**RFP 21-66211**

**TECHNICAL PROPOSAL**

**ATTACHMENT F1**

**Third-Party Administrative Services**

Please supply ***all*** requested information ***in the yellow-shaded areas*** and indicate any attachments that have been included. Document all attachments and which section and question they pertain to.

**1.1 General Information**

1. How long have you offered medical TPA services?

UMR is the third-party administrator (TPA) line of business for UnitedHealthcare, the largest business unit of UnitedHealth Group. UMR was formed in 2008 (13 years ago) by integrating three market-leading TPAs with a combined history in the health care industry dating back as far as 1948 (73 years).

1. Provide your covered commercial membership in self-insured medical plans nationally and in Indiana as of January 1, 2021

As of January 1, 2021, nationally UMR has 3,466 customers with 2,778,643 subscribers (5,535,088 members), with 1,132 customers with 123,095 subscribers (253,226 members) in Indiana.

1. Describe how your organization differentiates itself from your competitors. Specifically, what makes your organization the best partner for the State?

The health care space is a busy, noisy market, and you need more than a typical list of differentiators to convince audiences. In this space, experience does matter, and a legacy of proven performance and customer retention will tell you a whole lot about an organization’s long-term viability. Which is why UMR, a UnitedHealthcare company and the largest TPA in the country, stands head and shoulders above the rest.

Our claim payment system, CPS, was internally designed and is monitored by a team of system analysts who specialize in employee benefits administration. We make updates and modifications on an ongoing basis to respond to the needs of our customers, as well as trends in claim processing, employee benefit plans and the health industry. Not only can our system accommodate customized benefit designs, it also enables customer-specific functionality and self-service features. We use internal coding to program benefits specific to your plan. This coding automatically controls payments as well as tracks deductibles, out-of-pocket maximums, participation and plan maximums. In addition, our screening functions review claims prior to payment, so those in question automatically deny or pend for further review.

UMR only works with self-funded entities and can help make sense of benefits complexities. We have an extensive background working with large groups, including those represented by multiple bargaining units, such as labor organizations and state customers. Our approach is highly specialized, custom tailored for each of our customers and specific to their immediate and ongoing needs.

Our ability to analyze complex data and apply deep health care expertise and insights allows us to serve public sector benefits plans with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

UMR offers the resources and savings of the largest proprietary network in the country. Our combined technology allows us to easily comply with state and federal mandates, as well as develop new services. With UnitedHealthcare’s capital investment, our capabilities are continuing to grow. Highly flexible and focused on service, we’ve earned a reputation for keeping the customer’s best interests and bottom line in sight.

As a full-service TPA with a range of capabilities and solutions, we do it all, from medical administration and access to stop loss coverage and pharmacy benefits administration, to proprietary care management and wellness programs. In addition to the UnitedHealthcare networks, we work with more than 100 other PPO and physician hospital organization (PHO) networks. We have our own proprietary platform and a robust reporting system. It’s safe to say that UMR has all of the pieces that make up a strong machine, and we excel because of our breadth of industry knowledge and sound understanding of the nuances around self-funded plans.

Customers are assigned account management and support teams to help them deal with daily issues and long-term strategic initiatives.

With **umr.com**, members can also access their claims and benefits information anytime on their desktop, tablet or mobile devices. Our online services make it quick and easy to look up network providers, view recent claims and explanation of benefits (EOB) statements and check individual coverage and out-of-pocket amounts. Members can also visit **umr.com** to access decision support tools and extensive health and wellness information.

We walk our talk. It’s a rich history of listening to, solving for, and predicting customer needs.

**1.2 Medical Plan Administration**

1. Please confirm you are able to administer the State’s current plan designs as described without modification. Please indicate yes or explain areas that cannot be administered without modification.

Confirmed. UMR can administer your submitted plan design. However, upon review, we have discovered some opportunities to increase the plan’s automation within our system.

1. Please confirm you are able to administer a tiered network plan design as described in RFS 21-66772. The selected respondent will be expected to collaborate with provider groups and administer this custom arrangement using “lesser of” logic.

Confirmed.

1. Confirm your organization will assume full fiduciary responsibility for claim determination.

Confirmed. UMR will agree to be a named fiduciary under the Plan with respect to (i) performing initial benefit determinations and payment, (ii) performing the fair and impartial review of first level internal appeals and (iii) performing the fair and impartial review of second level internal appeals (if applicable).

UMR includes claim fiduciary services as part of our standard services. We will act as claims administrator, and will agree to serve as claims fiduciary pursuant to section 503 of ERISA, solely for purposes of determining claim payments and decisions under the submitted benefit design. If UMR performs claims fiduciary services, we will retain complete discretionary authority to construe the terms of the Plan to determine whether a claim is payable.

UMR will also handle first- and second-level claim appeals as part of our standard services. We do not assume fiduciary responsibility for funding of benefits, the monitoring of co-fiduciaries or other operational duties of the plan administrator, including benefit design and reporting and/or disclosure obligations.

The employer is the named plan administrator within the meaning of ERISA, and UMR is not and shall not be deemed a fiduciary with respect to the Plan. We are retained to perform ministerial functions, not discretionary functions as clarified in the Department of Labor (DOL) regulations under ERISA. In the event that the plan is found to have plan assets, the employer shall have absolute authority with respect to such plan assets, and UMR shall neither have nor be deemed to exercise any discretion, control or authority with respect to the disposition of plan assets.

1. What is the name of your claims processing system/platform?

UMR’s medical claim platform is called CPS. The CPS platform is proprietary, mainframe-based and internally maintained with the sophistication to handle a wide array of complex benefit and administrative needs. CPS was designed to accommodate a wide variety of medical plans as well as pricing arrangements. By using sophisticated, integrated logic with claims administration edits, we can automatically adjudicate all types of benefit structures.

1. Are you expecting claims processing system/platform changes over the course of this contract?

No. We do not anticipate making any major system changes at this time; however, if there is a significant change that would directly impact the State of Indiana, such as a design change to explanation of benefits (EOBs), we would send a communication prior to the change occurring.

1. Describe the claims adjudication process in detail including:

a. automated edits

b. manual edits and processing

c. requirements for “clean claim”

d. rejection or limiting claims based on service frequency or monetary maximums

e. monitoring for upcoding, duplicate claims, etc.

**a.** UMR uses a variety of system edits, benefit coding configurations and reimbursement policy edits to assist with appropriate claim adjudication and to help identify inappropriate or potentially excessive charges. Basic information about these different layers of edits is outlined below:

PROVIDER CLAIMS

■ **Internal system edits**: We include both CPS edits and benefit coding configuration/edits in this group. All claims received at UMR are subject to all internal system edits as defined below:

■ **CPS edits**: These include edits for elements such as: duplicate claims, fraud control, potential third-party liability, medical necessity and eligibility. Our claim payment system also edits for experimental and/or investigational care, and cosmetic coding.

■ **Benefit coding configuration/edits**: Our internal coding includes items such as: coordination of benefits (COB) option, deductibles, out-of-pocket maximums, participation and plan maximums. UMR completes this customer-specific coding after the intent meeting, during the case installation process. After coding, we will review live claim examples with the State of Indiana to ensure we have properly coded the plan.

■ **Reimbursement policy edits**: Depending on the individual provider’s relationship with UMR, each provider claim is routed through additional software, sometimes referred to as clinical editing software.

■ **UnitedHealthcare providers**: All UnitedHealthcare network provider claims are routed through the Ingenix Claims Edit System (iCES), an internal system, to review for bundling, unbundling, inappropriate diagnosis codes, age edits and other reimbursement policy edits specific to the provider contract. Claims are routed through iCES prior to repricing and prior to the internal system edits.

This system performs clinical practice review before claim payment to apply uniform billing and medical appropriateness rules to physician claims. Clinical modules are automated and are an indispensable part of claim payment.

The iCES software allows and denies charges, or pends the claim to the customer first representative (CFR) for review and determination. There is no additional charge for this service. The software is updated throughout the year as new updates are released.

Hospital claims are not routed through this system.

■ **Non-UnitedHealthcare and non-network providers**: We purchase Claims Edit System (CES) software from Optum, and route provider claims through this system to review for bundling, unbundling, upcoding and other provider billing practices. Claims are routed through CES prior to repricing.

The CES software is customized by edit to allow, deny or pend to the customer first representative (CFR) for review and determination. The software uses National Correct Coding Initiative (NCCI) edits as well as edits from other sources, and is updated throughout the year as new updates are released. Claims that indicate upcoding, unbundling or services not appropriate for the patient's condition will be identified and the software will apply coding corrections automatically. A comment will appear on the provider remittance advice explaining the correction.

UMR is able to track savings as a result of CES edit review. We also report on the codes that are denied or questioned and include those in our standard reporting package.

HOSPITAL/FACILITY CLAIMS

Hospital claims are subject to internal system edits, however, because these claims are billed with revenue codes that can include a range of services, rather than CPT/HCPCS codes, we do not review hospital claims for unbundling. Revenue coding limits the opportunity for unbundling. We also perform hospital bill reviews/large bill reviews on these claims.

**b.** Claims pass through our reimbursement policy editing software where they are reviewed for bundling/unbundling, duplication, exclusive services, modifiers, assistant surgeon, medical necessity of appropriateness of treatment and/or diagnosis, procedures and place of service, validation of age appropriateness and gender-specific procedures. If a claim edit is applied, additional review by our medical claim review (MCR) team is necessary.

**c.** Claims that commonly automatically adjudicate are clean claims that have all of the necessary information.

**d.** Our system has the capability to track maximum benefits and automatically deny claims once the maximum has been reached. Our claim payment system maintains all policy maximum benefit limitations online, including:

■ Individual and family deductibles

■ Individual and family out-of-pocket limits

■ Deductible carry-overs (we adjust claims if carry-over deducted is exceeded)

■ Annual maximums

■ Individual stop loss

■ Separate payments for noncompliance with utilization review procedures

■ Separate internal limits (such as outpatient psychiatric treatments)

**e.** The edits contained within CPS monitor claims at all levels. We have software that helps identify improper billing practices including the inappropriate unbundling and upcoding of claims. We also apply a set fee schedule on contracted claims or maximum reasonable and customary (R&C) percentile to non-network claims that cannot be negotiated through the prompt payment process. For non-network claims the amount billed over the R&C amount for the area is denied.

1. What percentage of medical plan claims auto-adjudicate without requiring handling by claims examiner after claims are initially input via electronic feed or data entry?

Our automatic adjudication rate is 76.3 percent.

1. Please describe your internal and external appeals process for self-insured plans. Confirm that your appeals process is compliant with state and federal rules/regulations. List the independent review organizations (IRO’s) that will be utilized for the state.

Confirmed. Our appeals process is compliant with state and federal rules/regulations. UMR’s objective is to ensure our members receive a full and fair review of their claim for benefits. We acknowledge written appeals, including those submitted via our website, within five business days.

FIRST-LEVEL APPEAL (MANDATORY)

Our internal claim appeal auditors complete first-level appeals. If a benefit denial was based in whole or part on medical judgment, we consult with a health care professional who has experience in the relevant field. The health care professional must be an unbiased third party who was not involved in the original denial decision and does not supervise the health care professional who treated the patient.

If members wish to dispute first-level appeal decisions, they may voluntarily request a second-level appeal if the plan has one in place.

SECOND-LEVEL APPEAL (MANDATORY OR VOLUNTARY WHEN ELECTED BY THE EMPLOYER)

Second-level appeals are reviewed by a claim appeal auditor who was not involved in the first appeal and is not under the supervision of the person who originally denied the claim. The reviewer takes into account all comments, documents and records that relate to the claim. As with first-level appeals, if the denial was based in whole or part on medical judgment, we consult with a health care professional who has experience in the relevant field. The health care professional must be an unbiased third party who was not involved in the original denial decision (or in the first-level appeal) and does not supervise the health care professional who treated the patient. The second-level reviewer may request additional information to either reverse or confirm the first-level appeal decision.

NOTIFICATION OF APPEAL DECISIONS

If an appeal determination is reversed, UMR will process an adjustment and notify the member. If the determination is affirmed, we will notify the member and include specific reasons and plan provisions as to why the decision was made. UMR may request additional information at any time during the appeals process. Likewise, members or their duly authorized representative may submit additional information. UMR may also consult with the employer according to the terms and conditions set forth in the administrative services agreement (ASA).

NOTIFICATION REQUIREMENTS

Notices of an appeal decision (mandatory level) are sent to the member and/or duly authorized representative within the following timelines:

■ **Urgent care claim (requiring prior authorization):** Decision made within reasonable time frame for medical circumstances; no later than 72 hours after receiving the request for review

■ **Pre-service claim (plan requires prior authorization):** Decision made within reasonable time frame for medical circumstances; no later than 30 calendar days after receiving the request for review

■ **Post-service claim:** Decision made within reasonable time frame; no later than 60 calendar days after receiving the request for review

■ **Concurrent care decisions:**

■ Decision made before treatment ends or is reduced

■ Voluntary, second-level appeals not subject to specific time frames

■ Mandatory, second-level appeals reduce time frames by one-half

RIGHT TO EXTERNAL REVIEW (IF APPLICABLE TO THE PLAN)

After the internal appeals process is complete, members may be eligible to submit a request for external review, which will be conducted by an independent physician external review group. The request for external review will have no effect on other benefits available under the plan. The request must be submitted within four months of the last adverse determination. Members must send a written request to the following address:

UMR - External Review

Appeal Unit

P.O. Box 8048

Wausau, WI 54402-8048

The written request should include the following information:

■ Specific request for an external review

■ Employee's name, address and member ID number

■ Designated representative's name and address (when applicable)

■ Denied service information

■ Any new and relevant information not provided during the internal appeal

Once UMR receives the request, we will provide the member with additional information on the external review process. Members may also contact UMR at the telephone number listed on their ID card.

As part of UnitedHealthcare, UMR has contracted with three accredited/licensed vendors who act as the independent review organizations (IROs) for our external review program. Our contracted IROs are:

■ Advanced Medical Review (AMR)

■ MCMC LLC

■ Medical Review Institute of America (MRIoA)

1. Provide an overview of the staff involved in reviewing appeals, as well as their qualifications and experience. Do different staff review initial and secondary appeals?

Our internal staff consists of appeals intake staff (who triage the incoming correspondence), appeal auditors (who review and respond to appeals), and registered nurses (RNs), as well as certified coders. If a review is based in whole or in part on medical judgement, it will be referred for independent review to a similar specialty provider. Level 2 appeals are reviewed by staff who were not involved in the Level 1 appeal. Through our parent company, UnitedHealth Group, UMR has contracted with three accredited/licensed vendors who act as the IRO for the external review program as required by PPACA.

1. Are paper/electronic ID cards the primary means of determining member eligibility? Describe your capabilities for verifying benefit eligibility in real-time for providers.

To verify member eligibility, providers can use our Internet application, call our customer service staff or use our IVR system. Providers can also use the 270/271 EDI transaction process available through our clearinghouse vendor, ChangeHealthcare.

1. Please describe any specific requirements you have related to submission of enrollment.

UMR can receive eligibility information through electronic submission, Internet enrollment or paper forms. The most efficient and accurate methods are Internet enrollment or electronic submission. To maintain data integrity, Internet enrollment and electronic submission are exclusive of one another.

ELECTRONIC SUBMISSION

We typically receive electronic submissions through a variety of media sources using the HIPAA National EDI 834 standard format or UMR’s standard electronic eligibility layout.

After a file has been loaded, we generate edit reports that identify questionable records or discrepancies. An enrollment specialist will work with the eligibility vendor or the State of Indiana to resolve all questionable records. It’s important we receive the necessary information to resolve discrepancies prior to the next scheduled load.

In situations where emergency care needs to be administered before we receive eligibility information, we can accept updates via phone, email or fax, provided all necessary information is included. We then confirm the data has been loaded.

If you need to make an update to data that was already submitted, we prefer to communicate the necessary change to you and have the subsequent file submitted electronically. This will ensure data integrity between your system and ours. Because manual updates are also performed, we recommend a monthly eligibility audit.

If a full electronic file cannot be provided, we can accept an Excel file for the initial eligibility load only. Ongoing eligibility updates can be done using our Internet enrollment process.

INTERNET ENROLLMENT

Through Internet enrollment, you can submit enrollment and change forms for:

■ New enrollments

■ Employee terminations

■ Dependent adds and terminations

■ Employee and dependent demographic changes

■ Employee and dependent benefit changes

■ Open enrollment for new and existing groups and members

Internet enrollment allows you to realize the following benefits:

■ Decreased time of enrollment cycle

■ Faster turnaround of enrollment applications

■ Reduced use of paper and copier-related tasks

■ Reduced calls, time and effort

■ Reduced rework and/or corrections

■ Decreased costs (paper/mailing)

■ Ability to see what is in the transaction system

■ Access 24 hours a day, seven days a week

■ Easier re-enrollment for employees because the system shows what is already posted for the employee and family

While our Internet application provides numerous advantages for ongoing enrollment submissions, it is not the recommended choice for initial loads. We prefer new customers’ initial loads to be performed through electronic submission.

PAPER FORMS

UMR uses a standard enrollment form for paper submissions. Any deviations from this form must be approved by UMR. Forms are submitted to the enrollment services department and loaded by a specialist. All changes and updates must be submitted using this form.

1. Please describe how you handle manual eligibility updates and the turn-around/timing of such updates.

In situations where emergency care needs to be administered before we receive eligibility information, we can accept updates via phone, email or fax, provided all necessary information is included. The email or fax should indicate “Rush” in the subject line for a same day update.

If manual or ad hoc changes are made to the enrollment data, the enrollment specialist will watch for the changes on the next electronic eligibility file. UMR ensures we have received and loaded the correct data through the verification provided on the next scheduled electronic eligibility file. In addition, we run monthly audit files to identify any discrepancies between the file and UMR’s system.

Our standard turnaround time for manual enrollment and edit reports is 95 percent within four business days.

1. Please describe your process for Medicare Secondary Payer administration including but not limited to: Roles and responsibility of the vendor and State; identifying and recovering Medicare mistaken payments where the State has primary responsibility, receiving payment and resolving outstanding issues, etc. What is your average turn around time in 2020 for resolving claims from CMS?

We process Medicare and non-Medicare claims on the same claim payment system. Our claim payment system is designed to provide consistent administration for a wide variety of benefit plans and pricing arrangements. The system is flexible and easily enhanced for new products and services. We can administer all standard options for coordinating plan payments with Medicare payments. We review the various payment methodologies during the initial plan intent meetings. We document and review the intent with the employer to ensure it is correct and review actual claim payment examples with the employer as a final check.

Once UMR receives the demand we would determine eligibility to make sure the members status is correct and if the member was active. UMR would review all of the claims that are submitted for the date span in the demand. All of the charges are reviewed to determine plan benefits. Once we determine the charges that are eligible per the plan benefits they are entered into the system for reimbursement to Medicare, this also includes any interest that is due. Checks are released as rush with the EOB, printed by the mailroom and if within 2 weeks the check and EOB are overnighted. Once it is received by CRC (Commercial Repayment Center) they review it to determine if they will accept the reimbursement amount, if excepted by CRC the case is closed, if they don’t except it then UMR would begin the rebuttal process. Our average turnaround time in 2020 for resolving claims from Centers for Medicare & Medicaid Services (CMS) was 60 days.

Coordination of benefits (COB) and processes to support proper application of COB are critical because of their importance in paying secondary to Medicare/Medicaid. To facilitate this process, UMR routinely captures and maintains coverage information. Our system alerts the CFR (representative processing the claim) when there is evidence of prior COB activity. It will not allow payment for individuals when the plan is secondary, unless the Other Insurance Allowable and Paid fields have been entered. We also share eligibility with Medicare, as required under the Federal Medicare Reclamation Act, to help ensure correct coordination with Medicare.

Our standard claim turnaround is 90 percent of claims being processed and paid within 10 business days. An average turnaround time in 2020 for resolving claims in CMS is not available at this time.

1. Please describe your third-party subrogation policy.

UMR partners with Optum, which is wholly owned by UnitedHealth Group, for our comprehensive subrogation program.

During the implementation process we will provide an overview of the subrogation process options and allow the State of Indiana to specify the criteria that will trigger a subrogation investigation. We will review options for customization of the program to meet your needs and expectations. For instance, we will ask you questions such as:

■ Do you want to use a “pursue and pay” or “pay and pursue” model?

■ What plan language should be included?

■ How would you like to handle workers’ compensation claims?

From the time of claim intake, subrogation opportunities are investigated and evaluated. Our claim system contains edits that automatically flag claims when subrogation potential is identified.

If a claim has a diagnosis related to a potential accident or injury and meets or exceeds the specified threshold, it is denied until we receive accident-related details. UMR will send an explanation of benefits (EOB) to the member, along with a letter requesting accident detail information. The member may respond by returning the information via mail, online at **umr.com** or through the IVR system.

Once accident details are received from the member, the subrogation team will review for potential third-party liability, applicable exclusions and coordination opportunities. More thorough investigation efforts will be used if required, to verify accident details or confirm priority of payment. We will process claims based on this review. Any paid claims with potential third-party liability will be pursued for post-payment recovery.

Our subrogation team will place all parties on notice of the plan’s subrogation interest in order to protect the State of Indiana’s rights. A trained subrogation professional will follow the case until funds are recovered, or it has been determined that no third-party funds are available.

As part of UMR’s comprehensive subrogation program, legal resources are included for cases that require litigation to get a case resolved. UMR has both internal legal representatives and a large network of legal professionals throughout the United States that we partner with to ensure files are handled through completion.

We estimate an average savings of 19.17 percent from subrogation efforts. This is the percentage of dollars recovered against the total paid claim value across all open subrogation files.

1. Is subrogation outsourced?

UMR provides subrogation services internally in partnership with Optum, which is wholly owned by UnitedHealth Group.

1. Are there guaranteed savings on the recovery rates?

UMR’s subrogation fee is 30 percent of savings achieved. There is no fee unless a recovery is made.

1. Are some of the subrogation savings retained for administration?

No. the State of Indiana will receive 100 percent of all recovered dollars. We will draw the fee associated with our subrogation services on the claim account and identify it as UMR SUBRO FEES on the check register.

1. Describe the procedures used to effectively administer COB with Medicare and other employer group plans.

COB and processes to support proper application of COB are critical because of their importance in paying secondary to Medicare/Medicaid and other group plans. To facilitate this process, UMR routinely captures and maintains coverage information. Our system alerts the CFR when there is evidence of prior COB activity. It will not allow payment for individuals when the plan is secondary, unless the Other Insurance Allowable and Paid fields have been entered. We also share eligibility with Medicare, as required under the Federal Medicare Reclamation Act, to help ensure correct coordination with Medicare.

1. How will COB savings be calculated and reported?

UMR offers the following COB provisions:

■ Option 1: Benefits allow 100 percent coverage between the primary and secondary plans.

■ Option 2: Benefits are coordinated by subtracting the primary plan payment from the total charge. The balance is then used to calculate the secondary plan’s benefits.

■ Option 3: Benefits are coordinated based on the secondary plan’s provisions. If the secondary plan’s benefit payable is less than or equal to the other carrier's payment, no payment is made by the secondary plan. If the secondary plan’s benefit is greater than the other carrier's payment, this plan will provide a benefit for what the plan could pay minus the other carrier’s payment. COB savings are not established with this option.

UMR offers the following COB provisions:

OPTION 1

Benefits allow 100 percent coverage between the primary and secondary plans.

Example:

$ 1,000 Bill

- 650 Paid by primary

$ 350 Balance due

$ 1,000 Bill

- 100 Our deductible

$ 900 Remaining after deductible

$ 720 With an 80 percent participation rate, we could pay

$ 650 Total paid by primary

+ 350 Total we paid

$ 1,000 Total paid on bill

OPTION 2

Benefits are coordinated by subtracting the primary plan payment from the total charge. The balance is then used to calculate the secondary plan’s benefits.

Example:

$ 2,000 Bill

- 650 Paid by primary

$ 1,350 Balance due

$ 1,350 Balance due

- 100 This plan’s deductible

$ 1,250 Remaining after deductible

$ 1,000 With an 80 percent participation rate, we could pay

$ 650 Total paid by primary

+ 1,000 Total we paid

$ 1,650 Total paid on bill

$ 350 Member responsibility

OPTION 3

Benefits are coordinated based on the secondary plan’s provisions. If the secondary plan’s benefit payable is less than or equal to the other carrier's payment, no payment is made by the secondary plan. If the secondary plan’s benefit is greater than the other carrier's payment, this plan will provide a benefit for what the plan could pay minus the other carrier’s payment. COB savings are not established with this option.

Example:

$ 2,000 Bill

- 650 Paid by primary

$ 1,350 Balance due

$ 2,000 Bill

- 1,100 This plan’s deductible

$ 900 Remaining after deductible

$ 720 With an 80 percent participation rate, we could pay

$ 650 Total paid by primary

+ 70 Total we paid

$ 720 Total paid on bill

$ 1,280 Member responsibility

COB paid claims activity is available within UMR’s online reporting tool, InfoPort. UMR customers have the option to filter on a COB type through several paid claims reports available to authorized users within InfoPort. Our customers can create, customize and run reports on demand or schedule reports in a secure environment within the InfoPort online reporting tool. If the reporting application does not contain reports that meet your needs, our customer reporting team provides ad hoc report support.

**1.3 COBRA Administration**

1. Confirm awareness of the two separate requests: 1) State of Indiana employees – Billing COBRA participants as well as establishing and monitoring periods of eligibility, including duration of eligibility and secondary events; 2) Participating School Corporations - Full COBRA administration including initial notification of COBRA rights, notice of COBRA eligibility, billing and monitoring periods of eligibility, including duration of eligibility and secondary events. Describe your COBRA administration procedures. Include responsibilities, workflow, and timing of the following: Importing qualifying event data from the client’s systems, participant notification, processing election forms, COBRA premium billing (coupons and collection), eligibility reporting including premium remittance to carriers, termination of COBRA coverage & notification, processing NSF checks, annual enrollment, accounting, management, reconciliation and reporting.

UMR’s COBRA administration team provides comprehensive COBRA administration services using a system designed to track all federally mandated election and grace periods. The COBRA administration team consists of staff in Wisconsin, telecommuters in Georgia, Minnesota, Ohio, Texas, New York, Colorado, and global staff in Manila. The system automatically produces all required notifications and electronically stores and attaches a copy of each notice to the qualified beneficiary’s record. Notice content is based on the federal COBRA regulation requirements and Department of Labor (DOL) model notice language when available. UMR’s compliance department reviews notice content to ensure that it meets the federal COBRA notification requirements.

Our dedicated COBRA team provides customer and member service Monday through Friday from 7 a.m. to 7 p.m. CT. Each customer is assigned a COBRA administrator who will serve as the primary contact for COBRA administration.

Our team is fully trained in federal COBRA administration. We provide new team members comprehensive training including hands-on practice. We also assign mentors to each trainee. While in training, all work is subject to a 100 percent quality review. Trainees must maintain a standard quality level over an extended period of time to be released from training. Once a trainee has been released on a skill set, all work is subject to a 3 percent random quality review.

UMR provides a choice of three methods which customers may use to report the occurrence of a COBRA qualifying event: Electronic file, online Web portal, or customized COBRA action form which can be submitted via email attachment or fax. When we receive notification of a COBRA qualifying event, the event information is entered into the COBRA administration system and a COBRA Election Notice is automatically generated overnight. We send all COBRA Election Notices via first class mail within 14 days of receipt of the qualifying event information.

If the qualified beneficiary does not elect COBRA continuation coverage within the 60-day election period, the COBRA administration system automatically terminates the qualified beneficiary’s record. If the qualified beneficiary elects COBRA continuation coverage during the 60-day election period, our staff enters the election into the COBRA administration system and the system generates a confirmation of COBRA election and mails the information to the qualified beneficiary. If we receive the initial payment of COBRA premium within the initial 45-day grace period, the system generates a set of payment coupons and mails the coupons to the qualified beneficiary. If we do not receive the initial payment within the original 45-day grace period, the COBRA administration system automatically terminates the qualified beneficiary’s record. Once UMR receives the initial payment, the qualified beneficiary’s coverage is reinstated in the UMR eligibility system. If the qualified beneficiary elects coverage that is administered by an outside carrier, the COBRA administrator will notify the outside carrier of the COBRA election through a mutually-agreed-upon notification method.

During the period of COBRA continuation coverage, UMR will collect the applicable premiums from the qualified beneficiary. If the COBRA participant does not make any subsequent payment within the 30-day grace period, the COBRA administration system will automatically terminate the qualified beneficiary’s record for late payment. The system will automatically generate a Notice of Early Termination. The qualified beneficiary’s COBRA continuation coverage will be terminated in the UMR eligibility system and we will notify the outside carrier of the termination, if applicable.

If the COBRA participant makes timely subsequent payments, the payment will be posted in the COBRA administration system and will be deposited to UMR’s bank account. If we receive a partial payment, the COBRA administration system will automatically generate an insufficient payment notice which will be sent to the qualified beneficiary informing them of the due date for the balance of the payment. If the COBRA participant makes a payment after the end of the grace period, we will return the payment to the qualified beneficiary along with a Notice of Early Termination due to late payment. We then terminate the qualified beneficiary’s coverage in the UMR eligibility system and notify the outside carrier of the early termination, if applicable.

When the qualified beneficiary has exhausted their maximum period of COBRA continuation coverage, the COBRA administration system will automatically terminate the qualified beneficiary’s record. A Notice of Termination due to end of COBRA will be generated by the system and mailed to the qualified beneficiary. At this point, we terminate the qualified beneficiary’s COBRA continuation coverage in the UMR eligibility system and notify the outside carrier of the termination, if applicable.

At the end of each month, the COBRA administration system generates a set of reports. The standard monthly reporting package includes the following reports:

■ Cash detail report

■ Applied premium detail report

■ General Notice listing

■ New Election Notice listing

■ Currently enrolled listing

■ Termination listing

■ Report codes cross reference

UMR provides the standard reporting package to the customer and refunds the COBRA premiums collected via electronic funds transfer (EFT) to the customer’s bank account. Additional ad hoc reporting is also available.

Our standard procedure in regard to disbursing COBRA premium payments to other benefit providers is to return the premium to the customer so they can allocate monies to other benefit providers.

1. How do you document COBRA notification materials sent to qualified beneficiaries? What records are kept and for how long?

UMR accepts COBRA qualifying event notification via mail, email, Web portal, fax or electronic file. During the generation process, the COBRA administration system automatically stores a copy of each notice and associates it with the member’s record in the system. The system also updates the member’s record to show the date the letter was printed. UMR sends COBRA Election Notices to members via first-class mail on the next business day.

