnel within the first 24 hours and 50% loss of personnel long-term. The interruption may impact a single site or multiple sites in a geographic area. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

- Loss of Critical Systems - Complete interruption and/or access of critical systems and data located at the various UnitedHealth Group Data Centers for an extended period of time. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

- Loss of Critical Vendors - Complete interruption in a service or supply provided by a third-party vendor(s). Recovery from anything less than complete interruption will be achieved by using appropriate portions of the plan.

Business functions which are classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed redundant operations and maintain a recovery time objective of 72 hours or less. UnitedHealth Group's critical business functions include, but not limited to, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations and core corporate functions.

A variety of business continuity strategies are deployed depending on the business function, criticality ranking and established recovery time objectives.

These strategies include:

- Resilient operations - include dual site operations and continuous availability solutions. In the event of an interruption at one site the business function is transferred to one or more alternate locations at which staff and facilities are already prepared to handle it.
- Remote working - includes the concept of "working from home or telecommuting" and working from other non-corporate locations through secured connections.
- Multiple shifts – makes alternate space available to greater number of staff by dividing staff into two shifts (e.g., morning and evening).
- Buddy up - makes use of existing in-company accommodation such as a training facility or lunch rooms to provide recovery space or increasing the office density.
- Off-loading – consists of off-loading additional critical tasks to staff at available sites or staff cross-trained to perform that function. .
- Displacement - involves displacing workspace used by staff performing less urgent business processes with staff performing a higher priority activity.

Disaster Recovery of Information Technology Readiness

UnitedHealth Group relies on a diverse array of interconnected information systems to meet the needs of its clients. The goal of disaster recovery planning is to protect the organization in the event all or key aspects of our operations are rendered unusable. Preparedness is the key. The company has instituted an Enterprise Disaster Recovery Program to first eliminate or reduce disaster recovery risk in critical technology areas, and then plans for the facilitation and of timely and predictable restoration of key applications, data, and supporting critical infrastructure.

UnitedHealth Group's approach to disaster recovery is based on the two fundamentals: prevention and protection. A focus on balancing the combination of disaster prevention and protection results in reducing both the probability and impact of a disaster. The Enterprise Disaster Recovery Program first eliminates or reduces disaster recovery risk in critical areas, and then plans for the most probable disaster scenarios.

- Prevention - Disaster Recovery usually means minimizing downtime while trying to restore systems and get them back online. UnitedHealth Group's strategy includes focusing on items that would assist in preventing a disaster from taking down systems in the first place. UnitedHealth Group has invested in creating an effective combination of people, process and technology that provides the fundamentals for a proven production method resulting in a stable, scalable environment for our applications to perform at operational excellence. This investment creates the "prevention" which is fundamental to the Enterprise Disaster Recovery Program. Prevention is the proactive remediation of known technology exposures.

- Protection - The Enterprise Disaster Recovery Program is based on anticipating and planning for the common types of disasters and designing solutions to address them. Disaster protection addresses recovery from the most probable disaster scenarios and a worst case scenario. The UnitedHealth Group Information Technology enterprise disaster

recovery strategy involves identifying critical business processes and transitioning these critical applications, data, and supporting infrastructure to an alternate recovery location in a timely manner, thereby reducing the impact of a technology event to our critical business clients.

Scenario Specific Technology Risk Management

a. The central computer installation and resident software are destroyed or damaged;

The Enterprise Disaster Recovery Program is based on anticipating and planning for the common types of disasters and designing solutions to address them. Disaster protection addresses recovery from the most probable disaster scenarios and a worst case "smoking hole" scenario.

Highlights of the disaster recovery protection components include:

- The UnitedHealth Group data centers can operate in a "lights out" mode for up to three days. If the data center continues to get fuel to run the generators, they are designed to run in this mode indefinitely.
- Operational backups are designed to use high performance disk-to-disk primary copy with physical offsite second copy tape.
- DR Active and DR Standby solutions employ active-active and/or active-passive components located in two geographically separate data centers where either site can fully support the production application in the event of a disaster with little to no manual intervention.
- Mainframe Storage Area Network (SAN) replication "rapid recovery" employs full asynchronous data replication between the production host and the geographically dispersed hot standby disaster recovery host.
- Distributed Storage Area Network (SAN) replication system "rapid recovery" employs full asynchronous data replication of production storage pools and failover of production processing to geographically dispersed non-production processing.
- Some distributed systems employ a hot internal solution with production to geographically separate non-production failover and tape data restore.
- Vendor site recovery agreements with tape restore are purchased for less critical and less integrated applications.
- Each critical application has a disaster recovery plan that is refreshed at least once each year and tested annually.
- Metrics in the form of key performance indicators are used to derive the "health" of the enterprise disaster recovery program.

b. System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system;

To minimize the impact of the threats identified in #ii, iii and iv, UnitedHealth Group has implemented redundancies in its network, hardware and software implementation.

Our latest data centers were built to the Uptime Institute's Tier 3 level with all the necessary environmental redundancies including critical areas of the building and the outside plant able to withstand 200+ mph winds or the strongest F3 tornado.

Our multi data center approach includes criteria for strategic placement of the critical applications' production processing as well as recovery, development and tape management environments. Each of our key data centers includes an Operational Command Center with 7x24 staff actively monitoring the components and systems.

If there was an event in one of the UnitedHealth Group data centers, staff located at the other data center would continue system operations. UnitedHealth Group has a dedicated data center facility management team that monitors, proactively maintains and manages all aspects of these data centers.

UnitedHealth Group IT provides application hosting services, for UnitedHealth Group business applications, in a completely redundant (power, firewalls, IPS/IDS, routers, switches, data lines, cables, etc.) internally managed data center. This environment was designed to eliminate single points of failure. In addition, UnitedHealth Group's production environment supports load balancing.

UnitedHealth Group's WAN is comprised of a diverse dual carrier MPLS network that provides redundant connectivity between the remote sites and the Data Centers. OSPF and BGP are used to detect path failure and restoration of services. Tuning and provisioning of the data paths, allows full failover to the alternate carrier in the event of a carrier outage and/or a circuit failure.

The remote sites use dual core backbone switches with redundant uplinks from the user connected work group switches. Dual routers with session load balancing and use of HSRP in the event of a failure are employed. Tier 0 servers at the remote locations are typically dual connected between the redundant core switches with HA functionality.

UnitedHealth Group uses dual DWDM fiber rings between their Data Centers that provides full redundancy and diverse media paths. All Tier 0 services are connected via HA and all media and switching capabilities are redundant in nature. HSRP is employed throughout the Data Center LANs.

Internet access at the Data Centers is via dual carriers in a fully redundant design. VPN, B2B, and other access are fully redundant by carrier diversity.

IP services provide DNS functionality with multiple deployed DNS servers. These servers provide zone transfers of IP data between devices and will fail over in the event of a server failure.

c. **System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system;**

UnitedHealth Group utilizes IBM's Tivoli Storage Manager (TSM) to manage its operational backups and employs a policy to maintain two copies of operational data at its secured technology centers.

A virtual tape library system is maintained at the primary data center that emulates physical tape and stores data on hard drives for the purpose of daily operational recovery in case of data corruption or accidental deletion. The data is then electronically transmitted to another disk based array or physical tape library located in UnitedHealth Group's geographically dispersed data center(s).

UnitedHealth Group maintains sole custody of the data at all times by transmitting over its secured channels.

d. **System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability;**

UnitedHealth Group's IT is a Healthcare technology leader in providing computer processing services delivered through UnitedHealth Group IT's portfolio of services with world-class efficiency and effectiveness. Our data centers and technology are self-managed and UnitedHealth Group IT has instituted a formal IT Infrastructure Library (ITIL) based service delivery model.

We maintain a 99.98% system uptime through the strength of our IT infrastructure, process and plans. Completely avoiding a technology outage is impossible. When incidents occur, they are managed though UnitedHealth Groups Incident Management program, that engages our Operations Command Center and the appropriate technical experts to restore technology quickly and minimize business disruption.

Scenario-Specific Technology Recovery Protocols

a. **The central computer installation and resident software are destroyed or damaged;**

This situation would immediately trigger mobilization of both the Event Management Team and the Technology Event Management Team. After a formal Disaster Declaration, the Enterprise Disaster Recovery team would lead the recovery as noted below, using our existing Disaster Recovery plans identify the application owners and responsible leadership that need to be engaged in a DR response.

b. **System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;**
c. **System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system;**
d. **System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability;**

These three scenarios, would be managed though UnitedHealth Group's Incident Management function. Our United Command Center will engage with UnitedHealth Group's Network Command Center in conjunction with Network Security, Information Risk Management, and/or UnitedHealth Group's Security Incident Response Team to provide oversight in the handling of all technology-related incidents across the enterprise.

Incidents are identified in one of three ways:

- A client identifies an Incident while using a system or application. Clients report the Incidents they identify by either by calling the United Support Center or by completing an on-line web form. Clients may also contact the United Support Center to request service not related to an Incident. For example, a client may need a password reset, procedural information, or have an issue with service. Both Incidents and other requests are logged by the United Support Center in an Incident record.
- IT Support Personnel (aka "Specialists) identify an Incident during the course of their daily activities. When an Incident is identified by a Specialist, it is also logged in an Incident record. However, Incidents logged by Specialists do not have an associated client, because the issue may or may not be limited to a single client, and/or the client(s) impacted may not be known.
- Finally, some Incidents are identified automatically via monitoring tools (e.g. HPOVO). If the necessary integration has been implemented, HP Service Manager Incident records are automatically created.

However it is identified, when an Incident occurs, critical information must be captured about the Incident and logged in an Incident record.

More information on UnitedHealth Group IT's Incident Management Process can be found in the accompanying document called, "UnitedHealth Group – Incident Management - Incident Management Process and Policy".

Scenario-Specific Technology Alternate Operating Plans

Business critical applications, as defined by the business continuity planning process, are given the highest priority and generally have a 72 hour or less recovery time objective (e.g., Mainframe DR Recovery Time Objective (RTO) is 8 hours; Recovery Point Objective (RPO), which reflects possible data loss is near zero hours).

Specifically, for core clinical and claim systems used for the State of Louisiana, we have the following DR RTO/DR RPO:

CareOne - RTO 72 Hours, RPO 48 hours

COSMOS - RTO 8 Hours, RPO 48 hours

a. **The central computer installation and resident software are destroyed or damaged;**

   In this situation, the Event Management Team would mobilize quickly to get the current situation update and then issue a Disaster Declaration. At that point, the DR plan would begin to be implemented to recover operations in alternate data centers.

   While our UnitedHealth Group IT department is restoring the technology infrastructure and critical applications, the business would be using their BC plan to minimize the disruption to operations while the restoration is occurring.

b. **System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;**

   In this situation, the Event Management Team would mobilize quickly to get the current situation update and we would use UnitedHealth Group's Incident Management program to manage the issue to resolution.

   This would include identifying and correcting the issue that led to dropped transactions, identifying the last successful transaction and determining steps that need to be taken to restore the missed transactions, which may include working with the business to reenter them if they cannot be restored from the transaction logs.

   While our UnitedHealth Group IT department is restoring the technology infrastructure and critical applications, the business would be using their BC plan to minimize the disruption to operations while the restoration is occurring.

c. **System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system;**

In this situation, the Event Management Team would mobilize quickly to get the current situation update and we would use UnitedHealth Group's Incident Management program to manage the issue to resolution.

This would include identifying and correcting the issue that led to data integrity issue, identifying the recovery point for data restoration and determining steps that need to be taken to restore the missed data, which may include working with the business to reenter transaction if they cannot be restored from the mirrored database or transaction logs.

While our UnitedHealth Group IT department is restoring the technology infrastructure and critical applications, the business would be using their BC plan to minimize the disruption to operations while the restoration is occurring.

d. **System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability;**

In this situation, we would anticipate the Event Management Team would mobilize quickly to get the current situation update and we would use UnitedHealth Group's Incident Management program to manage the issue to resolution.

While our UnitedHealth Group IT department is restoring the technology infrastructure and critical applications, the business would be using their BC plan to minimize the disruption to operations while the restoration is occurring.

Transitioning to Normal Operations

Returning to normal operations may not be an exact replacement of lost facilities, equipment, or restorations of processes. The goal is to reestablish normal operations in the most efficient manner. This may mean a change in geographic location, business practice, or the technology used to meet the requirement, depending on the impact experienced.

Scenario-Specific Return to Normal Procedures

a. **The central computer installation and resident software are destroyed or damaged;**

In the case where we have had a catastrophic event that has disrupted our datacenters, the Event Management Team and IT executives will determine what additional activities are

needed once the event response has stabilized and operations have been returned to near-normal levels.

At that point the decision would need to be made as to the best option for returning to normal. As our production and recovery environments are equal, we have multiple options, including failing back using the same DR plans and procedures, or rebuilding the datacenter as a new failover site. This decision would be made at time of event based on impact experienced.

b. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;

UnitedHealth Group's Incident Management program has standard procedures for incident notification, resolution and closure that would be used. Once the problem has been address and the transactions restored, we would be at normal business operations.

c. System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system;

UnitedHealth Group's Incident Management program has standard procedures for incident notification, resolution and closure that would be used. Once the problem has been addressed and the data restored, we would be at normal business operations.

d. System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability;

UnitedHealth Group's Incident Management program has standard procedures for incident notification, resolution and closure that would be used. Once the problem has been addressed we would be at normal business operations.

Claim Pre-Processing and Member Verifications

UnitedHealthcare Community Plan performs claims pre-processing for Bayou Health members including member and provider verification, and member authorization matching for services that require authorizations. Claims Operations is located in Wisconsin and would not be impacted by an emergency event affecting the State of Louisiana. Claims Operations will make changes to processing based on the exceptions and exemptions as determined and directed by DHH at time of event. Based on the impact of the event and DHH direction, processes could be amended to waive authorizations, and/or pay out-of-state providers. Claims Operations has emergency procedures as part of their Business Continuity Plan, for adjusting to changes in the

business that are affected by emergencies. The systems used for pre-processing Louisiana claims has a disaster recovery plan. The standard automated procedure for sending pre-processed claims to Molina will continue in an event.

Communications with DHH if Internet and Phones are down

UnitedHealthcare Community Plan will assign a designated representative(s) to participate in the DHH command center onsite, if requested by DHH. Otherwise, the UnitedHealthcare Community Plan Leadership team will utilize alternate communications tools such as texting, email, conference call lines, and couriers to communicate with DHH depending on the emergency situation.

DHH Mandatory and Ad hoc Reporting Requirements

With the Business Continuity Plan implemented, UnitedHealthcare Community Plan will be able to accumulate typical data for member outreach, and evacuations for members with special needs, and report the information to DHH. UnitedHealthcare Community Plan will rely on DHH to provide adhoc reporting requirements.