Federal COBRA regulations require that employees and their spouses be notified of their COBRA rights within 90 days of becoming covered under their employer’s group health plan. UMR assists customers with meeting this notification requirement by creating and mailing COBRA General Notices to employees and their spouses who enroll in coverage. The COBRA General Notice language is based on the model General Notice provided by the Department of Labor (DOL) and has been reviewed by UMR’s compliance department to ensure that it meets the federal COBRA notification requirements.

For customers who contract with UMR to provide COBRA administration for their plan, UMR extracts a file of all newly added employees and spouses weekly from the UMR eligibility system. The COBRA administration system downloads the file and generates a COBRA General Notice overnight for each employee and spouse.

The system automatically stores copies of all notices and letters sent to qualified beneficiaries. All COBRA related data and copies of notices are retained for seven years.

1. What is your process for notifying dependents of COBRA rights when the dependents have a separate qualifying event?

It is the responsibility of the employer to determine when a qualifying event has occurred and to notify UMR within 30 days of the date of the event. Notification must be made using a mutually-agreed-upon method.

UMR will send the COBRA Election Notice to the qualified beneficiary with a description of his/her rights within 14 calendar days from the date of receipt of the qualifying event from the employer. We send COBRA Election Notices via first class mail.

1. What review process do you use for certifying extended COBRA coverage?

In order to be approved for a disability extension, the COBRA participant must submit a copy of their notice of award or other documentation to the UMR COBRA administration department. Documentation from the Social Security Administration (SSA) must show their disability onset date and the SSA disability determination date. Two members of the COBRA team review all notices of award to verify they comply with the COBRA requirements for a disability extension.

1. Describe the process you will use to manage collection of COBRA premiums?

The qualified beneficiary is initially notified of the payment requirements through the mailing of the COBRA Election Notice. When UMR receives the first payment, we send an enrollment confirmation letter to the qualified beneficiary along with a set of payment coupons for future payments.

We accept premium payments in the form of a check, money order or cashier’s check. The employer also has the option to allow payment via Automated Clearing House (ACH) debit. We post all payments in our COBRA system, and deposit the payments within five days of receipt.

Our standard procedure is to return the premium to the customer so they can allocate monies to other benefit providers. At the beginning of each month, UMR generates customer reports for the previous month’s COBRA activity including receipt of payments. We provide these reports to the customer by the seventh business day of the month, and the total premiums collected are returned to the customer via electronic funds transfer (EFT).

1. What procedures are followed when a qualified beneficiary submits a premium payment for more or less than the required amount? When a qualified beneficiary submits a delinquent premium payment after the 30-day grace period?

We follow the “insignificant difference” rule as established by COBRA regulations when handling partial or incorrect payments. If we receive a partial payment, the COBRA administration system will automatically generate an insufficient payment notice which will be sent to the qualified beneficiary informing them of the due date for the balance of the payment. If the difference is insignificant, as defined by the federal COBRA regulations, the qualified beneficiary will be allowed 30 days to remit the difference.

When a qualified beneficiary’s coverage terminates due to late payment or non-payment of premium, UMR will mail a Notice of Early Termination to the qualified beneficiary via mail. We will allow seven days for mail time after the end of the grace period before mailing the Notice of Early Termination.

1. Describe your process for ensuring that employees in an election period at the time of transition will be sufficiently identified and addressed.

At the time of transition, UMR COBRA Administration will request a file of all qualified beneficiaries who are currently enrolled in COBRA and qualified beneficiaries in their COBRA election period. The following data will be requested for the qualified beneficiaries.

■ Social Security number (SSN)

■ Last name

■ First name

■ Middle name

■ Location, if applicable

■ Gender

■ Relationship

■ Date of birth

■ Loss-of-coverage date

■ Qualifying event date

■ Qualifying event

■ Address

■ City

■ State

■ ZIP code

■ Subsidy information

■ Coverage plan(s)

■ Coverage eligibility level

■ Monthly flex premium (if flex is administered by outside carrier)

■ Paid-through date

■ Dependent first name

■ Dependent last name

■ Dependent date of birth

■ Dependent gender

■ Dependent SSN

■ Dependent coverage plan(s)

■ Dependent relationship

Upon identification, UMR sends the COBRA Election Notice, via certified mail. When we receive notification of a COBRA qualifying event, the event information is entered into the COBRA administration system and a COBRA Election Notice is automatically generated overnight. We send all COBRA Election Notices via certified mail, providing the customer with delivery status tracking through the U.S. Postal Service.

**1.4 PBM & Third-Party Integration**

1. Please confirm your ability to administer an account-based plan design with an integrated medical and prescription drug deductible (including both HRA and HSA designs) with a carve-out PBM.

Confirmed. We can administer the full requirements in regard to integration of the prescription benefits between the pharmacy benefits manager (PBM) and the medical plan as defined by the IRS guidance, including:

■ Deductible amounts

■ Out-of-pocket limits

■ Preventive care (both medical and prescription)

We currently have integrated data feeds with most major PBMs. A PBM that UMR has an established connection with must be used.

UMR believes that pharmacy benefits play a key role within any consumer-driven health (CDH) design. Many participants are already familiar with consumer decisions that they can make around their pharmacy experience - like choosing generics over brand names, higher quantity ordering and using mail order facilities, to reduce cost. These approaches are even more powerful when used within an account-based CDH plan design.

Pharmacy benefits can either be carved out of the deductible and health reimbursement account (HRA) or integrated within the deductible and/or HRA. When an integrated prescription drug and medical HRA is selected, access to HRA dollars at the point of sale is through the use of a debit card. The card is set up to only be accepted at locations that sell prescription drugs, allowing your employees to continue to receive the benefit of automatic HRA processing for medical bills. This payment strategy assures medical provider discounts are taken prior to HRA access and that your employees have the benefit of no out-of-pocket payments at the pharmacy while HRA dollars are available.

Qualified high-deductible health plans with HSAs place the decision of using account dollars for their benefit responsibilities in the member’s hands. Member responsibilities for medical and pharmacy claims can be paid from the HSA or the member may pay by another means.

1. Please describe any restrictions or limitations of your proposed services based on a carve-out PBM.

UMR is able to work with some of the nation’s most prevalent PBMs, including CVS. In order to support an external PBM request, UMR must already have established connections in place to support shared accumulators and data.

1. Please list all PBMs who you have real time integration with (note if a batch process is used; clarify if medical claims are updated and sent with each batch).

While not real-time, we do have a nightly batch integration process with OptumRx and other approved PBM vendors, such as CVS. This information includes sharing of claim payments and application of deductibles and out-of-pocket information. We currently work with a total of 44 PBMs and are willing to provide a list upon award of business.

UMR is able to support shared deductible and out-of-pocket integration with an approved list of external PBMs. One of these approved PBMs must be used in order to support plans that require integrated deductible and out-of-pocket maximums. Requests to work with PBMs with whom UMR does not have established connections must be approved by UMR in advance of agreeing to the new PBM connections. Your sales representative will be able to confirm PBM supportability.

1. What is the highest frequency integration you are able to support?

UMR exchanges information daily with PBMs for plans where we support integrated deductible and out-of-pocket maximums. If we are integrated with the PBM, the member accumulator on the website reflects the balance, including pharmacy and medical accumulators. We work with approved PBMs to establish processes to share out-of-pocket accumulators and to notify the PBM that a member has reached their out-of-pocket maximum. This typically occurs via a file transfer process.

Integration for deductible and out-of-pocket accumulators requires the following data elements: deductible amount, out-of-pocket maximum amount, date of service, patient name, member name and UMR member number. The standard process requires UMR to send eligibility to the PBM. If there is a separate carrier for eligibility, customization to the process may be required.

1. Are you able to integrate member pharmacy claims data into your system to include in member tools like the website or mobile application? If so, please describe the capabilities (prescription history, claims payments, deductible and out-of-pocket amounts). Please note if these capabilities differ by PBM.

Yes. Integration of the pharmacy data is a critical part of the UMR CARE programs. We are able to absorb PBM claims data from all major pharmacy benefit management companies. We use this information to support a comprehensive medication reconciliation, ensure medication adherence, and monitor for opioid abuse. Upon receipt of the nightly claims batch from an approved PBM, we can add claims data into our website or mobile application. Online features include:

■ Formulary listing

■ Brand/generic alternatives

■ Electronic refill reminders

■ Check the status of mail-service prescription orders

■ Find drug information

■ Information about pharmacy benefit program

■ Drug coverage and pricing

■ Account summaries (check and pay balances)

■ Order supplies (envelopes, claim forms, etc.)

■ Locate a pharmacy

■ Interactive health management tools

■ Health information

■ Submit inquiries to customer service team

1. Are you able to integrate member pharmacy claims data into your system for clinical programs identification and management? Please note if these capabilities differ by PBM.

Prescription drugs alone do not trigger a CARE intervention; however, pharmacy data is incorporated into our CARE system to assist our clinical team in managing all aspects of a member’s care.

UMR recognizes the value of integrating our programs within the CARE system platform, Aerial. The system provides powerful, customizable workflow capabilities to streamline our CARE services. This increases the efficiency of our staff, while ensuring a high level of confidentiality. We can automate virtually unlimited business and clinical rules, including clinical protocols, which provide easily understandable, nationally recognized criteria for determining appropriateness of care, location and duration of service. Pharmacy data is incorporated into our CARE system to assist our clinical team in managing all aspects of a member’s care.

UMR does use pharmacy data to identify and stratify potential Ongoing Condition Care candidates. Clinical Intelligence Rules (CIR) uses Medical Episode Grouper (MEG) logic, a proprietary IBM Watson Health product. MEG can assign illness severity, which is augmented by risk scoring functionality using Cotiviti’s (formerly Verscend’s) DxCG software. Both MEG and DxCG are widely known and respected tools for determining condition severity based on diagnosis. These candidates are included in the inventory of actionable members presented for clinical review.

We also use pharmacy data (with medical claims data) to generate HealtheNotes. These are personalized notes mailed to participants and their health care providers that identify gaps in care and potential cost savings. For instance, these may include information on switching prescriptions from retail to mail order or recommending generic substitutions, when applicable.

1. Can you accommodate single-sign on (SSO) to and from your site to the PBM’s website?

Yes. UMR can implement both inbound and outbound single sign-on (SSO) capabilities if the third party uses security access markup language (SAML) 2.0 and integration is through PingFederate (open token). All external partners must first be approved through UnitedHealthcare's Data Release Registry process before UMR can implement an SSO connection. This is to ensure the proper security measures are in place and follow requirements issued by UnitedHealthcare's Information Risk Management program. Prior to any SSO development, UMR will assist your organization with the approval process to ensure a smooth and timely implementation.

1. Confirm you agree to provide weekly/monthly eligibility files to third-party vendors such as a PBM, wellness vendor, data warehouse and/or the State’s flexible spending account administrator.

Confirmed. We work with each vendor to transfer data electronically. We review the file layout and field requirements in detail, field-by-field, and send the vendor test files. Test files include an initial file with production type data and a second test file with specific change scenarios. After production begins, daily electronic eligibility files are sent. If the vendor returns a report with edits, the edits are processed, and updated records are sent on the next file. If an emergency update is needed, our enrollment staff calls the vendor to update their system immediately.

**1.5 Account Management**

1. Describe how the day-to-day account management will be handled. Will the team involved in this RFP be the same that serves to the State? Who will be the primary point of contact for the State?

The State of Indiana’s account will be assigned to a strategic account executive (SAE), who will be your primary contact. Along with the SAE, we will also assign a field account manager (FAM). These individuals will be dedicated to the State of Indiana.

STRATEGIC ACCOUNT EXECUTIVE

Chris Isaacs has been named as your SAE. Chris has worked in the SAE role for UMR for over eight years and prior to that worked for a local benefits consulting firm. Chris is a lifelong resident of Indiana. Chris will be responsible for the development and maintenance of the business relationship. Serving in a consultative role, Chris will work with your staff to develop short- and long-term strategies, ensure customer satisfaction and proactively manage your plan. Chris will work closely with you to gain an understanding of your benefit plans, business needs and organizational culture. This understanding, along with Chris’ knowledge of UMR will ensure we are able to meet your needs and goals. Chris will serve as your primary contact to UMR.

FIELD ACCOUNT MANAGER

Along with the SAE, we also assign a field account manager (FAM) who will be located in Indianapolis. The FAM’s principal responsibilities include ensuring the customer’s core needs are met and communicating/escalating service issues as appropriate.

The FAM assists with contract renewal, revenue maintenance, results reporting, ongoing evaluation, benefit plan design and strategic development. The FAM will be assigned upon UMR being awarded business.

CUSTOMER SPECIALIST

In addition, UMR assigns an operations customer specialist (CS) to each customer account. The CS’s role is to serve as the single point of contact for individual claim questions or concerns brought to UMR by the SAE or the customer’s human resources (HR) or benefits staff. The CS is responsible for resolving all operational questions and issues.

The account management team will work together to ensure your complete satisfaction.

GENERATIONYOU STAFF

We are offering the State of Indiana our GenerationYou (GenYou) service model. The assigned GenYou staff will be ability to complete many types of claim adjustments, as needed, at point of call.

The GenYou team will be trained on multiple products and able to help State of Indiana members:

■ Resolve questions about their medical plans

■ Find providers, including specialists, and steer members to high-quality, low-cost providers

■ Understand Wellness Clinical Advocacy Relationships (to) Empower (CARE) and other programs that may be available to them thereby helping them make full use of these programs

■ Navigate the complexities of today’s health care environment by serving as a member advocate

We will assign both a designated GenYou team, and a backup GenYou team based in our Indianapolis service center. Our system will route calls to your assigned GenYou team first, and then to the backup team as required to provide prompt service.

With the GenYou team focused on customer service, a separate Indianapolis-based claim processing team will also be assigned to the State of Indiana to focus on the day-to-day processing of incoming claims. This team, your assigned GenYou team and its backup team will all be thoroughly trained on your unique plan design and benefits philosophy, enabling them to accurately and promptly service your plan and its participants.

1. Please describe the clinical staff resources that will be made available to the State to support strategy and innovation in the plan(s).

Every client is assigned a CARE consultant to build lasting relationships with the customers. This strategic liaison will support data driven insights and modernization where needed. We understand a customer’s unique culture and tailor the CARE experience to fit their plan goals. CARE Consultants are experts on CARE programs, have the relationships with internal partners to get the information needed and to obtain insight into what other customers have implemented successfully. We are your partner with insights into the clinical programs and understand your needs.

1. At the time of implementation and on an ongoing basis, confirm you agree to attend enrollment meetings to educate employees on transition of care, and other events.

Confirmed. The State of Indiana will have an SAE, Chris, who serves as your main point of contact at UMR. This individual will work with you to determine your enrollment meeting needs. This may include assisting members with understanding their benefits or providing information and education on our products and tools, such as **umr.com**. On-site attendance is available and we have partnered with Professional Management Enterprises to support statewide coverage. Extenuating circumstances, such as the COVID 19 public health emergency may limit in-person meetings. Note that UMR has many virtual accommodations to help you deliver your enrollment meetings successfully. We use BrainShark or other WebEx presentations for those sites with fewer than 50 members, or when in-person meetings are not the preferred venue.

During the meetings your SAE, Chris, and FAM can be made available to present and/or field questions. Some topics typically addressed include:

■ Enrollment process

■ Filing a claim

■ ID card features

■ Network overview

■ Benefit design

■ Member tools on **umr.com**

Your SAE may also call upon additional people and resources, such as the marketing communications department, as necessary.

1. Please confirm you will provide full claims and enrollment data without deidentification, scrambling, or masking to the State’s selected data warehouse provider. Provide a sample claims extract file layout with your proposal.

UMR does not share layouts with external entities prior to being awarded the business.

UMR does have a number of data sharing relationships with our customer external third-party vendors. Due to the multitude of companies providing complementary or competitive services to our customers and prospective customers, our integration capabilities are continually evolving. We welcome the opportunity to work with you and your potential vendor partner to identify strategies for coordinating to meet your integration goals.

UMR does send claim and eligibility data in UMR standard formats which includes data such as member identifiable elements (names, dob, gender, id cards, address, city, state and zip) and effective, term date spans, account structure details to drill down into various subsets of the member population. Claims details include patient names, dobs, gender and service line level claim details (procedures, diagnosis codes, modifier, revenue code, place of service, type of service, dates of service, paid date, received date, account structure details). Data can be sent as frequently as monthly to the data warehouse vendor.

One time set-up fees do apply when sending plan data external from UMR. Fees quoted include data extracts to five external vendors in standard UMR format. If custom layouts are required, additional fees will apply and are dependent upon the required layout.

When sending claim information external from UMR, UMR does require external entities sign non-disclosure agreement before data can be released.

1. Confirm you will provide reporting including, but not limited to: case management and disease management enrollment, detailed lab data (e.g. LOINC Codes and any other available detailed fields), data from third party programs SPD elects to participate in (e.g. Omada), etc.

The UMR CARE reporting package includes accurate and timely data for each of its programs. The following provides details on available reports along with their delivery schedule and method.

UTILIZATION MANAGEMENT, COMPLEX CONDITION CARE, MATERNITY CARE

UTILIZATION MANAGEMENT AND COMPLEX CONDITION CARE AGGREGATE SAVINGS SUMMARY REPORT

■ Displays savings activity for Complex Condition CARE and Utilization Management. Utilization Management savings are split by categories; for example, durable medical equipment-home health care, skilled nursing facility. Complex Condition CARE provides aggregated saving results of the program.

■ Available monthly at the end of business day 10 following the close of the reporting period.

■ Posted to **umr.com**.

COMPLEX CONDITION CARE MONITOR REPORT

■ Lists cases under Complex Condition CARE that were open at least one day in the prior month. Columns included for each case are program ID, program start date, program status, closure reason, primary diagnosis description, prognosis and projected costs. Also provides counts of completed Complex Condition CARE screenings that had been initiated in the prior month.

■ Available monthly, at the end of business day 10 following the close of the reporting period.

■ Posted to **umr.com**.

COMPLEX CONDITION CARE UPDATE REPORT

■ Provides clinical and other information for the Complex Condition CARE program that are either currently open or have closed since the first of the prior month.

■ Produced monthly, prior to the end of business day 10 following the close of the reporting period.

■ Delivered by account management staff to customers who have a business need for this additional detail.

COMPLEX CONDITION CARE INITIATION NOTIFICATION REPORT

■ Shown on this report are Complex Condition CARE programs (excluding stop loss) that have a start date in the prior week and remain open or have a valid closure reason. Displayed are diagnosis and reason for Complex Condition CARE initiation.

■ Produced weekly.

■ Delivered by account management staff to customers who have a business need for this additional detail.

MATERNITY CARE QUARTERLY REPORT

■ Displays participation, activity and clinical measures, including: outcomes detail with delivery-related measures, enrollment summary detail by trimester, participation detail by tier level, activity detail by recruitment and management and savings activity.

■ Available quarterly at the end of business day 15 following the close of the reporting period.

■ Posted to **umr.com**.

ONGOING CONDITION CARE

ONGOING CONDITION CARE QUARTERLY REPORT

■ Illustrates member outreach and participation in the Ongoing Condition CARE program. Includes a management outreach summary, recruitment summary and participation in each of the tiers. The report also includes a primary condition and condition prevalence summary.

■ Available quarterly at the end of business day 15 following the close of the reporting period.

■ Posted to **umr.com**.

ONGOING CONDITION CARE CLINICAL OUTCOMES REPORT

■ Provides a picture of member behavior and health status measurements before and after nurse management has occurred. The count of members meeting the outcome expectation is divided by the count of members with a response for each of three outcomes per condition. Internal book-of-business benchmark rates are also provided.

■ Available semi-annually on a calendar year basis.

■ Posted to **umr.com**.

ONGOING CONDITION CARE FINANCIAL OUTCOMES REPORT

■ Displays costs, trends, savings and return on investment (ROI).

■ Available annually for new customers of over 1,000 employees 27 months after the effective date; available for smaller groups if deemed necessary.

■ Delivered via secure email.

WELLNESS CARE AND CLINICAL HEALTH RISK ASSESSMENT

CLINICAL HEALTH RISK ASSESSMENT COHORT POPULATIONS TREND REPORT

■ Provides a comparison of members who completed the CHRA in both year one and year two. This comparison view shows information on the wellness score, member demographics, health risks, specific biometrics and lifestyle factors.

■ Delivered annually. In order to protect members’ personal information, 25 or more completed CHRAs are required in both time periods.

■ Delivered via secure email.

WELLNESS CARE QUARTERLY ACTIVITY AND PARTICIPATION REPORT

■ Identifies the number of member outreach activities that have occurred in the Wellness CARE program. The report includes a recruitment summary and management outreach summary for the previous three-month and 12-month time periods.

■ Counts are provided for the following categories: recruitment letters, recruitment telephone calls, coach management calls, coach management letters, educational materials and newsletters.

■ Identifies the number of members in each of the Wellness CARE program tiers (Recruitment, Accepted, Non-engaged, Completed and Ineligible). Includes data specific to members identified for the tobacco cessation program, (program tiers, member-reported reasons for declining tobacco cessation coaching, member demographics, last known tobacco usage, length of time tobacco free).

■ Delivered quarterly, based on the Wellness CARE plan year.

■ Delivered via secure email.

MEMBER ACTIVITY AND PARTICIPATION REPORT

■ Identifies members, by name, who have or have not completed the following applicable Wellness CARE program components: CHRAs, biometrics and coaching. A requisition (REQ) is required for a report to run on a day other than Monday, or when non-standard data is requested.

PLAN YEAR COMPARISON REPORT

■ Provides a year-over-year comparison (up to three years) of CHRA activity and lab/biometric activity. Coaching outcomes from the prior plan year are included.

■ Trends are displayed for categories such as member demographics, general health, weight, biometrics, nutrition, physical activity, tobacco use and stress. Specific conclusions and recommendations for the group are included, and results of the member satisfaction survey are included if available.

■ Requires two sequential years in the Wellness CARE program.

■ Distributed approximately one month after the end of period report in the subsequent year and thereafter delivered annually, based on the Wellness CARE plan year.

■ Delivered via secure email.

1. Please describe your core management reports and provide samples of the deliverables.

InfoPort, UMR’s proprietary data analysis and reporting tool, offers users a proactive strategy to pinpoint potential issues before they have a negative impact on results. With our dynamic reporting tool, the State of Indiana will have the ability to create, customize and schedule reports on demand. InfoPort’s flexibility offers a broad range of online reports that are accessible via a secure, password-protected website. With data available daily (lag of only two business days), our reporting tool helps users to identify emerging trends and review alternative plan strategies.

The intuitive online reporting tool provides users with instant access to the following information:

■ Paid claims

■ Benefit utilization

■ Claim lag

■ Financial and plan cost activity

■ Network performance

■ Enrollment

■ Adult preventive service activity

■ Admission summary

With the ability to review reports to identify emerging trends and alternative strategies, InfoPort empowers users to:

■ Monitor plan performance

■ View incurred but not reported (IBNR) activity based on incurred/paid claims

■ Identify trends and outliers by analyzing multiple years of UMR data (if available)

■ Identify high-cost patient activity based on a user-defined dollar threshold

■ Access transactional data

■ Drill down to details (protected health information (PHI) authorized users only)

■ Access various report designs

■ Customize report criteria, allowing a myriad of report variations

■ Save customized report templates

■ Schedule recurring reports with dynamic dates

■ Export to multiple formats such as Excel, PDF, Word and Rich Text

■ Provide access to report data in both PHI and non-PHI versions

Please refer to **Attachment 1**, InfoPort Report Sample.

UMR also offers the UMR Benefits Analytic Manager reporting tool as a comprehensive decision support system. This tool allows customers to analyze health care costs, utilization, quality and performance trends and measures. Users can easily filter standard summary report templates to conduct ad hoc analysis and compare their costs to robust industry normative values. Data is updated monthly.

Reporting categories within the tool include:

■ Group health plan performance measures

■ Admission measures

■ Catastrophic (high cost) claimant overview

■ Clinical conditions measures

■ Cost and utilization overview

■ Dental overview (if available)

■ Distribution measures

■ Drivers of change

■ Eligibility demographics

■ Evidence-based medicine key measures

■ Preventive service activity

■ Pharmacy measures (dependent on pharmacy benefits manager (PBM) detail)

Please refer to **Attachment 2**, Benefits Analytic Manager Sample Reports.

PLAN PERFORMANCE AND ANALYTIC REVIEW REPORT

The plan performance and analytic review (PPAR) report is an annual report offering an integrated reporting package that includes several data components including eligibility, paid medical claim cost trends, high cost claimant activity, inpatient admission and emergency care visits, paid pharmacy claims (if received), CARE data, and population health by risk distribution into a series of reports. The report requires a minimum of one full year of incurred medical claims, with 15 months of paid claims data administered by UMR.

The PPAR report is available in a PowerPoint format and will be delivered to your SAE, Chris, 10 business days after request. Chris will then provide the dashboard report to the State of Indiana as part of an annual customer meeting. The report contains year-over-year (if data is available) customer comparisons for a 24-month period and/or comparisons of the most recent customer year evaluated to benchmarks derived from the UMR book of business. Key findings related to the metrics are highlighted and opportunities/recommendations for program improvement will be identified to assist the State of Indiana with strategic plan management.

TYPES OF DATA AVAILABLE INCLUDE:

■ Enrollment and demographics summary

■ High cost claimants comparison

■ Paid medical claims activity by claimant’s relationship to subscriber

■ Clinical condition reporting

■ Inpatient admissions activity

■ Claimant service utilization

■ Network performance summary

■ Preventive service activity and screenings with comparison to benchmark

■ Paid pharmacy claims on specific reports (if applicable/subject to availability)

■ UMR book-of-business benchmarks (customer data in our reporting data warehouse)

■ CARE dashboard by product and participation (for customer-elected services through UMR), including cost and utilization

■ Population risk profile (aggregated by severity) with comparison to benchmark

■ Dental claims activity (if applicable)

PLAN ACTIVITY AND CHECKPOINT EVALUATION REPORT

The plan activity and checkpoint evaluation (PACE) report is a comprehensive report package delivering data based on the State of Indiana’s paid medical claims and eligibility activity. The summary-level report includes an enrollment versus cost trend, network utilization, and paid claims activity by place of service. The year-over-year comparison assists with identifying plan cost breakout by high-cost versus non-high cost claimants and the number of readmissions based on inpatient claims activity.

The PACE report is available in a PDF format on a monthly basis after two months of UMR paid claims data has accrued. The report time frame will be based on the plan year established by the State of Indiana. The report will be available to your SAE, Chris, upon request.

TYPES OF DATA AVAILABLE INCLUDE:

■ Paid medical claims based on customer plan year

■ Medical claim utilization

■ Enrollment summary

■ High cost claimant activity (top 20)

■ Network performance summary

■ Paid pharmacy claims on specific reports (if applicable/subject to availability)

■ UMR book-of-business benchmarks

1. Describe your online reporting capabilities. Please describe the data/information and types of reports that can be accessed and downloaded from your online system.

InfoPort is UMR’s proprietary data analysis and online secure reporting tool, which provides authorized users with the ability to create, customize, schedule and run on-demand reports. Report types include paid claims, benefit utilization, financial activities, network performance, enrollment and more. Data is updated daily with a lag of two business days.

1. How many online reporting users are allowed to set up accounts for access under the core pricing?

There is not a set limit of InfoPort licenses for authorized users to access online paid claims and eligibility data. User setup is at the group level, protected health information (PHI) and no-PHI access. UMR’s Benefits Analytic Manager reporting tool includes three user licenses. Additional licenses are available if needed.

1. How long is detailed claims data held in the system before it is archived?

Our online reporting tool, InfoPort, houses five years of medical claims and eligibility data administered by UMR, in a secure environment. Historical UMR paid claims and eligibility data over five years is securely archived.

Claim history is maintained online in the claim payment system, CPS, for 24 months. This data is stored on disks. Copies of the data are also stored on computer tapes which are updated every four hours. The tapes are kept in the data center, with additional copies maintained off-site as part of our disaster recovery program. After two years, the data is archived and stored for seven years in accordance with legal retention guidelines.

The primary data repository retains UMR administered historical claims data for a minimum of seven years.

1. Do you agree to provide all utilization reporting to the State in excel format?

Yes. The InfoPort online reporting application allows users to export reports in these formats:

■ Excel

■ PDF

■ Word

■ Rich text

Summary analytical report template data in the Benefits Analytic Manager reporting tool can be exported into PDF and PowerPoint formats for dashboard reporting or presentations.

1. Do you agree to provide monthly reports (within 10 days of the close of the reporting period) with paid claims by plan and setting, utilization by plan and setting, enrollment by plan, large claims, network utilization, network discounts, and member cost share?

Confirmed. InfoPort provides authorized users with an option to create, customize, schedule and run on-demand reports. Report data associated with eligibility and paid claims administered by UMR is updated daily, with only a two-business day lag and include paid claim information, Enrollment data and paid claims data including utilization, high cost claims, network activity and discounts, and patient cost share can be filtered by a UMR client’s account structure (plan and location). In addition, utilization by plan and location, enrollment data by plan, large claim reporting, network utilization and network analysis reporting at a summary level that illustrates patient utilization is based on an overall discount percent of paid claims (both network and non-network) categorized by the customer’s provider network.

1. Confirm that the following large claimant data will be provided to the State under a self-insured contract: age, sex, relationship to employee, status (active, term, COBRA), paid amount, primary diagnosis, secondary diagnoses, additional case management notes containing prognosis. If any of these data elements are not available, please explain.

Confirmed. InfoPort’s Claim Summary by Member report provides authorized users with the option to run a high cost claimant report setting a dollar threshold. The report provides activity at the patient or family level including patient gender, age, relationship to employee, and paid amount. Family level reporting supports an additional report drill-in within the online report to view eligibility status, and drill-in to view the claim profile.

UMR CARE Services provides a monthly Case Management Large Case Monitor report that includes the start date and status of cases that fall into case management activity during the reporting period, including the prognosis for each active (open) case.

1. If desired, can the State update and maintain eligibility and check employee claim status online?

Yes. UMR can receive eligibility information through Internet enrollment. Using the Website, the State of Indiana can easily process the following transactions:

■ New enrollments

■ Member terminations

■ Dependent adds and terminations

■ Member and dependent demographic changes

■ Member and dependent benefit changes

■ Open enrollment for new and existing employer groups and members

There is no limit to the number of users for this service. There are also alternate enrollment options available with expanded functionality for a fee.

Employers, members, advisors, partners and providers can check the status of claims via our online claim inquiry. Summary information contains claims received within the last 30 days but may be expanded to view all claims (up to 200 claims will be displayed), claim status and deductible status. UMR maintains 24 months of claim history online. The type of information viewable is the same as that shown on the explanation of benefits (EOB).

1. Do you record all call center calls?

UMR has a maximum capture call recording plan, notifying the member during the greeting that the call will be recorded for quality or training purposes. The call recordings are stored and readily retrievable for up to 60 days and then archived and kept for three years at no additional cost.

While our targeted goal for call recording is 100 percent of all calls, 100 percent capture is not realistically achievable. Our average call capture rates generally exceed 95 percent. Listed below are some instances that limit the recording percentage.

■ If inbound call volume exceeds capacity, the excess calls are rerouted through outbound trunks which are not recorded. We strive to avoid this situation, but there are a few peak seasonal days each year when this may occur.

■ If a toll-free number has a certain population of people routed through an undisclosed IVR system, the system will not record those calls. Once identified, this can be easily fixed.

■ The occasional recording card or hardware failure prevents calls from being recorded for a short period of time.

■ Transferred and outgoing calls are not recorded.

1. Will you make call transcripts available to a designated State team member to review if requested related to a member issue?

Yes. We can provide an audio recording of the service interaction of the service interaction if requested by the State. UMR is able to provide issue-specific customer service reporting to our customers. You can request this information through your account management team. We document and track incoming call information in our Calltrak system which we are able to break down by various elements. Examples include: type of call (benefit verification, claim, eligibility or COBRA), who called (customer, dependent, internal personnel, member or other/miscellaneous) and the subject of the call.

1. Will you allow access to a designated State team member to listen to recorded calls if requested related to a member issue?

Yes. UMR records more than 95 percent of all calls. In order to facilitate issue resolution, we will share available recorded calls with an authorized representative of the State of Indiana through a secure method that meets HIPAA protocols.

1. Please provide your most recent customer experience survey results.

We stand behind our Customer First philosophy. As such, it is important for us to measure customers’ satisfaction with UMR and our services. We do this with an annual customer survey generated during the third quarter of each year.

The customer survey measures customer satisfaction with our organization, personnel and services. Customer-specific results are used to identify both successful efforts and potential opportunities for improvement with each unique customer. We use aggregated survey results internally to initiate process improvement efforts, monitor performance goals and track marketplace trends.

Through 2014, our customers were asked to rate their UMR experience on a scale of 1 to 7, with 7 being the highest rating. Today, elements of our survey are scored on a scale of 0 to 10 and incorporate a question used to calculate UMR’s Promoter Score. The annual customer survey is conducted by email through a survey tool called Qualtrics.

The Promoter Score is a core measure of customer satisfaction. This is a methodology used to measure customer loyalty that is widely used across other industries and sectors, as well as the insurance industry. It is based on the question "How likely are you to recommend UMR to a colleague?" Based on the response on a 0-to-10 point scale, customers are grouped into promoters, passives and detractors. The difference between the percent of promoters and the percent of detractors yields the Promoter Score. The higher the score, the more promoters a company has and the fewer detractors.

While we do not publish our actual Promoter Scores, we feel that our customer retention rate reflects on how well we are doing. When a customer comes to UMR they stay with UMR. Our year-over-year retention rate is 92.7 percent. Additionally, our self-funded customer base has grown at a rate of approximately 17.3 percent annually since 2006.

THREE AREAS RECEIVING THE BEST SATISFACTION SCORES

We consistently have had an average rating of Satisfied to Very Satisfied in the past five years. The three areas with the best satisfaction scores are: quality of UMR service and overall satisfaction with UMR.

HOW WE ADDRESS SURVEY RESPONSES

For every score of 6 or less, the assigned SAE or director of account management develops an action plan with the appropriate department leader to address, improve, or respond to the customer. The ultimate goal is to improve delivery. It is customer feedback that helps UMR to continually update processes, resources, tools or communications to meet needs in the marketplace.

1. Confirm you provide communication and marketing resources for State specific member communication materials (educational, open enrollment, benefit plan related, ongoing communications)? Describe the resources (digital and/or print, sample communications, and your proposed approach.

Confirmed. UMR is the expert in meeting customers and their members right where they are, and that includes our communication resources. Our extensive library of materials will help educate the State of Indiana’s members on applicable programs, services and benefits options. We will work with you to recommend pieces that meet the specific needs of your plan members.

We employ a team of marketing and communications and digital solutions staff. This team is composed of experienced writers and designers working across all media platforms who develop and maintain an extensive library of print and digital materials. The State of Indiana can use these resources to support your efforts in educating your employees on their benefits. Examples include:

■ Member materials for employee meetings, as well guides for presenters

■ Audiovisual resources for employee meetings (such as slides or Web conferencing for geographically dispersed employee populations)

■ Member-oriented videos

■ Online information at **umr.com**

■ Pre-composed emails to members

■ Bulletin board and other notices (posters, table tents, flyers, etc.)

■ Information that can be included in newsletters for members

■ Information on regulations that impact an employee benefit program

■ Other materials as needed

1. Do you plan to use contract employees to conduct open enrollment meetings or subsequent educational meetings for the State? If so, to what extent and how can you ensure high quality performance?

Your SAE, Chris Isaacs, will work with you to determine your enrollment meeting needs. This may include assisting members with understanding their benefits or providing information and education on our products and tools, such as **umr.com**. On-site attendance is available for groups with 50 or more attendees. Extenuating circumstances, such as the COVID 19 public health emergency may limit in-person meetings. Note that UMR has many virtual accommodations to help you deliver your enrollment meetings successfully. We use BrainShark or other WebEx presentations for those sites with fewer than 50 members, or when in-person meetings are not the preferred venue.

During enrollment meetings Chris and the assigned FAM can be made available to present and/or field questions. Some topics typically addressed include:

■ Enrollment process

■ Filing a claim

■ ID card features

■ Network overview

■ Benefit design

■ Member tools on **umr.com**

Your SAE may also call upon additional people and resources, such as the marketing communications department, as necessary.

We will work with the State to help meet any reasonable open enrollment objectives and are continually working to offer high quality performance. Enrollment materials are typically available two weeks from the time we receive notification of the final dates for the open enrollment period, workshop discussions or topics, and anticipated attendees.

Chris will also discuss the details of and work with the State of Indiana to accommodate participation and materials for health and benefit fairs or other educational meetings.

Additionally, UMR will complete substantial up front training with our contracted partners to ensure they are fully aware of and engaged with the details of the State’s plan. Following open enrollment events we will debrief to ensure the event has met expectations.

1. What educational materials do you provide on an ongoing basis? Can these be provided electronically for the State to use or adapt?

UMR has an extensive library of materials that can be used to help educate the State of Indiana’s members on applicable programs, services and benefits options. These educational pieces are available in a variety of formats, such as flyers, posters, brochures, table tents, post cards, newsletter articles, payroll stuffers and interactive media. We will work with you to recommend pieces that meet the specific needs of your plan members. We are willing to provide these materials electronically and willing to discuss the State’s adaptation of these materials further.

UMR CARE offers a selection of flyers and newsletters to educate and motivate plan members. For example, the tri-annual publication of Healthy You digital magazine is part of an enhanced strategy to extend the reach of our award-winning health information as we continue to grow our online readership. Healthy You is promoted through UMR’s digital channels to keep members engaged throughout the year. Part of our engagement strategy will include monthly Healthy You email blasts to share with your employees.

As a UMR CARE customer, you’ll receive the Microsoft Outlook email templates as attachments to your monthly Healthy You messages. The ready-to-deliver email messages will extend Healthy You to readers’ inboxes, with links to each season’s magazine and related content. We are able to provide the same content in a PDF, if needed. The information can be forwarded as an attachment or posted to an Intranet site to share with employees.

In addition, as part of a 12-month communication schedule, the State of Indiana can receive a monthly news article focused on a specific health topic, along with a related poster for distribution/display. You can publish the news article in your own internal newsletter, or post on your employee website or other resource. We can provide some information in Spanish upon request.

1. Please confirm that actuarial modeling, underwriting, cost projections, member impact assessment, etc. will be provided for special requests at no additional charge.

The following actuarial services are included in base administration fees:

■ Non-certified premium equivalent rates and COBRA rates can be obtained from underwriting.

■ Non-certified IBNR/reserve recommendations are available via the UMR InfoPort reporting tool.

■ Estimates of the financial impact of benefit changes can be obtained from underwriting.

The following actuarial services are available for purchase:

■ Certified premium equivalent rates/COBRA rates. These are sometimes called working rate projections and actual rate recommendations for current year and future years because this analysis accounts for group-specific cash flows to determine the rates.

■ Certified IBNR/reserves/lag analysis.

Following are examples of other certified services you can purchase either from UMR Actuarial Services or Optum Actuarial Services:

■ Creditable coverage calculations for Medicare Part D

■ Post-retirement valuation reports (also known as FAS 106)

■ Mental health parity quantitative testing

■ Retiree drug subsidy (RDS) attestations

■ Optum Actuarial Toolbox

■ OptumHealth Technology Pipeline Suite (HTP)

Actuarial Services are optional to the group or broker and will be charged based upon the complexity of the project requested. The amount of work depends on the size of the group, the level of services, and the amount of complexity with the data (such as integrating pre-UMR data). All costs are determined in advance and agreed to prior to any work being performed.

1. Will you draft (both initial and final) Summary Plan Descriptions (SPDs) and Summaries of Benefits and Coverage (SBCs) for the plan(s) and provide electronic copies to the State?

Yes. UMR will help the State of Indiana create a summary plan document (SPD) that is compliant with federal regulations. We maintain a staff of 57 plan writers who have an average of 11 years of experience. Plan writers are responsible for their assigned documents, from initial draft and formatting to the final, approved version. They capture your benefit design requirements during implementation and modify the document accordingly. An electronic copy of the SPD is included in our fees; paper copies are available on a cost-plus-postage basis.

UMR will also assist the State of Indiana in creating a summary of benefits and coverage (SBC) document to comply with the health care reform (HCR) mandate. This mandate ensures that benefits and coverage information is presented in clear, consistent language to help consumers better understand their coverage and more easily compare options. The SBC document is not to exceed four double-sided pages and requires the use of 12-point type and mandatory headings and content.

We offer two options for creating an SBC document. Both include coverage examples with calculations:

■ Full: We will coordinate with OptumRx and integrate pharmacy benefits information to complete the entire SBC.

■ Partial: If we provide medical administration but an external vendor is used for other benefits services, we will create the document for UMR services only. The customer is then responsible for completing any information from an outside vendor and calculating coverage examples within the SBC document. However, if UMR approves an exception, we can include external vendor information for an additional fee.

SBC documents are provided in Microsoft Word to the customer electronically. Additional fees apply for printing and distributing as well as translations into non-English text and more than two SBC requests per year.

**1.6 Member Services**

1. Confirm the hours of operation for your customer service team.

We are proposing a GenerationYou (GenYou) team dedicated to the State’s plans. UMR offers live GenYou member service 24 hours a day, seven days a week, excluding major holidays. Employers who do not wish to have member calls handled by our Philippine employees can request exclusion from the extended service hours program.

Members will also be able to contact GenYou guides by email. Guides return emails within 24 to 48 hours, or by the next business day.

1. Will the State of Indiana have a dedicated 800 number?

Yes. We can assign a dedicated toll-free number.

1. How are calls handled that are received after hours (if applicable)?

UMR provides extended member service 24 hours a day, seven days a week, excluding major holidays. We also offer live member chat services through our website at **umr.com** through our Customer Connect program. This service is an optional program. Employers who do not wish to have member calls handled by our Philippine employees can request exclusion from the extended service hour program.

For providers and members, especially for those employers who do not wish to take advantage of our extended member service hour program, we also provide after business hours support online at **umr.com**. With just a single click, members can view and download eligibility, benefits and claim detail information. Members can also update other insurance and accident detail information online or by using our 24-hour automated voice service. For customers who purchase NurseLine, callers can access triage nurses 24 hours a day, seven days a week.

1. Is there an IVR system in place?

Yes. UMR offers the following IVR capabilities for members.

■ Flexible spending account (FSA):

■ Fax status

■ Claim status

■ Payments

■ Account balance information

■ Provide other insurance or accident details

■ Order ID cards

1. What is the location of your call center(s)?

We anticipate providing claim and customer service for the State of Indiana primarily out of our newly-aligned Indianapolis, Indiana, office located at 7400 Woodland Drive. UMR has a group of experienced GenYou guides who telecommute to allow better member service across time zones. All guides have access to our fully integrated systems and can use instant messaging, telephone and email as a means of communicating with other internal UMR staff. These guides have access to the same information as in-office guides and are subject to the same security practices and quality standards. Our sophisticated reporting systems provide consistent monitoring of all metrics for both telecommuting guides and in-house guides.

1. What call center(s) would be responsible for servicing the State’s members?

We anticipate providing claim and customer service for the State of Indiana primarily out of our newly-aligned Indianapolis, Indiana, office located at 7400 Woodland Drive. Other customer service will be provided by GenYou guides telecommuting from their homes.

1. Could you provide a call center in Indiana if desired by the State?

Yes. We anticipate basing the State’s services out of the Indianapolis, Indiana, office located at 7440 Woodland Drive.

During the transition to UMR, we will support the State’s members and providers using our GenYou services located in UMR’s Wausau, Wisconsin, office. We anticipate hiring around 40 full-time employees to service the State of Indiana’s plan.

1. Are you proposing a dedicated (i.e. only the State) or a designated customer service call center for the State?

We are proposing a team dedicated to the State’s plan and will base the team out of the Indianapolis office. GenYou guides will be dedicated only to the State. The State of Indiana’s claim/service team will consist of 12 claim processors, 21 GenYou guides and five provider call representatives.

1. If customer service call center representatives are designated, on average, how many clients does one team service?

We are proposing a team dedicated to the State of Indiana’s plan and will base the team out of the Indianapolis office. GenYou guides will be dedicated only to the State of Indiana. The State of Indiana’s claim/service team will consist of 12 claim processors, 21 GenYou guides and five provider call representatives.

1. What is the average length of service of the representatives that will be supporting the State?

Upon award of business, we will begin identifying possible representatives, selecting existing staff and hiring the most experienced dedicated team for the State of Indiana. While we do not have statistics available for a team that will be created specifically for the State of Indiana and its membership, we can tell you our book-of-business representatives have an average of 2.9 years’ experience.

1. Are member and provider calls handled by the same or separate customer services units?

We are proposing a team dedicated to the State of Indiana’s plan and will base the team out of the Indianapolis office. GenYou guides will be dedicated only to the State of Indiana. The State of Indiana’s claim/service team will consist of 12 claim processors, 21 GenYou guides and five provider call representatives.

1. Are customer service calls handled by the same person administering claims, or are they separate units/processes?

We are offering the State of Indiana the GenYou service model.

With the GenYou guides focused on customer service, separate claims processors will be assigned to the State Indiana to focus on the day-to-day processing of incoming claims. This team, your assigned GenYou guides and a backup team will all be thoroughly trained on your unique plan design and benefits philosophy, enabling them to accurately and promptly service your plan and its participants.

We will also assign a customer specialist (CS) to the State who is accessible to your human resources (HR) staff for employer-level customer service.

1. Does your customer service system allow representatives to record comments so other customer service representatives can view previous notes to assist members?

Yes. The intuitive GenYou advocacy dashboard gives our guides the ability to log the actions they have taken on phone calls. These logged actions help us to better understand what is happening on the phone calls and will help us to report on the effectiveness of the program. The dashboard also helps identify opportunities and gaps in care, offering guides a wealth of member information at their fingertips. The dashboard links to different system points for additional detail and contains real-time information organized in easily readable tiles, so that guides and CARE Support guides can review and access information quickly and easily. By decreasing the need for guides to access multiple programs for the information they need, we increase efficiency during each member call.

In addition to the advocacy dashboard, GenYou guides also access the Call to Action application, which displays the unique advocacy priorities that the customer outlines as important for their members. These priorities are collected from the account management team and customer and are loaded into the dashboard. Call to Action gives guides and CARE Support guides the ability to better understand specific customer priorities and engage the member in a focused conversation beyond their initial call reason.

Call to Action also includes a member's specific Things to Do list, which are data-driven, personalized and prioritized suggested next-steps. For example, a member's Call to Action might include:

■ Complete their Story of You activation questionnaire

■ Switch providers to a higher-quality, lower-cost in-network option

■ Seek alternative places of service for those frequenting emergency rooms

■ Connect to a primary care physician (PCP)

■ Pursue important immunizations

■ Register for or use their Teladoc benefit

■ Engage in a CARE clinical program, such as Maternity CARE or Ongoing Condition CARE (disease management)

1. Describe your online support capabilities where a member can chat online with a customer service representative or email a question.

If you choose GenYou services and allow offshoring of calls, guides will be available for member calls 24 hours a day, seven days a week. If you do not allow offshoring of calls, guides will be available for member calls between the hours of 7 a.m. to 7 p.m. CT, Monday through Friday. After these hours, calls will be routed to our after-hours staff.

By using our employees in the Philippines, UMR can expand our customer service hours and offer telephonic and chat services for both medical and dental members, 24 hours a day, seven days a week excluding major holidays. These extended hours are available at no additional cost, and each customer has the option of opting out of the 24-hour service if that is their preference.

If the customer does not allow offshoring calls and a matter requires guide intervention, the after-hours staff will leave a message with the GenYou team to reach out to the member at an agreed upon time.

Online chat is available for the GenYou model through our website at **umr.com**; however, chats are responded to by a regular customer service representative, not a guide. Chat is offered 24 hours a day, seven days a week, excluding major holidays. Online chat services are only available for customers allowing offshore member services.

We also provide after business hours support online at **umr.com**. With just a single click, members can view and download eligibility, benefits and claim detail information. Members can also update other insurance and accident detail information online or by using our 24-hour automated voice service. For customers who purchase NurseLine, callers can access triage nurses 24 hours a day, seven days a week.

1. How do you ensure that your representatives are providing accurate information to members?

Our quality team randomly monitors each GenYou guide. The results are used as part of a guide’s evaluation. We run daily reports that show the average speed of answer, abandonment rate, total calls received and average talk time. We use these reports to adjust staffing to meet and exceed our service objectives. In addition, the member is given the opportunity to complete a customer service survey at the completion of their call. The survey results are part of the guide’s evaluation. The State will receive data related to this member feedback as part of your GenYou reporting package.

1. What languages are available to members through the call center? What services are available for members with a speech or hearing disability (e.g. IP CTS)?

For members who speak other languages and need an interpreter, UMR uses a national vendor called Telelanguage. This vendor provides interpretation services for more than 200 languages and is available 24 hours a day, 365 days a year. This is not a voice-activated system, and the UMR GenYou guide stays on the line with the member and the translator.

UMR does not have TTY or TDD (telecommunications device for the deaf) capability Many hearing-impaired members contact us, as they do other companies and physicians, using the telephone company’s relay service. This service is free, HIPAA-compliant and available to anyone who requires assistance and has TTY equipment. It is provided throughout the United States.

1. Can you “warm transfer” calls to the PBM or other vendors?

Yes. Our GenYou guides can transfer callers to external contacts such as PBMs, employee assistance programs (EAPs) and other third-party vendors. However, external vendors must be willing to provide UMR with a toll-free number that will bypass any IVR functionality and prioritize our calls with their agents. External vendor information is captured in the advocacy dashboard for easy access.

1. Please provide your most recent customer experience survey results.

UMR is committed to delivering and demonstrating excellence. In accordance with this value, and to measure member satisfaction, we offer telephonic surveys upon completion of their service call.

The survey requests feedback on the member’s interaction with the customer first representative (CFR) along with other customer service factors. Survey results and feedback are trended and used internally to identify opportunities to change and improve processes and procedures to effect a positive change in the overall service experience of our members.

MEMBER SURVEY RESULTS

Our member satisfaction survey is delivered telephonically upon completion of the service call and asks five questions. The first two questions are related specifically to the member’s customer service interaction and experience with the customer first representative. These two questions offer 11 rating response choices ranging from extremely satisfied (10 rating) to not at all satisfied (0 rating). We calculate the percent positive results by taking the number of questions answered as satisfied on completed surveys, which range from a 6 to a 10 rating, and dividing that number by the total number of questions answered. The remaining three questions are specific to other aspects of the service provided including an open-ended question that solicits feedback on what we can do to improve the member experience.

The five survey questions are shown below:

■ How satisfied were you with the accuracy and completeness of the information you received in response to your questions?

■ How satisfied were you that the person you spoke with demonstrated concern for your needs?

■ Was the reason for your call answered? (yes/no)

■ How many contacts did it take to resolve your question?

■ What can we do to better serve you?

OVERALL MEMBER SATISFACTION RESULTS

Over the past five years UMR has continually exceeded our 90 percent positive member satisfaction standard. The percent of positive book of business member satisfaction results by year are:

2020 2019 2018

Medical member satisfaction results 96.9% 97.3% 98.5%

Dental member satisfaction results Not yet available 99.3% 99.0%

Flexible Spending member satisfaction results Not yet available 98.5% 99.3%

While UMR does not report member satisfaction survey results by question, claim supervisors use the survey results to monitor individual CFR member satisfaction survey ratings and address any issues. The survey results are also one metric of many included in rating the CFRs performance weekly, monthly and annually. Performance to these metrics is one factor used in determining annual merit increase amounts for the CFRs.

Customer-specific survey results are used internally. Since member survey participation is voluntary, and the number of surveys completed for individual employers are most often not statistically valid, we do not share survey results with our customers as a standard. However, we will work with the State of Indiana to find a mutually agreeable solution to meet your needs, which may include sharing any plan-specific or vendor comments with you.

CUSTOMER-SPECIFIC MEMBER SATISFACTION SURVEYS

UMR is willing to offer a customer-specific member satisfaction survey based on a mutually acceptable format. This could include negotiated performance targets for inclusion in performance guarantees.

There may be a cost associated with a customer-specific member satisfaction survey depending on the complexity involved, work required in administering it, and number of surveys expected to be sent.

1. Can you customize the website your organization provides for the State?

Yes. UMR customizes the member portal at a group and individual level. During the implementation process, we will work with the State of Indiana to determine the information that will be available to your members.

Our employer information center is customized at the individual user level. Employer-level users see only what they need to in order to administer their benefit plans successfully.

1. Discuss your online services available to members, including tools and information available through the portal.

We empower our members by equipping them with tools to manage their health that are easy to access and intuitive to use. Our website, **umr.com**, offers members 24 hours a day, seven days a week access to:

■ Online self-registration for the Website

■ Claim inquiry

■ Eligibility inquiry

■ Benefits inquiry

■ Online chat (depending on service location)

■ Email access to customer service

■ Cost-estimation tools (dependent on network)

■ Online provider directory

■ Ability to view and download ID card

Our site also offers members tools to help them make sound health care decisions:

■ **Enrollment and Plan Modeling**: Decision support is available through our Benefit Plans Comparison Tool (BPCT). This consists of tools that help consumers model their expected care events in the coming year and select the most appropriate benefit plan based on their needs. They will also help determine contribution amounts to health savings accounts (HSAs) and flexible spending accounts (FSAs) with integrated HSA/FSA calculators.

■ **Health Education Library**: Content is available via our Health Education Library, in both English and Spanish, which has more than 20 different modules in four broad categories to increase the health literacy of consumers, including:

■ Health content which includes:

■ Diseases and conditions

■ Self-care and nutrition

■ Injuries, surgeries and procedures

■ Questions to ask your doctor and Discharge instructions

■ Drug content which contains:

■ Drug encyclopedia

■ Drug interaction checker

■ Interactive health tools which include:

■ Health navigator (symptom checker)

■ My Checkups

■ **Wellness tools and calculators**

■ **Healthcare Cost Estimators/Calculators**: These tools are offered via UMR’s cost transparency program. This consists of our Provider Search and Cost Transparency tool and Treatment Cost Calculator (TCC) tools, which provide members pre-service, cost estimations for improved “shopping” abilities. Members can estimate treatment costs using robust calculation logic and also see what their out-of-pocket cost is expected to be, given their current benefit plan and accumulators.

■ **Links to Health and Wellness Centers**: We offer these as well as links to other sites which promote education and healthy behaviors.

1. Do you offer a mobile application or a mobile optimized website?

Yes. UMR supports mobile member users in two ways:

Registered members have access to the full functionality of **umr.com** through a mobile-responsive website. Users can place a bookmark icon on their device’s home screen for easy, frequent access.

Members who prefer a native app experience can download the UMR Claims & Benefits app from the Apple App or Google Play stores. This first-generation app gives members access to claims benefits information and a digital ID card. It also allows them to link to the mobile responsive site for additional information.

Our goal is to make the mobile experience as quick and easy as possible. We will continue to support the mobile-responsive website as we further develop our native app capabilities.

1. Describe any enhanced customer service options (e.g. concierge services) that you offer?

We are proposing our internal member advocacy program, GenYou. GenYou is a truly personalized, uniquely targeted solution that breathes life into the member experience. We align advocacy and CARE capabilities to steer members toward more optimal health care decisions. By offering customer service and clinical services through one source, our members experience a one-stop shop approach to advocacy that meets them where they are in their health journey.

Some components that set GenYou apart:

■ Story of You digital onboarding experience to help members get to know their plan and proactively drive early outreach to high-risk members

■ Personalized alerts and notifications to prompt members to become active agents in their health care

■ Care Prepare consultations offering members rewards for pursuing pre-service education on the highest-quality/lowest-cost options

■ Expert guides and CARE Support guides available to advise members by phone or chat

■ Intercept and redirect providing opportunities for member steerage through proactive outreach

■ An expansive stratification engine that goes beyond the standard to identify members needing support – including (but not limited to):

■ Story of You member questionnaire responses

■ Social determinants of health risk scoring based on location

■ Diagnosis and historical utilization patterns (medical and pharmacy)

■ Customized incentive opportunities

■ Integrated CARE programs offering clinical support across the health continuum, including behavioral health/substance use disorder needs and recovery, and assistance with specialty medications

GenYou’s multi-channel engagement strategies offer a modernized approach to personalized and meaningful engagement that educates, empowers and steers members to consistently make more optimal health care decisions. For members, this means improved health conditions by ensuring they have the right level of care at the right time and clinical support to coach them along the way. Employers see improved outcomes, lower costs and greater employee satisfaction.

1. Please describe the tools and resources available to members on their mobile device.

UMR offers our members mobile access to our website. When accessing **umr.com** on a mobile device, members can:

■ Look up claims

■ View benefits and coverage

■ View account balances (health reimbursement accounts (HRAs) and flexible spending accounts (FSAs))

■ View or fax a copy of their ID card

■ Find a provider (plan-specific)

■ Access health and wellness tools

Features available outside of the login include:

■ Our public “Find a Provider” functionality

■ How to contact UMR

■ Information about UMR products and services

1. Describe any online transparency tools you have available that members can access to view quality and cost information on your network providers. How updated is the information on the site and can the tool show the state-specific tier for each provider?

UMR delivers to members a consolidated provider search and cost tool that allows members to complete intuitive and comprehensive searches on upcoming, planned care. The tool utilizes a natural language search which delivers a clean and easy to engage experience for members. Members can search using simple terms like “knee pain” or “baby” and see a list of shoppable carepaths that they can select from and drill down into. Member can also search by provider name, location, specialty, type of service, and condition. The tool covers over 900+ carepaths and service codes allowing members to get educated and informed on the vast majority of all shoppable care.

The tool is updated frequently as it mirrors data utilized with our providers and facilities to pay claims. Quality data is available on both objective and subjective metrics through the UnitedHealthcare Premium Designation program and our partnership for consumer ratings with Healthgrades and is updated frequently. Cost estimates generated through the tool also integrate live benefit plan design and accumulators allowing members to have visibility to their expected out-of-pocket (OOP) member responsibility based on current status. The provider search and cost tool does have the ability to reflect tiered benefits (depending on specific design) and associated iconography that allows members to visually confirm top tier providers.

This tool is also used extensively by our advocates/plan advisors and member service support teams to assist members in making optimal choices and understanding tiered benefit designs when selecting a provider. Our tool is being utilized across a membership base of more than 31+ million members and has been volume and quality tested extensively. The tool is available through all digital channels including the member portal and allowing mobile access through our responsive design member experience.

1. Do your cost transparency tools account for member specific benefit plan provisions including network tier when displaying estimated costs?

UMR delivers a provider search and cost tool that allows for tiered network benefits (within certain parameters) that are reflected with clearly visible iconography in search results – allowing members to easily identify where a provider may fit in the tier structure. Tiered iconography also allows UMR Advocates/Plan Advisors and member service teams to provide steerage/education around the benefits of using a top tier provider.

1. What reading grade level are your written and website communications written to?

Standard UMR print and digital member communications do not exceed a literacy level of eighth grade, and many are written at a lower grade level.

As part of our mission to help people live healthier lives, UMR and UnitedHealth Group are addressing low health literacy nationwide and working to empower people to more easily access, understand and act upon important health information. We are striving to create clear, simple and understandable health resources.

We are also helping to align the company's businesses with new health literacy standards outlined in the PPACA, and by federal and state governments, regulatory and accrediting groups, customers and consumers.

Our goal is to provide consumers with the simplest, most understandable and actionable health information possible. To this end, we developed:

■ Health literacy awareness and skills training programs taken by over 30,000 internal and over 1,000 external participants

■ Guidelines for creating written communications in plain language and using appropriate design principles

■ Just Plain Clear English-Spanish Glossary - a resource providing more understandable words for complex terms

■ Doc Scrub - a tool for calculating a document's reading grade level based on Flesch-Kincaid results

The Flesch-Kincaid readability scale calculates the complexity of a communication in terms of sentence length and the number of syllables in the words used. UMR is capable of producing communications within the level requested, depending upon the content of the communications.

Our explanation of benefits (EOBs) have readability scores around 40 percent, which generally places the form at an eighth to 10th grade reading level, depending on whether you are checking the standard detail with legend or the field explanations. We have a standard member communication that translates each component of the EOB into simple explanations. We also can provide this flyer in Spanish.

Unfortunately, health care includes many multi-syllabic words (such as deductible and emergency), which cause reading levels to run higher. UMR provides support materials to assist members in understanding common health care terminology, such as our Learn the Language of Health Care flyer.

We employ marketing communications and digital solutions staff composed of writers and designers working in all media. This team develops and maintains an extensive library of print and digital resources the State of Indiana can use to support your efforts to educate your employees on their benefits.

1. When health plans include tiered provider networks to drive lower cost and better quality, consumers generally need to be more knowledgeable about various aspects of health care and health insurance. What communication strategies will you use to educate employees and the dependents of the employees?