Plan Distribution, Training, and Exercises

Distribution

All members of the BC/DR plan recovery team must maintain a copy of the recovery plan in a secured location for use during a disaster.

BC/DR plans are stored in the following locations:

- Living Disaster Recovery Planning System (LDRPS)
- Secured Segment BCP SharePoint Site
- Secured Share Drive
- Electronic and Paper Copies.

Training

A variety of training methods are utilized throughout the process for employees:

- Business Continuity Emergency Management CBT. A computer based training course is utilized to provide employees with the necessary information for addressing emergencies which may occur at this site location. When the auditors are on site, we would be happy to show them the course and discuss content.

- Business Continuity Plan Development CBT. A computer based training course is utilized to provide all business continuity team members with the knowledge and tools necessary to develop and maintain a successful business continuity plan. When the auditors are on site, we would be happy to show them the course and discuss content.
- Structured Plan Walk Through. Annually, recovery team members participate in a walk through exercise of their business continuity and disaster recovery plans. The objective is to train/refresh team members on their roles and responsibilities, refresh awareness of plan documentation and recovery steps, and prepare the team for the annual business continuity or disaster recovery plan exercise.
- Business Continuity Annual Exercise. The annual business continuity exercise objectives are to reinforce and enhance the competence of the business continuity planners/recovery team members to ensure recovery team members are familiar with the business continuity plan content, understand their roles and responsibilities during an event, and are better prepared to respond effectively to business disruptions. This exercise is an opportunity for plan owners and recovery team members to ensure recovery strategies identified in the BC Plan are validated, and are sufficient to meet the Recovery Time Objectives required for the business.
- Disaster Recovery Annual Exercise. Disaster recovery plans are exercised utilizing a variety of methods that include tabletop and functional exercises. The team members demonstrate familiarity with plan content along with their abilities to recovery applications. Infrastructure, policies and procedures are validated to ensure they can support a successful recovery.

Additionally, a variety of forums exists for knowledge sharing including bi-weekly business continuity and disaster recovery lead meetings, annual on-site summits and quarterly business meetings with their plan owners and executive sponsors.

Exercises

The business continuity plans are tested annually through a variety of test techniques including tabletop (practical or simulated exercise), structured walk-through (functional), large or full-scale (live or real-life exercise) and emergency response. Exercise dates vary by plan and span the entire calendar year. A formal test exercise report, identifying any gaps, issues and/or enhancements identified through testing, is published and monitored for remediation. When the remediation is complete, the business continuity plan is certified by the appropriate Executive Leadership. This certification process must occur annually and is monitored by the Program Steering Committee.

Business continuity exercise participants will vary depending on the nature of the exercise. At a minimum, as part of the annual exercise for BC plans, participants include business leadership

who are identified as recovery team members in the BC plan, business segment observers; and both facilitators and observers from the Enterprise Resiliency & Response Office.

For functional exercises, the business participants will vary depending on the recovery strategy being tested, and exercises are designed in such a way to minimize impact on business operations. Each year our businesses determine which of their operations will conduct functional exercises to validate that they can move to alternate locations, use cross-trained staff and implement manual workarounds for applications.

BC exercises are not rated as pass/fail: the walkthrough and tabletop scenario are used to exercise and stretch the recovery teams, the Call Tree Exercise is done until the business can successfully convene 100% of their recovery team in 30 minutes, and the functional exercises (done for a subset of BC plans) have success criteria defined in advance to scope the exercise, however unexpected outcomes are as valuable as expected ones in terms of learning's and plan updates.

Other

Registry of Healthcare Provider Volunteers

On an annual basis as part of UnitedHealthcare Community Plan's normal outreach efforts, our Provider Advocates will discuss volunteering with our PCP network, encouraging them to consider participating in this valuable program. Providers who agree to volunteer will be directed to register on the DHH Louisiana Volunteers in Action Emergency Volunteer Registry website for Physicians at

http://www.getagameplan.org/

This will ensure that the State retains control of the registry, and has the most current provider information, including contact numbers. Any volunteer information that UnitedHealthcare Community Plan receives at time of event will be given to DHH Emergency Management team members.

Electronic Health Records (EHR) for Provider Access to Member Health History

The State of Louisiana has not yet implemented an Electronic Health Record (EHR) system for their Medicaid programs. However, when appropriate UnitedHealthcare Community Plan will be able to provide member claims history to providers and hospitals during the disaster, and ensure that all services rendered during evacuation are tracked in the claims system.

In addition, in cases where UnitedHealthcare Community Plan is providing care management services for moderate or chronic health conditions, we will ensure that our clinicians continue to provide quality care for evacuated members, and update our clinical records directly. UnitedHealth Group's electronic health records will not be impacted by a disaster that occurs in Louisiana.

Coordination with Other Entities

UnitedHealth Group's locally-based Market Medical Directors have established relationships with local health care providers, local medical societies, state medical licensure boards and state and local health departments. Our medical directors work in collaboration with public health agencies to help ensure access to care in the event of a public health emergency. Relationships are also well-established with regulators and other government agencies, our customers, members and local community groups. Our medical directors work in collaboration with public health agencies and non-governmental organizations, such as the American Red Cross, to help ensure access to care for our members in the event of a disaster.

SECTION IV – PUBLIC HEALTH EMERGENCY PLANNING

Public Health Emergency Objectives

As a health and well-being company, we believe it is critical to plan for the impact of a public health emergency, including pandemics, on our customers, members, providers and our own operations. Pandemics can spread very quickly, and companies need to be vigilant and prepared. Where a pandemic involves a virulent strain, we may experience a surge in the need for our services, but may simultaneously see a reduction in our ability to provide these services. Therefore, pre-planning is critical to address any adverse impact to our services and systems from anticipated demands. Understanding what we need to address in advance, and being prepared to readily implement these actions will help sustain our operations and minimize impact to our customers during a pandemic or other public health emergency.

UnitedHealth Group plans for such public health emergencies within the Enterprise Resiliency & Response Program to ensure the availability of critical services for our customers and members. Individual business continuity plans require planning for a loss of 50% of personnel, loss of facilities, critical vendors and loss of or disruption to our technology. The event management plan provides the command and control structure to ensure effective monitoring, communication and decision making during the emergency. Information technology disaster recovery plans are in place to manage any impact to technology infrastructure and applications that could negatively affect our ability to serve customers, physicians, members, and others. As a national company with vast local resources, we have geographically dispersed computing, customer service

facilities and health care networks that can support and supplement the work of compromised localities.

During a pandemic, health services access will likely be altered from the services that are provided now. For example, demand for elective medical and surgical procedures will probably decrease; demand for acute care services in emergency departments and hospitals will likely increase. Public health officials will have the responsibility of triaging and prioritizing where, when and how health services will be provided.

We will work in collaboration with local and state health department officials to disseminate information on the availability of health services and will adhere to the public health direction on prioritization efforts for the provision of such services. We will use our communication vehicles, including print and electronic media, to make information on provisions and availability of services widely accessible to our members, as well as members of the broader community where we operate.

We are committed to providing our customers, physicians who contract with us, members and others with timely clinical information. We will work to ensure that benefit designs and their interpretation will facilitate socially and medically appropriate access to clinical care, medical supplies, vaccines and pharmaceuticals. For example, we will assure that quantity limits for antiviral medications used to prevent and treat influenza are consistent with recommendations of the Centers for Disease Control and Prevention (CDC).

Clinical Resources Available in a Public Health Emergency

With over 16,000 physicians, nurses, and clinical practitioners directly on our staff, we have the national and local resources to respond quickly and effectively during a public health crisis. The event management team serves as the vehicle to provide our customers with timely clinical information based upon CDC guidance, expert health professionals' input, and our real-time experience in serving more than 77 million people across the nation. This team is also responsible for reviewing and providing any information that is relevant to changes in UnitedHealth Group policies and procedures that may affect customers, members and clinical partners.

We can support federal, state, and local health department disease surveillance activities to identify and track disease outbreaks through data on emergency room usage, visits to physicians for a particular illness, and the filling of prescriptions.

It can be expected that health services access will be altered in a public health crisis or pandemic from the services that are provided now. Public health officials will have the responsibility of triaging and prioritizing where, when and how health services will be provided. Epidemiologically-based decisions will be made to provide critical services in appropriate places.

For example:

- Hospital care will probably be limited to those who are most critically ill from the pandemic and from other conditions. Services to those who are immunocompromised will not be provided in the same facilities as services for those who are critically ill with infection from a pandemic virus.

- Emergency medical services will be triaged by public health officials. We will work in collaboration with these agencies to ensure that our members, as well as all persons in the community, have access to appropriate health services. Non-pandemic-related medical care that is now delivered in the emergency room likely will be delivered in other settings.

Public Health Event Management Approach

UnitedHealth Group has established procedures for handling emergency management situations including: initial assessment of the severity of the situation; prioritization of actions needed to resolve the immediate care needs of our members; development of an action plan, which includes assigning resources for implementation; implementation of action plan, including continuous monitoring; documenting successful interventions; and validation of successful intervention.

Our Event Management Team monitors for impending disasters such as those caused by hurricanes and flooding and proactively mobilizes the appropriate planning and response resources to address the needs of our business, members and providers.

The Public Health Event Management Team assesses the risk and engages both enterprise-level executives and local health plan leadership to mobilize a complete response. Leaders engaged in the response may include health plan CEO's, Medical Directors, Provider Services, Member Services, Communication Specialists, Compliance Officers, and others as appropriate. The Public Health Event Management Team convenes to discuss the current situation and defines actions to be taken, resources to be deployed, and specific timeframes and touch points for monitoring to ensure continuous communication and care continuity for members and providers.

Each disaster is unique and our response is customized based on need and based on the services UnitedHealthcare provides to members in the impacted area. The following activities may be included as part of our overall efforts:

Medical benefits may be temporarily modified to assist members preparing for, or responding to, the disaster in order to ease access to healthcare.

The Optum Crisis Counseling line may be made available to a multi-state region as a whole to provide mental health support to those who may need it. These services are free of charge and open to both members and the community (region) at large who are impacted by the event.

Our local clinical directors collaborate to identify members currently hospitalized or at long-term care facilities, evaluate the provider capacity within the geographic area, and where appropriate, identify reassignments and communicate this information to members and providers.

Our Medical Directors review case management and disease management files to identify members at most risk due to disease severity or fragility. These members are a priority to contact to arrange for care continuity and determine if they need evacuation assistance.

UnitedHealthcare's employees and local leaders often participate in community recovery and rebuilding efforts as part of our social responsibility efforts to support the communities in which we work.

Our compliance team proactively searches for any regulatory orders related to the event, such as state-level Executive Orders, Department of Insurance Orders or federal-level HHS or CMS orders, to ensure we are addressing all regulatory requirements.

SECTION V – CONCLUSION

In support of UnitedHealth Group's mission to help people live healthier lives, we are committed to providing vital services to our members and community during times of calm as well as crisis. The Enterprise Resiliency & Response program, with the interrelated services of event management, site emergency planning, business continuity planning, disaster recovery planning, and public health emergency response, are designed to ensure we can react quickly to all forms as disasters, minimizing potential negative impacts to our operations and vital services.

If additional information is required regarding any component of this program, please direct questions to United Healthcare Community Louisiana leadership team.

SECTION VI – AUTHORITIES AND INTERNAL REFERENCES

AUTHORITIES

1) UnitedHealth Group policy directive UHG Information Security Policy 12.0 Business Continuity and Disaster Recovery Policy; and its related directives and guidance Enterprise Resiliency and Response Event Management Plan

INTERNAL REFERENCES

1) UnitedHealth Group Enterprise Resiliency and Response Event Management Plan
2) UnitedHealth Group Information Technology – Technology Event Management Plan

SECTION VII – FUNCTIONAL ANNEXES

Attachment 1 – UnitedHealthcare Community Plan Louisiana Storm Call Reporting Procedure
Attachment 2 – UnitedHealth Group Information Security/Privacy Incident Response Process Overview
Attachment 3 – UnitedHealth Group ITSM Incident Management Process and Policy
Attachment 4 – UnitedHealth Group IT High Priority Incident Management

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan of Louisiana, Inc.

Attachment #1
UnitedHealthcare Community Plan Louisiana
Storm Call Reporting Procedure

Louisiana Storm Call Reporting Procedure		
Step	**Task**	**Action**
1	Activate Outbound Dialer Support - Blast Dialer	One-to-two days before a Tropical Storm or Hurricane makes landfall, Community Plan Louisiana will send a request to UnitedHealth Group Outbound Dialer Support primary contact to have a Blast Voice Message sent to Level 1, 2 & 3 members. Steps to enable Outbound Dialer: 1. Send the primary contact a list of Level 1, 2 & 3 members including member ID, and member phone number in a Comma Separate Value (CVS) format. 2. Provide the voice message that will be directed to the members, and the callback number for Member Services. 3. Provide the Caller-ID Number and Alpha display for Community Plan Louisiana that will be displayed on the members' phones who are receiving the voice message.
2	Special Communications to Members and Providers	To do specialized messaging, which may be required for Members and Providers at time of event, through the Call Centers, IVR, and/or web portal, follow the documented procedure appended to the BCP entitled "C&S Health Plans – Procedure for Member and Provider event related messaging."
3	Healthy First Steps (HFS) & Neonatal Intensive Care Unit (NICU) Case Management – Tracking Member Inbound Calls	To meet State requirements for tracking member inbound storm-related calls, Community Plan Louisiana will notify HFS and NICU prior to the storm landfall that tracking will be required. HFS and NICU will: 1. Track inbound member calls on a daily basis from 8:00 a.m. until 3:00 p.m. and from 3:00 p.m. to 8:00 a.m. for each of the units supporting Community Plan Louisiana. 2. Provide a tally of all inbound calls from HFS and NICU members by Community Plan Louisiana region (Regions 1 – 9). 3. No later than 3:00 p.m. and no later than 8:00 a.m. - Send tally report of all inbound calls to Community Plan Louisiana, to the Louisiana Group Email Address twice daily. 4. Continue tracking and reporting HFS & NICU Case Management member inbound calls until notified by Community Plan Louisiana to stop monitoring member inbound storm-related calls.

4	Transplant Care Solutions Care Management – Tracking Member Inbound Calls	Community Plan Louisiana will also notify Transplant Care Solutions to track member inbound storm-related calls. Transplant Care Solutions will: 1. Track inbound member calls for each of the units supporting Community Plan Louisiana. 2. Provide a tally of inbound calls from Transplant Care Solutions members by Community Plan Louisiana region (Regions 1 – 9). 3. No later than 8:00 a.m. - Send a tally report of all inbound calls to Community Plan Louisiana, to the Louisiana Group Email Address daily. 4. Continue tracking and reporting Transplant Care Solutions member inbound calls until notified by Community Plan Louisiana to stop monitoring member inbound storm-related calls. 5. Reports will be provided once per day before 8:00 a.m. to Community Plan Louisiana.
5	Special Needs Case Management – Tracking Member Inbound Calls	Pre-Event – Special Needs Case Management will make proactive telephonic care calls to Level 3 members 8am-5pm M-F. Community Plan Louisiana will notify Special Needs Case Management when to begin tracking Level 3 member inbound storm-related calls. Special Needs Case Management will: 1. Track inbound member calls from 8:00 a.m. until 5:00 p.m. After hours, calls will rollover to NurseLine, and NurseLine will track member inbound storm-related calls. 2. Provide a tally of inbound calls from Special Needs Case Management members for Community Plan Louisiana by region (Regions 1 – 9). 3. No later than 8:00 a.m. - Send a tally report of all inbound calls to Community Plan Louisiana, to the Louisiana Group Email Address daily. 4. Continue tracking and reporting Special Needs Case Management member inbound calls until notified by Community Plan Louisiana to stop monitoring member inbound storm-related calls. 5. Reports will be provided once per day before 8:00 a.m. to Community Plan Louisiana.

6	Special Needs NurseLine – Tracking Member Inbound Calls	NurseLine is open 24x7. Community Plan Louisiana will notify the NurseLine when to track member inbound storm-related calls. Special Needs NurseLine staff will perform the following steps: 1. At time of event, a VCC pop-up will alert staff to begin the tracking of member inbound calls that are storm-related. This alert will be programmed into the system to start at the beginning of June and end at the end of storm season. 2. A communication will go out to all NurseLine staff when there is storm forecasted for the State of Louisiana. Community Plan Louisiana will be responsible for alerting the NurseLine primary contact of any impending storms with the potential to impact the State of Louisiana. 3. When NurseLine staff receives a call from a member that is related to the storm; the nurse will reference the Education Guideline "Emergency Preparedness" process to track those specific member inbound calls. 4. Reports will be provided once a day at 3:00 p.m. to Community Plan Louisiana.
7	Provider Services – Tracking Provider Inbound Calls	Community Plan Louisiana will notify Provider Services when to track provider inbound storm-related calls. Provider Services will: 1. Track inbound Provider calls from 8:00 a.m. until 3:00 p.m. and from 3:00 p.m. to 8:00 a.m. 2. Provide a tally of inbound provider calls for Community Plan Louisiana by region (Regions 1 – 9). 3. No later than 3:00 p.m. and no later than 8:00 a.m. - Send a tally report of all inbound provider calls to Community Plan Louisiana, to the Louisiana Group Email Address twice daily. 4. Continue tracking and reporting Provider Services incoming provider calls until notified by Community Plan Louisiana to end tracking.

8	Member Services – Tracking Member Inbound Calls	Community Plan Louisiana will notify Member Services when to track member inbound storm-related calls. Member Services will: 1. Track inbound member calls from 8:00 a.m. until 3:00 p.m. and from 3:00 p.m. to 8:00 a.m. 2. Provide a tally of inbound member calls to Community Plan Louisiana, by region (Regions 1 – 9). 3. No later than 3:00 p.m. and no later than 8:00 a.m. - Send a tally report of all inbound member calls to Community Plan Louisiana, to the Louisiana Group Email Address twice daily. 4. Continue tracking and reporting Member Services incoming member calls until notified by Community Plan Louisiana to end tracking.
9	Reporting Member Inbound Calls	Community Plan Louisiana to report Storm Calls to the State of Louisiana at 8:00 a.m. and 3:00 p.m. daily until the State of Louisiana directs the health plan to stop reporting inbound calls.
10	Post Event	Review the Storm Call Reporting Procedure, and document and remediate changes as needed.

UnitedHealthcare Community Plan of Louisiana, Inc.

Attachment #2
UnitedHealth Group
Information Security/Privacy
Incident Response Process Overview

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Information Security/Privacy Incident Response Process Overview – January 2013

UnitedHealth Group understands the responsibility it has to protect confidential and proprietary information and maintain availability and integrity of information systems and assets. This commitment is integral to the relationships we have with all of our customers and vendors alike.

UnitedHealth Group also understands the sensitivity and seriousness of an information breach, regardless of how it was affected. However, UnitedHealth Group also recognizes that not all reported breaches are actual, and that not all actual breaches are the result of an inappropriate or malicious intent. UnitedHealth Group's commitment is to ensure that reported breaches are appropriately managed and thoroughly investigated.

The core components of the Information Security/Privacy Incident Response program are defined below:

I. **UnitedHealth Group Information Risk Management Security Incident Response Team**
UnitedHealth Group has designated a Security Incident Response Team, to provide oversight in the handling of security and privacy related incidents across the enterprise. Each UnitedHealth Group business segment information security and privacy officer serves as members of the Security Incident Response Team. This Security Incident Response Team has the following responsibilities.

- Coordinating incident detection, analysis, containment, mitigation, recovery, and final reporting efforts to assure timely resolution of all security and privacy incidents upon identification.
- Coordinating any/all notification to required entities as an outcome of a security/privacy related incident.
- Participating in the activities and decisions across cross-functional workgroups in developing the Security/Privacy Incident Response requirements, conducting gap-analysis, recommending compliance action plans, reporting, and tracking security and privacy incident trends, and providing process improvement recommendations.

II. **Security and Privacy Incident Response Training and Resources**
All UnitedHealth Group employees are required to complete privacy and security training, which includes, reporting security and privacy related incidents to the appropriate parties. Training is offered through corporate Integrity and Compliance training (Privacy Overview and Information Security modules) and through the specific business area's training program. In addition, various resources, including the UnitedHealth Group Security Policy and Resource Knowledgebase (SPARK), are available to employees to provide guidance in proper protocol and intake points into the Security and Privacy Incident Response Process.

III. **Policies and Procedures**
UnitedHealth Group Computer Security and Privacy Incident Response operations are conducted under well-defined, formal policy, processes, and operating procedures. These policies and procedures are documented to provide for consistency across the organization and also serve as a reference tool for the employee. UnitedHealth Group IT Information

Risk Management and individual business areas provide training to all employees, as necessary and appropriate for the employees to identify security incidents and notify the appropriate parties in a confidential manner. The policy and procedure documents address the following areas:

- Purpose, Scope, and Authority
- Incident definitions
- Incident Types
- Incident response roles and responsibilities
- Notification Channels
- Escalation and Categorization Criteria
- Incident Handling Procedures
- Points of Contact

Reporting and Archival
The UnitedHealth Group Computer Security and Privacy Incident Response Team maintains a repository of security and privacy related incidents as the method of tracking response action data. This provides reporting of identified trends within the information technology environment to key stakeholders and constituents, reducing the risk of repeat occurrences with timely response by leveraging historical remediation data.

Access Control and Secure Transmission
Following UnitedHealth Group's Risk Management approach to security implementation, numerous policies, procedures, and technical controls have been selected to manage access to systems and information. Information security and privacy incident responders are required to connect to UHG systems via secure remote access technologies, ensuring all data is encrypted and not susceptible to interception. Secure Transmission Standards have also been selected and corresponding controls have been implemented to ensure the confidentiality, integrity and availability of electronic PHI transmitted via public networks. Controls utilize appropriate encryption and authentication or equivalent means to protect the transmitted information. Role-based access to security systems has been implemented to assure data has been handled by users possessing the appropriate authority.

Incident Response

Due to the proliferation of the Internet and technology in recent years, new types of incidents have emerged and the definition has expanded. The following definitions have been adopted to identify security incidents within the scope of the UnitedHealth Group Computer Security and Privacy Incident Response process.

Incident Definitions

Privacy Related Incidents

Privacy Incident
As defined by the Gramm-Leach-Bliley Act and/or federal, state and local laws, PHI (Protected Health Information) is used or disclosed in a manner, which causes a breach of confidentiality, by UnitedHealth Group and/or state and local laws. Specific definitions include, but are not limited to, Nonpublic Personal Information and/or Nonpublic personal financial information.

Confidential/Proprietary Incident
Confidential or proprietary information is used or disclosed in a manner, which causes a breach of confidentiality to or by UnitedHealth Group.

Security Incident
Violation of UnitedHealth Group information security policies and/or federal, state and local laws related to information security through unauthorized access, inappropriate usage or malicious code. Certain security incidents may be further classified as HIPAA security incidents.

HIPAA Security Incident
Successful or concerted attempt to misuse, damage, or destroy electronically stored PHI (Protected Health Information) through unauthorized access, inappropriate usage or malicious code. For the purposes of this definition, "concerted attempt" is an attempt that, in the judgment of UnitedHealth Group information security personnel, is a human driven, focused, intelligent, concerted effort to misuse, damage or destroy electronically stored PHI through unauthorized access, inappropriate usage or malicious code.

Security Incident Types

The following security incident types are identified to assist in classification and prioritization of security incidents, which facilitate the incident response process and establish efficiency:

Denial of Service (DoS)
An attack that prevents or impairs the usage of a network, system, or application by exhausting system processor, memory, disk space and/or bandwidth.

Malicious Code
A program that is stealthily inserted into another program with the intent to destroy data, execute intrusive programs or otherwise compromise the confidentiality, integrity, or availability of a victim's data or system.

Unauthorized Access
A person gaining access to a resource that they were not intended to have. This can occur through application vulnerabilities, passwords/cracking, improper configurations, and social engineering.

Inappropriate Usage
The violation of UnitedHealth Group acceptable use policies.

Multiple Component
One security incident that is comprised of two or more other incidents. This can encompass Data loss/disclosure due to loss of physical assets, blended network attacks, and internal threat in relationship to information assets.

UnitedHealth Group Information Security/Privacy Incident Response Program is designed to ensure that accurate and authentic information is available when and where needed, to respond to information risks in a timely manner. It is designed to be detailed enough to guide UnitedHealth Group through incident response measures, but general enough to encompass all forms of security and privacy incidents.

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UnitedHealth Group continues to strive and improve on policies, processes and technology, ensuring appropriate general computing controls are in place to support UnitedHealth Group customers and regulatory requirements.

UnitedHealthcare Community Plan of Louisiana, Inc.

Attachment #3
UnitedHealth Group ITSM
Incident Management Process and Policy

Contains Confidential Commercial/Financial and Other Protected Information
Exempt from State or Federal Law or Regulation, including the Freedom of Information Act (FOIA), 5 U.S.C. §552.

Information Technology Service Management
Incident Management Process and Policy

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Table of Contents

1. Revision History

Date	Version	Description	Author
8/27/10	1.0	Initial Draft	C. Dysthe

2. Introduction

This document defines, at a high level, UHG's Incident Management Process and business principles.

2.1 Key Terminology

2.1.1 Incident

"An Incident is any event which is not part of the standard operation of a service and which causes, or may cause, an interruption to, or degradation in, the quality of that service."

Examples of Incidents include:

- Unable to print to default printer
- Entire application or service not available
- Part of an application or service not available
- Degradation in response time, reported by a user or as identified by an automated alert
- Hardware down
- Automatic alert indicating a potential disruption to service

2.1.2 Work Around

A work around is a method to reduce or eliminate the impact of an Incident or Problem for which a full resolution is not yet available."

For example, a Client reports the following Incident: "I am unable to print anything to my default network printer".

The Client is given instructions to re-route to a different network printer, which allows the Client to print his document. The action of re-routing the Client to a different network printer is a "work around" for the reported Incident.

2.1.3 Solution

A solution is a permanent method of removing the impact of an Incident. The solution is the "final fix" to the Incident.

In the above example ("I am unable to print anything to my default network printer"), upon further investigation, it is determined that the network printer had a hardware failure. The hardware is replaced. The Client can once again print to the network printer.

2.1.4 Problem

"A problem is an unknown underlying cause of one or more Incidents."

Using the above network printer example, while the user was provided with a work around to enable him to print, the underlying cause for the printing disruption has not been identified. This unknown cause is considered a Problem.

2.1.5 Service Request

A Service Request is a user request for new or additional service or for information in general.

Examples of Service Requests include:

- Request for training

- Request for new hardware or software
- Request for relocation of equipment
- Request for configuration changes
- Request for new reports
- Request for new or modified security access
- Request for application / infrastructure enhancements
- Client calls related to service disruptions during planned outages.
- Request for a password reset

2.2 The Goal of Incident Management

ITIL defines the primary goal of the Incident Management process as follows "*To restore normal service operation as quickly as possible and minimize the adverse impact on business operations, thus ensuring that the best possible levels of service quality and availability are maintained.*"

2.3 The Relationship between Incident and Problem Management

The Incident Management Process is reactive. For any given Incident, the Incident Management Process is focused on restoring service and minimizing the impact the Incident has on the business within established service targets. In other words, it is concerned with providing either a work around or solution to an Incident as quickly and effectively as possible. It is not concerned with understanding or removing the underlying cause of the Incident or ensuring the Incident does not reoccur.

3. Roles and Responsibilities

Role	Definition
Client	a. Detects an Incident b. Reports the Incident to the United Support Center c. Provides detail about affected components, systems and/or applications, symptoms, impact
Service Desk Analyst	a. Creates Incident records for Incidents reported by clients b. Looks for active Primary Incidents or Changes related to the new Incident c. Uses Knowledge to identify work arounds and solutions d. Restores and closes Incident records when possible e. Assigns Incidents to appropriate Workgroups when restoration at the USC is not possible f. Engages an Incident Manager for new Priority 1 and 2 Incidents
Support Specialist (Level 2/3 Support)	For Priority 1 and 2 Incidents: a. Contacts the USC Incident Management Team when a new Priority 1 or 2 Incident is identified b. Attends War Room activities as requested c. Completes restoration activities as assigned d. Communicates status of assigned activities to the UCC Incident Manager For Priority 3 and 4 Incidents: e. Investigates assigned Incidents f. Creates an Incident record for Incidents that are not reported by a client. Clients reporting Incidents should be referred to the USC or the USC Self Service Portal g. Keeps assigned Incident records up-to-date with current information h. Keeps the client informed of Incident status, and documents all client interactions in the Incident record i. Optionally, opens and manages Primary Incident records for Low Priority Incidents. j. Confirms Incident restoration with the client k. Utilizes the Change Management Process as necessary to implement work arounds and solutions l. Closes the Incident when a solution has been implemented m. As appropriate, opens a Problem record when further root cause analysis is required

Role	Definition
United Command Center Incident Manager	For Priority 1 and 2 Incidents: a. Validates the Priority of the Incident b. Creates and manages the Primary Incident record throughout the life of the Incident c. Facilitates the War Room (as needed) d. Identifies and engages appropriate resources e. Gathers and documents Service Availability data f. Creates a Problem record in response to all Priority 1 Incidents, and for some Priority 2 Incidents (those caused by a Change, impacting a key service or as requested) g. Creates an Incident Change record if a Change is needed to restore a High Priority Incident h. Closes the Incident Record
Workgroup Owner	a. Maintains the Workgroup record: membership, classification codes, description b. Monitors active Incidents assigned to the Workgroup c. Serves as the escalation point for service issues associated with the items assigned to the Workgroup

4. Incident Management Policies

These policies provide strategic guidance for the Incident Management process. They serve as a central frame of reference for process decisions and are approved by senior leadership.