UMR is the expert in meeting customers and their members right where they are, and that includes our communication resources. Our extensive library of materials will help educate the State’s members on the available tiered network options. These educational pieces are available in a variety of formats, such as flyers, posters, brochures, table tents, post cards, newsletter articles, payroll stuffers and interactive media. We will work with you to recommend pieces that meet the specific needs of your plan members.

GenYou Intercept and Redirect also will help members navigate to the most optimal provider in terms of cost, quality and location. CARE Support guides will reach out to members who have made or are likely to make non-optimal decisions in pursuing care from a non-network provider, or from a non-optimal network physician or facility, including those providers in Tier 1.

How it works:

■ Member steerage is triggered when a CARE guide or GenYou guide receives a prior authorization request or benefit inquiry for a non-network provider. Some prior authorizations for network services also provide an opportunity for steerage.

■ The CARE guide or GenYou guide will research if a higher-quality, more cost-efficient option is available. The guide will take into consideration location, availability and cost.

■ If a preferable option is found, the CARE guide or GenYou guide will contact the member via phone, email and/or mail to encourage redirection of care.

■ The CARE guide or GenYou guide can help the member schedule appointments and transfer medical records to the new provider or facility.

By intercepting the member during this process, the CARE guide or GenYou guide can navigate them to higher-quality, network providers and facilities, resulting in better health outcomes and cost savings for the member and the plan. The GenYou member portal and app will also display notifications, alerts and important messages relating to the member’s upcoming services, providing member steerage and education on the benefits, cost savings and quality of network treatments (when applicable).

1. Are your website and mobile application compliant with WCAG 2.1 AA accessibility standards? If not, which guidelines do not meet the standards and when do you expect to become compliant?

Although UMR’s website is not fully WCAG 2.1 compliant, our developers have experience building websites across diverse business segments and have access to standards, best practices and experts highly experienced in Web accessibility.

In general, our approach is to implement accessibility during new development with customer-facing functions. With existing websites, we look to address accessibility with our Web development road map. In addition, we take our customers’ feedback seriously. When feedback is submitted and/or improvements suggested, we assess those needs and determine how we can potentially accommodate such needs based on our Web road map, organizational requirements and feasibility.

UMR’s member portal is assessed annually by the UnitedHealthcare Digital Accessibility Program to identify areas that need to be addressed to provide greater accessibility and functionality for all users.

The GenYou mobile app is designed to offer modern digital experiences and meet WCAG accessibility standards.

1. What is your frequency and method of distribution of EOBs?

If payment is made to the employee, the check and EOB are mailed when the claim is adjudicated. If payment is made to the provider, the EOB is generated weekly on the same day the provider check and remittance advice is mailed. This ensures all parties receive the information at the same time, reducing any confusion.

To help us all reduce our carbon footprint, members will not receive a mailed, paper EOB if they have no payment responsibility for the claim or if their only responsibility is a flat copayment. Members can view their claims and all EOBs electronically on the **umr.com** member portal. Members without Internet access can call the toll-free customer service number on their UMR member ID card for claim information.

1. Are your EOBs customizable for the State?

Yes. Our options for customizing EOBs include adding a corporate logo, customer-specific telephone number and custom URL. Because the design has limited characters and spacing, other requests for customization are reviewed on a case-by-case basis.

1. Are EOBs provided to each dependent for their services and mailed to the subscriber’s address on file unless a request has been made by the dependent for an alternative mailing address?

Yes. We can use alternate addresses for dependents upon request by the member and EOBs will be delivered to those addresses. If payment is made to the employee, the check and EOB are mailed when the claim is adjudicated. If payment is made to the provider, the EOB is generated weekly on the same day the provider check and remittance advice is mailed. This ensures all parties receive the information at the same time, reducing any confusion. To help us all reduce our carbon footprint, members will not receive a mailed, paper EOB if they have no payment responsibility for the claim or if their only responsibility is a flat copayment. Members can view their claims and all EOBs electronically on the **umr.com** member portal. Members without Internet access can call the toll-free customer service number on their UMR member ID card for claim information.

* 1. **Legal, Regulatory, and Compliance**

1. Confirm that you will support the State in complying with the Patient Protection and Affordable Care Act, as applicable, and any future changes to health care regulations.

Confirmed. UMR is compliant with HIPAA, EDI, Department of Labor (DOL) and Health and Human Services (HHS) laws and state regulations as they apply to TPAs. The administrative services UMR provides comply with federal regulations. UMR is committed to ensuring we are continually compliant and invests significant resources into keeping ourselves well informed. This includes trade association memberships, regulatory newsletters, benefit society memberships and news services from legal/legislative sources. We assign a high priority to the institutionalization of these legislative requirements from both an operational and budgetary perspective.

For each provision being implemented, UMR creates an overview document explaining the provision, how it affects self-funded plans and any UMR operational impacts. As additional guidance is received these communication documents are updated and your SAE will share as appropriate.

1. What is your standard practice for communicating and implementing forthcoming legislation impacting the State’s plans?

Your strategic account executive (SAE) will provide ongoing communication regarding PPACA and other federal requirements. For each provision being implemented, UMR creates an overview document explaining the provision, how it affects self-funded plans and any UMR operational impacts. As additional guidance is received these communication documents are updated and your SAE will share as appropriate.

Any other organizational or system updates will also be communicated through your assigned SAE in advance of their implementation.

1. Please explain your practices relative to ensuring that the Plan is kept in compliance with the following regulations: PPACA, HIPAA, GINA, and Indiana statutory obligations.

UMR will provide the State of Indiana with key information on legal/regulatory changes as well as our business plan to address those changes. We will also provide materials to assist in your compliance efforts and offer sample notifications, as applicable. The administrative services UMR provides comply with federal regulations. UMR is committed to ensuring we are continually compliant and invests significant resources into keeping ourselves well informed. This includes trade association memberships, regulatory newsletters, benefit society memberships and news services from legal/legislative sources. We assign a high priority to the institutionalization of these legislative requirements from both an operational and budgetary perspective.

1. In the event of a loss of PII or PHI, will you agree to provide credit monitoring services to members free of charge?

UnitedHealthcare will provide credit monitoring (12 months at no expense to the member or the State of Indiana to any affected individuals, if the breach compromises any personal information that may have an adverse effect on the individual's financial identity.

1. Confirm you agree to allow the State, or its representative, the right to audit all claims?

UMR recognizes that from time to time the State of Indiana may wish to perform an audit for quality purposes. We are happy to assist with external audits as long as they are based on a statistically valid random sampling. The intent of the audit must be to evaluate the overall performance of UMR’s claim administration services. Audits may encompass any relevant information reasonably required that is consistent with professional auditing practices and procedures, as mutually agreed upon. We require a confidentiality agreement to be signed prior to an external audit; these are developed on a case-by-case basis once the scope of the audit is identified.

Aside from Department of Labor (DOL) or regulatory audits, we support one audit per year. UMR will select and compile the requested records, including computer-selected samplings, specific types of claims identified through random selection or stated dollar amounts and/or ranges. The audit must encompass a random sampling processed during no less than the recent six-month period and no more than the recent 18-month period, unless special or severe circumstances exist and are agreed to by UMR.

While we provide internal support at no additional cost, charges incurred by the audit firm are your sole responsibility. Please note: The auditors cannot be compensated based on a percentage of errors found, percentage of recovery or other similar contingency. UMR must be informed of the audit intent at least 30 calendar days prior to the audit. UMR will have the opportunity to review a draft report of the audit and provide responses prior to final issuance.

1. Confirm you allow the State or its representative access to physician and hospital provider contracts for the purposes of conducting the audit, subject to a non-disclosure agreement?

We are agreeable to an audit provision that affords the State of Indiana or a mutually acceptable entity the opportunity to audit us once per calendar year to determine whether medical claims are being administered in accordance with benefit plan requirements under our administrative services agreement (ASA). We permit annual claim processing audits that are consistent with generally acceptable auditing standards, such as a statistically valid, random sample audit that employs acceptable sampling and audit methodologies where the audit firm is not paid on a contingency basis and does not include electronic/data mining audits that are used for purposes of recovery discovery.

As part of the random sample claim audit, we provide enough data to support the confirmation that the plan is paid in accordance with plan agreements and provider agreements. Once the audit sample is selected, and the audit firm is on-site at our UnitedHealthcare facility, they will be able to view the claim payment system which contains the provider contracted amounts that the claims were processed from. They may also view the fee schedule screens to determine that the claim was calculated correctly against the provider fee schedule.

The audit firm may view specific facility contracts for up to 10 percent of the claim sample in order to validate for a subset of the sample that the system is correctly applying the provider contract rates. The specific contracts would be chosen prior to the audit so that these can be in place for the audit firm during the on-site audit process. Requests for inclusion of facility contracts require additional preparation time prior to the on-site audit to secure the contract information.

1. Identify any legal actions or proceedings TPA has been involved in related to providing network services and claims administration services to self-funded clients.

From time to time, UMR is named as a defendant in various civil matters during the ordinary course of business. None of such lawsuits, either individually or in the aggregate, have at any time, even if the outcome were to be unfavorable to UMR, been of such a nature to materially or adversely impact UMR operations or our financial situation. We are unable to disclose further information and related details, as they are deemed confidential.

* 1. **Provider Network(s)**

1. Please provide the name of the network(s) you are proposing for the State. Please provide a listing of your proposed network(s) in electronic format. The list should include the names of specific clinics and facilities in each network tier (if applicable).

In addition to offering our UnitedHealthcare Choice Plus network, we are also offering our UnitedHealth Premium program as a tiered network option. Both network options offer a robust national network while provide quality and cost-efficient care. The Premium program evaluates and recognizes physicians who meet national industry standards for quality and local market benchmarks for cost efficiency. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help your employees locate quality and cost-efficient providers. Physician designations include a range of specialties, including primary care and sub-specialties, which account for more than 80 percent of an employers’ average medical spend.

QUALITY

Physicians are evaluated using quality criteria derived from evidence-based medicine standards, national guidelines published by clinical societies and with input from leading physicians practicing in specialty areas. A physician’s quality outcome is determined by comparing a physician’s observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. This is important for customers implementing programs across their entire population, as the definition of quality is consistent across all markets.

COST EFFICIENCY

Physicians that meet quality standards often provide appropriate testing, medications, procedures and follow-up care more efficiently. Cost efficiency is defined as using the least costly medical resources to treat a medical condition to achieve a desired outcome and/or level of care. Cost efficiency criteria are based on patient care provided over an entire procedural episode of care, including use of diagnostic testing, the procedure itself and follow-up care. Total treatment costs based on UnitedHealthcare claims data are compared to market standards.

UMR has approximately 247 customers using custom network solutions. As we work with our customers to develop custom network solutions, we review any carve-out network arrangements to ensure compliance with our primary network solution.

Links to provider directories are posted online at **umr.com**. The directories are updated regularly (the frequency of updates varies based on the network). Members will also find links to their specific network’s website in the member portal.

1. Is the network(s) you are proposing a national network? If not, what is your solution for servicing members residing outside of Indiana.

Yes. The providers included in Tier 2 will be included in the UnitedHealthcare Choice Plus national network. The network is available in all 50 states.

1. Is the network(s) you are proposing a rental network? If so, please provide detailed information specifying the locations in which the network is rented, the network partner and how the network is integrated in your claims system.

No. We are proposing the UnitedHealthcare Choice Plus network in whole. This network is a part of the UnitedHealth Group company. However, the network does lease the MDX network in Hawaii and VI Equicare in the U.S. Virgin Islands.

1. If applicable, describe how an employee or dependent that requires care while outside of Indiana will be provided services. Example: a dependent who requires care over an extended period while away from home (e.g. student attending college). Do you have “guest” or “visitor” status programs for people who are temporarily domiciled outside of the service area (including while out of the country)? What are the terms and conditions of such programs?

We offer an extensive national network, meaning that eligible dependent children or spouses living apart from the employee can receive coverage for eligible health care services from a network physician in their area. Members may use our member website, **umr.com**, to search our directories, or they can call toll-free to the customer care center for assistance in locating network physicians or other health care professionals.

Our network contains thousands of physicians, hospitals and pharmacies. As an additional value, we now also offer network coverage through walk-in convenience care clinics, including many retail sites, with no appointment needed. We also have a comprehensive national urgent care network including our acquisition of MedExpress. MedExpress is a neighborhood medical center company with more than 165 locations, serving members on a national basis.

We do not have a network or contractual relationship with health care providers outside the United States.

1. Please provide a GeoAccess network accessibility and disruption analysis in SOI RFP\_Attachment F1.1\_Medical TPA Services\_Network Access. If you are proposing a combination of owned and leased networks, please provide your results separately by network. This GeoAccess analysis must be provided for the network you are proposing for the State.

Please refer to the completed **Attachment F1.1** found with within this response section. Additionally, please refer to the Supporting Network Information folder within this response section for full GeoAccess network reporting.

1. Based on the data provided, please identify any major hospital system and/or physician group contracts that are up for re-negotiation before the anticipated 1-1-22 effective date.

The majority of UnitedHealthcare contracts with physicians and hospitals do not have an expiration date. They have an initial term (generally three years), and after that time, the contract is evergreen and continues indefinitely, unless one of the parties submits a termination. While there may be potential termination situations that arise during 2021, we are confident that the vast majority will be successfully renewed without disruption.

1. Describe how the State health plan can participate in hospital pricing negotiations to achieve savings.

Typically UnitedHealthcare does not engage the customer in contract negotiations as it only complicates matters. However, we have had unique situations for re-negotiations that aren’t trending favorably and have requested customers write a support letter, place a phone call, etc. We do not include customers in contract meetings or in conversations between us and providers. We understand and welcome The State’s approach in developing and maintaining a strong tiered solution to drive savings for its members and drive change within the Indiana health care ecosystem. As a result, we are open to bringing the State to meet with the health systems and providers with us as we develop this customized solution.

1. Do you anticipate any significant provider contract changes during the term of this contract? Describe any expected changes.

No. The majority of our contracts with physicians and hospitals do not have an expiration date. They have an initial term (generally three years), and after that time, the contract is evergreen and continues indefinitely, unless one of the parties submits a termination.

When notified by the responsible network, UMR network services will notify SAEs of a substantial network change that may impact customers with 25 or more employees in the same three-digit ZIP code location in which the substantial network change may occur. A substantial network change is defined as a hospital or large practice group of physicians terminating. Our standard is to make that notification at least 30 days in advance or as confirmation of a potential termination is received. The SAEs communicate this information to their individual customer contact, and our GenYou guides have access to current provider lists to address inquiries from members.

We encourage members to verify their provider is participating in the network before they schedule an appointment. Listed on their ID card is a toll-free number, which can be used to obtain provider status. In addition, each network has a website that enables members to search for providers by name and/or region.

1. Describe your standard procedure for an out-of-network “RAP” (radiology, anesthesiology, pathology) claim that is associated with an in-network surgery or facility charge. Please describe your standard process when the RAP claim is received before associated hospital or surgery claim.

The customer determines how radiology, anesthesiology, pathology and laboratory service providers are paid via their benefit plan.

Typically, non-network radiologists, anesthesiologists, pathologists, ER physicians and lab technicians who are part of a network facility are paid at the network level of benefits. If these providers are located at a non-network facility, UMR will try to obtain a discount through our shared savings program, but still pays the services at the network level of benefits, if that is how the plan is written.

1. Please describe your other network options (e.g. tiered or narrow networks). Please include commentary on the discount differences between these networks and the network proposed.

UMR is offering the UnitedHealth Premium program through UnitedHealthcare as a tiered network option. The Premium program evaluates and recognizes physicians who meet national industry standards for quality and local market benchmarks for cost efficiency. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help your employees locate quality and cost-efficient providers. Physician designations include a range of specialties, including primary care and sub-specialties, which account for more than 80 percent of an employers’ average medical spend.

QUALITY

Physicians are evaluated using quality criteria derived from evidence-based medicine standards, national guidelines published by clinical societies and with input from leading physicians practicing in specialty areas. A physician’s quality outcome is determined by comparing a physician’s observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. This is important for customers implementing programs across their entire population, as the definition of quality is consistent across all markets.

COST EFFICIENCY

Physicians that meet quality standards often provide appropriate testing, medications, procedures and follow-up care more efficiently. Cost efficiency is defined as using the least costly medical resources to treat a medical condition to achieve a desired outcome and/or level of care. Cost efficiency criteria are based on patient care provided over an entire procedural episode of care, including use of diagnostic testing, the procedure itself and follow-up care. Total treatment costs based on UnitedHealthcare claims data are compared to market standards.

DESIGNATIONS

Premium Care Physicians who meet the UnitedHealth Premium criteria for providing quality and cost-efficient care have the following Premium Care Physician designation:

Premium Care Physician

The physician meets the UnitedHealth Premium program quality and cost-efficient care criteria.

Other possible designations include:

Quality Care Physician

The physician meets the Premium program quality care criteria but does not meet the program’s cost-efficient care criteria or is not evaluated for cost-efficient care.

Not Evaluated for Premium Care

The Physician's specialty is not evaluated in the UnitedHealth Premium program, the physician does not have enough claims data for program evaluation or the physician's program evaluation is in progress.

Does Not Meet Premium Quality Criteria

The Physician does not meet the UnitedHealth Premium program quality criteria so the physician is not eligible for a Premium designation.

Members are able to find which physicians meet the criteria for quality and cost efficiency on **umr.com** with the “Find a Physician” search tool:

■ The UnitedHealth Premium Care Physician symbol helps people quickly and easily find doctors recognized for providing value.

■ UnitedHealth Premium Care Physicians have received the Premium designation for quality and cost efficiency.

BENEFIT TIERING

Benefit tiering to Premium providers is only available for providers with a UnitedHealthcare two blue hearts designation. Members in plans that offer tiered benefits may see lower copayments and coinsurance amounts for services provided by UnitedHealth Premium Care Physicians.

Members in a Premium benefit tiered plan are able to find which physicians meet the criteria for quality and cost efficiency on **umr.com** with the Find a Physician search tool. The UnitedHealth Premium Care Physician two blue heart symbol helps people quickly and easily find physicians recognized for providing value.

Plans that tier benefits using Premium Designation will see the Tier 1 Blue Dot on **umr.com**

Benefit tiering to Premium providers can provide 2 to 8 percent savings depending upon the tiered plan design utilized.

1. Briefly describe the initial credentialing process. How often are physician, hospital, and other contracts (labs, imaging facilities, DME, home health care) reviewed?

The goal of our network selection criteria is simple: to choose physicians, other health care providers and hospitals that practice sound, evidence-based medicine. We apply rigorous quality standards and select providers who not only meet those standards, but who are also personally committed to providing their patients with high-quality, affordable care.

Our National Credentialing Center conducts all phases of the credentialing process. The vendor Aperture is used at times to support primary source verification. We hold a 3-year NCQA Accreditation in Credentialing and Recredentialing.

PHYSICIAN CREDENTIALING CRITERIA

Physician credentialing criteria includes the following:

■ Malpractice history and insurance coverage

■ Education verification/Board certification

■ Professional license

■ Drug Enforcement Administration (DEA)/Controlled Drug Substances (CDS) status

■ Five-year work history

■ Hospital privileges

■ Sanction and licensure restriction or limitation information

All data are audited to ensure compliance with accreditation and regulatory agencies, and are reviewed by our credentialing committee. Our Physician and Provider Sanction Committee continually monitors sanction activity from the Office of Inspector General, state licensing entities and several other sanction-reporting entities.

HOSPITAL AND ANCILLARY FACILITY CREDENTIALING CRITERIA

We require that network hospitals and ancillary facilities provide accessible, high-quality care. We also require that network institutions be financially sound. We use objective criteria linked to facility type to meet these goals. As part of the credentialing process, we collect documentation of the following criteria:

■ State and/or federal licensure status

■ CMS program eligibility and participation

■ Malpractice insurance coverage

■ General liability insurance coverage

■ Accreditation by an acceptable entity is recommended but not mandatory

Acceptable accreditation entities for hospitals and ancillary facilities include the following:

■ American Association for Accreditation of Ambulatory Surgery Facilities (AAASF)

■ Accreditation Association for Ambulatory Health Care (AAAHC)

■ American Board for Certification of Prosthetics and Orthotics (ABCPO)

■ Accreditation Commission for Health Care, Inc. (ACHC)

■ American College of Radiology (ACR)

■ American Osteopathic Association (AOA)

■ Healthcare Facilities Accreditation Program (HFAP)

■ College of American Pathologists (CAP)

■ Commission on Accreditation of Rehabilitation Facilities (CARF)

■ Community Health Accreditation Program (CHAPS)

■ Commission on Office Laboratory Accreditation (COLA)

■ Joint Commission (formerly known as JCAHO)

■ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (DNV NIAHO)

■ American Association of Blood Banks/Immigration DNA Diagnostic Center (AABB)

■ American Association for Laboratory Accreditation (A2LA)

■ American Society for Histocompatibility and Immunogenetics (AHSI)

■ Center for Improvement in Healthcare Quality (CIHQ)

■ Institute for Medical Quality (IMQ)

If the facility provider has not been accredited by one of the approved accrediting bodies but has undergone an on-site review by the state or the CMS, we request a copy of the CMS certification. We conduct an initial on-site quality assessment for any facility that has not had a site survey to confirm they meet our standards for participation with two exceptions (per NCQA guidelines):

■ If a facility location is verified as falling within a defined rural area (as determined by the U.S. Census Bureau), then a site visit is not required.

■ If a facility has multiple locations that follow the same policies and procedures as the primary location, then one completed site visit at the primary location also suffices the site visit requirement for the other locations.

All data are audited to ensure compliance with accreditation and regulatory agencies. Recredentialing of network facilities occurs at least every three years unless a more frequent cycle is dictated by law.

1. Describe the programs and methodologies currently in place to gather and measure meaningful provider quality and efficiency data that can be shared with members.

UMR is offering the UnitedHealth Premium program through UnitedHealthcare. The Premium program evaluates and recognizes physicians who meet national industry standards for quality and local market benchmarks for cost efficiency. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help your employees locate quality and cost-efficient providers. Physician designations include a range of specialties, including primary care and sub-specialties, which account for more than 80 percent of an employer’s average medical spend.

QUALITY

Physicians are evaluated using quality criteria derived from evidence-based medicine standards, national guidelines published by clinical societies and with input from leading physicians practicing in specialty areas. A physician’s quality outcome is determined by comparing a physician’s observed practices to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. This is important for customers implementing programs across their entire population, as the definition of quality is consistent across all markets.

COST EFFICIENCY

Physicians that meet quality standards often provide appropriate testing, medications, procedures and follow-up care more efficiently. Cost efficiency is defined as using the least costly medical resources to treat a medical condition to achieve a desired outcome and/or level of care. Cost efficiency criteria are based on patient care provided over an entire procedural episode of care, including use of diagnostic testing, the procedure itself and follow-up care. Total treatment costs based on UnitedHealthcare claims data are compared to market standards.

DESIGNATIONS

Members are able to find which physicians meet the criteria for quality and cost efficiency on **umr.com** with the Find a Physician search tool. Premium Care Physicians who meet the UnitedHealth Premium criteria for providing quality and cost-efficient care are identified with a Premium Care Physician (two blue hearts) designation.

Other possible designations include:

**Quality Care Physician**: One blue heart and one white heart indicates that a physician meets the Premium program quality care criteria but does not meet the program’s cost-efficient care criteria or is not evaluated for cost-efficient care.

**Not Evaluated for Premium Care**: Two white hearts represent that the physician's specialty is not evaluated in the UnitedHealth Premium program, the physician does not have enough claims data for program evaluation or the physician's program evaluation is in progress.

**Does not Meet Premium Quality Criteria**: Two grey hearts are used to identify physicians who do not meet the UnitedHealth Premium program quality criteria, so the physician is not eligible for a Premium designation.

1. Describe how you identify providers that are outliers on cost and/or quality and how you address these issues.

Physicians targeted for these programs generally use more medical services and are accountable for greater costs, while also being less adherent to evidence-based medicine.

Quality management is not delegated to medical groups. Instead, we maintain national oversight of network providers, including quality control of the physicians and other health care professionals in the network. Our contracts require that physicians and other health care professionals provide their quality improvement data, as well as participate in our quality assurance initiatives.

We evaluate the care that health care professionals deliver through a variety of tools designed to offer actionable information that helps them improve practice patterns and the care they deliver. Using a combination of information from all tools enables us to identify physicians and other health care providers with practice patterns that indicate significant variation from their peers. These health care professionals are presented with the data, and the health plan works collaboratively with them to achieve elimination/improvement of the variation.

Our physician data-sharing program identifies certain network physicians for intensified data sharing, including peer-to-peer meetings with our local health plan medical directors. Our local health plan medical directors work with the identified physicians in sharing this data, providing an interpretation, answering questions and developing a plan of improvement.

In addition, the UnitedHealth Premium group reports contain quality results for each physician who is in an eligible specialty. These are available to medical group leaders and may be shared and discussed during peer-to-peer visits with the groups. They are used by the group leaders to evaluate and provide feedback to their individual physicians regarding practice patterns that may need improvement.

1. What percentage of providers in your network are using electronic health records (EHR)?

While we know that network providers are currently using electronic health record (EHR) systems, we do not currently have a method in place to track the percentage of contracted providers using this technology. We recognize that EHRs and Health Information Exchanges (HIEs) are a critical component of realizing the promise of health care modernization and reform and support efforts toward EHR and HIE expansion. HIEs promote sharing of health information and clinical expertise as directed by patients in a secure environment among physicians, hospitals, labs and radiology centers at the local, regional and state level. HIEs also enhance clinical decision-making to enable more effective and efficient care. To further our plans to expand the use of EHRs and support HIEs, we offer a solution called Optum Data Exchange (ODX), developed by our company, based on past experiences, customer input and lessons learned. The ODX solution is a cloud-based, multi-tenant offering that builds on the functionality and services originally provided by the legacy Optum HIE while providing a greater level of product flexibility and scalability.

The ODX solution is currently exchanging health information with all of the top EHR systems nationwide.

We deliver integrated, intelligent solutions that work to modernize the health system, improve overall population health and help build and enable sustainable health communities – communities capable of producing enduring health for people. In order for a health community to be truly sustainable, it must be connected, intelligent and aligned – which leads to better care outcomes, more efficient use of resources and most importantly, happier, healthier people.

1. Describe your strategy for expanding the use of EHR or increasing interoperability.

Encouraging the use of certified electronic health records by providers is an integral part of our value-based, outcomes focused culture. Our value-based compensation initiatives embrace the use of certified electronic health records either as a performance measure to earn a financial incentive or as a requirement for participation in our programs.

We actively promote the use of health information technology (HIT) in physician offices by making that an integral part of innovation programs such as performance-based compensation (PBC) and Accountable Care Organizations (ACOs) whereby physicians who use technology meaningfully will be rewarded by enhanced payments for quality-based outcomes.

In addition, our UnitedHealthcare Clinical Services (UCS) team is responsible for collecting and reporting HEDIS data annually, which requires collection of clinical data from medical records. We are exploring ways to more efficiently incorporate data from electronic medical records (EMRs). We are currently using data provided by our HEDIS vendors (who actually collect and abstract data from the medical records) to identify physicians and medical groups that use EMRs.

At the end of each HEDIS season, the vendors report providers who were identified for review and are using EMRs. We are exploring ways to more efficiently incorporate the data from their EMR systems. Ideally, this would include an electronic exchange of data. This project demonstrates another way we are working to assess and leverage technology for greater efficiency making the health care system work better for everyone.

1. Discuss your urgent care network. How do you communicate to members which stand-alone urgent care providers truly bill as urgent care facilities versus billing as an emergency room?

Our provider directories allow our members to search for free standing convenience care clinics and urgent cares as well as hospitals with emergency room access. However, we do not communicate the billing practices of our providers.

We define urgent care as treatment of a sickness or injury that is not life threatening, requires outpatient medical care but is not serious enough to warrant a visit to an emergency room. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash or an ear infection. We define an urgent care center as a facility that provides urgent care services.

UMR will administer benefits as directed in your plan design. Depending on provider network participation, the system will either take a discount or make a reasonable and customary (R&C) reduction on physician claims if the billed amount is over the rate for that area.

1. Discuss your behavior health network. Do you subcontract with a third-party? How do you ensure access and availability of in-network providers?

When your members use a UnitedHealthcare network, they will have access to the Optum Behavioral network. The access is included in the network access fee, and the network is NCQA-accredited.

Our national behavioral health network consists of more than 3,292 facilities and 191,946 licensed clinicians, including psychiatrists, psychologists, master’s-level social workers and other mental health counselors, as well as master’s-level advanced practice RNs with prescriptive authority. The total number of rostered clinicians is 51,661, and the total number of rostered groups is 7,376. This includes clinicians in all 50 states as well as the District of Columbia, Puerto Rico and the Virgin Islands.

In addition to its size and breadth of specialties, our network is differentiated by our ability to offer market-leading discounts to customers, our focus in clinical quality (as evidenced by Achievements in Clinical Excellence (ACE) program), quality management programs and the close partnerships we have established with network clinicians and facilities.

1. Describe your strategy for increasing access to behavioral health providers over the next 3 years.

When your members use a UnitedHealthcare network, they will have access to the Optum Behavioral network. The access is included in the network access fee, and the network is NCQA-accredited.

Optum Behavioral Health is committed to maintaining a comprehensive network that provides easy access to both facility-based and outpatient emotional, mental health and substance use disorder (SUD) support. Network managers in our behavioral network services department regularly analyze the network and continually recruit new clinicians and facilities to enhance the scope and size of our network. Staff members maintain and continually update a detailed, state-by-state action plan that identifies the specific geographic, clinical and cultural recruitment needs for each state.

1. Do you require participating network hospitals to bill for services at free-standing emergency rooms separately from emergency room services performed at the main facility?

Because hospital claims are billed with revenue codes that can include a range of services, rather than CPT/HCPCS codes, we do not review hospital claims for unbundling. Revenue coding limits the opportunity for unbundling. Instead, we conduct hospital bill audits to ensure that the providers are billing with the correct revenue code.

1. Please describe how you handle high-dollar patient medical transportation claims, typically via airplane or helicopter. Please differentiate between emergency and non-emergency use of medical transportation. For example, do you have “in-network” air transport providers? Do you apply a maximum allowable charge/ reasonable and customary allowance to out-of-network air transport claims? If yes, what is the source of the charge/ allowance?