4.1 Protected and personal information should not be stored within the HP Service Manager (HPSM) application.

This includes, but is not limited to, information such as members' Social Security numbers, claims information, and passwords. Storing such items within the HPSM is not consistent with UnitedHealth Group's Security Policies or the intent of this application. To adhere to company policy:

4.1.1 Protected and personal information should only be requested if it is required to perform the support being provided. Only request the minimum necessary information to address the situation.

4.1.2 When such information is required, it should be recorded only in the "Confidential" field on the Incident Details tab of the Incident record.

4.1.3 The contents of the "Confidential" field will be deleted automatically upon closure of the Incident.

4.1.4 It is against company policy, and may be a violation of various federal and state laws, to inappropriately use, disclose, store, or sell protected and personal information that was obtained for purposes of supporting HPSM inquiries. IT Service Management will conduct a regular audit to measure compliance. Violations are subject to disciplinary actions up to and including dismissal.

Any questions concerning this process should be directed to IT Service Management at UHG Problem Management@uhc.com. Questions about UnitedHealth Group's Security Policies should be directed to SPARK.

4.2 Anyone can report an Incident to the United Support Center (USC).

There are no restrictions as to who can report an Incident to the United Support Center.

4.3 Authority to log an Incident on behalf of a Client is restricted to Service Desk Analysts.

Incidents detected by Clients will be logged by the Client either through the USC Self Service Portal or by contacting the United Support Center.

4.4 Authority to set the Priority of an Incident to Priority 1 or 2 and to downgrade the Priority of an Incident from Priority 1 or 2 is restricted to the Incident Manager

Restricting the authority to confirm or downgrade from High Priority is necessary to ensure consistent Priority assessment across the organization.

4.5 Reassignments from one workgroup to another should be at the workgroup level.

4.5.1 The assignment of an Incident to an Individual is allowed if the receiving Individual verbally approves the assignment.

4.6 All actions taken to restore an Incident will be documented in the Incident record.

Accurate and up-to-date documentation of all actions taken regarding the investigation, diagnosis, restoration, and closure of an Incident is necessary to:

- Allow all teams and individuals working on the Incident to understand actions that have already taken place, thereby streamlining the restoration process.
- Provide a history of the actions taken to facilitate the restoration of like Incidents that may occur in the future.
- Enable quality improvement initiatives related to the Incident Management process.

4.7 Closed Incident records cannot be re-opened.

If it is determined that an Incident in a "Closed" status has reoccurred, a new Incident record should be created. The ID number of the "Closed" Incident should be referenced in the new Incident record.

4.8 Incident assignments cannot be rejected.

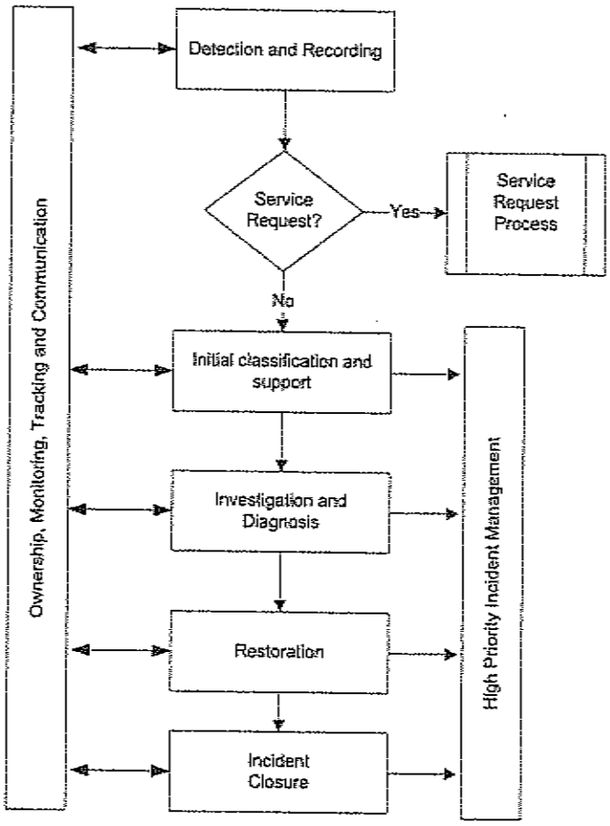
If an Incident is assigned incorrectly, it is the responsibility of the receiving Workgroup to determine the appropriate assignment group. If the Workgroup is unable to determine the appropriate assignment, the United Support Center should be contacted for assistance.

4.9 Problem Records will be opened for all Priority 1 Incidents, and for some Priority 2 Incidents.

A Problem record will be opened by the United Command Center Incident Manager for all Priority 1 Incidents and for Priority 2 Incidents caused by a change or impacting a key service.

5. Incident Management Process Flow

5.1 Process Model



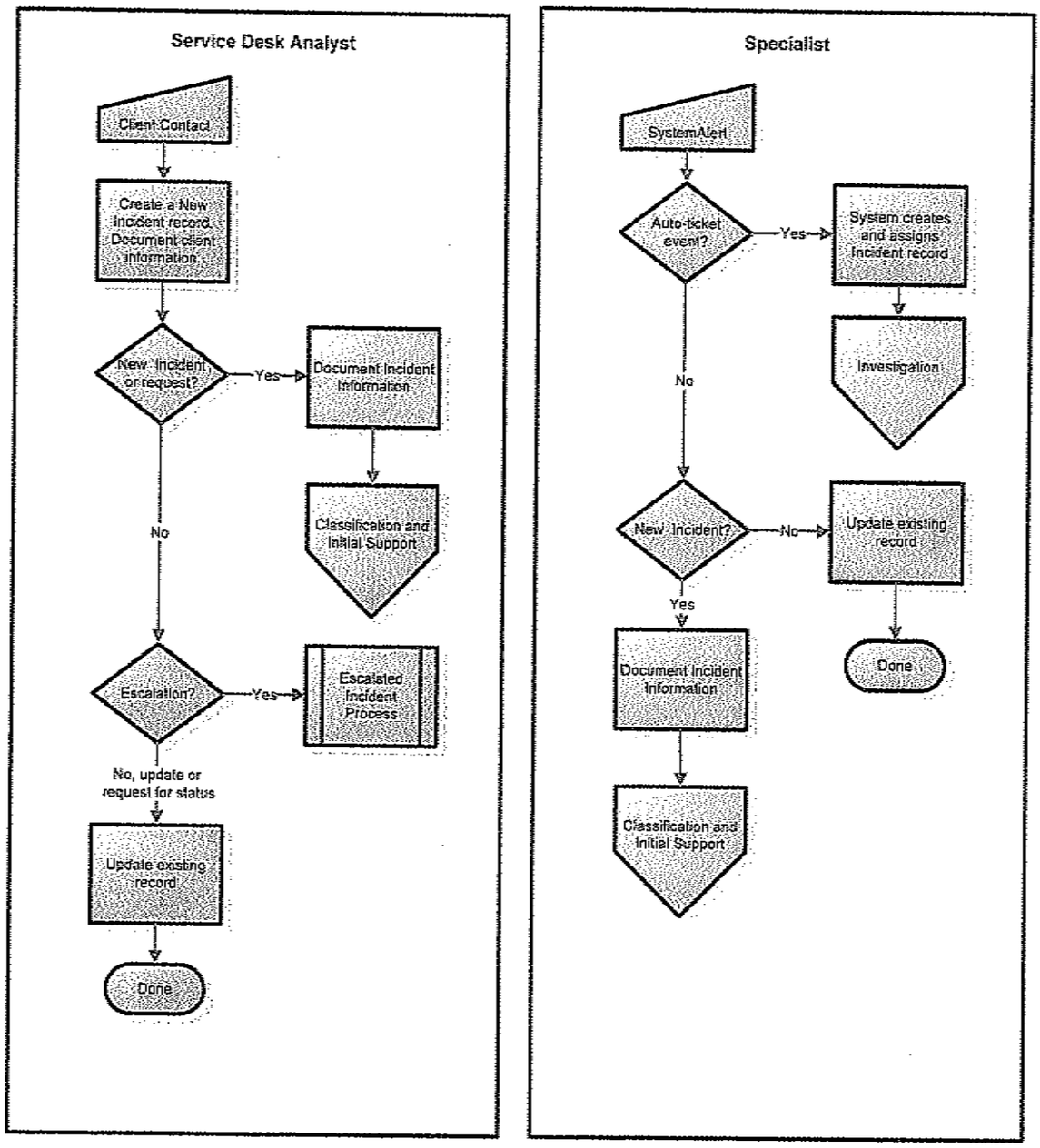
5.2 Detection and Recording

Incidents are identified in one of three ways:

1. A client identifies an Incident while using a system or application. Clients report the Incidents they identify by either by calling the United Support Center or by completing an on-line web form. Clients may also contact the United Support Center to request service not related to an Incident. For example, a client may need a password reset, procedural information, or have an issue with service. Both Incidents and other requests are logged by the United Support Center in an Incident record.
2. IT Support Personnel (aka "Specialists) identify an Incident during the course of their daily activities. When an Incident is identified by a Specialist, it is also logged in an Incident record. However, Incidents logged by Specialists do not have an associated client, because the issue may or may not be limited to a single client, and/or the client(s) impacted may not be known.
3. Finally, some Incidents are identified automatically via monitoring tools (e.g. HPOVO). If the necessary integration has been implemented, HP Service Manager Incident records are automatically created.

However it is identified, when an Incident occurs, critical information must be captured about the Incident and logged in an Incident record.

Incident Detection and Recording



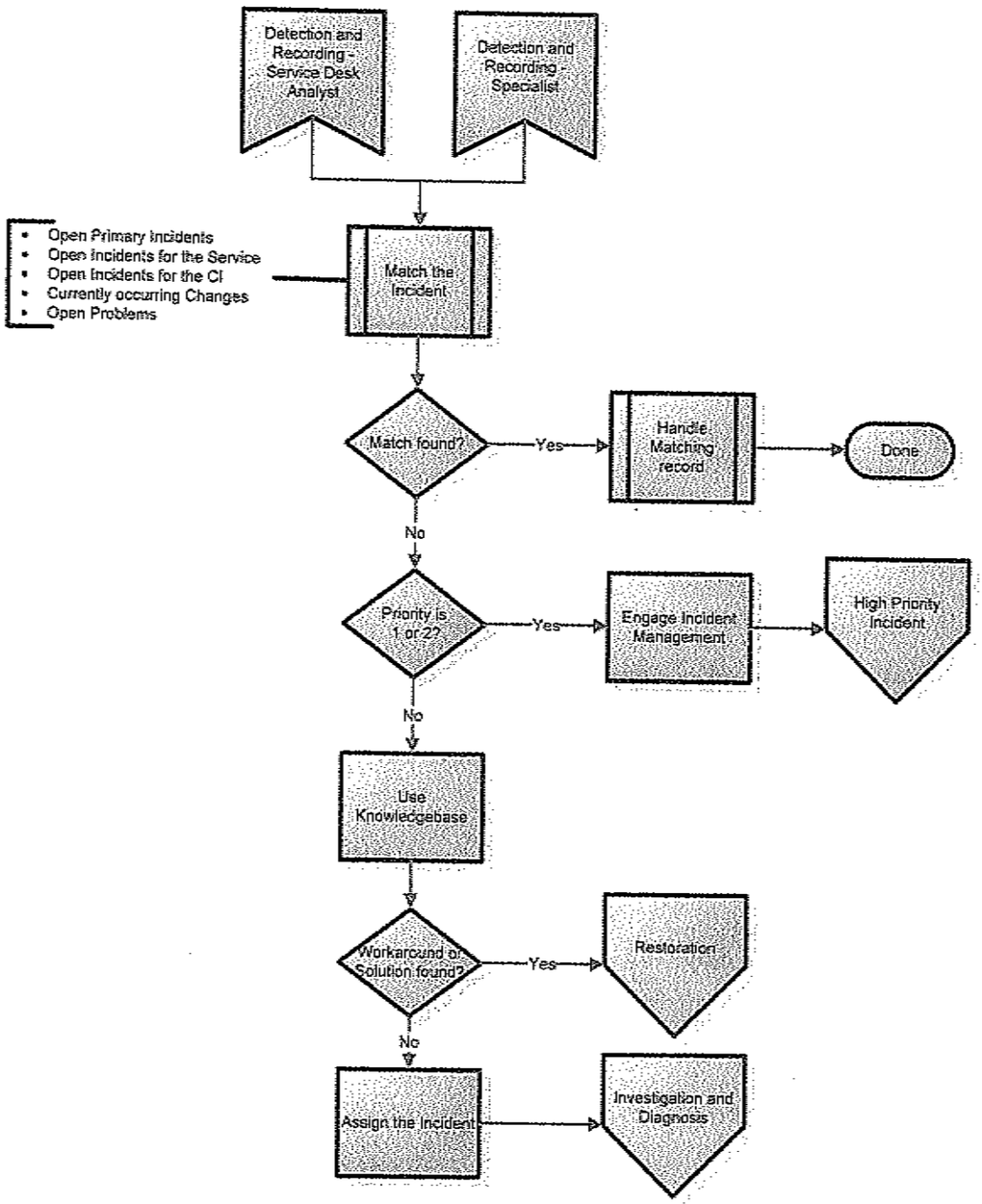
5.3 Classification and Initial Support

After the basic information about the Incident has been documented, the process of looking for work arounds or solutions begins.

The first step of this process it to look for other records to which the Incident may be related. If no related records are found, the department's expertise / knowledge bases are used to attempt to identify a work around or solution.

If a work around or solution can't be identified, the Incident is reassigned for further investigation.

Incident Classification and Initial Support



5.4 Investigation and Diagnosis

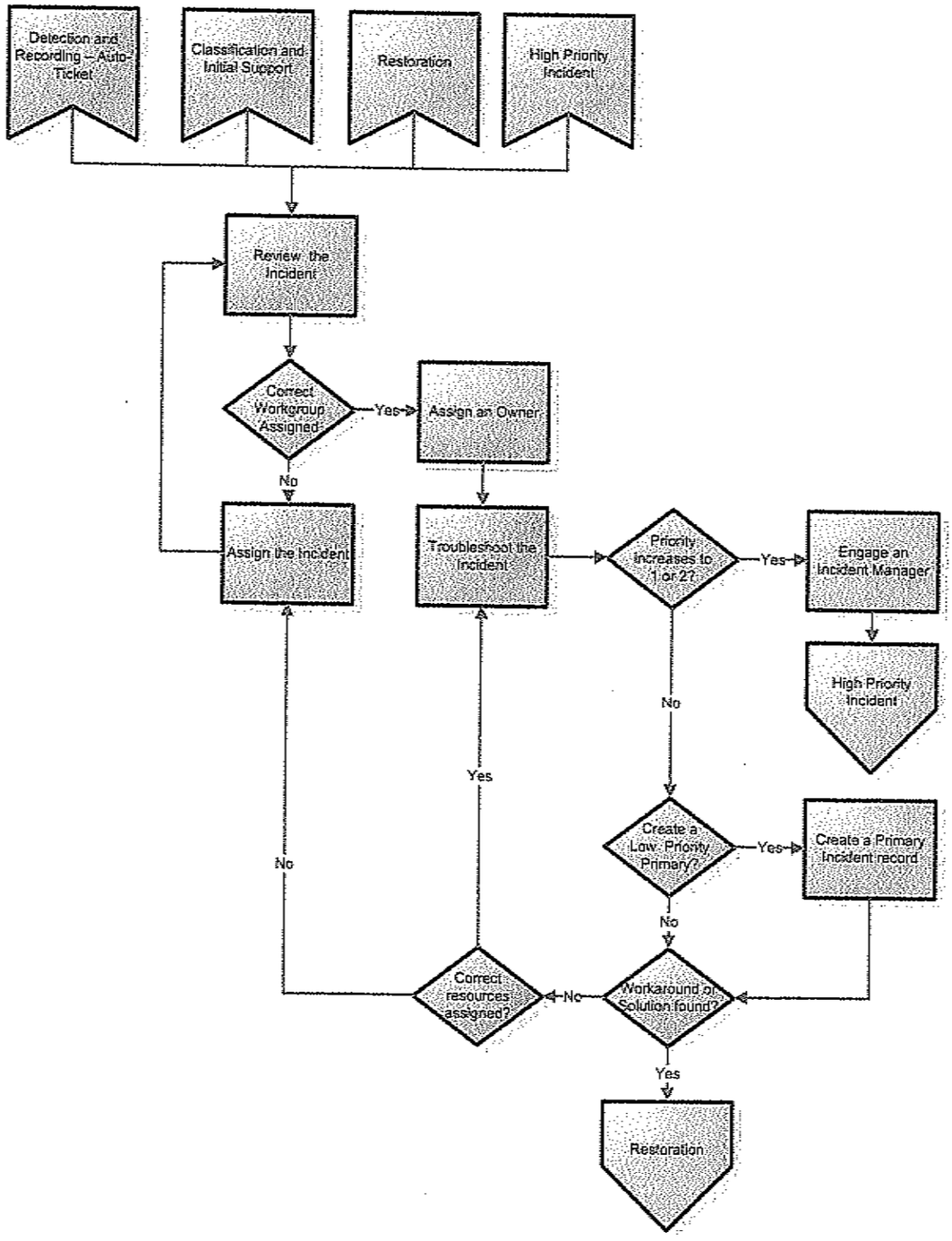
The assigned Workgroup reviews the Incident and assigns it to an Owner.

The Owner of an Incident, once assigned, is responsible for troubleshooting the Incident and for maintaining the Incident record during the investigation. While investigating the Incident, the Owner:

- Keeps the Incident record updated with current information
- Contacts the Client (if any) to gather additional information as needed
- Engages an Incident Manager if the Priority changes to 1 or 2
- Optionally creates Primary Incidents to manage multiple records related to the same Priority 3 or 4 Incident
- Reassigns the Incident, if different resources are required

Once a work around or solution is identified, the process continues with restoring the Incident.

Incident Investigation and Diagnosis



5.5 Restoration

The Incident is considered "restored" when impact has been removed by implementing a work around or by implementing a solution.

Once a work around or solution has been identified, it needs to be implemented. The Owner of the Incident must first determine if a Change is required in order to implement the work around or solution.

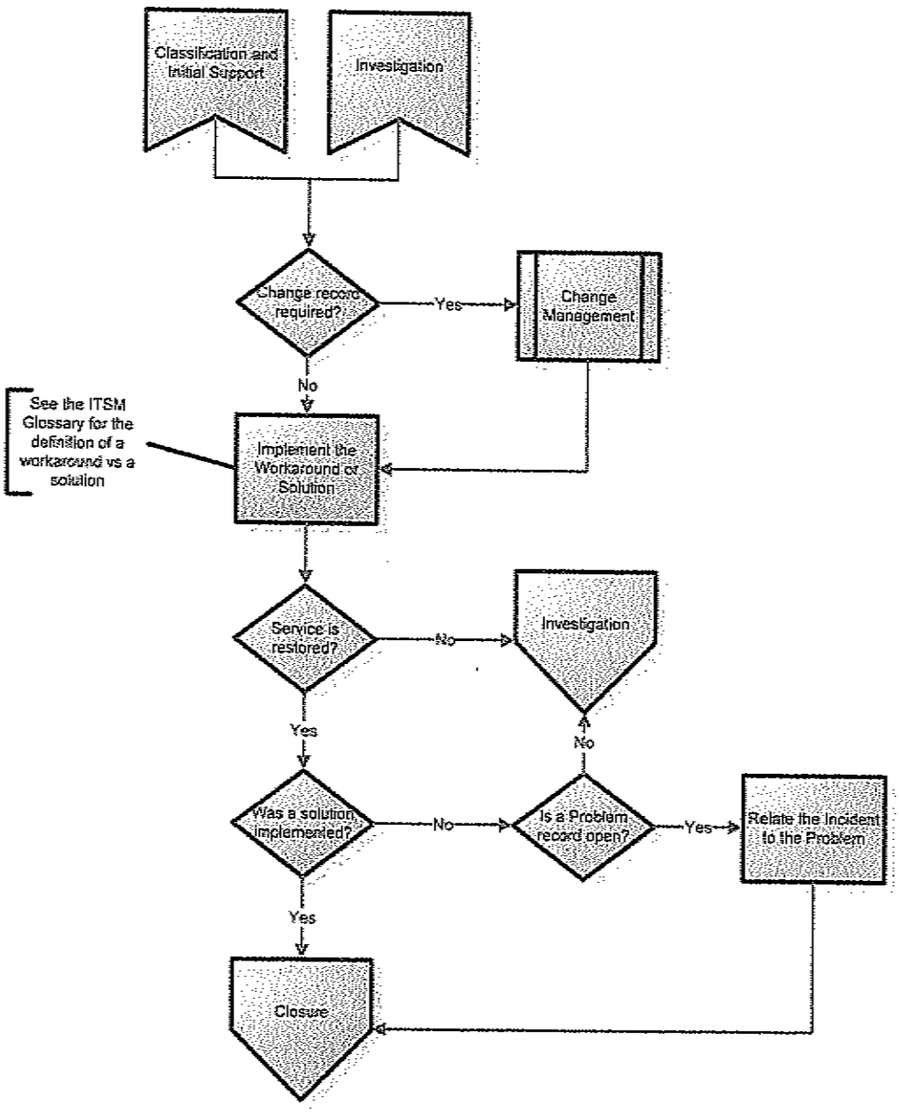
- If a Change is required, the Owner requests the Change according to the Change Management Process. The Change Owner is responsible for relating the Change record to the Incident record.
- If a Change is not required, the work around or solution can be implemented immediately.

If a solution is successfully implemented, the Incident can be closed. But, if a work around is successfully implemented, while the service target for the Incident is considered met, the Incident continues to be investigated until:

- A solution (not just a work around) is successfully implemented or
- The Incident is related to an open Problem.

When either a work around or solution is implemented, the Owner is responsible for confirming whether or not it successfully removed the impact of the Incident. If the Incident has an associated Client, the Client is contacted for confirmation.

Incident Restoration



5.6 Closure

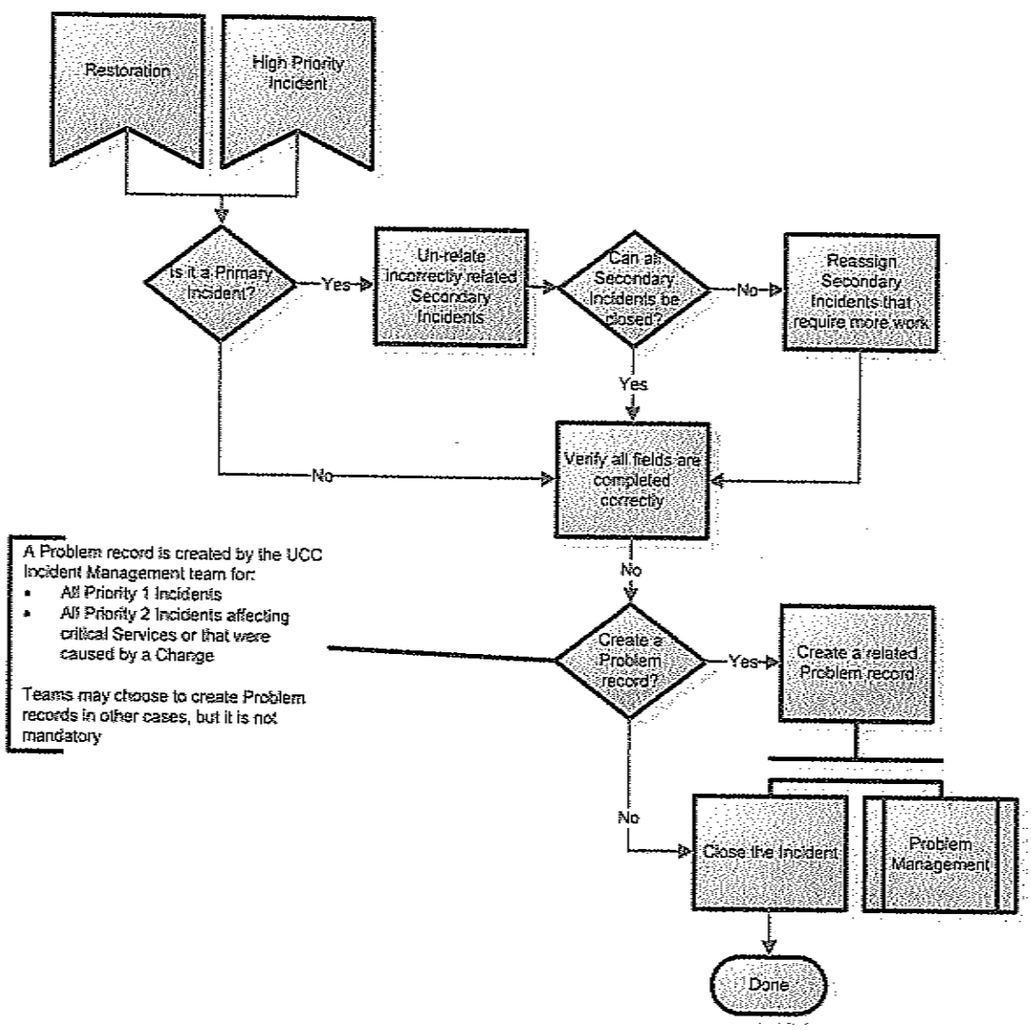
An Incident is ready to be closed if it meets one of the following criteria:

- A permanent fix (i.e. "solution") has been implemented
- A work around has been implemented and the Incident has been related to an open Problem record
- The Incident should not have been logged in the first place. If a Client reported the Incident, the Client must request that it be withdrawn.
- The Incident appears to have resolved itself or cannot be reproduced.
- The Incident was a related to an approved, planned Change currently occurring in the environment.
- After several attempts, you could not reach the Client for information needed to investigate the Incident.

Before an Incident is closed, the record is validated. Primary Incidents are reviewed to ensure the implemented fix addressed all the clients that reported the issue. If not, individual issues are reassigned to Workgroups for further investigation. A problem record may be created as required by the Problem Management process.

Issues reported by clients are left in a "Pending Closed" state for 5 business days to allow the client to confirm the issue is truly resolved. If the client does not contact support within this 5-day period, the Incident is automatically closed.

Incident Closure



5.7 High Priority Incident Management

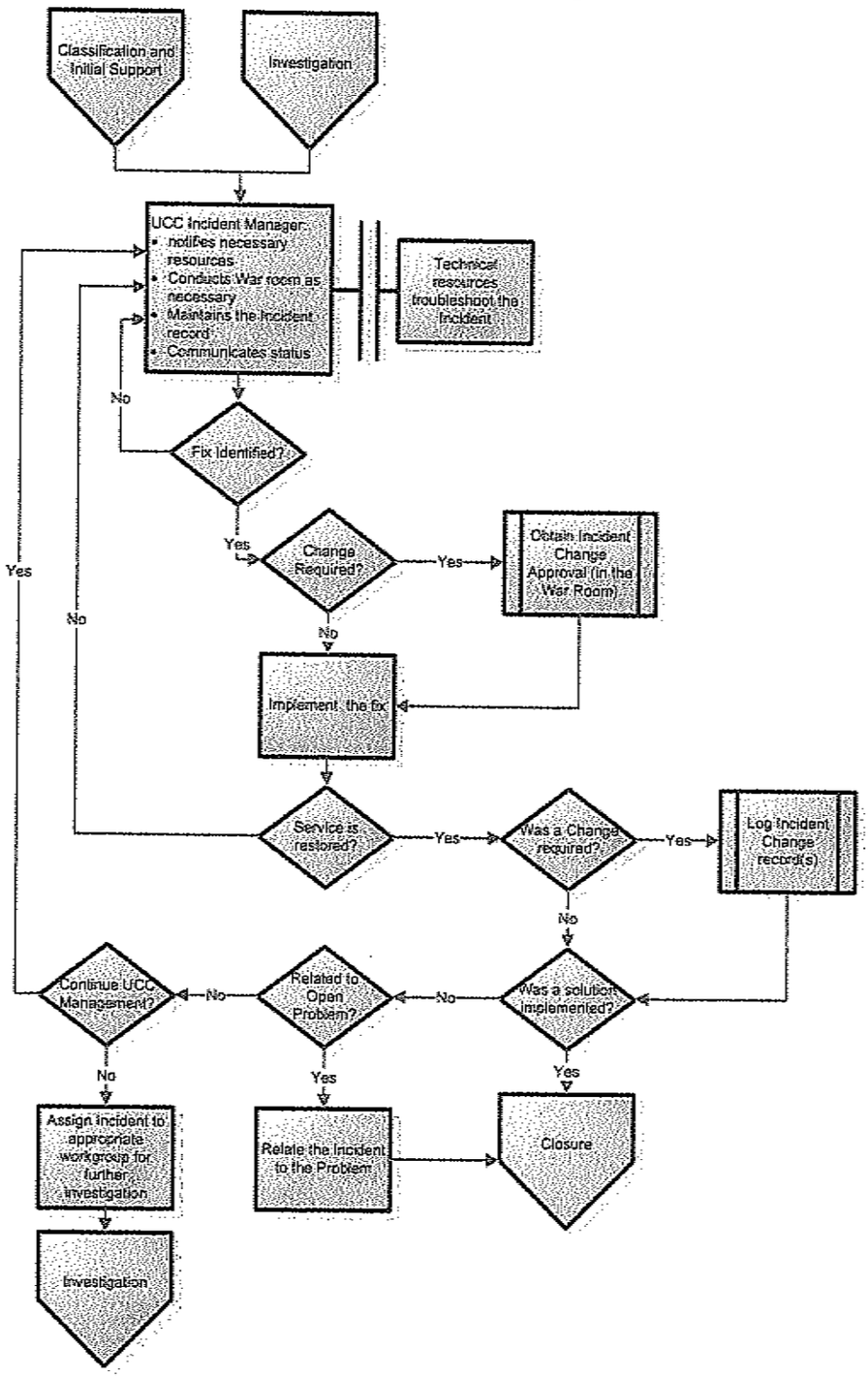
If it is determined that the Priority of an Incident is "1" or "2", an Incident Manager must be engaged.