Air ambulance provider participation in any network is minimal. Payment of emergent and non-emergent air ambulance services is dependent upon a customer’s plan design as well as air ambulance network participating status. If an air ambulance provider is participating in the customer’s primary network, then the primary network contract rate is applied. If the air ambulance provider is not participating in the customer’s primary network, then the air ambulance claim will route to the customer’s out-of-network program. The out-of-network program utilized by the customer determines the way by which the claim will be reduced and, as previously stated, the customer’s benefit plan will also impact the way the claim is adjudicated.

1. Please describe how your Reasonable & Customary (R & C) rates are developed. What is the database you use to develop R & C rates and profiles? What percentage do you reimburse out of network providers? How does this differ for hospitals versus physicians versus other providers?

Our suite of out-of-network programs does not include the use of U&C/Fair Health as a means by which to provide reasonable reimbursement to out-of-network providers. As described previously, UMR is recommending our CRS Benchmark Program as the out-of-network solution to help the State and the State’s members save money on out of network claims. The program enables us to apply cost management strategies on out-of-network claims to limit balance billing to members and protect the plan from egregious provider billing. Here’s how the CRS Benchmark Program works:

■ A percentage of Medicare is used to establish the benchmark value for the claim. The benchmark provides a fair level of reimbursement for providers.

■ Claims meeting the benchmark are process through the Multiplan Complimentary Network.

■ If a claim is not eligible for the network discount, Multiplan will negotiate with the provider to reach a benchmark value.

■ If negotiation is unsuccessful, Multiplan’s Data iSight pricing methodology is applied.

Members are protected from balance billing when network or negotiated pricing is applied. The Data iSight methodology is a highly defensible and providers accept the pricing over 90 percent of the time. Multiplan also requests that the provider contact them directly regarding any questions pertaining to reimbursement.

1. Describe the network access and/or risk sharing arrangements proposed for the State. What is the estimated annual cost of these charges and how are they charged to the State (as fees or as claims)? Do you agree to provide full transparency with respect to these charges?

We are making considerable progress with regard to driving greater adoption of performance-based contracting in the marketplace. The shift toward increased collaboration, outcome-based payment and new benefit design is transforming how we pay for health care and how health care is delivered. UnitedHealthcare is taking an industry-leading approach to this transformation by leveraging years of experience with incentive-based contracting models. Through the expansion of our existing programs and the creation of new innovative programs, we are rewarding providers for delivering improvements in quality (as defined by evidence-based guidelines) and cost-efficiency. We are committed to paying for value and for what is right for the patient.

We recognize that all providers are not the same in terms of their readiness to move towards a risk- based contract, yet we want each of them to take more accountability for the care they deliver. Therefore, we developed a modular suite of value-based incentive models that we can leverage with providers based on their risk readiness and other criteria. We recognize that a “one-size-fits-all” approach will not be effective and thus we have not prioritized one single model. Our modular suite of value-based programs enables us to customize our approach with providers across all stages of the risk continuum and support them as they become more accountable for cost, quality and experience outcomes.

In addition, our strong analytical capabilities, data and reporting tools help our partner Accountable Care Organizations (ACOs) identify areas of improvement. We can provide clinical support to assist ACOs in developing and/or augmenting clinical programs. We also offer products that encourage our members to become engaged. Through our sister company, OptumInsight, we offer an array of industry-leading tools and capabilities for our ACO partners. Finally, as the leading national carrier to offer Medicare, Medicaid and Commercial plans, the size and variation in the population we represent allows us to test our ACO strategy across a more varied population.

We have deployed performance-based programs, Centers of Excellence and ACOs nationally that incorporate the value-based contract models below:

■ Primary care incentives

■ Performance-based contracts

■ Episode/bundled payments

■ Shared savings/risk

■ Capitation plus performance-based incentives

We currently have value-based contracts in place with more than 1,100 hospitals and 110,000 unique physicians participating in our Accountable Care Platform. More than $75 billion of our network health care spend is tied to value-based contracts across our commercial, Medicare & Medicaid businesses. We expect this figure to continue to increase over time.

At the most advanced end of the value-based spectrum are our programs focusing on population health, encompassing shared savings/shared risk models ACOs, as well as capitation and capitation-plus-performance-based contracting. We are currently involved in 124 ACOs across the country. These organizations are focused on driving innovation in payment and delivery system reform with the triple aim of improving population health and patient experience, delivering the best possible quality outcomes, and reducing medical cost and medical trend.

Some of our programs are claim-based, where incentives are built into the contracted rates and paid at the time of normal claim payment. Other programs, like Accountable Care Organizations (ACOs) are not claim-based and involve payment of an additional performance bonus which will be reported as a separate medical expense payment. Value-Based Contracting (VBC) Customer Reports are produced on a quarterly basis for all self-funded customers. The reports provide information on VBC payments funded, savings estimates, and attributed member counts.

For additional payments not included in traditional claims payments, customers will receive regular reports on payments made to providers, and the frequency of these reports will be consistent with provider payout frequency. However, at this time, UMR is able to allow the State of Indiana to opt out of our value-based programs. This means that the State of Indiana will have access to and benefit from our value-based programs, but will not be liable for the bonus payment arrangements associated with such programs.

1. The current state plans include a provision where emergency department claims are denied based on medical necessity (i.e. non-emergent claims at the ED are denied). Confirm that your organization can administer this or something similar. Describe how you would administer this provision? Do you have experience with other plan sponsors on this issue or related issues?

Confirmed. UMR will administer benefits as directed within the submitted plan design. We administer many plans, wherein non-emergent care delivered in an emergent setting is paid at a significantly lower reimbursement rate or potentially denied. An emergency is defined as a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

**1.9 Clinical**

1. How do you define total cost of care? Describe how your strategy, network agreements, clinical model, service model, and technology are aligned to move toward efficient and cost-effective outcomes.

The total cost of care strategy involves coordinated care efforts that go beyond managing specific cases or situation to improving the health outcomes, by providing members with a spectrum of services directed at behavior change and healthy lifestyles to obtain optimal outcomes. UMR CARE programs focus on improving health outcomes by providing better access to care, improving the quality of care and increasing preventive care. In doing so, there is the potential to decrease the total cost of care while significantly improving health outcomes quantitatively. Through advanced analytics risk stratification and predictive modeling, the CARE model will be able to identify at risk members preemptively providing intervention; therefore, decreasing catastrophic cases. Therapeutic relationships and increased goal attainment related to higher accountability are developed with the nurse/member interactions.

1. Describe your organization’s quality initiatives. How do you define and measure quality of care?

At UMR, we continuously strive to improve the overall quality of care and service provided to members by our health care delivery system. Quality improvement efforts are focused in the areas of adult and child preventive measures, chronic disease management including medication adherence, behavioral health, patient safety, access and availability of care, coordination and member satisfaction.

Medical management interfaces with and supports clinical quality improvement in a variety of ways. Through the Quality of Care referral process, screening criteria are used by clinical staff to identify potential quality of care concerns. When appropriate, the Medical Director will discuss quality concerns with the member’s provider. All potential quality of care concerns are forwarded to the customer quality department for review, tracking, trending and follow-up. Other processes that contribute to and are evaluated by customer quality departments include various audit results, clinical outcome measurements, and member satisfaction results.

All GenYou CARE Support decisions are supported by relevant clinical and technological information appropriate to each case dependent upon the complexity of the case. CARE Support tools include clinical protocols, guidelines and resource information to support the collection of the necessary information to conduct case management procedures. These tools are easily accessible by the program staff as well as others included in the case management process, and can be used in the quality management process.

Clinical tools are reviewed and updated at a minimum annually, and more often as necessary with evidence-based medicine (EBM) guideline changes, in accordance with the Clinical Content Review Procedure. The Clinical Practice Guideline Subcommittee performs annual review and its activities to the Quality Oversight Committee (QOC).

The GenYou CARE Support program is evaluated and formally documented annually. UMR’s case management leadership team coordinates the evaluation with input from operations and quality, and other functional areas as needed. The evaluation includes a written description of how the program performed throughout the year and if identified objectives were implemented and met for the program. CARE Support program evaluation is also reviewed and approved by the QOC. Subsequent programs, activities and action plans are developed based upon evaluation of the previous year’s metrics (i.e., identification of components of the program that need to be expanded revised or deleted). Audits are performed by the Clinical Audit Team which randomly selects two cases per month for review. Generally it will be an open active case and a case that was closed within the last month. The elements on the audit tool are based off of NCQA quality guidelines for case management.

The GenYou CARE Support program evaluation, which is conducted on the prior year’s activity, includes but is not limited to, the following components:

■ Review and evaluation of the program structure and functions

■ Monitoring parameters outlined in the concurrent year’s business plans

■ Trending of measures to assess performance of monitors and indicators

■ Recommendation of program objectives and direction for the succeeding year

■ Review of criteria, care strategies and processes used to determine medical appropriateness for the members served under case management

■ Evaluation of the overall impact of the case management program on members and member satisfaction

1. What HEDIS measures do you track and report on?

UMR does not offer HEDIS reporting. However, the measures used in the UnitedHealth Premium program physician designations include HEDIS measures, evidence-based process measures, gaps in care measures, patient safety and outcome measures. Our member website, **umr.com**, includes several tools to help individuals assess the quality of care for physicians, including the capability to filter on physicians that have the UnitedHealth Premium quality and cost-efficiency designation. We also provide information on the member website about the methods that we use to evaluate quality and cost efficiency in the program.

HEDIS results are reported by our health plans once a year, representing the preceding year’s claim data and supplemented by chart review information for selected measures. Each year, NCQA dictates new measures, revises existing measures and may retire certain measures. Our reporting of HEDIS results is collected according to the NCQA's HEDIS technical specifications for data collection, and our processes for the production of results are audited by NCQA-licensed HEDIS compliance firm, Attest Health Care Advisors.

In general, we do not recommend customer-specific HEDIS reports, as there is usually not enough data on a single-customer basis to produce a statistically credible report. Since the results are computed via the administrative methodology (hybrid methodology is not used due to the high cost), many of the customer-specific results in the Effectiveness of Care domain would not be accurate representations of your actual performance for these measures. Many of the HEDIS measures are relevant only in the context of the entire UnitedHealthcare physician and other health care professional network, and not for any single customer's use of that network.

1. Provide your most recent book-of-business HEDIS results. Indicate your ability to respond to the full scope of HEDIS measures

UMR does not offer HEDIS reporting for book-of-business. However, we have provided UnitedHealthcare network’s national HEDIS report as **Attachment 3**.

HEDIS results are reported by our health plans once a year, representing the preceding year’s claim data and supplemented by chart review information for selected measures. Each year, NCQA dictates new measures, revises existing measures and may retire certain measures. Our reporting of HEDIS results is collected according to the NCQA's HEDIS technical specifications for data collection, and our processes for the production of results are audited by NCQA-licensed HEDIS compliance firm, Attest Health Care Advisors.

1. Do members have access to provider quality information?

Yes. UMR is offering the UnitedHealth Premium physician designation program. The program consists of quality and cost-efficiency evaluations with quality serving as the primary measurement. The results of these evaluations are used together to determine a designation result that is displayed on UnitedHealthcare’s public websites.

■ Quality evaluations compare a physician’s observed practice to UnitedHealthcare’s national rate among physicians in the same specialty. Quality standards are based on national standardized measures.

■ Cost-efficiency evaluations compare a physician’s health care costs to the case-mix adjusted costs of peers in the same specialty and geographic area. Cost-efficiency standards are based on local market benchmarks for the efficient use of resources in providing care.

Designation information is available to all members as an integrated part of UnitedHealthcare’s national network. Customers do not pay additional network access fees for the UnitedHealth Premium program.

1. Are you accredited by the National Committee on Quality Assurance ("NCQA")?

UMR’s GenYou CARE support program achieved NCQA accreditation in October 2018, Ongoing Condition CARE achieved NCQA accreditation in January 2017, and Wellness CARE NCQA program achieved accreditation in January 2019.

Our Utilization Management program is URAC-accredited. The Utilization Management program originally received accreditation in 1994. We maintain our accreditation every three years for this program.

1. Please provide a list of clinical and utilization management (UM) programs available.

UMR offers a full suite of integrated care management services comprised of Utilization Management, Complex Condition CARE, NurseLine, Maternity CARE, Ongoing Condition CARE and Wellness CARE programs.

UTILIZATION MANAGEMENT

The primary focus of our URAC-accredited Utilization Management program is the determination of medical necessity and appropriate length of stay of proposed medical services. We achieve this through prior notification review, concurrent review and transitions to lower levels of care. The program also works to identify cases that require additional intervention through Complex Condition CARE or Ongoing Condition CARE. Early referral to these programs often results in great cost savings.

COMPLEX CONDITION CARE

We designed our Complex Condition CARE program to promote quality, cost-effective outcomes for members with a catastrophic or high-cost condition. Cases are identified that may be impacted from a member advocate perspective or from a cost-of-care perspective. The program achieved NCQA accreditation in October 2018. (Previous certification was with URAC.)

Our Complex Condition CARE program is all-inclusive. It has separate, specialized teams that cover all general cases and specialty cases, including:

■ Transplant

■ Behavioral health

■ Oncology

■ Complex case management

■ Pediatric

■ Neonatal intensive care unit (NICU)

■ High-risk maternity

UMR employs registered nurses (RNs) to perform Complex Condition CARE services. CARE nurse managers work each case to ensure the member understands their condition and treatment process. These nurses also work to negotiate rates for added claims savings.

NURSELINE

NurseLine offers members the ability to call an RN with medical-related questions and concerns, 24 hours a day, seven days a week. Members offered NurseLine also have access to live Nurse Chat, 24 hours a day, seven days a week, through one-on-one, secure, real-time connections with RNs on the UMR Web portal Health Center. In addition to advice, the nurses can display Web pages and suggest helpful resources.

MATERNITY CARE

UMR’s Maternity CARE program provides:

■ Information and coaching to women considering pregnancy

■ Prenatal education and guidance to those who are pregnant

■ High-risk pregnancy identification to help expectant mothers carry their babies to term

Once enrolled in the Maternity CARE program, participants are contacted by maternity health coaches who are registered nurses with clinical backgrounds in obstetrics/gynecology. If a pregnant member is identified as high-risk, she will be transitioned to Complex Condition CARE and a CARE nurse will monitor the member more closely and provide additional educational information and support as dictated by the member’s specific condition(s). The nurse case manager will continue to work with the member during her hospital stay and will also pursue the reduction of claim costs, where possible, through network steerage and negotiating reduced inpatient rates if non-network services are used. Oversight and referrals are provided for lower levels of care, when appropriate.

ONGOING CONDITION CARE

UMR’s patient-centered Ongoing Condition CARE program helps members manage their chronic conditions through education and counseling. The NCQA-accredited program focuses on conditions known to have escalating health care, disability and productivity costs over time. Conditions managed through the program include asthma, heart failure (HF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, hypertension and depression. These are manageable conditions that with the application of generally accepted, evidence-based guidelines demonstrate a high probability for successful intervention. In addition to the core conditions, if a member is identified as moderately high risk through predictive modeling, a CARE nurse will contact the member to assist, support and educate as needed regardless of diagnosis.

WELLNESS CARE

The Wellness CARE program works to help program participants understand that taking care of their health today provides incredible return on investments in their future. UMR’s Wellness CARE program achieved NCQA accreditation in January 2019. The primary goal of the program is to identify current and future health risk within an employee population. Another goal of the program is to increase the participant’s awareness of his or her personal risks and how they are linked to future health conditions, such as diabetes, heart disease and hypertension. Program interventions focus on four key lifestyle choices:

■ Nutrition Habits: Helping members adopt healthy, balanced eating behaviors

■ Exercise Habits: Assisting members to identify ways to become more active

■ Weight Management: Promoting safe, effective weight loss and weight management

■ Tobacco Cessation: Helping members develop a quit plan and take action that results in successful smoking cessation

1. What is the process for identifying patients for UM?

Members may be required to call UMR and notify us of upcoming services; however, in most cases, the member delegates this responsibility to the provider(s). Regardless of a member’s diagnosis, UnitedHealthcare Choice Plus network providers who recommend any services or procedures on the prior authorization list are obligated to request prior authorization. Providers are required to supply us with medical documentation for the services requiring prior authorizations.

Once notified, our intake specialists prepare the necessary case information and task the case to a utilization management nurse if medical necessity review is required. Once a decision is made, follow-up with written confirmation to the member, provider and facility is done within 24 to 48 hours of the decision. UMR Care Management submits decisions and authorizations through an EDI feed to our claims department daily.

UMR’s intake specialists and nurse reviewers are well versed in insurance, managed care, medical terminology and customer service. They possess strong analytical skills and offer efficient, friendly service to members and providers.

1. What are the triggers to identify cases for UM?

It is a fact that early intervention can often lead to claim cost reduction. We work closely with our customers to understand their culture and benefit plan objectives. We have a recommended list of inpatient and outpatient procedures for prior authorization review, and allow our customers to customize this list, based on their requirements. UMR also has more than 1,500 ICD/CPT triggers built into our claims and CARE systems. Services requiring prior authorization, initial and continued inpatient stay, as well as certain treatments which could be experimental/investigational, potentially cosmetic, etc. trigger for utilization management.

1. How do you calculate UM savings?

The Utilization Management program achieves savings through various actions and tasks performed during the utilization management process, including:

■ Inpatient days avoided

■ Services received in a less intensive, lower-cost setting

■ Denial of services ordered but not medically necessary

1. How do you engage with medical group and hospital staff in the UM function?

In our Utilization Management program, we strive to make appropriate clinical staff easily accessible to providers and other health care professionals. We provide a toll-free number for providers to use throughout the utilization management process. Providers may communicate with us live via telephone, with an option to leave a prompted voicemail notification, or electronically through **umr.com**, our provider website.

After an admission, our reviewers determine if an inpatient setting is necessary or if other options, such as outpatient or home care, are more suitable to the member’s needs. We also regularly request clinical updates and conduct concurrent review to ensure the length of stay assignment is appropriate and observed. We monitor all inpatient cases for timely discharge. If a case is still open on the last scheduled inpatient day, our utilization management team calls the hospital staff to follow up on the case. If the patient is discharged on time, we record that data in our system.

UMR reviews the member’s transition plan during a concurrent review with hospital staff. In this manner, a prior authorization for a lower level of care can be reviewed by medical necessity based upon the benefit plan.

A UMR medical director oversees the entire concurrent review process. Should a case have unique circumstances, a medical director reviews the case to determine the best course of action and reaches out to the member’s physician for a peer-to-peer discussion, as needed.

1. How are concurrent reviews conducted? Are all cases reviewed, or just those with specific diagnoses? What is the percentage of cases approved for additional days beyond those originally authorized?

UMR performs concurrent review to determine the most appropriate setting for a member who requires additional care. Our reviewers determine if an inpatient setting is necessary or if other options, such as outpatient or home care, are more suitable to the member’s needs. We also perform concurrent review to ensure the length of stay assignment is appropriate and observed. We monitor all inpatient cases for timely discharge. If a case is still open on the last scheduled inpatient day, our Utilization Management team calls the facility to follow up on the case. If the patient is discharged on time, we record that data in our system.

If a member requires additional inpatient days, we perform another review to establish medical necessity for those days and the appropriate level of care. We also review the case to determine if referral to GenYou CARE Support or Ongoing Condition CARE services is appropriate.

UMR reviews the member’s transition plan during a concurrent review. In this manner, a prior authorization for a lower level of care can be reviewed for medical necessity based upon the benefit plan. The concurrent review and transition planning acts as a trigger for GenYou CARE Support.

A UMR medical director oversees the entire concurrent review process. Should a case have unique circumstances, a medical director reviews the case to determine the best course of action and reaches out to the member’s physician for a peer-to-peer discussion, as needed.

1. What is the process for identifying members for large case management and how are claims transferred to case managers?

During implementation, we assist our customers in implementing an automated identification tool inclusive of diagnosis codes and CPT procedure codes. A case is also identified when a member’s length of stay reaches five to seven days. Most of our referrals are real time using prior authorizations as a trigger to open a case. In addition, we use predictive modeling to determine which members are considered high risk but did not trigger a case in Complex Condition CARE. A Complex Condition CARE program triage registered nurse (RN) reviews all current and past clinical information prior to assigning a case to the appropriate CARE nurse manager.

When a catastrophic claim is identified, UMR assigns a single CARE support nurse manager to work with the member and the health care team. Part of the CARE nurse manager’s role is to collaborate with our claims staff and the stop loss vendor (when appropriate). This person also acts as an advocate for the member and can assist, along with the GenYou guide, to explain claim submissions and explanations of benefits (EOBs).

1. What are the triggers to identify cases for large case management?

Our GenYou CARE Support program is all-inclusive. It has separate, specialized teams that cover all general cases and specialty case management, including:

■ Transplant

■ Behavioral health

■ Oncology

■ Complex case management

■ Pediatric

■ Neonatal intensive care unit (NICU)

■ High-risk maternity

In addition, CARE Support has a proprietary risk score encompassing past history, predictive episodes of care that needs intervention, and social determinants of health. We gather data from many resources to quantify into one health risk score. The family is a key player in the health of the member. When we are discussing care for the triggered member, we are concerned with the family also. If a member’s family member needs assistance with support, education or has their own medical condition, CARE Support nurse managers incorporate them in the member’s plan of care or opens a case for them managed by the same nurse manager. CARE Support nurse support builds relationships with families and promote self-advocacy.

COMPLEXITY SCORE

■ Diagnosis/procedure from prior authorizations

■ Multiple hospital admissions

■ Length of stay

■ High risk for readmission

■ Discharge planning

■ Frequent outpatient services

■ Utilization review nurse identification/referral

■ Diagnosis/procedure from medical claims

■ High claims expenditures

■ Calling/notification requirements/plan design

■ Referrals: provider, member or customer

■ Case findings/other concerns from voluntary calls to NurseLine

■ Website visit characteristics: e-messaging

■ Psychosocial indicators

■ EDI, caller information and internal reporting/referral

■ Questionnaires (e.g., enrollment, clinical health risk assessments (CHRAs), homepage surveys for personal medical records)

■ Automated decision tree logic

■ Pharmacy data

■ Maternity CARE nurse reviewer identification/referral

■ High-risk scores as determined by predictive modeling

1. How do you calculate case management savings?

Individual customer savings results vary and are dependent on several factors including

group size, plan design. management commitment, member participation, communication,

incentives and other factors.

Utilization management and GenYou CARE Support savings are

captured based on interventions that result in decreased or avoided costs and often

improve quality of care and patient outcomes. These savings are reported to customers

monthly.

Examples of savings events include: Decreased level of care, decreased lengths

of stay, prevention of or decreased incidence of readmissions, prevention of or decreased

ER utilization, avoidance of medical complications or errors and closing gaps in care.

Utilization management savings also result from identification of services not meeting

medical necessity criteria, shortened length of stay, favorable changes in clinical treatment.

CARE Support management savings events include steerage to network

providers and/or Centers of Excellence program, identification of alternative care solutions,

identification of alternative funding sources, negotiation of rates and identification of

duplication of services.

1. Describe your physician engagement. What reports are provided to individual physicians, offices, or contracted groups? How frequently is information provided to physicians? Are results used during the re-credentialing process?

UMR’s CARE programs consistently outreach to providers to communicate their patient is engaged in one of our CARE programs. In addition, we ask for their input to include in the member’s plan of care. Our CARE nurses also send the plan of care to the physician for their review and information. GenYou CARE Support nurse managers routinely engage the attending physician, facility and member telephonically throughout the implementation and duration of CARE Support. Engagement with the attending physician includes working with the physician for utilization and CARE Support activities, with the goal of being a collaborative member of the patient’s care team. We include providers in the member’s care; however, we do not provide reports.

1. How do you work with medical groups and hospital staff in the case management function?

All opened CARE Support cases require a detailed treatment plan reviewed in conjunction with the member’s health care providers. CARE Support is a collaborative process in which the CARE nurse manager consults with members/families, physicians and other providers in order to develop a plan of care to achieve the highest quality, cost-effective care for the member. Upon contacting the treating physician, the CARE nurse manager requests the following information: current diagnosis(es) and date of onset, past medical history, current treatment plan, prognosis and other specialists. The CARE nurse manager seeks out history and physicals, discharge summaries, and current provider notes to obtain a full picture of the member’s medical history and treatment plan. Our CARE nurse managers review the member’s treatment plan prepared by the provider for clinical appropriateness and look for opportunities to increase plan effectiveness, while reducing expenses for the member and the health plan.

1. How do you evaluate provider practice patterns and identify actions to take to improve outcomes?

UnitedHealthcare uses a variety of methods to measure and provide feedback to our contracted physicians on their performance.

Through the UnitedHealth Premium program, we give each physician who has been evaluated for designation access to details of the data used for their evaluation. This includes information on quality and cost-efficiency metrics, compliance rates, treatment sets, and patient-level claims details. Our goal through this program is to also provide detailed information to physicians in evaluated specialties to support their efforts in continued quality improvement. We provide actionable information to physicians to support their continued quality improvement and advance the cost efficiency of their practices. We are deploying market medical directors and expert physicians to coach those physicians in need of improvement.

Physicians who appear to practice below optimal levels receive a summary of their data, either by mail or by visit, and the data is discussed with them to see if there are acceptable explanations for their variance. If there is not, methods of correcting the variance are given. Follow-up data is obtained, and those who continue to have significant variances are further encouraged through clinical and network programs to implement practice changes. Physicians are not sanctioned based on data-sharing information.

1. Describe processes you have in place to authorize behavioral health services, including professional, intensive outpatient, and inpatient.

UMR offers integrated behavioral health services internally with our medical administration. Our CARE program features a specialty behavioral health team that provides preadmission notification services, as well as GenYou CARE Support and Ongoing Condition CARE services, according to the benefit plan design. Behavioral health CARE nurse managers work closely with the patient and health care providers throughout the course of treatment, resulting in optimal clinical outcomes and conservation of plan dollars.

We manage behavioral health through Utilization Management when the customer requires prior authorization for services. Recommended prior authorizations include inpatient behavioral health services, residential and day treatment programs. UMR offers GenYou CARE Support for those cases that have a potential to be complex and/or high cost.

UMR provides discharge support for members with a diagnosis of depression, bipolar, alcoholism, opioid use and sedative use. CARE Support begins with outreach to the member while inpatient, or in a residential or rehab facility, to ensure transition planning is in place when the member is discharged to a lower level of care. The CARE nurse manager contacts the member two to three days post-discharge to ensure the member has a follow-up appointment, their medication, social support and an emergency plan in case of lapse or relapse. The member is followed for three months to provide the support that is needed during the most difficult time after discharge.

There are components of behavioral health integrated within all UMR’s clinical programs from a holistic treatment perspective. For example, behavioral health components in managing an ongoing condition, attempting to quit smoking, learning healthy eating habits, triggers for unhealthy actions, as well as screening for post-partum depression after a delivery. The CARE nurses assist the engaged member with provider location assistance.

1. What programs or processes do you have to help control emergency room utilization? Will you be able to identify “frequent flyers”? What proactive steps are taken to manage that member either through physician engagement, disease management, or other methods?

GenYou CARE Support clinicians provide the support needed for members who are utilizing the emergency room (ER) frequently. We focus on the clinical issues that are driving members’ ER use and the opportunities for members to proactively manage their health. In addition to condition management, medication reconciliation and support, CARE Support nurses redirect members to the appropriate level of care through education of appropriate ER use, benefits available and alternate levels of care.

UMR has a stratification tool that uses medical claims and pharmacy data to identify members for the coaching program. Members who have four or more ER visits within a rolling 12-month period of time are eligible to participate.

1. Do you have a relationship with a national provider for laboratory services? If so, what are your protocols with providers to ensure usage of network labs?

Yes. UnitedHealthcare’s agreements with Laboratory Corporation of America (LabCorp) and Quest Diagnostics, Inc. (Quest), leading national providers, in combination with our extensive network of more than 1,500 other regional and local laboratory services providers and our national network of specialty and genetic testing laboratories, offer our customers and members an optimal combination of network affordability, quality, usability and access.

UnitedHealthcare network physicians are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us. We maintain a robust network of national, regional and local providers of laboratory services. These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in our network. This network's vast size ensures physicians will have no difficulty locating and using a network laboratory.

In the unusual circumstance that a specific laboratory test is required for which no participating laboratory appears to be available, physicians are instructed to contact us to confirm that the specific laboratory test is covered. We then work with the physician to assure that covered laboratory tests are performed, even if that means the use of a non-participating laboratory.

If we identify an ongoing and material practice of physician referrals to non-network laboratories, we inform the physician of the issue and remind them that physicians in our network are required by contract to refer their patients to other network providers. While these actions are rarely necessary, continued referrals to non-network laboratories may, after appropriate notice, subject the referring physician to one or more of the following actions for failure to comply with protocols:

■ A change in eligibility for the performance-based compensation (PBC) program

■ A decreased fee schedule

■ Termination from the network

1. Do you currently have a limited or preferred infusion network (e.g. MedExpress/Coram)?

UMR adopted a recommended prior authorization list for medical specialty medications as determined by UnitedHealthcare. The national pharmacy team determines medical necessity for the medications and determines site of care for a subset of the list. If there is a denial for site of care, the member is given a 30-day grace period to a find another facility that is a lower level of care. We do not have a limited or preferred infusion network, but members can access infusion services through the UnitedHealthcare network of providers.

1. Do you currently have any clients that have “carved-out” select therapeutic categories of specialty drugs from the medical benefits to be administered through the pharmacy benefit exclusively? Would you support such an initiative should the State desire?

Yes. We do currently have a small percentage of customers who have carved-out select specialty drugs from the medical benefit. UMR would work very closely with the State of Indiana in order to provide education and support to meet their needs. We have developed plan language which the customer can use to document the carve out. Claim edits would be put in place in order to ‘reject' or ‘deny' the specific codes that are carved out of the medical plan. The carve out (lock-out) would also be documented in the utilization management reference library for the customer in order to educate the provider and/or redirect to the specialty PBM.

1. Describe any other strategies or programs you have in place to address drug spend, including specialty drug spend, in a medical setting? Confirm you will work with the State to report on medical pharmacy utilization.

For specialty medications covered under the medical benefit, our programs target use of specific medications to allow clinically appropriate, evidence‐based coverage at the right site of care. We thoughtfully analyze utilization and apply clinical rules (prior authorization/notification, supply limits, step therapy, site of care redirection), when they appropriately impact utilization and affordability, while considering access needs. Coverage criteria are updated at least annually or when new clinical information/evidence is available, based on FDA labeled indications for use, review of clinical information, studies, summaries and internal and external clinical experts.