The Incident Manager (UCC) will:

- Create a Primary Incident record
- Notifies the necessary resources, and, as necessary, convenes a War Room
- Maintains the Incident record through restoration of the Incident
- Communicate status of the Incident through restoration.
- Opens a Problem record, as required by the Problem Management process
- Closes the HP Service Manager Record

Specialists are required to respond to UCC Incident Manager notifications and perform resolution tasks as assigned.

High Priority Incident Management



UnitedHealthcare Community Plan of Louisiana, Inc.

Attachment #4
UnitedHealth Group IT High Priority Incident Management

UnitedHealth Group®

UHG IT High Priority Incident Management

A Guide for High Priority Incident Management at UnitedHealth Group IT

UnitedHealth Group

Information Technology

Released by the United Command Center, a team within UnitedHealth Group IT

Version History

Date	Reviewer	Version	Revision Comment
12-01-05	Rob Gardner	1.0	Initial draft
1-15-07	Mark Vukelich	1.1	Problem ticket process and SCM
2-07-07	Rob Gardner	1.2	Update refined processes
10-31-07	Rob Gardner	1.3	Update role responsibilities
9-16-08	Bob Keller	1.4	Annual update
11-10-08	Rob Gardner	1.45	Updates to versioning
11-12-08	Bob Keller	1.5	Updates & add Appendix C
01-04-10	Brent Shaback	2.0	Substantial re-write.
07-15-11	Brian Louhi	2.1	Updates to align to CBT course content.
08-17-11	Brian Louhi	2.2	Updated the problem record 4.4.3 per ITSM's recommendation.
06-24-2013	Marne Hunt	2.3	Page 5 Business Communication Process for High Priority Incidents

Table of Contents

UnitedHealth Group

High Priority Incident Management

1. Overview

This document describes the United Command Center's protocol for restoring High Priority Incidents within the IT Service Management framework within UnitedHealth Group IT. It describes the roles, responsibilities and expectations of participants during High Priority Incident restoration activities. This document also provides an overview of the Technology Event Management process.

The United Command Center (UCC) organization within UnitedHealth Group Information Technology operates a full time, 24x7 operations team to monitor the health and availability of UnitedHealth Group IT assets. The UCC is responsible for coordination of and technical communication during High Priority Service restoration activities for UnitedHealth Group.

2. The Scope

The scope of this document is limited to High Priority Incident Management activities, which includes initiation of Technology Event Management, which is a pre-cursor to, if required, the declaration of a Disaster.

2.1 Purpose

The purpose of this document is to describe the protocol for performing High Priority Incident restoration for High Priority Services within the UHG IT Service Management framework. It describes the roles, responsibilities and expectations of participants during High Priority Incident restoration activities. This document also provides an overview of the Technology Event Management process.

2.2 Objective

Create awareness and understanding of the protocol for a War Room convened by the United Command Center (UCC) to restore high priority incidents and the responsibilities of all parties who may be requested to join a War Room.

The objective of the High Priority Incident Management process includes:

- Restore service as quickly as possible.
- Promptly engage the appropriate technical support.
- Minimize the time commitment for all participants.
- Ensure War Rooms are conducted with urgency, objectivity, consistency, and professionalism.
- Minimize the impact of high priority technology incidents to the business.
- Communicate business impact and progress of Service restoration to key stakeholders.

2.3 Audience

The primary audience of this document includes any application, infrastructure, process, or other technology support resources that interfaces during High Priority Incident restoration activities. This may also include individuals from the business who may be asked to participate in UCC War Room conference calls to facilitate triage, testing, or business validation of incident restoration.

3. High Priority Incident Identification and Prioritization

High priority incidents are identified and reported to the United Command Center in two ways:

1) United Support Center (USC) through user/client contact.

   USC Analysts utilize knowledge bases, including the Service Registration entry in HP Service Manager to categorize the priority of the incident based on the impact and priority definitions. After confirming the incident warrants high priority designation, the USC Incident Management team notifies the United Command Center (UCC) of the incident. The USC will create a primary incident record.

2) UCC detection of a monitoring alert through instrumentation

   The UCC can be alerted of impact application and / or infrastructure components that warrants high priority incident designation through instrumentation, if implemented. The UCC creates a High Priority primary incident and initiates restoration activities.
   Example: Monitoring probes for a portal indicates the portal is down, which is confirmed by UCC analyst as application checkout script fails.

Upon detection of an incident and determination that it warrants high priority (Priority 1 or 2) designation, a primary incident record is created in HP Service Manager. This record will be the authoritative source of detail for incident-related activities including the details, work log and various activities related to the primary incident including end-user-reported incidents (Incident Records), changes occurring that contributed to the incident (Change record), and new/existing Problem records.

War Room protocol and the associated activities from resource engagement through restoration and closure are described in detail in Section 4.

Roles and responsibilities of the various participants involved during the process are discussed in Appendix A.

4. War Room Protocol

It is imperative that all participants understand War Room protocol and their respective roles and responsibilities. This will enable Services to be restored as expeditiously as possible, efficiently utilizing technical resources and minimizing impact to the business.

The UCC is responsible for managing the incident record and driving restoration efforts. The UCC Call Manager will assume the "command and control" on all high priority primary incidents.

- What is command? Has the authority to allow actions to be taken for Service restoration. Has the understanding of the processes to be followed toward Service restoration.
- What is control? Manages the incident to ensure all actions being taken are aligned toward Service restoration. Maintains objectivity and discipline related to process to ensure compliance.

4.1 Starting a War Room

The UCC utilizes a set of reserved toll-free conference bridges to convene the required parties to restore service. The UCC Call Manager initiates the War Room call by opening the conference bridge and immediately sending a page (Technical Page) to the associated technical support groups with the incident number, telephone number and pass code to join the War Room. In an effort to tactically resolve the issue, only individuals required to facilitate Service restoration activities are requested to join. This minimizes communication activities that do not contribute directly to Service restoration activities and enables the technical support resources to focus their activities on restoring service either by fixing the issue or implementing a work-around to restore Service.

If an individual who is requested to join the War Room does not respond within 10 minutes, a second page is sent. When five minutes has elapsed after the second page, a page and/or direct communication is sent to the designated escalation contact or the requested participant's manager. This continues at five minute intervals until resources have been secured to facilitate Service restoration activities.

4.1.1 Supplemental Priority 1 War Room Activities

Priority 1 Incidents either severely impacts, or have the potential to severely impact mission critical business operations, and/or have high visibility to external customers. As such, there are supplemental participation and communications that are associated with Priority 1 Incidents.

- Senior Exec On-Call Paging Communications
  - Immediately following the distribution of the Technical Page, a page is sent to the Senior Executive On-Call resource to join the War Room call. The incident number, a brief description of the Service impacted, and the conference bridge details are provided.
- Senior IT Leadership Paging Communication
  - Immediately following the distribution of the Senior Executive On-Call page, a Priority 1 page is distributed to IT Leadership to raise awareness to the issue. The incident number is supplied with a brief description of the impacted Service. No conference bridge details are provided in this communication.
- Priority 1 Email Communication Bulletin
  - Within 15 minutes of the Priority 1 incident, an email communication is distributed to individuals who have subscribed to the Priority 1 Email Communications bulletin. This communication contains the impacted Service(s), the incident number, the business impact (if known) and the current status.

4.2 Joining the War Room

The following responsibilities apply to participants joining the War Room for Service restoration efforts:

- After connecting to the call, participants will wait for a clear gap or pause in the conversation, and state their name and workgroup. The UCC Call Manager will be recording names in the incident record.
- Participants should mute their phone when not speaking or use *6 to mute and *6 to un-mute the phone.
- Respect others on the call and wait for a gap or pause to respond.
- Participants should review the HP Service Manager incident record to understand the current status of the incident rather than request status upon joining the call. Failure to do so can result in disruption to the call participants as a disproportionate amount of time is spent recapping the issue rather than restoring service.

4.3 During the War Room

Initial War Room discussions involve impact assessment and fault isolation. Activities then ensue to isolate the issue by correlating the incident description, reported impact, recent changes, other active incidents, monitoring alerts, and active system/application health checks performed by technical resources to identify the source of the issue. Upon identification, Service restoration activities commence with the objective of using all prudent measures to restore service to the impacted Service(s) without adversely impacting other Service(s) in the environment.

Incidents are worked at the highest priority that they were established at any time during the incident lifecycle. If the priority of the incident was increased to a Priority 1 from a Priority 2, at no time shall the incident be "downgraded" to a lesser priority – even if the impact has subsided and the then-current impact reflects a lesser priority based on the HP Service Manager Service Registration entry.

The War Room remains open until the incident has been restored. The incident is restored when the initially reported impact is no longer present. If there is lesser impact, a non-High Priority incident can be opened and/or a problem record may be requested and the support teams may continue to progress a permanent fix and/or root cause assessment through the Problem Management process.

There may be extenuating circumstances that present justification for a War Room to be temporarily suspended and a reconvene of the group to be scheduled. Decisions to reconvene are made at the discretion of the UCC. This often happens when there are finite activities that take a period of time to complete. As an example, an incident may require data to be restored from backup media. This could be a multi-hour process due to the volume of data. It would not be a productive use of time for individuals to remain on the War Room call. As such, a reconvene is scheduled with the understanding that if the process completes in less time than forecasted, individuals may be paged to join the War Room call again prior to the scheduled reconvene.

4.3.1 War Room Responsibilities

The following are the high level, role-based responsibilities during the War Room. A more detailed description and list of the responsibilities for each role is described in Appendix A:

- The **UCC Call Manager,** may also be referred as **UCC Incident Manager**, will initiate the War Room call and engage required resources during the call. The UCC Call manager will guide the restoration process in a structured, methodical and consistent manner using UCC Standard Operating Procedures for leading teams, communication, incident documentation and triage according to UHG IT Service Management process methodology and in accordance with UnitedHealth Group General Computing Controls.
- The **Incident Owner** (or designee) for the impacted Service is expected to have:
  - A detailed knowledge of the Service
  - Knowledge of the infrastructure for which the Service resides
  - Awareness of all applications and infrastructure components for which the impacted Service is dependent on

  As such, the **Incident Owner** is the individual primarily responsible for directing technical restoration activities.
- For Priority 1 incidents, the **UCC Duty Manager** monitors progress and ensures the restoration activity is proceeding quickly and efficiently. The **UCC Duty Manager** has the authority to escalate to additional technical resources and senior management at the individual's discretion.
- All participants must recognize that all comments may be recorded or used by others on the call. Participants must be sensitive to other business and IT segments on the call and conduct themselves in a professional manner consistent with the Company Integrity policy.

- It is the responsibility of all participants to consciously keep unnecessary conversations to a minimum to maintain focus on Service restoration.
- Only team members actively engaged to resolve the incident will be asked to join or remain on the call. As appropriate, teams or individuals who clearly have no involvement in recovery may ask to leave the call or will be asked to leave. However, at no time are individuals involved with restoration activities permitted to dismiss themselves from the call unless approved by **UCC Call Manager.**
- The **UCC Duty Manager** will determine if it is necessary, based on business impact and number of participants, to open another War Room. The additional War Room will be used for application support.
  - The **UCC Duty Manager** will identify the leader for the application support War Room.
  - A UCC representative or a UCC designate will provide status updates to the application support War Room.
  - The **UCC Duty Manager** may combine the War Rooms as appropriate.
- The **UCC Call Manager** will update the incident record with appropriate content at a frequency no greater than 15 minute intervals.
- The **Incident Owner** may request decisions from Business Representatives in order to make necessary changes to restore service or implement a temporary workaround.
- The **Incident Owner** (or designate) is responsible for distributing communications to the affected business stakeholders per the Business Communication Process for High Priority Incidents at the stated intervals (see Target timing for Incident notifications section).
- For a Priority 1 incident, if the incident has not been restored within 60 minutes, the **UCC Call Manager** will declare a breach. The **UCC Call Manger** will notify Senior Management via text message and Priority 1 Email Bulletin of the status of the incident.
- The **UCC Duty Manager, UCC Director**, and/or the **Senior Executive On-Call** will engage Event Management and Technology Event Management teams when appropriate. (See Appendix B for process)
- **War Rooms are designed and resourced to facilitate High Priority incident restoration activities.** Although convenient because of the captive nature and accessibility of resources, all Problem Management discussions and activities **MUST** be performed outside of the War Room calls. The Incident Management process is designed to facilitate Service restoration activities. Once service has been restored the call will be adjourned. It is imperative that **ALL** War Room contributors respect the process to enable the UCC resources to complete remaining documentation required to close the Incident and to free resource to facilitate restoration of other High Priority incidents in the environment.

4.3.2 Incident Change (if required)

During High Priority incident restoration activities, there are instances when there are change-related activities that must be performed to restore service. In these instances, an Incident Change is the only type of Change that can be implemented *prior* to the creation of a Change record and is only used to restore service to a Priority 1 or 2 Incident, which is managed by the United Command Center (UCC) via a War Room.

The Change Owner begins to coordinate the implementation of the Change after receiving authorization to proceed from the UCC Duty Manager (Priority 2 Incidents) or the UHG IT Senior Executive On-Call (Priority 1 Incidents) on the War Room call.

As part of the implementation, the Change Owner is accountable for validating the success of the implementation. Once the change implementation activities are complete and service has been restored, the UCC will create an Incident type Change record in HP Service Manager and relate the

record to the Priority 1 or 2 Incident record. **The Change Owner must update the Change Record within 24 hours of service restoration.**

Note: Changes performed to return components to their pre-incident state, providing the components/functions work exactly as it did prior to the failure do not require Incident change to be performed providing that the required activities will not knowingly cause an outage for any component not already impacted by the Incident.

4.4 Closing the War Room

Once technical restoration activities are believed to be complete, a series of validation activities or "Checkouts" are performed. If successful, a formal impact assessment is made and recorded to enable availability calculations to be performed. If appropriate, a problem record will be created and/or associated with the incident. The incident is then closed and the War Room call is adjourned. This section describes in greater detail each of the aforementioned activities.

4.4.1 Checkout

Prior to closing the War Room, the UCC Call Manager must get confirmation from the Incident Owner and/or Business Representative that service has been restored, a progressive series of Checkouts are performed to validate restoration is complete.

Upon completion of Checkout activities the UCC Call Manager will set the status of the Incident to "Restored".

System Checkout

This stage is performed by technical platform owners or infrastructure teams. These teams confirm that the hardware, Operating System and key system processes are enabled and working as intended. They will give the 'all-clear' and state to the UCC Call Manager that the infrastructure systems have been validated and are ready for Functional Checkout of the software/application.

Functional Checkout

This two-stage process is performed first by the Incident Owner to confirm that the platform requirements are configured correctly and running as intended. The second step involves end-users who perform acceptance testing to confirm the software performs as intended. The Application Operations and Maintenance team will engage with the end-users to begin using and testing the application for response and functionality and report back to the War Room participants. Once the end-users have validated their step the Operations & Maintenance team will inform the UCC Call Manager that they are ready for Business Checkout as they have confirmed that the Service is functional.

Business Checkout

This final step is the culmination of System and Functional Checkout. The sign-off from business that their capabilities and functionality have been confirmed as restored is handled in this step. This will be reported either by the Business Representative (if present) or the Incident Owner.

4.4.2 Impact Assessment

The Incident Owner, with facilitation from the UCC Call Manager, must validate the duration from the first monitoring alert or first Service Call received from an end-user. Then, based on the Vital Business Function definition of the Service Registration entry in HP Service Manager, the availability modifier (percent impact) is assessed for the incident. If percentages are not designated in the Service Registration entry for the Service, the percentage impact must be estimated. The UCC Call Manager will record the duration, availability modifier, and the name of the individual who assessed the impact in the incident record. This information will be used to generate Availability reporting.

4.4.3 Problem Record

The UCC Call Manager will identify the Problem Owner for:

- All Priority 1 incidents,
- All Priority 2 incidents caused by change,
- All Priority 2 incidents related to a set of pre-defined Services, and
- Other Priority 2 incidents as requested.

The UCC Call Manager will denote the need to create a problem record. When a Problem record is created as part of the resolution of a High Priority Incident, the UCC Call Manager has the authority to assign that Problem record to a Workgroup and Owner according to their best judgment and information made available during the War Room. The recipient of the problem record (Problem Owner) must be on the War Room. The Problem Owner can initiate requests to various other Infrastructure and Application Support teams through creation of Work Orders associated with the Problem record. Any appeals regarding Problem record assignment should be directed to ITSM Problem Management.

The exception to this assignment process is if the Infrastructure Support team requests assignment of the Problem record or if the incident is clearly caused by a hardware failure.

Note: A single Problem record will be created for each Incident. Contact ITSM Problem Management for additional information on the Problem Management process.

4.4.4 Incident Closure

The UCC Call Manager will update the incident record, and assign the incident record to the workgroup whose efforts last contributed to restoring service. The status of the incident in HP Service Manager will be changed to "Closed". At this point, any future recurrence of impact will require a new incident to be created.

After the incident is closed, post-incident communication activities are performed for Priority 1 Incidents. Paging communications are sent to the Senior IT Leadership paging group to indicate the incident has been restored and the duration of the impact. The Priority 1 Email Communications Bulletin is also distributed to subscribed distribution list.

Appendix A Role Descriptions

The following roles are defined in detail below:

- UCC Call Manager
- UCC Duty Manager
- UCC Enterprise Manager
- Incident Owner
- Technical Specialist (SME: Subject Matter Expert)
- Senior Executive On-Call
- Business Representative

A-1 UCC Call Manager

The UCC Call Manager, may also be referred as UCC Incident Manager, is responsible for documenting all activities associated with the Incident and facilitating the War Room call. The UCC Call Manager communicates with the Incident Owner to assess business impact and identify the technical resources to engage. The UCC Call Manager follows UCC Standard Operating Procedures to facilitate the War Room call to drive service restoration.

A-1.1 War Room / Communication

- Performs standard communication (workgroup paging and Priority 1 Email Communications Bulletin) to initiate and progress service restoration activities, and upon closure of the War Room call.
- Must always be present on the call.
- Consistently follows UCC Standard Operating Procedures.
- Adhere to IT Service Management discipline.
- Direct actions in accordance to UHG General Computing Controls.
- Provides regular status communications to UCC Senior Management.
- Coordinates with Event Management and Technology Event Management teams when appropriate. (See Appendix B for process).
- Opens and convenes additional War Rooms as requested by the UCC Duty Manager.

A-1.2 Incident Record Maintenance

- Maintains the incident record, including creation, maintenance and closure of associated Availability Alerts.

A-1.3 Incident Troubleshooting and Restoration

- Responsible for validating incident priority.
- Validates business impact throughout the incident.
- Works with the Incident Owner to establish the action plan for the technical investigation and restoration of the incident.
- Facilitate troubleshooting activities as directed by the Incident Owner and UCC Duty Manager.
- Keeps War Room participants focused on service restoration.
- While remaining calm, ensure a professional environment yet maintain a sense of urgency to pursue service restoration.

A-2 UCC Duty Manager

The UCC Duty Manager oversees and drives the process of restoring service during Priority 1 War Rooms.

The UCC Duty Manager has responsibility of all resources on the War Room and for ensuring service restoration activities progress to closure. The UCC Duty Manager ensures the UCC Call Manager has sufficient resource engagement and support to manage the incident. The UCC Duty Manager will join all Priority 1 War Rooms to monitor service restoration activities and ensuring that they progress to closure. The UCC Duty Manager is available for escalation related to technical support constraints, obstacles that impede service restoration progress, and to approve Priority 2 Incident Change. The UCC Duty Manager will support the UCC Call Manager to direct the conversation on the War Room to progress service restoration. The UCC Duty Manager's goal is to optimize and/or reduce mean time to restore for the incident. Specific responsibilities include:

A-2.1 War Room / Communication

- Supports the UCC Call Manager in directing the War Room conversations.
- Ensures notifications, communications, and escalations to management for high priority incidents occur.
- Ensures War Room governance procedures are followed.
- Manages the escalation process.
- Engages Event Management and Technology Event Management teams when appropriate. (See Appendix B for process).
- Ensures status is appropriately communicated to UCC Leadership.

A-2.2 Incident Record Maintenance

- Ensures the incident record is appropriately maintained by the UCC Call Manager.

A-2.3 Incident Troubleshooting and Restoration

- Responsible for ensuring the incident has been prioritized correctly.
- Ensures technical investigation and restoration activities are proceeding as expeditiously as possible, ensuring a consistent and methodical approach to diagnosis and restoration.
- Drives accountability to ensure defined actions are performed and timeframes are met.
- Escalates to higher-level technical resources or senior level management as needed to progress restoration.
- Review Priority 2 Incident Change and authorize or deny the change.
- Responsible for resource prioritization to ensure incidents with the greatest impact to the overall organization have the required attention.

A-3 UCC Enterprise Operations Manager

The UCC Enterprise Operations Manager serves as an escalation point and support for all UCC employees and activities performed in the United Command Center. This role provides additional support to ensure progress is being made towards service restoration. If necessary, has the authority to escalate concerns to Senior Level IT Management to request additional technical support.

The Enterprise Operations Manger will be engaged in the review of and the approval or denial of Priority 2 Incident Change requests, should the Duty Manager become unavailable.

In addition to actively participating on the War Room call, the Enterprise Operations Manager will collaborate in parallel with the UCC Director and the On-call Executive to determine if the incident warrants a "Technology Event". A "Technology Event" is designated when an incident causes impact to the business for an extended duration. For more information regarding the Technology Event management or TEM, you can reference Appendix C.

A-4 Incident Owner

The Incident Owner is the single point of contact accountable for technical restoration of service when a disruption occurs. An Incident Owner is defined for each Service. At present, this is the individual identified as the Incident Owner in the HP Service Manager application. The Incident Owner is responsible for determining, coordinating and managing the technical aspects of the restoration effort. The Incident Owner works closely with the UCC Call Manager and is required to participate in the War Room at all times.

A-4.1 War Room

- Responds within 10 minutes to notification page to join the War Room.
- Responsible to provide the technical direction of the call.
- Always be present on the call.
- Responsible for communicating to the Service Level Owner of the incident impact. The Service Level Owner is responsible for distributing communications to the affected business stakeholders per the Business Communication Process for High Priority Incidents at the stated intervals.
- In some instances, the Incident Owner will also be the Service Level Owner.

A-4.2 Incident Record Maintenance

- Coordinates with the UCC Call Manager to ensure the incident record is updated with appropriate content (timing information, who is involved, changes in status, impact, and milestone activities).

A-4.3 Incident Troubleshooting and Restoration

- Be available for high priority incident restoration activities 24x7 for assigned Services.
- Ensures a backup has been identified for contact when unavailable.
- Assists with the validation of the incident impact and priority determination.
- Accountable for establishing the action plan for the technical investigation and restoration of the incident.
- Accountable for identifying and managing the needed technical resources required for investigation, diagnosis and restoration.
- Escalates to higher-level technical resources (level 3 or strategic partners) or senior level management as needed to progress service restoration.
- Uses a methodical triage approach to quickly narrow faults and find a solution/workaround.
- Works to restore service within the recovery goal of 1 hour for Priority 1 incidents and 4 hours for Priority 2 incidents.
- Facilitates any associated change activity required to restore service.
- Ensures that a Partner ticket is opened for vendor issues, if needed.
- Responsible for communication with the business community on their Service disruption following incident restoration.

A-4.4 Problem Management

- Assists with Problem Owner identification.
- Assists with definition of Root Cause analysis tasks.
- Creates and assigns Work Orders within HP Service Manager to workgroups to facilitate root cause identification and permanent solutions to minimize potential for the incident to reoccur.

A-5 Technical Specialist (SME: Subject Matter Expert)

- The Technical Specialist is the technical Subject Matter Expert (SME) responsible for restoring application or infrastructure components for which they are responsible.

A-5.1 War Room

- Is expected to join the War Room within 10 minutes of being paged. Within those 10 minutes, the SME is responsible for being prepared to troubleshoot the issue before joining the call. Timely engagement and escalation, to appropriately skilled resources, are critical to achieving service restoration within the Service Restoration Goal. The UCC will aggressively escalate when paged resource do not join the War Room within 15 minutes.
- Participates in War Room activities as requested.
- Communicates the progress and status of assigned restoration activities to the UCC Call Manager.
- Incident troubleshooting and restoration.
- Completes restoration activities as assigned within set timeframes.

A-6 Senior Executive On-Call

The Senior Executive On-Call representatives are the designated UHG IT Operations Leaders that work on a rotating basis to participate in the War Room call and facilitate restoration. The role was created to ensure there was appropriate visibility and representation from IT operations leadership during Priority 1 Incidents. These leaders also supplement the communication process during extraordinary events.

A-6.1 General Responsibilities

The Senior Exec On-Call has four primary responsibilities:

1) Participate on Priority 1 Incident restoration War Rooms
2) Participate as an approver in Emergency Change Advisory Board (eCAB) meetings
3) Support standard and/or perform supplemental IT Communications during High Priority Incidents and Events.
   a) Facilitate further escalation if necessary to Senior UHG IT Executive Management.
4) Act as the escalation authority at the UHG IT level across all IT operational teams.

A-6.2 War Room Responsibilities

When asked to join a War Room, the UHG IT Senior Executive responsibilities include:

- Promptly join the War Room call within 10 minutes when notified to join the bridge.
- Remain on the Priority 1 War Room call for the duration of the Incident.
- Understand restoration effort status and next steps.

- Ensure all resources required are appropriately engaged.
- Ensure incident investigation and fault isolation proceeds in a logical and timely manner.
- Oversight, ensuring progress and an appropriate level of urgency.
- As necessary, assist with the identification and engagement of Management resources and other required resources outside of UHG IT scope of control, including vendors.
- Authorize and approve Incident Change(s) required to restore service.
- Where appropriate
  - Deflect and/or handle distractions to enable technical teams to remain focused.
  - Communicate status to the CIO(s) and all other significant business leaders.
  - Act as the single point of contact for business leadership communications during the High Priority Incident.

A-6.3 Emergency Change Advisory Board (eCAB) Responsibilities

The eCAB process is not part of High Priority Incident Restoration activities, but it is noted here that the Senior Executive On-Call has the responsibility to serve as the UHG IT leadership representative and approver for Emergency Changes. Similar to a War Room, the Senior Executive On-Call will be paged to join eCAB conference bridges to review the requested change, assess potential impact, and approve or decline the change during the call. The Senior Executive On-Call will be assigned an approval work order in HP Service Manager to be approved or declined based on the response provided on the eCAB.

A-6.4 Communications Responsibilities

Technology incidents have the potential, to become technology events or disasters. This may be caused by a number of contributing factors including impact reassessment or duration and may include, but are not restricted to, multi-day restorations of Priority 1 events, primary system failures that wholly impact a site or sites that incur major work stoppage, Technology or Business Continuity events, or other catastrophic events. For the purposes of this discussion, these will be known as Events.

To better insulate the technology teams, allowing them to remain focused on restoration and to more accurately and thoroughly communicate objectively to all audiences, there are various supplemental communication activities during Events that may be warranted in addition to the UCC Managed War Room bridge(s). This may include: (1) IT Leadership bridges; (2) Technology Event Management bridges; (3) Business bridges (leadership and other types); (4) Other special focus bridges.