UMR uses the strength of our data and analytical capabilities to routinely monitor overall health care cost trends. Specialty drug spend on medical benefits account for a significant expenditure that can grow rapidly, particularly as new drugs are introduced to the market. As part of our trend and cost management strategy, we deploy sound payment approaches to rein in specialty drug spend. We are aggressively moving away from less controllable percentage of billed charge payment reimbursement methods to a fixed-rate specialty drug fee schedule. This methodology eliminates paying providers based on a unilaterally created price. Our preferred approach reimburses specialty drug facility claims at a percentage of the Medicare rate. Medicare builds their fee schedules based on the acquisition price of the drug.

We will work with the State of Indiana to report on medical pharmacy utilization.

1. Confirm you agree to pass through all rebates on prescription drugs through the medical plan.

Confirmed. UMR will return 100 percent of the collected rebates to the customer. There are no criteria required to be eligible.

1. Please describe your telehealth/virtual care capabilities. Include whether the services are provided in-house or through a third party. Provide the length of relationship and renewal/expiration with third parties as applicable.

We are proposing the OC24health program. Established as American Health Network (AHN) was formed in 1994, when a group of physicians founded the company as an independent practice. The company became part of Optum in 2017 and transitioned from a traditional fee-for-service to value-oriented care with flexible delivery models that our physicians share and improve upon. The company utilizes the full power of Optum to advance high-quality, physician-led ambulatory care across three areas: primary care, specialty care and post-acute care.

OC24health can provide benefits that include, but are not limited to:

1. Talk to Indiana-based doctors and providers

2. Receive quality care via video through mobile application or computer

3. Prescriptions are sent to pharmacy of choice, if medically necessary

4. Less expensive than urgent care or ER

5. Doctors/providers are able to refer to high quality and lower cost specialists if needed

6. Assign a primary care physician to members to do not already have one

OC24health currently offers three-care service lines:

■ General medicine

■ Dermatology

■ Behavioral health

OC24health providers provide coverage to the General Medicine service line daily from 8 a.m. to 8 p.m. EST.

The partnership with Teladoc was initiated in March 2019 with a three-year contract. Renewal of the contract is March 2022. AHN plans to renew the contract and continue to partner with Teladoc to provide telemedicine visits.

1. Please describe the telehealth provider network. What scope of services do the telemedicine providers offer? Do you limit the CPT codes providers bill? List the CPT codes if applicable.

AHN currently is composed of 1,500+ employees, 300+ providers and 75+ locations across Indiana and Ohio. OC24health provides quality health care to members anytime (24/7/365) and anywhere (at work, in the comfort of their home and even while traveling). OC24health is staffed with Indiana-based AHN providers and Teladoc providers.

OC24health currently offers three-care service lines:

■ General Medicine (CPT 99421)

■ Dermatology (CPT 99213)

■ Behavioral Health (CPT 99204, 99213, 90834)

1. How are telemedicine providers credentialed?

OC24health doctors/providers are board certified in their respective specialties in the State of Indiana and by American Health Network.

1. Confirm that administration costs for telemedicine/virtual care are included in your quoted base ASO fee.

Confirmed. Telemedicine is included in our quoted fees.

1. Please explain how your telehealth capabilities have changed due to COVID-19 and if the State should expect changes after the pandemic?

OC24health was providing access and quality care virtually to patients prior to the pandemic and during the pandemic. We want to continue this mission post pandemic. OC24health/American Health Network as part of Optum is in the process of growing the number of dedicated local providers to cover all telemedicine visits and plans to expand coverage for after-hours visits. The Optum Digital Advocacy team provides regular best practice updates. Our leaders also actively share new information for treating the most common diseases. The Virtual Health Medical Director communicates the best practice guidelines to each provider via email.

1. Describe how you will work with State of Indiana to identify high-volume facilities and providers, establish measurable opportunities of savings derivable based on variations in facility/provider performance, and quantify savings achieved based on volume shift?

UnitedHealthcare plans to continue to apply a disciplined approach to contract negotiations, including harnessing industry-leading competitiveness analyses to ensure that negotiations are fact-based and data-driven. Their reimbursement methods represent a balance between their national strength and operating efficiencies and local market dynamics. UMR would like to further discuss with the State of Indiana how best to identify these facilities and providers and potentially incorporate quality, cost and performance measurements into a network solution for the State.

UnitedHealthcare also continues to explore and implement multiple innovative payment and delivery system configuration models. The focus is on the triple aim of 1) improving population health and patient experience, 2) delivering the best possible quality outcomes and 3) reducing medical cost and medical trend. Examples of current and planned value-based contracting approaches are noted below:

■ Performance-based compensation (PBC) ties contract rate increases for medical groups and hospitals to performance on quality and cost-efficiency metrics. We currently have hundreds of hospital and physician performance-based contracts and plan to significantly expand the PBC program over the next few years.

■ Our condition / service line programs encompass Centers of Excellence, ancillary capitation, and bundled/episodic payments and include over 2,300 physicians, 25 ancillary providers, and 160 facilities. We worked with eleven medical oncology groups around the country to initiate a cancer-care payment model that focuses on best treatment practices and better health outcomes. The first-of-its-kind program is aimed at improving the quality of care for patients with breast, colon and lung cancers. We also currently have bundled payment pilots for three episode categories in multiple markets. They are focused on orthopedics (total joint replacement – hip and knee), gastroenterology (screening colonoscopy) and maternity (perinatal). These bundles represent significant opportunity to generate savings and improve quality. We are also launching pilots for orthopedic prospective bundles.

■ At the most advanced end of the value-based spectrum, we are currently involved in over Accountable Care Organizations (ACOs) across the country. These organizations are focused on driving innovation in payment and delivery system reform with the “triple aim” of improving population health and patient experience, delivering the best possible quality outcomes, and reducing medical cost and medical trend.

The goal for all of these innovative value-based contracting models is improved quality outcomes and lower health care utilization and costs.

1. Please describe the processes used in addressing fraud, waste, and abuse. Please address methods for monitoring for fraud or abuse, follow-up and corrective measures, and reporting.

UMR’s fraud control procedures:

INTERNAL SYSTEM EDITS AND STAFF TRAINING

We work with industry organizations to identify and monitor trends in insurance fraud. To address fraud, we have created internal system edits, developed review procedures and provided special training to our claim professionals to help them identify potentially fraudulent situations.

CLAIM SPECIAL INVESTIGATION

Questionable cases that cannot be resolved through claim professional verification are referred to our Special Investigation Unit (SIU). This area is dedicated exclusively to detecting and investigating situations that could negatively impact our customers. The area's investigation technicians work closely with our legal and medical personnel.

In order to minimize possible fraudulent activity, SIU keeps detailed records of questionable cases in an in-house system that tracks the key components of a case from start to finish. Suspicious activity is recorded and providers with recurring problems are identified.

Once identified, any future claim from the provider is referred to SIU for review prior to payment. Because they understand the importance of communication during the investigation process, our staff will keep in close contact with the provider, employer or the member as appropriate.

INTERNAL SECURITY

We also maintain internal security through a specially designed system of checks and balances built into our organizational structure. This structure separates claim administration into four distinct areas, each with highly controlled authority levels. The four primary functions are:

■ Adding providers to the system

■ Updating and adding member eligibility information

■ Entering the plan benefits into the claim system

■ Processing the claim

FRAUD HOTLINE AND EDUCATION

In addition, we encourage members to participate by providing a toll-free hotline for their use in reporting suspected cases. The toll-free number appears on each explanation of benefits (EOB) statement, along with a brief explanation on the importance of controlling fraud. If desired, we will also provide you with educational materials to distribute.

FRAUD REPORTING

UMR can provide a report to our customers regarding fraud control activities and results based on our book of business and can provide a report of the savings specific to the State upon request.

* 1. **Disease Management**

1. Please describe your disease management (DM) offering. Please address if your offering includes the following conditions:
   1. Arthritis
   2. Asthma
   3. Chronic Kidney Disease
   4. Chronic Pain Management
   5. Congestive Heart Failure
   6. Chronic Obstructive Pulmonary Disease (COPD)
   7. Coronary Artery Disease (CAD)
   8. Depression
   9. Diabetes
   10. Hypercholesteremia
   11. Hypertension
   12. Liver Disease
   13. Low Back Pain/Musculoskeletal
   14. Oncology
   15. Rare Diseases (specify)

a. Arthritis: Arthritis is included within our Utilization Management CARE Support program when it is a complex/catastrophic episode of care.

b. Asthma: Asthma is addressed within our Ongoing Condition CARE program (adult and pediatric).

c. Chronic Kidney Disease: Chronic kidney disease is included as a core condition.

d. Chronic Pain Management: Chronic pain management is available as a standalone program and addresses back and neck pain; it can be purchased independently. Separate reporting is provided.

e. Congestive Heart Failure: Congestive heart failure is addressed within our Ongoing Condition CARE program.

f. Chronic Obstructive Pulmonary Disease (COPD): COPD is addressed within our Ongoing Condition CARE program.

g. Coronary Artery Disease (CAD): CAD is addressed within our Ongoing Condition CARE program.

h. Depression: Depression is addressed within our Ongoing Condition CARE program.

i. Diabetes: Diabetes is a condition within our Ongoing Condition CARE (Type 1 and 2).

j. Hypercholesteremia: Hypercholesterolemia is addressed as a comorbidity within our Ongoing Condition CARE program.

k. Hypertension; Hypertension is addressed within our Ongoing Condition CARE program.

l. Liver Disease – Hepatitis C is included.

m. Low Back Pain/Musculoskeletal: Chronic pain management is a standalone program and can be purchased independently. Separate reporting is provided. Complex/catastrophic musculoskeletal care is addressed within our Utilization Management and CARE support programs.

n. Oncology: Oncology care is addressed within Ongoing Condition CARE.

o. Rare Diseases (specify): Other programs included are Multiple Sclerosis, Rheumatoid Arthritis, Sickle Cell Anemia, HIV, GI conditions, neuromuscular conditions. Rare diseases are managed in CARE Support.

1. Describe the methodology used to determine and calculate ROI for your DM programs. If ROI varies by condition, please describe or include as an attachment.

UMR’s customers generally see an ROI of 2:1 approximately 18 months after rolling out an Ongoing Condition CARE program, with increasing returns in the years that follow. However, for groups with fewer than 5,000 employees, the results tend to fluctuate dramatically from year to year because the number of members in the program is not high enough to yield a consistent pattern on results. We advise our customers to review their ROI over a 24- to-36-month period and avoid making ROI calculations until at least 18 months after the program begins.

Please note the most significant factor for obtaining a high ROI is member engagement and participation, which is heavily influenced by management commitment, electing to use an opt-out model, member communication and incentives.

Please see **Attachment 4** for a sample Ongoing Condition CARE ROI measurement report.

The following is an explanation of how we calculate ROI:

■ Populations with chronic managed conditions and without those conditions are held constant during both reporting years. We use only those members continuously enrolled during the full two-year period.

■ To be included in the conditions group, members must have had physician/facility (not diagnostic testing only) claims during the year prior to the first year (if that history is available) or in the first year.

■ We exclude members with a condition claim in the second year, but not the first (or the year prior to the first year) from both groups.

■ We calculate the trend for the group without conditions.

■ We multiply this trend factor times the first year total unique claims (less exclusions) for the group with conditions to determine the expected second year claims.

The difference between the trend established expected claims and actual second year claims (less exclusions) for the group with conditions represents the claim savings. Net savings to the customer is the claim savings minus the cost of the program.

1. Are you willing to customize your care management/DM programs and services for the State? If so, please explain and provide an example.

UMR has extensive experience customizing our Ongoing Condition CARE programs to best meet the State of Indiana’s culture, health goals and budget. In addition, we review our programs annually to reflect medical trends, treatment breakthroughs and remain up to date with evidence-based clinical practice guidelines. We would be glad to discuss your customization requirements upon award of business. Please note: additional costs may apply for customization.

1. Describe the process and methods used in identifying members for care and disease management programs.
   1. Are patients stratified by risk?

Yes. UMR utilizes predictive modeling for Ongoing Condition CARE. Members are stratified by risk and we focus on the members who are high risk.

* 1. For which conditions/diseases?

UMR’s experience has found that managing the conditions listed below provides maximum value for customers:

■ Asthma (children and adults)

■ Chronic obstructive pulmonary disease (COPD)

■ Heart failure (HF)

■ Coronary artery disease (CAD)

■ Diabetes (type 1 or 2) (children and adults)

■ Hypertension

■ Depression

■ HIV

■ Hepatitis C

■ Sickle cell anemia

■ Rheumatoid arthritis

■ Multiple sclerosis

■ Chronic kidney disease

■ GI conditions

■ Neuromuscular conditions

* 1. Methodology used (e.g., predictive modeling)?

UMR uses predictive modeling software to identify candidates for coaching in our Ongoing Condition CARE program, and as part of claim analysis to risk-score populations and project future costs. We use products from two different vendors for these capabilities: MEDecision’s Clinical Intelligence Rules (CIR) for Ongoing Condition CARE and UMR’s Benefits Analytic Manager for risk scoring and cost projections. The CIR tool analyzes all medical and pharmacy claims to identify and stratify potential candidates for our Ongoing Condition CARE program.

* 1. How strata are defined?

The risk strata are determined through predictive modeling and MEDecision considers this information proprietary.

* 1. How interventions are adjusted to the respective risk strata?

The low and moderate risk members do not receive outreach by an Ongoing Condition CARE health nurse. They receive the mailed newsletter, online Healthy U magazine, introduction mailings, Web portal access to online tools and education. If a low or moderate risk member with one of the Ongoing Condition CARE conditions requests a nurse intervention, the member is enrolled and coached in the appropriate Ongoing Condition CARE program.

**High risk**: Telephonic coaching and education with an RN certified as a chronic care professional (CCP) and trained in behavior change, written education, Web portal access to online tools and education.

* 1. Do interventions vary by status of disease? Please describe your process and intervention approach.

Our CARE nurses focus on high risk members. The member status is reviewed monthly so any change in status is noted and the appropriate action taken.

1. Briefly describe how you involve the member’s primary care or treating physician.

UMR strongly supports the member-provider relationship, which helps both parties stay fully engaged and apprised of the member’s health status. Our program encourages provider participation by sending a letter to the member’s primary care physician (PCP) after enrollment, which notifies the provider of the member’s participation in our program, as well as the CARE nurse’s name and contact information. The letter also asks the provider for the most recent lab results and how we can support their plan of care. Approximately 30 percent of PCPs who receive this communication collaborate with the Ongoing Condition CARE case manager nurse by providing current lab values and suggesting opportunities for the case manager to support the provider’s plan of care.

Our CARE nurses discuss strategies members can use to effectively and promptly communicate issues and symptoms with treating providers. They also discuss barriers to treatment adherence and encourage member/provider collaboration. Members receive a condition-specific Questions for Your Doctor flyer to facilitate conversation and improve dialogue.

Coordination of care is a critical issue. The patient/health plan member is a critical partner in the flow of information. We help by assessing the member’s overall health care utilization and faxing a letter that is electronic record friendly directly to the provider.

HealtheNotes is another tool that assesses and provides messaging to members and their health care providers regarding discrepancies in treatment from standards of care. A discussion and written recommendations of targeted questions for providers help the member have necessary conversations with their providers, enabling them to obtain clear, consistent direction and move them toward better health outcomes.

1. Describe your approach to member engagement as it relates to DM.

We define participation or active engagement in our Ongoing Condition CARE program as any member who is working one on one with a CARE nurse to manage his or her condition(s).

UMR has found that successful Ongoing Condition CARE programs are those with senior management support, persistent communication and the integration of incentives.

We encourage customers to communicate the value of our program to their members during implementation. Our support includes a customer-specific marketing plan with year-round communication materials to educate and promote the program. We also track and administer incentives.

We contact members to educate and enroll in our programs through a variety of communication channels: mailings, phone calls, emails and texts. Members who are identified for one of our CARE programs receive two written communications inviting them into the program and an unable to contact letter if appropriate. These are sent via mail or email. Once we have the member’s consent to use text messaging, we include that in our ways to communicate. In addition, we make two outreach phone calls to the member at different times and days to adapt to any schedule changes they may have. We communicate with the member in the way they prefer and at the times that are most convenient.

As part of our efforts to enhance engagement, UMR CARE will be introducing Vivify for participants in all of our CARE programs. This digital platform will connect members with CARE nurses and coaches, improving member activation and engagement. Members will receive emails, texts and push messaging not only to engage members to participate in our CARE programs but also to continue participation in the program with friendly nudges.

1. Describe how you coordinate members involved in more than one program, for example members with diabetes and congestive heart failure.

When a member is identified with multiple conditions, each condition is addressed through our Ongoing Condition CARE program by one CARE nurse. The member does not have one nurse for one condition and one nurse for the second condition. We believe the nurse-patient relationship is foremost in assisting the member make changes. Our care management software system is designed to handle multiple conditions without repetitive questions and education from the CARE nurse. In situations where multiple conditions are present, the most medically serious condition is viewed as primary, while other conditions are treated as comorbidities. The Ongoing Condition CARE nurse communicates with the member by phone or email focusing on managing the overall health of the member to account for multiple disease states. Approximately 23.39 percent of our Ongoing Condition CARE participants have multiple conditions.

1. Do your care managers assist members with non-chronic significant medical events (e.g. maternity, knee surgery)? Describe the outreach program to identify and follow-up with these individuals.

Post-discharge outreach (contacting a member after the member has been discharged from the hospital) is part of our GenYou CARE Support services. We routinely trigger an assessment call within 24 to 48 hours after discharge to ensure the member has a follow-up appointment, the correct medications and knows the signs and symptoms of complications and what to do about them.

We identify members who are planning on a total knee or hip replacement through the prior authorization process. The CARE Support nurses call the member to offer their assistance with preadmission counseling in addition to discharge support.

Our CARE Support nurses work with members who have frequent ER visits, have specialty medications, are inpatient for a BHSUD condition and transitioning to a lower level of care, and/or need assist with denials and appeals.

Our Maternity CARE program identifies pregnant members through claims and invites the member to work with a Maternity CARE nurse during the journey of her pregnancy. Dedicated OB-GYN nurses provide the support the member needs regardless of risk.

1. Provide the average number of telephonic outreach attempts made by your care managers to engage individuals in programs.

UMR uses a comprehensive recruitment/enrollment approach. We first contact individuals identified as high risk via a welcome letter, followed by two outbound recruitment calls, if needed, at various times of the day. If we do not receive a response, we mail an unable-to-contact letter. This letter serves as our final opportunity to invite the targeted member to enroll in our Ongoing Condition CARE program.

In addition, we also make outreach using email and text. We find that it is best to contact the member by the method they prefer at the time that is most convenient

Once we successfully contact a potential participant, our enrollment specialists schedule the first coaching call. Our health coaches and enrollment specialists are trained on the behavioral change model for engaging members at all levels and engaging them in goal setting and moving forward with healthy changes in their daily lives.

Enrolled members who do not actively engage receive a follow-up call and an unable-to-contact letter before being moved into quit participation status.

High-risk members who choose to not participate or do not respond to our contact attempts will continue to receive outreaches approximately every nine to 10 months inviting them to take advantage of support available to them through the Ongoing Condition CARE program.

1. What is the average percentage of members who are actively engaged in health risk management programs after receiving an invitation through an outbound call?

Out of the total member population, we typically see 19.8 percent who have one or more of the ongoing conditions managed through our program. Within that sub-group, we expect to find 44.2 percent that are high risk. From those members who are high risk, approximately 8.9 percent actively participate in the coaching program, which equates to 1.09 percent of the total employee population.

Member participation rate is calculated by dividing the number of active/maintenance Ongoing Condition CARE participants by the difference between the number of active/maintenance participants and those members who are not engaged.

Active Ongoing Condition CARE participants are defined as members identified with one or more of the ongoing conditions that have completed their initial coaching call.

Not engaged refers to at-risk members with an ongoing condition who did not respond to calls and letters, refused, quit or notified UMR (either via telephone or in writing) that they wish to cease participation in the program and are choosing not to work directly with a CARE nurse.

1. Besides telephonic outreach, describe any additional methods that you are using to encourage engagement (e.g. texts, physician engagement, family engagement, etc.)

We contact members to educate and enroll in our programs through a variety of communication channels: mailings, phone calls, emails and texts. Members who are identified for one of our CARE programs receive two written communications inviting them into the program and an unable to contact letter if appropriate. These are sent via mail or email. Once we have the member’s consent to use text messaging, we include that in our ways to communicate. In addition, we make two outreach phone calls to the member at different times and days to adapt to any schedule changes they may have. We communicate with the member in the way they prefer and at the times that are most convenient.

As part of our efforts to enhance engagement, UMR CARE will be introducing Vivify for participants in all of our CARE programs. This digital platform will connect members with CARE nurses, improving member activation and engagement. Members will receive emails, texts and push messaging not only to engage members to participate in our CARE programs but also to continue participation in the program with friendly nudges. When a member and CARE needs a call with the provider, chat is an option for a three-way call.

1. What clinical assessment tools/clinical content do your nurses/care managers have access to in order to assist members?

To assist members, we give them online access to pertinent review information and assist members. UMR recognizes the value of integrating our programs within the CARE system platform, Aerial. The system provides powerful, customizable workflow capabilities to streamline our CARE services. Access to this information increases the efficiency of our staff, while ensuring a high level of confidentiality. We can automate virtually unlimited business and clinical rules, including clinical protocols, which provide easily understandable, nationally recognized criteria for determining appropriateness of care, location and duration of service. Data is incorporated into our CARE system to assist our clinical team in managing all aspects of a member’s care.

UMR CARE offers digital app capabilities which is available to all members regardless of risk. The population will have access into basic tools supporting wellness. Members in Complex CARE and Ongoing Condition CARE will have access into additional capabilities including remote monitoring used to empower members to understand long term condition management. These tools include Bluetooth glucometers, weight scales, blood pressure cuffs, and pulse oximeters at a device by device fee, or through self-entry of their biometric values. Included in the digital app is a comprehensive risk assessment and additional daily questions which are used for the nurse to gauge progress or if the member needs an intervention. Hundreds of videos are available through the app as members go through the health-pathways learning about their chronic condition and longstanding interventions to empower the member to achieve self-care and stabilization.

Our CARE programs offer full range health support. Real-time risk stratification with machine learning incorporates social determinates of health; connectivity into pharmacy claims for medication reconciliation detecting missed medication fills (coming in 2023); digital clinical episodes for individualized care; ability to screen patients for services and transmit referrals; and multi-party virtual visits. The member stays closely connected with their assigned nurse on a daily basis through digital messaging and clinical monitoring.

We also offer a clinical health risk assessment (CHRA) tool. The CHRA identifies and stratifies populations based on current medical conditions and future risks in areas of life that have the potential to positively affect the member’s health. Our CHRA assists with those actively managed members by guiding their participation in the program. To understand the current health status of the member, we designed our CHRA to identify those members eligible for participation in health and lifestyle coaching programs. UMR CARE coaches have real-time access to member CHRA results and other pertinent information.

1. Does your organization offer the opportunity for members to work with the same care manager/nurse?

Yes. Our Ongoing Condition CARE program is an integrated program. Members who have more than one condition have the benefit of working with the same CARE nurse to address and prioritize actions to be taken. Of the members who participate in our Ongoing Condition CARE coaching program, 98.5 percent complete the program.

Our GenYou CARE Support nurses work with the member with dual diagnoses of medical and BHSUD. One nurse supports the relationship and builds trust. The member is not split between two “specialists,” so the nurse gets an overall picture and is able to provide better care and support.

1. Describe how you can leverage data from the State’s Population Health Management vendor to inform your disease management programs. How will you integrate lead lists from the State’s data warehouse vendor into the identification and management process?

UMR will integrate with the State’s Population Health Management vendor but is unable to determine how the information will be used in our CARE programs without knowing what data can be provided.

1. Do you send reminder notices for wellness screenings? If yes, please indicate which screenings, how frequently reminders are sent, and who receives the notice (member or provider).

Yes. UMR’s HealtheNotes Reminders include a number of preventive treatment reminders to increase the number of individuals who receive the following:

■ Recommended mammograms

■ Cervical cancer screenings

■ Pediatric immunizations

■ Adolescent immunizations

■ Low-density lipoprotein (LDL) screenings for individuals with coronary artery disease

■ Comprehensive exams for individuals with diabetes

These messages encourage individuals to take advantage of screening(s) that can prevent serious illness or reduce the risk of death from illnesses. The reminders are mailed to the appropriate members in a user-friendly, personalized and timely format based on the recommended treatment schedule, and are available in English and Spanish.

HealtheNotes Reminders inform members about the importance of self-care and speaking to their providers about how to care for their health. The reminders are generated from evidence-based medical guidelines.

1. What programs do you offer to address mental health issues and depression?

UMR has a dedicated behavioral health team that provides utilization management services for all levels of care for mental health and substance abuse treatment, according to the plan benefit design. The behavioral health team consists of social workers and nurses, with an average of more than 17 years of experience in the field, as well as additional training in alcohol and drug treatment and case management.

When requests are initially received for authorization, the clinical reviewer reviews and follows the case concurrently for medical necessity. UnitedHealthcare guidelines, LOCUS guidelines and American Society of Addiction Medicine (ASAM) criteria guidelines are used. If a case appears not to meet medical necessity, it is sent for physician review. We use a nationally known external review vendor that is URAC-accredited. Each review is physician-specialty matched.

The behavioral health team works diligently with the utilization management contact at the facility to advocate for quality treatment at the appropriate level of care. We assist the provider in identifying discharge needs, using available plan benefits for optimum results. Additionally, the team works collaboratively with CARE support staff when referral criteria are met.

Depression is included as an Ongoing Condition CARE module. This program is offered to adults with indicators for comorbid depression that is not being managed or not managed effectively. Coaching and education topics include:

■ Disease knowledge

■ Seeking an initial evaluation and ongoing monitoring

■ Treatment, including depression medication adherence and psychotherapy

■ Self-care behaviors that support recovery from depression

■ Stress management

■ Support from family and friends

■ EAP and other sources of help

1. Describe your maternity management program. How do you measure the success of this program?

Please find information below regarding our Maternity CARE program:

HEALTHY BEGINNINGS FOR MOTHERS-TO-BE

UMR’s Maternity CARE program provides pre-pregnancy coaching, prenatal education and high-risk pregnancy identification to help expectant mothers carry their babies to term. The result is an increased number of healthy, full-term deliveries and a decrease in costly, extended hospital stays.

PRE-PREGNANCY COACHING

We provide pre-pregnancy coaching to your plan members at no additional charge. Members planning to start a family can contact UMR CARE to receive information about actions they can take before becoming pregnant to reduce the risk of certain birth defects and of pregnancy complications.

PROACTIVE IDENTIFICATION AND ENROLLMENT

We identify pregnant participants through sources such as claim edits, claim triggers and utilization review. Members may also self-enroll online by completing a Web enrollment survey at **umr.com** or by calling our toll-free number.

UMR CARE uses an aggressive recruitment approach. For members identified via the Web enrollment survey, an enrollment specialist makes two outbound recruitment telephone calls. If we are unable to connect by telephone with the pregnant member, we mail a recruitment letter. For those identified via other methods, we mail an initial recruitment letter, followed by two outbound recruitment calls and, if necessary, an unable-to-contact letter.

Once enrolled in the program, a Maternity CARE nurse who has an extensive clinical background in OB/GYN contacts the expectant mother. The CARE nurse completes an assessment to determine risk level and provides the expectant mother with timely education, coaching/support for taking actions to support the goals of a healthy pregnancy/delivery, and credible references, based on the member’s needs.

The CARE nurse assesses the member for changes in risk each trimester and provides ongoing education, coaching/support and references, based on the member’s needs. After delivery, we contact mothers one more time to discuss postpartum concerns, including newborn issues, and assess for symptoms of postpartum depression. Postpartum depression is the number one risk/complication of delivery.

RISK-REDUCING INTERVENTION

In high-risk cases, the maternity management nurse case manager provides the member with education, coaching/support and references. The Complex Condition CARE nurse manager monitors the member’s condition and claims, keeping the group informed of high-cost situations and assisting to reduce claims costs throughout the high-risk pregnancy and post-delivery period.

EFFECTIVE INCENTIVES

To encourage members to enroll early in their pregnancy, we offer an incentive reward for participation as well as an incentive reward for successful completion of the program. All members who join the Maternity CARE program are eligible to receive a gift of their choice from a selection of high-quality books and other materials. These materials contain helpful information about pregnancy, pre-term labor, childbirth, breastfeeding and infant care. Members who enroll in the program in their first or second trimester and successfully complete the program are also eligible to receive a UMR-funded $25 prepaid reward card. Members who wait until their third trimester are also encouraged to join the program and will receive the educational offerings but are not eligible for the program reward card.

HEALTHFUL RESULTS

UMR customers who purchase our Maternity CARE program consistently show a smaller percentage of premature births versus those customers without our program. Over the past six years, this difference ranged from a 5 percent to 48 percent reduction in premature births for those customers with our maternity CARE program. (Reported reductions in premature births is based on a claims analysis for the full group and includes members who did not participate in the Maternity CARE program.)

1. Please describe your approach to opioid management. Describe your ability to work with the State’s PBM to identify and manage appropriate opioid use.

Beneficial for some medical conditions, opioids are potent drugs that present a high risk of abuse and dependence. Negatively impacting families and communities, abuse of opioids has reached epidemic levels within the United States. UMR and OptumRx are committed to addressing the opioid crisis through proactive prevention, treatment for those who are addicted and supporting long-term recovery by providing a multitude of programs and advocacy. We have deployed a comprehensive strategy utilizing evidence-based interventions delivering holistic member supports when appropriate. UMR provides access to CARE and other programs which provide assistance in addressing the opioid epidemic using multiple methods. The clinical management strategies include proactive identification of at-risk membership, which is essential to managing opioid dependence throughout the continuum of care. UMR screens for opioid abuse patterns throughout all of our programs. UMR also provides a behavioral health/substance use disorder discharge support program to support those that have recently been discharged from an inpatient setting. We are willing to work with the state’s PBM to identify and manage appropriate opioid use.

**1.11 Implementation & Transition**

1. Please provide an implementation plan and timeline with key milestones. Please assume a 1/1/2022 effective date.

UMR will establish a carefully developed implementation plan and assigned team for the State of Indiana. The implementation team is comprised of an experienced transition leader, Jackie Fox, skilled SAE, Chris Isaacs, and other leadership and technical experts. This team works directly with your designated staff to ensure a smooth transition, minimizing disruption for members.

Provided as **Attachment 5**, we have created a sample implementation project plan. The plan captures the details of the implementation process and tracks target dates, responsible parties and task dependencies. It includes tasks that address the exchange of information electronically, as well as other agreed upon deliverables.

As we begin implementation, UMR will conduct an in-depth assessment and due diligence of your business requirements, so we can tailor the project plan. When UMR is notified we are awarded the contract, we will immediately assemble the implementation team for a kickoff and planning session.

As shown in the sample project plan, your staff members play an active role as members of the implementation team. Some examples of the tasks they will be responsible for include, but are not limited to:

■ Providing benefit and program information

■ Participating in detailed intent discussions with our subject matter experts

■ Confirmation of intent documentation

■ Assistance with communications

UMR’s implementation strategy is designed to proactively involve you in all material decisions as part of the implementation team. In addition, your assigned SAE (Chris) will be heavily involved throughout the implementation and post-implementation, working very closely with you and assisting with open enrollment/educational sessions. We will continually monitor the project plan to ensure we are on track for a smooth, successful transition.

UMR carefully plans and executes the transition process to minimize the impact of change to members. We know it’s important that coverage is not interrupted, so we offer a meticulous implementation process that leaves little to chance.

POST-IMPLEMENTATION CHECK-OUT PROCESS

As your implementation process comes to an end, UMR performs a check-out process to ensure the plan’s accuracy. This process is unique in the industry and will give the State of Indiana peace of mind as the transition comes to a close.

The benefit check-out process allows you to verify that the outcome of claim processing meets the intent of the benefit design. If the State of Indiana identifies necessary changes, we update the benefit design prior to going live within our system.

The areas of review can be:

■ Deductible and out-of-pocket (including any cross feeding)

■ Office visit copayments (primary care physician (PCP) vs. specialist)

■ Routine

■ Ambulance, emergency, urgent care

■ Chiropractic

■ Physical therapy/occupational therapy

■ Inpatient (facility and physician)

1. Who will lead the implementation team? Please describe the experience and qualifications for the implementation manager.

UMR will establish a carefully developed implementation plan and assigned team for the State of Indiana. The implementation team is comprised of an experienced transition leader (Jackie Fox), skilled SAE (Chris Isaacs) and other leadership and technical experts. This team works directly with your designated staff to ensure a smooth transition, minimizing disruption for members.

1. Will the Account Team be part of the implementation?

Yes. The account management team will support the State of Indiana both during the transition and after implementation is complete.

1. How long after “go-live” will the implementation manager remain with the team?

Participating members of the implementation team that will not be involved in ongoing service will phase out when the implementation is completed, ensuring a smooth transition for ongoing service in their department.

1. Discuss the level of assistance that will be provided during the implementation process (including but not limited to support at employee meetings) and the availability for meetings with State’s benefit staff to discuss ongoing issues.

The State of Indiana will have an SAE, Chris Isaacs, who serves as your main point of contact at UMR. Chris will work with you to determine your enrollment meeting needs. This may include assisting members with understanding their benefits or providing information and education on our products and tools, such as **umr.com**. On-site attendance is available and we have partnered with Professional Management Enterprises to support statewide coverage. Extenuating circumstances, such as the COVID 19 public health emergency may limit in-person meetings. Note that UMR has many virtual accommodations to help you deliver your enrollment meetings successfully. We use BrainShark or other WebEx presentations for those sites with fewer than 50 members, or when in-person meetings are not the preferred venue.

During the meetings Chris and the assigned field account manager (FAM) can be made available to present and/or field questions. Some topics typically addressed include:

■ Enrollment process

■ Filing a claim

■ ID card features

■ Network overview

■ Benefit design

■ Member tools on **umr.com**

Chris may also call upon additional people and resources, such as the marketing communications department, as necessary.

Ongoing, Chris will be responsible for the development and maintenance of our business relationship with the State of Indiana. Serving in a consultative role, Chris will work with the State of Indiana to develop short- and long-term strategies, ensure your satisfaction and proactively manage your plan. Chris will work closely with you to gain an understanding of your benefit plans, business needs and organization culture. This understanding along with Chris’ knowledge of UMR will ensure we are able to meet your organizational needs and goals. Chris will act as your liaison at UMR.

1. Please describe any requirements of the incumbent vendor to a successful transition (e.g. claims files, account structures) and how you expect to work with the incumbent during the transition.

For a successful implementation, UMR requests key deliverables be provided, such as, but not limited to, the following:

■ Customer contact list (names, email addresses, phone and fax numbers)

■ Account structure, including locations

■ Benefit design(s)

■ Eligibility test and production files

■ Provider network arrangements

■ Banking requirements

■ Reporting specifications

■ Billing requirements

■ Any necessary claim accumulators

■ Signed administrative services agreement (ASA)

If requested by the State of Indiana, UMR can accept benefit accumulators from your prior carrier. We will work with them to determine format and the data elements needed based on your requirements. UMR prefers that data be provided in an Excel document, since this will allow for a one-time load. There are certain fields required to load accumulators:

■ Employee Social Security number (SSN)

■ Employee first and last name

■ Employee date of birth

■ Patient first and last name

■ Patient relationship code

■ Patient date of birth

■ Patient sex code

■ Accumulative amount (dollar amount to be applied)

■ Accumulator type (calendar year benefit, deductible, out-of-pocket)

■ Date/year of accumulator (used when loading historical data, such as calendar year deductibles)

We are able to convert files to the fields/format needed to load accumulators as long as we receive the required data. This service is of our accumulator load process.

Our CARE team also works with other vendors to establish smooth data transfers so cases that are ongoing at the time of the contract effective date transition to our CARE programs. We identify appropriate contacts within the previous care management vendors and communicate with them well before the transition date to get case‑specific information and to avoid any missed care management opportunities. We will honor prior authorizations approved prior to UMR’s effective date, unless a change in plan language creates exclusions or limitations, in which case the request is reviewed as a new prior authorization. We also work internally with our staff to ensure that training, according to group specifics and needs, occurs prior to implementation.

The percent of the transition leader’s time and involvement during implementation, as well as the number of accounts assigned, depends on the size, complexity and needs of the customer. When assigning transition leaders we select experienced staff with capacity, and focus on customer needs, to ensure a smooth, successful transition for all new customers and members.

1. What are your standard transition of care procedures? How can they be customized for State of Indiana?

UMR offers assistance and guidance to help you determine if a transition of care benefit would be helpful. Transition of care benefits are intended to enable patients who have certain medical conditions, which are either chronic or being actively treated by non-network providers, to have continuity of care until safe transfer to a network provider can be arranged. These services will be authorized for a specified and limited period of time, jointly agreed to by you and UMR.

We can request that the present carrier send a report showing members who are currently receiving critical care. We will then flag those member files in our claim payment system.

Members contact our customer service team to access transition of care benefits. Our GenYou guides will receive the call, verify a transition of care benefit is available, ask the member questions related to the specific condition and determine if the member qualifies for the benefit. The GenYou guides follow these procedures:

■ Contact the network to verify the provider is truly non-network

■ If the provider does participate in the network, the member does not need a transition of care approval.

■ If the provider does not participate in the network, the GenYou guides will proceed with the approval process.

■ Verify the condition for which the member is seeking treatment

■ If the condition is not on the list of approved diagnoses, the GenYou guides will inform the member that the condition is not eligible for transition of care benefits. The member will need to seek treatment from a network provider or their benefit will be payable at the non-network level.

■ If the condition is on the list of approved diagnoses, the GenYou guides will approve the transition of care benefits and notify the member of the effective and expiration date of the approval based on the plan’s chosen guidelines.

■ If the uncertain whether the condition falls into one of the approved diagnoses, the GenYou guides will conference in UMR CARE or the care management vendor of the plan to help make the determination. If the GenYou guides is still unable to decide, they can contact the CS.

■ Document the call

■ Complete the transition of care approval form and forward to the appropriate UMR internal areas

■ Notify their supervisor to place a note in the member’s file along with the begin and end dates of the approval

■ Notify the CS by providing them with the OnBase document number of the transition of care form.

Transition of care benefits can also be initiated by the State of Indiana by working through a CS.

1. Describe your protocol and testing around establishing file transfers.

We will work with the State of Indiana’s chosen vendor partner(s) to ensure you and your members’ sensitive information is protected. We have well defined processes in place to secure a seamless claim and eligibility data transfer process. In fact, once your external vendor partner is identified, we immediately alert our data release team. A member of the team will be assigned as a designated contact to guarantee a smooth data transfer process. This is a standard practice for our customers.

A PROACTIVE PROCESS

In connecting with external vendor partners, we develop an integration strategy during implementation which allows us to focus on:

■ Defining data requirements, business needs and usage

■ Establishing timelines around delivery of information

■ Reviewing any potential setup errors

■ Identifying possible file feed discrepancies

■ Addressing agreements that may need to be in place

Our data transfer review doesn’t just end after the effective date; we will continue to have ongoing calls with our established vendor contacts throughout the life of the contract with file feeds and other key milestones of the data transfer process.

A PROVEN PARTNERSHIP

We have successfully worked in partnership with over 200 vendor partners demonstrating that our established procedures work.

UMR is willing to work with additional vendors upon request. Due to the multitude of companies providing complementary or competitive services to our customers and prospective customers, our integration capabilities are continually evolving. We welcome the opportunity to work with you and your potential vendor partner to identify strategies for coordinating to meet your integration goals. This could include data needs addressing file structures, frequency and modes of transmission and establishing appropriate privacy and security protocols.

1. How much lead time is necessary for you to guarantee that ID cards will be received by members prior to the plan year effective date?

Timing to receive ID cards is dependent upon when UMR receives accurate and timely eligibility information from the State of Indiana or your prior carrier. ID cards will be received by the effective date if clean eligibility data is received 40 days prior to a January 1 effective date. Please refer to AttD1 for our proposed performance guarantee details.

1. Can you launch a pre-open enrollment website for members with resources about your company and the State’s benefits?

Yes. Prior to the plan effective date, members can see general benefit information and provider networks information online, assuming eligibility is loaded.

**1.12 Network Strategies**

1. Describe your current tiered-network and high quality/high performance network capabilities/ offerings.

Benefit tiering to Premium providers is only available for providers with a UnitedHealthcare two blue hearts designation. Members in plans that offer tiered benefits may see lower deductibles, out-of-pocket maximums, copayments and coinsurance amounts for services provided by UnitedHealth Premium Care Physicians.

Members in a Premium benefit tiered plan are able to find which physicians meet the criteria for quality and cost efficiency on **umr.com** with the “Find a Physician” search tool. The UnitedHealth Premium Care Physician two blue heart symbol helps people quickly and easily find physicians recognized for providing value.

1. What data, information, and methodology are used to place provider groups into cost and quality tiers?

We rely primarily on paid claims data to evaluate the quality and cost efficiency of care. Paid claims data are commonly used by many types of organizations (e.g., health plans, academia, regulatory agencies) to analyze and understand many aspects of health care delivery. The data are readily available, comprehensive, and can provide detailed information about the type, quantity and cost of services patients receive. The measures used in the Premium program have been designed specifically for use with administrative claims data.

1. Describe your programs to evaluate physicians and facilities for your high quality/performance network, specifically addressing the following:
   1. Criteria (e.g., quality, cost, efficiency)

The UnitedHealth Premium program evaluates and recognizes physicians on two levels of care: quality, and if the physician meets Premium quality criteria, then cost efficiency. The program uses national standardized measures to evaluate physicians across 16 specialty and 47 sub-specialty areas of focus to advance safe, timely, effective, efficient, equitable and patient-centered care. Quality measures are based on national standardized measures and clinical guidelines that are specialty specific, case-mix and severity-adjusted.

There are two measurements applied for the evaluation of cost efficiency: patient total cost measurement and patient episode cost measurement. The physician’s Premium program uses the cost measurement(s) applicable to the physician’s Premium specialty. For specialties measured using patient total cost, when the physician does not have a sufficient number of patients attributed, the Premium program uses the patient episode cost measurement.

All physicians who meet both the quality and cost-efficiency criteria receive a Premium Care Physician designation. Physicians who only meet the quality criteria receive a Quality Care Physician designation.

* 1. What are your sources of quality and performance information on physicians and facilities?

Quality is the primary program measurement, evaluated using national standardized measures. We base the criteria for measuring individual physicians on process standards and outcomes indicators that measure the following aspects of care:

■ Preventive care – Cancer screening and other indicated screening interventions

■ Evidence-based care – Follows evidence-based guidelines for use of medications and diagnostic tests

■ Chronic disease care – Monitoring for control, progression, and complications

■ Patient safety – Avoiding duplicate testing or adverse drug interactions and monitoring safety

■ Sequencing of care – Diagnostic tests and procedures, treatment and monitoring

■ Effectiveness of procedures – Lack of failed therapy and complications

The Premium program first uses clinical quality measures from the National Quality Forum (NQF)-endorsed measures when available for the specialties being evaluated. Those measures are supplemented with others as necessary to evaluate clinically important conditions and specialties. Additional measures are selected from or developed using published literature and information from organizations such as:

■ The NCQA

■ American Medical Association Physician Consortium for Performance Improvement (PCPI)

■ Specialty societies relevant to a specific disease and clinical condition

■ Government agencies

■ Other national expert panels

From these sources, the Premium program uses relevant measures that can be evaluated using health plan claims data and that are useful in determining differences in physician performance.

* 1. How is quality information conveyed to plan enrollees?

Members are able to find which physicians meet the criteria for quality and cost efficiency on **umr.com** with the Find a Physician search tool. Premium Care Physicians who meet the UnitedHealth Premium criteria for providing quality and cost-efficient care are identified with a Premium Care Physician (two blue hearts) designation.

Other possible designations include:

**Quality Care Physician**: One blue heart and one white heart indicates that a physician meets the Premium program quality care criteria but does not meet the program’s cost-efficient care criteria or is not evaluated for cost-efficient care.

**Not Evaluated for Premium Care**: Two white hearts represent that the physician's specialty is not evaluated in the UnitedHealth Premium program, the physician does not have enough claims data for program evaluation or the physician's program evaluation is in progress.

**Does not Meet Premium Quality Criteria**: Two grey hearts are used to identify physicians who do not meet the UnitedHealth Premium program quality criteria, so the physician is not eligible for a Premium designation.

1. Do you currently rank providers based on quality and/or cost? If “yes” how do you determine the specific quality ranking of each provider and facility? How often is each provider's quality ranking revisited?

Yes. The UnitedHealth Premium program evaluates physicians annually, using updated quality- and cost- efficiency methodologies and data. We use a quality-first methodology, where only those physicians meeting quality criteria are then eligible for a cost-efficiency evaluation. Physicians who meet quality or quality- and cost-efficiency criteria receive one of the following designations:

■ Physicians who meet the criteria for following guidelines for national standardized quality measures receive a Quality Care Physician designation. The outcome is determined by comparing a physician’s observed practice to our national rate among other physicians who do the same interventions.

■ Physicians who meet quality and cost efficiency criteria receive a Premium Care Physician designation. Physicians that meet quality criteria often provide care more efficiently. Cost efficiency is defined as using the least costly medical resources to achieve a desired outcome and/or level of care.

The UnitedHealth Premium program re-evaluates physician designations for their performance against national quality and market cost-efficiency criteria no less frequently than every two years. That is in accordance with the NCQA's Physician Quality (PQ) certification requirements, which we continue to meet. Performance on quality is measured based on adherence to national standardized measures. As new guidelines are developed, they have been incorporated into the overall designation methodology.

1. Is your system capable of administering plan design differentials when a tiered network is in place? Are there minimum differentials between benefits in each tier?

Yes. Benefit tiering to Premium providers is only available for providers with a UnitedHealthcare two blue hearts designation. Members in plans that offer tiered benefits may see lower deductibles, out-of-pocket maximums, copayments and coinsurance amounts for services provided by UnitedHealth Premium Care Physicians. Our Premium Program with benefit tiering does require benefit differentials between each tier. The benefit differentials can be through copayments or coinsurance. The following is an outline of the copayment and coinsurance requirements:

Copayments – Maximum co-pay differential: Tier 2 non-Premium Care Physician is three times greater than Tier 1 Premium Care Physician not to exceed a $60 differential.

Coinsurance – Up to 30 percent coinsurance differential allowed between Tier 1 Premium Care Physicians and Tier 2 network non-Premium Care Physicians. Preventive care allowed at different level (e.g. 100 percent coinsurance).

Members in a Premium benefit tiered plan are able to find which physicians meet the criteria for quality and cost efficiency on **umr.com** with the “Find a Physician” search tool. The UnitedHealth Premium Care Physician two blue heart symbol helps people quickly and easily find physicians recognized for providing value.

1. Do you require that members select a PCP if a tiered network is in place?

No. The tiered network solution we are proposing does not require a PCP selection.

1. Is your Tiered network associated with any ACO arrangements? If so, please explain the relationship (e.g. Tier 1 physicians are ACO network providers).

No.

1. Do you have a Centers of Excellence (COE) offering? Please describe the facilities, locations, and conditions included in your COE.

Yes. UMR offers customers Optum’s industry-leading specialty networks, which are built through quality measurement and value-driven contracting and are unique in the health care industry. Optum continuously evaluates contracted and non-contracted programs for their clinical excellence and economic value.

The following programs and services promote safe, successful and cost-effective treatment options for many complex medical conditions:

■ Bariatric Resource Services (BRS)

■ Cancer Resource Services (CRS)

■ Congenital Heart Disease (CHD)

■ Fertility Solutions

■ Kidney Resource Services (KRS)\*

■ Orthopedic Health Support (OHS)

■ Transplant Resource Services (TRS)

\*KRS is not a network solution. It is a clinical support program that refers members to dialysis centers. UMR customers accessing the UnitedHealthcare Choice Plus, Options PPO, CORE, NexusACO and Select Plus networks have access to all KRS dialysis centers and UMR customers accessing rental/leased networks can purchase KRS for a fee.

BARIATRIC RESOURCE SERVICES

Optum Bariatric Resource Services (BRS) is a program designed specifically for individuals considering weight loss surgery. The BRS program provides access to top-performing bariatric surgery programs and clinical case management from specialized Optum bariatric nurses. The BRS program has been proven to reduce initial procedure costs, reduce complications and help avoid inappropriate surgeries.

Members are encouraged to enroll in the BRS program where they are assigned to an experienced Optum nurse who educates and guides them through a three-phase process. This process is designed to help them understand and manage the conditions associated with morbid obesity before and after surgery and encourages successful long-term weight loss through surgical intervention. Optum nurses steer enrolled members to Optum Centers of Excellence network providers to help reduce costs and prevalence of complications with their surgery.

BRS Centers of Excellence average:

■ 19 percent lower mortality rates

■ 30 percent lower inpatient readmissions

■ 24 percent lower reoperation rate

■ A single source for individuals to obtain bariatric surgery information, support and benefits guidance

■ Experienced clinicians who educate and guide individuals through a three-phase process designed to help them understand and manage the conditions associated with morbid obesity before and after surgery, and encourage successful long-term weight loss through surgical intervention, including:

■ Assessments to determine if patients are ready for surgery and meet all evidence-based requirements

■ Steerage to centers that provide excellence in bariatric surgery, helping to better control the disparity of care and variability of surgical outcomes

CANCER RESOURCE SERVICES

Cancer Resource Services consists of Optum Centers of Excellence network access with UMR Complex Condition CARE providing critical treatment options and support to members newly diagnosed with a rare or complex cancer. This includes direct access to specialized and experienced oncology nurses who help members understand their diagnosis and make informed decisions about second opinions, treatment options (including the availability of clinical trials) and preferred treatment facilities.

CONGENITAL HEART DISEASE RESOURCE SERVICES

Congenital Heart Disease Resource Services (CHDRS) is a specialized network of the nation’s leading congenital heart disease (CHD) facilities with the best contractual savings in the industry. Each facility within the specialized network undergoes a rigorous Centers of Excellence qualification process.

CHDRS consists of Optum’s Centers of Excellence network access while UMR Complex Condition CARE provides critical treatment options and support to members diagnosed with CHD.

CHDRS Centers of Excellence was created to deliver better outcomes while reducing average lengths of stay and overall charges. Fifty percent of infants and children referred for a heart transplant have some form of CHD. By aligning with the transplant network, the CHD Centers of Excellence network provides expanded treatment options for these patients.

FERTILITY SOLUTIONS

Fertility Solutions addresses costly health concerns through proactive management of fertility treatments. It offers access to experienced and specialized Optum fertility nurse consultants who provide detailed information to help individuals determine their best course of action for fertility treatment.

With access to leading fertility Centers of Excellence providers, participants are more likely to become pregnant and less likely to become pregnant with multiples. Optum promotes evidence-based guidelines for fertility management to reduce the possibility of multiple births and unnecessary fertility treatments.

KIDNEY RESOURCE SERVICES

Kidney Resource Services (KRS) provides access to a preferred provider dialysis network and support from UMR Complex Condition CARE to deliver high value by collaborating with the patient to delay the progression of the disease to renal failure and by targeting the largest cost drivers of dialysis and inpatient days.

UMR Complex Condition CARE end-stage renal disease (ESRD) specialty nurses focus on the following approaches and treatments in order to drive the highest value for our members and customers by:

■ Early referral to a nephrologist (specialist in kidney disease)

■ Referral to top performing, network dialysis centers

■ Monitoring and management of comorbidities such as diabetes, hypertension and obesity

■ Nutrition/dietary/fluid management and support

■ Management of medications through preferred pharmacy utilization to assure the most cost-effective treatment and treatment setting

■ Dialysis adequacy monitoring

■ Early referral for kidney transplant evaluation, when appropriate

■ Connecting patients with behavioral health specialists and other resources throughout treatment and recovery

■ Efficient conversion to Medicare as primary payer for eligible patients

ORTHOPEDIC HEALTH SUPPORT

Optum’s Orthopedic Health Support (OHS) is a holistic solution that helps empower members and manage costs by providing access to specialized advocates and high-performing, efficient providers across the continuum of care, from early back pain onset through treatment and beyond, including:

■ Early intervention and appropriate care

■ Coaching to support behavior change

■ Shared decision making

■ Pre- and post-surgical counseling

■ Guidance to preferred providers and Centers of Excellence

■ Long-term support

Optum’s Center of Excellence network delivers more than 20 percent savings compared to standard network rates and uses contracted, all-inclusive bundled payments that align incentives around quality and cost.

An enhanced plan design is required to receive OHS services. Required plan design changes include a $1,000 or greater differential (through plan design or fixed incentive) to encourage members to use the Optum Centers of Excellence network, which leads to better outcomes and cost savings.

We are happy to discuss a variety of benefit options with the State.

TRANSPLANT RESOURCE SERVICES

UMR’s transplant Centers of Excellence network is available through Optum with UMR Complex Condition CARE providing specialized support. During implementation, you will be asked if you want to participate in Transplant Resource Services (TRS).

For more than three decades, Optum has identified providers experienced in treating costly, complex and catastrophic conditions. Through a rigorous qualification process, Optum developed Centers of Excellence network products that include access to clinically superior providers of complex medical care. Optum has 22,726 payer groups overall, representing over 73 million lives, with access to the transplant Centers of Excellence program. This purchasing power, along with Optum’s contracting expertise, results in the most effective contractual cost savings in the industry. Through Optum’s comprehensive contracts, network customers save an average of 56 percent off standard industry charges for transplants, as well as reduce expenses through shorter lengths of hospital stays and lower incidence.

TRANSPLANT ACCESS PROGRAM

Transplant Access Program (TAP) is considered Optum’s transplant secondary network. It provides geographic access, economic value, and administrative relief to address the challenge our customers face when someone they insure opts to seek care with transplant programs outside of the Centers of Excellence network. Facilities still demonstrate a basic level of clinical qualification criteria; however, some Centers of Excellence criteria factors (volumes, financials, etc.) prohibit them from qualifying as a Centers of Excellence.

VENTRICULAR ASSIST DEVICE

The Ventricular Assist Devices (VAD) program identifies and qualifies the top VAD centers in the nation and provides access to quality providers for VAD implantation, as well as post-surgical maintenance. This program is available to all individuals who have Optum’s TRS product.

The VAD Centers of Excellence network is proven critical to superior clinical outcomes. VAD procedures performed at non-Centers of Excellence have shown higher discharge and one-year mortality rates than VAD procedures performed at a VAD Centers of Excellence.

EXTRA CONTRACTUAL SERVICES

In the rare instance that a member may need to access a program outside of the Optum transplant network, Optum’s contracting team provides extra contractual services (ECS) for negotiation on a case-by-case basis at the request of UMR on behalf of the customer.

SPECIALIZED PHYSICIAN REVIEW

Optum Specialized Physician Review (SPR) provides written medical appropriateness opinion services for transplants.

1. Describe your selection processes for providers in the COE offering. Are the providers identified as a “COE” by any nationally recognized accrediting organization?

Optum uses proprietary evaluation criteria, developed through its Clinical Sciences Institute (CSI), to select medical centers eligible to participate in its Centers of Excellence networks.

The CSI is comprised of practicing experts in the medical fields related to Optum’s network products (e.g., transplant physicians and surgeons, oncologists, neonatologists, pediatric cardiologists, etc.).

Evaluation criteria are reviewed and revised regularly in order to incorporate current quality parameters and benchmarks as they relate to the applicable field of medicine.

These criteria assess:

■ Program’s procedural volume and associated outcomes

■ Compliance with the appropriate Centers of Excellence selection criteria

■ Program team changes, stability of the team and the ability of the back-up team to manage the program

■ Projected trends and technological advances in the specific field of medical science

■ Program’s overall commitment to their field through the synergy of multiple, related programs within the medical center

Upon receipt of a completed evaluation, the CSI conducts a detailed analysis of the program’s responses to both clinical and administrative components, and compares the responses to evaluation criteria. Programs that do not meet established criteria are rejected. Programs that do meet the criteria proceed to the contracting step of this process.

Optum requires that all participating programs in their Centers of Excellence networks complete the evaluation process annually. A change in network status may occur as a result of the quality review process of the annual survey. This process assures that customers have access to only those programs that demonstrate continued clinical excellence in their field.

1. Please describe any bundled payment arrangements that exist. What procedures have you set up using a bundled payment strategy (knees, hips, other)?
   1. For each bundled payment, describe your definition of the bundle payment (e.g. what is included or excluded, and the time period covered)

Optum developed its Centers of Excellence solution to provide safe, successful and cost-effective support of individuals with complex health concerns. There are no financial arrangements between Optum and their Centers of Excellence networks other than contracting in order to meet these outcomes. Optum uses the largest available database of claims data to model payment methodology and rates.

Standard Centers of Excellence contracting methodology varies by Complex Medical Conditions product, but focuses on all-inclusive, fixed pricing through case rates (i.e., bundled reimbursement).

In limited cases, Optum has negotiated aggressive discounts. However, in all cases, they will use their data, contracting expertise and purchasing power to provide the most predictable and lowest average costs available.

UMR provides links on our member website to information about Optum’s Centers of Excellence networks. Descriptions of covered services can be found in the member's benefit information.

* 1. List procedure codes and any modifiers that are used to identify bundles?

Optum OHS does not share this information externally as they consider this proprietary. Optum transplant is outlined in ASA.

* 1. What criteria do patients need to meet to be treated under bundled payments?

UMR presents our customers with the option to enroll in Optum programs during implementation. Customer usage and requirements vary within each of these programs.

* 1. What providers are eligible for a bundled payment strategy?

Providers associated with the appropriate programs (OHS, TRS) within the COE network.

* 1. Are quality measures incorporated within this payment strategy? If so, what is the structure?

OHS

Volumes:

- ≥ 200 knee replacement procedures within previous 12 month (combination of all codes, includes primary and revisions)

- ≥ 200 hip replacement procedures within previous 12 month (combination of all codes, includes primary and revisions)

- ≥ 200 spine procedures within previous 12 month (combination of all codes, includes primary and revisions)

30-day mortality rate:

- Spine: ≤ 1%

- Hip and Knee Replacements: ≤ 1%

90-day surgical site infection (SSI) rate:

- Spine: ≤ 2%

- Hip and Knee Replacements: ≤ 2%

30-day all-cause readmission rate:

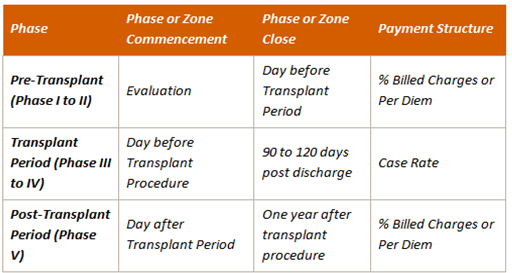
- Spine: ≤ 5%

- Hip and Knee Replacements: ≤ 5%

TRS

Optum offers the most comprehensive contracting methodology in the industry, averaging a 57% contractual discount for our clients. We employ a five-phase approach using a bank of days concept that allows the payer to apply any unused days included in the original case rate to subsequent admissions within 90 to 120 days of the initial discharge.

Our case rate includes the inpatient confinement (Phase III), as well as 90 to 120 days post discharge (Phase IV). Optum further segments these phases into Pre-Transplant (Phases I and II), Transplant or Case Rate Period (Phases III and IV), and Post-Transplant. The table below summarizes phases and payment structure.



This approach has proven to better protect customers from the economic exposure related to clinical setbacks often seen within the first 90 days post-discharge.

As stated above, the bank of days approach applies any unused portion of defined days for Phase III to inpatient admissions during Phase IV. Pre- and post-transplant charges for inpatient services in Phases II and V are paid at a fixed per diem rate, and transplant-related outpatient services are paid at a discount off billed charges.

Savings are an integral component of the transplant network product design and are made possible through this comprehensive contract structure.

* 1. What challenges have you faced incorporating this strategy with commercial clients and hospital systems?

In conjunction with the Clinical Sciences Institute, Optum reviews and revises evaluation criteria on a regular basis to incorporate current quality parameters and benchmarks as the field of medicine continues to evolve. These criteria assessments include compliance with the appropriate Centers of Excellence selection criteria, as well as program team changes, stability of the team and the ability of the back-up team to manage the program. Upon receipt of a completed evaluation, the Clinical Sciences Institute conducts a detailed analysis of the program’s responses to both clinical and administrative components and compares the responses to evaluation criteria. Optum rejects programs that do not meet established criteria.

Programs that do meet the criteria proceed to the contracting step of this process. Optum requires that all participating programs in their Centers of Excellence networks complete the evaluation process on an annual basis. A change in network status may occur because of the quality review process of the annual survey. This process assures that customers have access to only those programs that demonstrate continued clinical excellence in their field and comply with components required to be considered an Optum Centers of Excellence.

1. Describe your current state of ACOs in Indiana.

We are currently involved in over 100 Accountable Care Organizations (ACOs) across the country. UnitedHealthcare has ACO arrangements in Indiana with American Health Network, Community Health Network and Franciscan Health.

1. What percent of 2021 contracts in your book-of-business are risk-based, and what percent of providers in Indiana are risk-based?