During High Priority Incidents, the UCC Duty Manager, the UCC Director, and the Senior Executive On-Call will communicate in parallel to the primary War Room call to determine if the "Incident" warrants "Event" designation. If an Event designation is warranted, these individuals will determine whether it is most appropriate to engage segment IT leadership or to engage the broader Technology Event Management process.

Although each situation will be unique, some general guidelines for Event communications are as follows:

- During Events impacting a finite group of users or business segment, the Senior Executive On-Call will be responsible for convening an IT Leadership update bridge with the affected Segment CIO or designated representation to keep leadership apprised of status.
- If the Event warrants convening the Technology Event Management (TEM) team, the UCC Director will work with the Senior Executive On-Call to initiate the TEM and determine appropriate next steps, up to and including the declaration of a disaster. If more broad business communication is warranted, the decision will be made by TEM to identify the single voice

responsible for communication with the business including the frequency and agenda for this communication. This function may or may not be performed by the Senior Executive On-Call due to the duration of the event and decision by the TEM.

The individual identified to be responsible for the communication directly to the Business has the following responsibilities:

- Sponsor the call
  - Take charge to convene regular (discretionary, as determined at a consistent interval) conference calls with the business, business leaders, or EMT to proactively and assertively deliver appropriate and timely communication updates on the system failure and the progress to date.
  - Be on the call in a timely manner, be prepared, be organized, and speak with authority and confidence. Know who is on your call, which businesses they represent, and to some degree what is important to them.
- Manage the call
  - Deliver the updates diplomatically, and appropriately. Manage the expectations, address questions with fact-based, objective responses. Take action to follow up on questions unable to be responded to at the time. Establish communication frequency and intervals, but avoid committing to restoration times without facts to substantiate them.
  - Take a commanding role to ensure documentation is being captured to reflect meaningful events within the lifecycle, including post incident actions. Personal notes may be helpful for post incident review clarity. There also may be a need to do supplemental written communications (in addition to the UCC brief) subjectively driven during an Event.
- Follow up
  - Following restoration, ensure that the business feels they have reasonable closure, and any existing gaps are addressed in real time or are captured as action items, either independently, within the Incident record requesting action in the Problem Management process, or directly into the Problem record.
  - Senior Executives may be requested to participate in the Problem process and post-incident investigation for the Event. Communications that may be warranted include:
    - An accurate, IT summary with relevant milestones and timelines.
    - An accurate and timely IT Leadership summary that includes actions and remediation steps.

This process is intended to improve the client experience, actively communicate both status and progress, better utilize IT resources, and minimize post incident/Event follow up and communications.

A-7 Escalation Authority

In the event there are multiple high priority incidents that are competing for strategic resources, the Senior Executive On-Call leader will work in conjunction with the UCC Enterprise Manager to prioritize and supplement resources from across UHG IT, non-UHG IT segments, or third-parties to support high priority incident restoration. This may require use of the Senior Executive On-Call's knowledge of the network of support resources that may not be directly involved with daily support operations.

A-8 Business Representative

The Business Representative is responsible for representing the Business perspective of the Incident. Although representatives from the business are not typically requested to participate on War Room calls, periodically they are requested to facilitate impact assessment and to further articulate the impact of the incident. This helps to enable the technical teams to isolate the issue, resolve the issue either through a permanent resolution or a temporary workaround, and then validate that Service has been restored.

A-8.1 Incident Troubleshooting and Communication

It is imperative that technology incidents are reported to the United Support Center promptly. Users must articulate the issue and associated impact to enable correct prioritization of impact and engagement of the appropriate resources to commence and progress incident restoration activities. Providing quality information at the time of incident reporting will better enable IT resources to quickly identify the source of the issue and restore Service. Below are items that should be provided when reporting incidents, when available/known:

- Provide the name of the Service that is not functioning as designed.
- Provide details about the incident including but not limited to:
  - Number of sites impacted
  - Number of people impacted
  - Details on disrupted functionality (i.e., what works, what doesn't work, when it last worked)
- Performs due diligence to ensure procedural issues are not reported as system issues.
- Performs investigation tasks and testing (to duplicate error or validate restoration) as requested. For example, provides screen shots of error messages or where the issue lies.
- Communicates any previous troubleshooting steps.
- Communicate status to other business teams or team members as appropriate.

A-8.2 War Room Conference Bridge

If requested to participate in a War Room Conference Bridge:

- Participates in War Room activities as requested.
- Holds non-critical questions about technical details until post restoration.
- Be respectful of War Room protocol and follows UCC Call Manager instruction.

Appendix B Enterprise Resiliency & Response/Event Management

B-1 Event Management Team (EMT) Overview

Incidents that have evolved or escalated to become Events may require engagement with the Enterprise Resiliency and Response (ER&R) or Event Management Team (EMT) to facilitate business planning and communication.

B-2 UHG IT and EMT Role and Responsibility Delineation

Both UHG IT and EMT have roles and responsibilities during an Event. It is important to define and understand these roles and responsibilities to minimize confusion and overlap during an Event. During Events, the UHG IT will be represented by the UCC unless the TEM process has been engaged.

Responsibility	Responsible	Supports
Technical Incident Prioritization	UCC	N/A
Technical Service Restoration Coordination	UCC	N/A
Technology Event Declaration	UCC	EMT
Non-Technology Event Declaration	EMT	UCC
Business Continuity Actions including Staffing Decisions during Technology Events	EMT	UCC
Technology Disaster Declaration	TEM	EMT
UHG IT Leadership Event Communication	UCC	N/A
Segment IT Leadership Event Communication	UCC	N/A
Impacted Application Business Owner Communication	Service Level Owner	UCC
Segment Leadership Event Communication	EMT	TEM
Senior Leadership Event Communication	EMT	TEM

B-3 ER&R Event Criteria/Categorization

Categorization	Business Impact	Engagement Timelines
Category I Standard Incident	A critical portal is impacted, e.g. 'Myuhc is unavailable'	Issue is supported and managed within IT through the life of the incident
Category II Standard Incident	Several critical applications are impacted, e.g. 'UNET TOPS is experiencing degraded performance affecting B2B and IDT'	Issue is supported and managed within IT through the life of the incident
Category III Standard Incident	Multiple call center operations are impacted, e.g. 'Virtual Contact Center environment is experiencing connectivity issues affecting 4 Ovations call centers'	Issue is reported to EMT within 30 to 60 minutes as an informational notification, no action taken by EMT but they may inform their business constituents
Category IV Non-Standard Incident	One or more segments are unable to perform business operations, e.g. 'Eagan Data Center is experiencing a power outage affecting multiple Unimise claim and call center applications'	Issue is reported to EMT within 10 to 30 minutes, once the assessment is confirmed, EMT to take action in parallel with IT to restoration

Appendix C Technology Event Management (TEM)

Technology Event Management (TEM) is a process initiated upon determination that scope, impact, restoration activities, or communication requirements dictate that extraordinary efforts that may circumvent standard Incident Management process are required to accomplish Service restoration. During these events, restoration activities and communication with affected parties will be coordinated by the TEM team.

TEM will often warrant notification to one or more levels of Senior IT leadership. The purpose for engaging Senior IT Leadership is to inform leadership of significant technology events and receive validation of the plan of action currently being invoked. Depending on the severity of the event and the business impact, a higher level of authority may be required to determine the subsequent course of action (e.g., declaration of a disaster).

The TEM process may be invoked under the following conditions:

- Coordination of technology activities in conjunction with Enterprise Resilience & Response (ER&R) because of the invoking of a Business Continuity plan caused by a natural disaster or pandemic.
- Loss of facility power to a non-Technology Center event is not considered a Technology Event and is handled as a standard Incident unless impact warrants an elevated response.
- Service availability issues deemed to be high impact because of the loss of functionality for one or more High Priority Services for an extended period of time.
- Partial or complete loss of a Technology Center due to natural disaster or a significant environmental or facility issue.

The United Command Center (UCC) is responsible for the Technology Event Management process, including the declaration of a Technology Event. During high priority events, the United Command Center will liaise with the Senior Executive On-Call leader and Senior IT Operational Leadership to determine if/when to initiate the TEM process. Depending on the circumstances, the management of the event may be passed to other individuals who will preside over the larger event. However, the UCC will remain a focal point for the process.

C-1 Non-Technology Center

C-1.1 ER&R/EMT Initiated

During a Non-Technology Center Event, ER&R or various other groups will notify the UCC of the event through standard process. The UCC will engage with ER&R and other constituents as necessary to discuss the incident and determine if it is an Event. Minor incidents such as facility power or environmental issues are handled within normal incident management process and do not require the TEM process to be engaged. However, major Events affecting one or more sites and potentially regions (e.g., hurricane) will often require initiation of the TEM process. The UCC will manage the technology aspects of the Event including engagement with the necessary support teams. The UCC will report status and communicate with the business through the ER&R (EMT) Bridge at agreed upon intervals throughout the duration of the Event.

C-1.2 Extended High Priority Incident

Periodically, there are technology incidents that breach defined restoration goals, and activities to restore Service may require extended periods of time (days or weeks) to restore Service. This may include, but not be limited to fatal non-redundant hardware failure, data corruption, or security-related events. During these types of Events, extraordinary efforts may be required to restore Service that requires re-prioritization of activities by multiple workgroups. The Service Level Owner for the Service impacted by the outage will be engaged in the Incident and has primary responsibility for

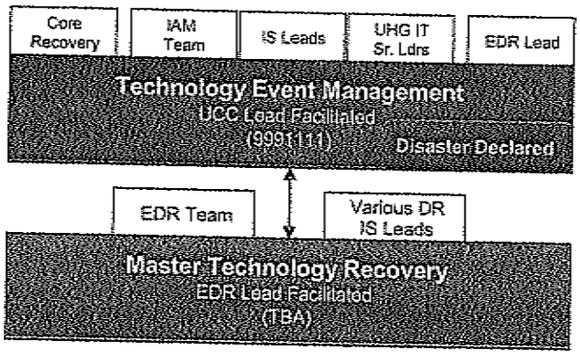
engaging the Business Segment(s) impacted by the Incident. The Senior Executive On-Call, through discussion with the UCC Duty Manager and UCC Director may determine that it is appropriate to engage the TEM process. This will ensure appropriate and effective leadership, communication, required resource engagement, and reprioritization is brought to the Event.

C-2 Technology Center Event

If a Technology Center Event occurs, the incident will initially be handled as a standard High Priority Incident. When impact is determined to be widespread to a Technology Center, the UCC Director will be notified and will invoke the TEM process.

The UCC will open a TEM conference bridge line and initially page the TEM Core Team to the bridge. The TEM core team includes the Sr. VP for Infrastructure Services and immediate Operational direct reports, the UHG IT BCP lead, and the Enterprise Disaster Recovery Lead. After an initial assessment of the situation, additional groups may be paged including the CRM Team, Infrastructure Services Directors, and UHG IT Senior Leadership.

If the nature of the Event warrants the declaration of a Disaster, this declaration will be made on the TEM Bridge. The Master Technology Recovery bridge facilitated by the Enterprise Disaster Recovery Lead will then initiate the Disaster Recovery Plan activities based on the scope and location of the disaster. The specifics of this activity are documented and maintained by the Enterprise Disaster Recovery team.



Within 60 minutes of convening the TEM Bridge, the UCC will notify ER&R (EMT) of the Technology Event. The ER&R team may elect to open the EMT Bridge to advise the business of the Event and provide status accordingly. The TEM will designate a senior individual responsible for providing status to the EMT Bridge on the progress of the Technical Event Management activities.

Tom Schedler
Secretary of State

State of Louisiana
Secretary of State

COMMERCIAL DIVISION
225.925.4704

Fax Numbers
225.932.5317 (Admin. Services)
225.932.5314 (Corporations)
225.932.5318 (UCC)

Name	Type	City	Status
UNITEDHEALTHCARE OF LOUISIANA, INC.	Business Corporation	BATON ROUGE	Active

Previous Names

UNITED HEALTHCARE OF LOUISIANA, INC. (Changed: 5/26/2010)
COMMUNITY HEALTH NETWORK OF LOUISIANA, INC. (Changed: 12/30/1996)
SOUTHEAST HEALTH PLAN OF LOUISIANA, INC., A LOUISIANA CORPORATION (Changed: 5/17/1988)

Business: UNITEDHEALTHCARE OF LOUISIANA, INC.
Charter Number: 34205615D
Registration Date: 4/9/1986
State Of Origin:

Domicile Address

5615 CORPORATE BLVD
STE 400B
BATON ROUGE, LA 70808

Mailing Address

3838 NORTH CAUSEWAY BOULEVARD
SUITE 2600
METAIRIE, LA 70002

Status

Status: **Active**
Annual Report Status: **In Good Standing**
File Date: 4/9/1986
Last Report Filed: 3/28/2014
Type: Business Corporation

Registered Agent(s)

Agent: C T CORPORATION SYSTEM
Address 1: 5615 CORPORATE BLVD., STE. 400B
City, State, Zip: BATON ROUGE, LA 70808
Appointment Date: 12/30/1996

Officer(s)

Additional Officers: No

Officer: GLEN JOHN GOLEMI
Title: Director, President
Address 1: 3838 NORTH CAUSEWAY BOULEVARD
Address 2: SUITE 2600
City, State, Zip: METAIRIE, LA 70002

Officer:	ROBERT WORTH OBERRENDER
Title:	Treasurer
Address 1:	9900 BREN ROAD EAST
City, State, Zip:	MINNETONKA, MN 55343

Officer:	JOHN JOSEPH MATTHEWS
Title:	Secretary
Address 1:	4560 GROVE PARK DRIVE
City, State, Zip:	TALLAHASSEE, FL 32311

Mergers (1)

Filed Date	Effective Date:	Type	Charter#	Chater Name	Role
12/30/1996	**12/30/1996**	**MERGE**	**34205615D**	**UNITEDHEALTHCARE OF LOUISIANA, INC.**	**SURVIVOR**
			34166793D	METRAHEALTH CARE PLAN OF LOUISIANA, INC.	NON-SURVIVOR

Amendments on File (13)

Description	Date
Amendment	4/7/1988
Name Change	5/17/1988
Amendment	12/9/1988
Disclosure of Ownership	3/29/1993
Disclosure of Ownership	11/18/1994
Merger	12/30/1996
Name Change	12/30/1996
Disclosure of Ownership	8/1/1997
Disclosure of Ownership	4/16/1998
Disclosure of Ownership	8/3/1998
Disclosure of Ownership	1/8/2001
Domicile, Agent Change or Resign of Agent	1/29/2008
Name Change	5/26/2010

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