Retrospective or prospective risk adjustments are not a component of our national contracting and reimbursement plan. However, ACOs contracts may include risk adjusted total cost of care targets.

Levels of risk sharing will vary greatly by the degree to which providers are accountable for the total cost and quality of care. For example, ACOs offer a much greater incentive opportunity than a program with a limited number of measures. Over time, some programs may add more measures offering enhanced incentive opportunities. The current payment mechanism for accountable care is one of de-emphasized fee-for-service on the front-end in order to reduce costs, manage traditional insurance risk, manage provider cash flow and manage our customer cash flow without disruption or cost-additive administrative changes.

1. Is your model “attributed” or “actively enroll”? Describe how you attribute members. What percentage of your Indiana membership is attributed/actively enrolled?

Fundamental to the ACO reimbursement model is the member-attribution process. Our attribution model is utilized for all of our commercial accountable care programs so that we avoid any potential for assigning the member to multiple programs and providers. The model is primary-care based in that we attribute members only to internal medicine, pediatric, and general practice or family practice providers. The self-funded employer is standardly charged for active members who are attributed to an ACO provider at the time of reimbursement calculation. The attribution model will look back 24 months for a specific set of evaluation and management codes as well as prescription claims data that is used to infer and attribute the patient to his or her PCP.

However please note UMR is able to allow the State of Indiana to opt out of our value-based programs. This means that the State of Indiana will have the access to and benefit from our value-based programs but will not be liable for the bonus payment arrangements associated with such programs.

As part of our standard ACO data analytics and reporting, on a monthly basis, we provide a panel report that details the members attributed to specific physician and medical groups. It is important to note that members reflected on this report could change over time as they have the freedom to choose one primary care physician over another.

The rationale is due to the requirement to account for an open access market where members can choose where care is received. After analyzing several methodologies, the methodology was chosen as it yields the greatest number of attributed lives along with maintaining a credible line between member/patient and physician. This credibility is paramount as all costs associated with that attributed member’s care are the responsibility of the attributed physician.

1. How are ACO arrangements monitored for quality/cost efficiencies.

We produce and review reports such as total cost of care, quality and efficiency metrics, high-cost/high-risk reports, emergency room frequent utilizers and daily census summarized quarterly with the ACO and the ACO’s leadership, focusing on areas for improvement.

1. How is your provider risk-share target developed?

This may vary based on the specific program and its location. Our ACOs and customers will share in the savings resulting from their focus on implementing best practices. Our ACOs have agreed to be measured based upon their delivery of high-quality patient care, patient satisfaction and reduced costs – as well as effective management of care for the chronically ill and efficient transitions of care for patients. All programs will include a gain-sharing component in the first year of the agreement with the intent to implement a shared risk component at some point in the agreement. While we do not expect these programs to adopt capitation, we are striving to move ACOs toward this continuum by providing actionable data that will assist in minimizing and/or eliminating medical outliers that currently prohibit and/or hinder capitation.

Overall, the payment mechanism for accountable care is one of de-emphasized fee-for-service on the front-end in order to reduce costs, manage traditional insurance risk, manage provider cash flow and manage our customer cash flow without disruption or cost-additive administrative changes.

1. Do your risk-based contracts include prescription drugs administered through the medical benefit?

This depends upon the type of provider or facility. Many physicians dispense sample medications to their patients as a routine practice. In other cases, providers take a larger role in dispensing specialty medications. For instance, we are working with 11 medical oncology groups and one cancer center around the country to initiate a new cancer-care payment model that focuses on best treatment practices and better health outcomes. The first-of-its-kind program is aimed at improving the quality of care for patients with breast, colon and lung cancers. The program approaches physician reimbursement for cancer care in a new way, basing it on the overall treatment of the patient. It does this by reimbursing participating medical oncologists upfront for an entire cancer treatment program, which marks a shift away from the current fee-for-service approach. This episode payment will be based on the expected cost of a standard treatment regimen for the specific condition, as predetermined by the physician.

We calculate the cancer care payment based on the amount of money the oncology group would make on chemotherapy drug profits, using the difference between the group’s current fee schedule and the drugs’ costs. A case management fee is also added to reflect the time and resources that the oncologist’s office spends in managing the patient relationship. As part of the pilot, office visits, chemotherapy administration and other ancillary services like laboratory tests are paid based on fee-for-service rates.

The oncologist will be paid the same fee regardless of the drugs administered to the patient – in effect, separating the oncologist’s income from drug sales while preserving the ability to maintain a regular visit schedule with the patient. Patient visits will continue to be reimbursed and chemotherapy drugs will be reimbursed at the manufacturer’s cost.

For patients with relapsed cancers who may be treated for indefinite periods, the fee is renewed every four months. For adjuvant treatments that are given immediately after curative surgery, the fee is a single event.

In this program, each medical group must agree to two key requirements to participate: (1) they must choose a standard chemotherapy regimen for each of the 19 clinical presentations associated with breast, colon and lung cancer and (2) they must participate in performance reviews of their data with the other participating oncology groups. The various treatment regimens selected by the groups will be evaluated to identify which are the most effective for a range of clinical presentations (e.g., physical signs and symptoms and diagnoses). We will play no role in determining which treatment plan the oncologists choose, but the intent of the program is to identify and reduce unnecessary drug administration that does not improve the patient’s health outcomes. The medical group is free to change their drug regimens at any time, but the cancer care payment does not change.

Also, our ACO arrangements include pharmacy spend in total cost of care measures. We employ a dynamic and retrospective, primary care-based attribution model that combines a 24-month look back at member's medical and pharmacy claims where applicable. Our commercial attribution model includes members under 64 years of age. A member attributed to an ACO physician is considered eligible.

Utilizing the attributed population, conceptually, the design of our ACO agreements can be understood as follows:

We establish the total cost of care of a provider in the form of a risk-adjusted PMPM

We then set the target at a level that will result in medical cost savings

UnitedHealthcare’s share of the savings is subsequently passed on to fully insured and self-insured purchasers through lower medical cost trends that are reflected in future premiums and prior year cost settlements.

1. What are your strategies for ACO payment arrangements and financial risk sharing? How will this benefit the State? Comment on specific payment initiatives, provider incentives, and quality and efficiency measures. Describe how you would collaborate with the State in these efforts.

UnitedHealthcare has been on the leading edge of innovative payment models. We were one of the first to recognize top-performing medical centers that practice evidence-based medicine. More than 20 years ago, we launched our Centers of Excellence program to direct our members to facilities that excel at treating complex medical conditions like cancer and congenital heart disease.

Over time, our partnerships with physicians, hospitals, and provider organizations expanded to build performance-based payment models and ACOs. While ACOs are an important model on the continuum of innovative payment and delivery system reform, only certain provider organizations have the necessary infrastructure, physician leadership, and care management capabilities to be prepared for success in an ACO relationship.

In 2010, the Affordable Care Act (ACA) brought these payment models to the forefront by promoting a close partnership between patient and physician and the importance of an integrated care team. The ACA created multiple programs for ACOs and Patient-Centered Medical Homes (PCMHs) with Medicare, Medicaid and CMS.

Today, UnitedHealthcare has the deepest, most integrated value-based incentive platform in the industry.

We meet providers where they are, not where we expect them to be. Each arrangement is unique and based on the provider’s ability and desire to manage care and risk. These partnerships bring value to our customers, and continue to deliver a positive, affordable health care experience for your employees.

By “value,” we mean a balance of quality, efficiency and lower costs. We place metrics around the value and use these metrics to determine how we pay providers. We pay based on how well providers meet or exceed the metrics, not for the number of services they perform.

We are currently involved in ACOs in a growing number of geographies across the country. We will continue to develop ACO relationships with a variety of hospital systems and large physician organizations with whom we will collaborate for the purpose of improving health, patient experience, quality outcomes and driving lower total medical costs.

In addition, our strong analytical capabilities, data and reporting tools help our partner ACOs identify areas of improvement. We can provide clinical support to assist ACOs in developing and/or augmenting clinical programs. We also offer products that encourage our members to become engaged. Through our sister company, OptumInsight, we offer an array of industry-leading tools and capabilities for our ACO partners. Finally, as the leading national carrier to offer Medicare, Medicaid and Commercial plans, the size and variation in the population we represent allows us to test our ACO strategy across a more varied population.

While our ACO contracting strategy continues to evolve primarily because we continually incorporate results, best practices and lessons learned into our programs, the objectives of our ACO model are still grounded in the Triple Aim. Additionally, we have expanded the view of the Triple Aim by incorporating an employer lens as we review the program. Further, as we evolve our strategy in 2021, our focus will show a shift away from volume, whereas over the past four years we have rapidly expanded the number of providers with whom we collaborate. Also, it will involve a shift towards driving meaningful value from our ACO partners and programs. Finally, we will focus on how to incorporate our ACO partners, where appropriate, into our high-performing network strategy.

As such, patient experience is an integral part of our focus.

Conceptually, the design of our ACO agreements can be understood as follows:

1. We establish the Total Cost of Care of a provider in the form of a risk-adjusted per-member-per-month (PMPM) value

2. We then set the target at a level that will result in medical cost savings

Our share of the savings is subsequently passed on to fully insured and self-insured purchasers through lower medical cost trends which are reflected in future premiums and prior year cost settlements.

However, our ACO model differentiates itself from current day models by coupling both quality and cost. Unlike our competitors, providers in our ACO model can only achieve a bonus by achieving a minimum score from our robust suite of quality and efficiency metrics.

Our accountable care strategy includes three categories of programs that offer varying levels of integration with care providers depending on their ability to assume financial risk and affect health outcomes. By creating a flexible approach, we are able to align its programs with all types of care providers across its employer-sponsored, Medicare and Medicaid benefit plans.

Part of our strategy around our value-based contracting includes the development of products that leverage our ability to direct care to certain providers. Those tailored products include narrow networks, tiered networks and specialty networks. When executed with the right provider partner, an ACO can dovetail nicely into a product such as a narrow network, which is one of the reasons we are selective about our prospective provider partners.

Regarding provider turnover, we employ a retrospective, primary care-based attribution model with a minimum of 24 months of customer experience utilized. A member attributed to an ACO physician is considered eligible. Using this attribution methodology, we look for a minimum threshold of lives before deploying an ACO. This threshold acts as a buffer as providers and members/patients move in and out of the ACO. In addition, we require open panels to ensure members have access to the services delivered by the ACO.

Finally, with regards to health management services, care management has been a significant focus for us recently.

1. What is the expected value of the provider performance payments as a percentage of total annual reimbursements?

On average, our value-based payment models realize 3 percent to 6 percent gross savings on total medical and pharmacy cost, and we generally share 50 percent of savings with providers. Generally, we project that approximately 70 percent of members will be attributed to providers that participate in a value-based payment model. These factors can be applied to a customer’s baseline per-employee-per-month (PEPM) total medical costs to estimate an average PEPM savings. Also, please note that some of our higher performing ACOs generate savings larger than 3 percent.

Please note we are able to allow the State of Indiana to opt out of our value-based programs. This means that the State of Indiana will have the access to and benefit from our value-based programs, but will not be liable for the bonus payment arrangements associated with such programs.

1. What percentage of your payment models include downside provider risk?

At this point only a small number of our ACO providers have downside financial risk in their ACO agreement, although more will be moving to a downside-risk model in the future. If earned, shared savings are generally 40 percent to 50 percent of total savings and usually capped at a certain level.

1. What amount of performance-based provider payments are paid up-front as a PMPM payment vs shared savings?

There is no administrative cost to customers for participation in these programs. For self-insured customers, claims costs for the health care services provided to members will continue to be paid and deducted from the claim bank account as they are today.

PER-MEMBER-PER-MONTH PROSPECTIVE PAYMENTS

Any prospective per-member-per-month (PMPM) amounts paid to participating providers to compensate them for the additional services are deducted from the customer’s bank account. A self-funded customer sees these payments reflected in their Banking Report only when the employer has members attributed to a participating primary care provider.

SHARED SAVINGS BONUS

Bonus payments are retrospective payments calculated and paid at the end of the measurement period for the program. Providers earn bonuses based on a share of savings, generally 50 percent, if their performance exceeds the target for the previous year. Once the cost targets are achieved, a quality factor is added. Performance quality influences whether the provider receives the full payout or a reduced percentage of the total payout. Customer’s charges are based on the number of attributed members participating in the rewarded program. While the experience for a specific customer will vary, customers will benefit from overall reduced medical trends and improved quality.

1. How are ACO programs communicated to members?

Through the care management component of the ACO, the practice becomes more responsible for their patients and develops specific marketing and communication strategies and tools to outreach to both individual patients and also to populations of patients that share common risks. As a partner with the ACO, we augment the information provided to the practice to help identify and manage patients and populations. In addition, we are planning specific communications targeted to the members attributed to the specific ACO, highlighting the benefits of ACOs. Some employers may also elect to communicate the benefits of ACOs to their members.

1. Describe your hospital cost containment initiatives. Provide specific examples including the cost savings strategy, the outcome and how it is measured. Are you willing to offer performance guarantees around these cost savings strategies?

UnitedHealthcare has been on the leading edge of innovative payment models. We were one of the first to recognize top-performing medical centers that practice evidence-based medicine. More than 20 years ago, we launched our Centers of Excellence program to direct our members to facilities that excel at treating complex medical conditions like cancer and congenital heart disease.

Over time, our partnerships with physicians, hospitals, and provider organizations expanded to build performance-based payment models and ACOs. While ACOs are an important model on the continuum of innovative payment and delivery system reform, only certain provider organizations have the necessary infrastructure, physician leadership, and care management capabilities to be prepared for success in an ACO relationship.

In 2010, the Affordable Care Act (ACA) brought these payment models to the forefront by promoting a close partnership between patient and physician and the importance of an integrated care team. The ACA created multiple programs for ACOs and Patient-Centered Medical Homes (PCMHs) with Medicare, Medicaid and CMS.

Today, UnitedHealthcare has the deepest, most integrated value-based incentive platform in the industry.

We meet providers where they are, not where we expect them to be. Each arrangement is unique and based on the provider’s ability and desire to manage care and risk. These partnerships bring value to our customers, and continue to deliver a positive, affordable health care experience for your employees.

By “value,” we mean a balance of quality, efficiency and lower costs. We place metrics around the value and use these metrics to determine how we pay providers. We pay based on how well providers meet or exceed the metrics, not for the number of services they perform.

We are currently involved in ACOs in a growing number of geographies across the country. We will continue to develop ACO relationships with a variety of hospital systems and large physician organizations with whom we will collaborate for the purpose of improving health, patient experience, quality outcomes and driving lower total medical costs.

In addition, our strong analytical capabilities, data and reporting tools help our partner ACOs identify areas of improvement. We also can provide clinical support to assist ACOs in developing and/or augmenting clinical programs. We also offer products that encourage our members to become engaged. Through our sister company, OptumInsight, we offer an array of industry-leading tools and capabilities for our ACO partners. Finally, as the leading national carrier to offer Medicare, Medicaid and Commercial plans, the size and variation in the population we represent allows us to test our ACO strategy across a more varied population.

UnitedHealthcare plans to continue to apply a disciplined approach to contract negotiations, including harnessing industry-leading competitiveness analyses to ensure that negotiations are fact-based and data-driven. Their reimbursement methods represent a balance between their national strength and operating efficiencies and local market dynamics. The focus is on the triple aim of 1) improving population health and patient experience, 2) delivering the best possible quality outcomes and 3) reducing medical cost and medical trend. Examples of current and planned value-based contracting approaches are noted below:

■ Performance-based compensation (PBC) ties contract rate increases for medical groups and hospitals to performance on quality and cost-efficiency metrics. We currently have hundreds of hospital and physician performance-based contracts and plan to significantly expand the PBC program over the next few years.

■ Our condition / service line programs encompass Centers of Excellence, ancillary capitation, and bundled/episodic payments and include over 2,300 physicians, 25 ancillary providers, and 160 facilities. We worked with eleven medical oncology groups around the country to initiate a cancer-care payment model that focuses on best treatment practices and better health outcomes. The first-of-its-kind program is aimed at improving the quality of care for patients with breast, colon and lung cancers. We also currently have bundled payment pilots for three episode categories in multiple markets. They are focused on orthopedics (total joint replacement – hip and knee), gastroenterology (screening colonoscopy) and maternity (perinatal). These bundles represent significant opportunity to generate savings and improve quality. We are also launching pilots for orthopedic prospective bundles.

■ At the most advanced end of the value-based spectrum, we are currently involved in over 50 Accountable Care Organizations (ACOs) across the country. These organizations are focused on driving innovation in payment and delivery system reform with the “triple aim” of improving population health and patient experience, delivering the best possible quality outcomes, and reducing medical cost and medical trend.

The goal for all of these innovative value-based contracting models is improved quality outcomes and lower health care utilization and costs.

**1.13 Direct Provider Pricing Arrangements**

1. The State intends to enter into direct provider pricing arrangements with providers in order to facilitate competitive pricing and benefit structure. Please confirm your willingness to administer State-specific provider fee schedules (if desired by the State). [Reference RFS 21-66772 for more information]

Confirmed. UMR has extensive experience working with our hospital customers and non-hospital customers to administer custom network arrangements. We can administer the State of Indiana’s custom network contract arrangements as well as a custom-tailored tiered network solution. Our UnitedHealth Network team is also willing to work as a liaison for the State of Indiana to work with local physicians and facilities to provide analytic help and support to facilitate and negotiate State of Indiana specific provider fee schedules.

1. Describe any limitations that would restrict the State’s ability to implement custom provider fee schedules.

While we do not anticipate any such limitations, UMR reserves the right to review all custom provider fee schedules prior to approval and fee schedule implementation to ensure we can systematically maintain, price and adjudicate claims utilizing the agreed upon fee schedule formats.

1. Describe your ability to validate claims at the time of adjudication using a Medicare multiplier.

Yes. UMR can price to a % of Medicare.

1. Describe your organization’s capability to adjudicate all types of claims on a “percent of Medicare” basis for a commercial population. Please include examples such as professional services for which the Procedure Code does not have a CMS-defined RVU, facility services that are not covered by Medicare, and other similar situations.

We are able to use a gap fill methodology based on RBRVS to fill in those codes not defined by Medicare. RBRVS values are determined by the RVU X the based rate per CPT code.

1. Describe how your proposal will change based on the community interest level in RFS 22-66772. Include factors that will necessitate a change such as quantity of providers and/or size of providers. Provide distinction and clarity by defining the quantity of providers, the size of the providers and other factors listed.

While we do not anticipate any such limitations, UMR reserves the right to review all custom provider fee schedules prior to approval and fee schedule implementation to ensure we can systematically maintain, price and adjudicate claims utilizing the agreed upon fee schedule formats. UMR would like to collaborate with the State of Indiana to formalize an implementation plan to accommodate for volume of provider and facility agreements within a given time frame, the complexity of the fee schedule arrangements, and the impact to UMR’s installation and prioritization schedules.

1. Could you track and report on State specific quality metrics?

Yes. Our UnitedHealth Network team will work with the State of Indiana to develop State-specific quality metrics and a quality reporting package that best meets the needs of the State of Indiana.

**1.14 Innovation and Cost Containment Approaches**

*Reference-Based Pricing*

1. Do you currently have the capability to support reference-based pricing?

Confirmed. UMR has the tools and capabilities to administer a referenced-based pricing (RBP) offering through an acquired entity, HealthSCOPE Benefits. This is not a model we would recommend as there is potential for balance billing to your plan participants. Our goal is to partner with you to find solutions and opportunities to achieve your long-term strategies. The solutions we are proposing would include working with the health systems on behalf of your plan participants to create a custom offering applying our expertise in network contracting.

1. If applicable, how many plan sponsors and corresponding member lives are you currently administering reference-based pricing for?

HealthSCOPE Benefits provides RBP administration for more than 40 customer and their 42,000 members.

1. Do you provide reference-based pricing as an in‐house service, or is it outsourced to a third-party vendor?

These capabilities are not outsourced to a third-party vendor.

1. Does your reference-based pricing structure vary by region or network? If yes, please provide an overview of variation between markets (including breakout of markets).

We would defer this question to our RBP vendor partner for response.

1. Do you require specific plan design provisions to support reference-based pricing? If so, please describe.

There are no specific plan design provision requirements currently.

1. Please explain how you integrate your member transparency tools into the health care purchasing process for customers who have implemented reference-based pricing.

Member transparency tools are part of the RBP model and are incorporated into the member support team.

1. Are your customer service representatives provided specific training for plan sponsors that have implemented reference-based pricing?

Confirmed. HealthSCOPE Benefits patient advocates receive extensive training on the intricacies of RBP.

1. Please share any validated results your organization has to date related to reference-based pricing outcomes.

We have seen up to 10 percent savings with customers who have elected to offer RBP. We do not have clients within Indiana on this product and would not be able to validate results.

1. Provide a typical strategic timeline and steps required to implement a successful reference-based pricing strategy.

Provided as **Attachment 5**, we have created a sample implementation project plan identifying key RBP tasks and timing if this was an avenue you would elect to pursue.

1. Would additional fees apply for reference-based pricing administration? If yes, please specify PEPM fees.

Confirmed. A proposal can be furnished upon request.

*“Medicare Plus” Reference-Based Pricing*

1. The State, at its discretion, may choose to pursue a “Medicare Plus” reference-based pricing approach whereby reimbursements are based on a multiple of standard Medicare reimbursement rates. Please confirm your ability and willingness to administer a Medicare Plus program to a statewide network.

UMR has the ability to administer a “Medicare Plus” reference-based pricing approach. We would like the ability to further explore and discuss this option with the State of Indiana to understand potential impact operationalizing such agreements as well as determine if our local UnitedHealth Network team can work with the State of Indiana to help facilitate such agreements on the State’s behalf.

1. Would the implementation of "Medicare Plus" reference-based pricing change your cost proposal? If yes, please explain.

Yes. We’d like the opportunity to review this request with the State of Indiana in order to determine pricing impact based upon those discussions.

*Centers of Excellence*

1. Describe your platform’s ability to administer incentives, including cash awards, for utilizing centers of excellence.

UMR offers customers Optum’s industry-leading specialty networks, which are built through quality measurement and value-driven contracting and are unique in the health care industry. Optum continuously evaluates contracted and non-contracted programs for their clinical excellence and economic value. The following programs and services promote safe, successful and cost-effective treatment options for many complex medical conditions:

■ Bariatric Resource Services (BRS)

■ Cancer Resource Services (CRS)

■ Congenital Heart Disease (CHD)

■ Fertility Solutions

■ Kidney Resource Services (KRS)\*

■ Orthopedic Health Support (OHS)

■ Transplant Resource Services (TRS)

\*KRS is not a network solution. It is a clinical support program that refers members to dialysis centers. UMR customers accessing the UnitedHealthcare Choice Plus, Options PPO, CORE, NexusACO and Select Plus networks have access to all KRS dialysis centers and UMR customers accessing rental/leased networks can purchase KRS for a fee.

UMR has experience partnering with Centers of Excellence to administer action-based incentive plan designs. UMR will work with the Centers of Excellence to gather the member participation information and apply it to the State of Indiana’s incentive plan design. UMR can support the following reward mechanisms:

UMR offers the following reward types:

PREPAID REWARD CARD

The prepaid reward card allows for a single load or a reloadable funding option. The prepaid reward card requires a minimum of $25 for card generation and reloads. Cards can be used at any merchant accepting Mastercard. Merchant categories restrict the purchase of alcohol, tobacco or gaming.

HEALTH SAVINGS ACCOUNT INCENTIVE CONTRIBUTIONS WITH OPTUM BANK

Designed to work with a qualifying high-deductible health plan (HDHP), a health savings account (HSA) is a great mechanism for rewarding healthy activities. HSAs offer significant tax advantages. The employee owns the HSA and contributions are non-forfeitable.

HEALTH REIMBURSEMENT ACCOUNT CONTRIBUTIONS

A health reimbursement account (HRA) is a notional consumer account managed by UMR. The HRA contributions are used to pay for qualified medical and prescription drug out-of-pocket expenses for employees and their covered family members. Once the dollars are deposited into the member’s account, they are automatically applied to eligible expenses at the same time as the member’s deductible. HRAs can be set up for all members or only members eligible for certain incentive programs, such as Ongoing Condition CARE. HRAs are a family bucket of dollars, where all members covered under the medical plan use the dollars to offset member responsibility.

HEALTH INCENTIVE ACCOUNT CONTRIBUTIONS

Health incentive accounts (HIAs) are set up as a separate account to receive incentive contributions used to pay qualified medical and prescription drug out-of-pocket expenses for employees and their covered family members. Once the dollars are deposited into the member’s account, they are automatically applied to eligible expenses at the same time as the member’s deductible. HIAs can be set up for all members or only members eligible for certain incentive programs, such as Ongoing Condition CARE. HIAs are like health reimbursement accounts (HRAs) in that they are a family bucket of dollars, where all members covered under the medical plan use the dollars to offset member responsibility.

DEDUCTIBLE MODIFICATION

Deductible modification is an effective mechanism for rewarding healthy activities. The employer determines the amount of dollars to modify the deductible at the start of the plan year. UMR adjusts the deductible threshold within our claims system to the customer’s approved dollar amount(s) at the start of the plan year. Members can view their deductible amount on their explanation of benefits (EOB) and the UMR member portal. They can also call UMR’s customer service to inquire on their deductible amount at any time. Deductible modification is available with UMR’s custom incentive solution models.

ONLINE REWARDS

Online Rewards allows members who have earned points within an incentive program to use their points for gift cards, debit cards or for merchandise from a variety of retailers. Incentive points are redeemable by the member immediately upon earning them, subject to minimum number of points requirement for the select catalog.

1. Describe how you educate and influence members to utilize identified centers.

UMR offers customers Optum’s industry-leading specialty networks, which are built through quality measurement and value-driven contracting and are unique in the health care industry. Optum continuously evaluates contracted and non-contracted programs for their clinical excellence and economic value.

The following programs and services promote safe, successful and cost-effective treatment options for many complex medical conditions:

■ BRS - Optum has a dedicated clinical team that assists/educates members who have engaged in the program and steers them to Centers of Excellence facilities – Customer is encouraged to mandate enrollment and Centers of Excellence in benefit design.

■ CRS - Purchase of the program is not recommended for customers utilizing UnitedHealth Network. Facilities that Optum has accredited as Centers of Excellence are already part of UnitedHealthcare Network. This is for in-network access for customers who utilize rental/leased networks or have membership in New York and/or Utah.

■ CHD - Purchase of the program is not recommended for customers utilizing UnitedHealth Network. Facilities that Optum has accredited as Centers of Excellence are already part of UnitedHealthcare Network. This is for in-network access for customers who utilize rental/leased networks.

■ Fertility Solutions - Optum has a dedicated clinical team that assists/educates members who have engaged in the program and steers them to Center of Excellence facilities. The customer is encouraged to mandate enrollment and Center of Excellence in benefit design.

■ KRS - KRS is not a network solution. It is a clinical support program that refers members to dialysis centers. UMR customers accessing the UnitedHealthcare Choice Plus, Options PPO, CORE, NexusACO and Select Plus networks have access to all KRS dialysis centers and UMR customers accessing rental/leased networks can purchase KRS for a fee.

■ OHS - Optum has a dedicated clinical team that assists/educates members who have engaged in the program and steers them to Centers of Excellence facilities. The State of Indiana is encouraged to put in a plan differential for QHDHP members (ex: 80 percent to 100 percent) or a HSA, gift card, etc. for those members who enroll in OHS and utilize a COE (mandates are not approved for OHS).

■ TRS - UMR customers using Optum TRS is for network and contract access only. The UMR CARE team assists members in locating transplant facilities knowing that members need to access TRS Centers of Excellence for in-network access and transplant contracting.

UMR’s clinical team identifies and manages 100 percent of transplant referrals. Everyone who is referred for a transplant will be managed. The assigned GenYou team will also be fully educated on the State of Indiana’s Centers of Excellence and will be fully supportive in assisting to steer members toward these programs.

**1.15 Site-of-Service Optimization**

1. Describe your capabilities to implement controls to influence/optimize site-of-service for healthcare services that can appropriately delivered via different care settings.

UnitedHealthcare has expanded their position to recognize the additional savings opportunities by using less costly, freestanding service facilities and to encourage their use through lower out-of-pocket costs for the member. The place of service tiering program can be used alone or combined with the UnitedHealth Premium designation tiering for greater savings. The focus of this program is on high-cost, high-spend areas where appropriate steerage could have a material savings for members/purchasers for the following services:

■ Outpatient surgery

■ Diagnostic procedures

■ Lab testing

■ Advanced imaging

The place of service tiering program offers members lower cost-sharing for using care at less expensive sites of service, such as freestanding labs, clinics and ambulatory surgical centers. It allows for differing cost sharing between hospital-based/outpatient hospital and freestanding facilities. Cost sharing options include:

■ Per occurrence deductibles

■ Coinsurance

Some of the advantages of this program include:

■ Plan design flexibility. We have the ability to focus on a customer's area of need (imaging, labs and/or outpatient surgery spend) and craft the plan design to address concerns.

■ Provider-specific understanding of freestanding versus outpatient hospital-based providers.

■ Meaningful member tools, including indicators of freestanding flags on **umr.com** provider look-up.

GenerationYou (GenYou) Intercept and Redirect helps members navigate to the most optimal provider in terms of cost, quality and location. Clinical Advocacy Relationships (to) Empower (CARE) Support guides will reach out to members who have made or are likely to make non-optimal decisions in pursuing care from a non-network provider, or from a non-optimal network physician or facility. How it works:

■ Member steerage is triggered when a CARE guide or GenYou guide receives a prior authorization request or benefit inquiry for a non-network provider. Some prior authorizations for network services also provide an opportunity for steerage.

■ The CARE guide or GenYou guide will research if a higher-quality, more cost-efficient option is available. The guide will take into consideration location, availability and cost.

■ If a preferable option is found, the CARE guide or GenYou guide will contact the member via phone, email and/or mail to encourage redirection of care.

■ The CARE guide or GenYou guide can help the member schedule appointments and transfer medical records to the new provider or facility.

By intercepting the member during this process, the CARE guide or GenYou guide can navigate them to higher-quality, network providers and facilities, resulting in better health outcomes and cost savings for the member and the plan. The GenYou member portal and app will also display notifications, alerts and important messages relating to the member’s upcoming services, providing member steerage and education on the benefits, cost savings and quality of network treatments (when applicable).

1. If applicable, how many plan sponsors and corresponding member lives are you currently administering site-of-service optimization strategies for?

We do not track customers or membership that have implemented a place of service tiered benefit plan.