



PacifiCare Commercial Business Planning & Integration

Commercial Advisory Council Meeting

October 9, 2007

PacifiCare®

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- Network
 - PPO One
 - EPDE
 - PHCS
 - CCI
- Regulatory Update
- Dedicated Service Model
- Migration

Sally Verrilli

Ross Lippincott

John Haben

Paul McCarthy

Sue Berkel

Kerri Balbone

Jason Greenberg



Network

- PPO One
- EPDE
- PHCS
- CCI



PPO One Update

Sally Verrilli

Critical Dependency	Owner	Status
1. Successful system connectivity and daily claim file transfer between Nice, Iliad, Rims, ASI, HNS, and UHC (UFE, NDB, iCES, ppoONE)	Peterson/ Tsou/Verrilli	NICE: Fully tested ready to deploy. Iliad: Will be fully tested and ready 10/20. Qiclink: On target for 11/1 deployment. 60% complete as of 10/5. All systems must be deployed simultaneously. 11/1/07 go live confirmed. ASI estimated to go live 3/08.
2. PHS contracts remediated/readied	McDonnell & McFann	~100 OR providers and ~200 SW pilot physicians go live on 11/1/07. Significant volume for OR for 12/1/07. Notice requirements sent based on ppoONE launch date.
3. Remediated contracts loaded into UNET and ppoONE; Dual loading for pilot providers as contingency plan.	Guisinger	Manage Emptoris mass maintenance risks ; OR/SW 11/1/07 providers on target to be dual loaded and reconciled. Capacity planning in progress for upcoming volume.
4. System (UHC) capacity to handle double current volume on the repricing engine	Hames	Enhancement completed .
5. Provider status alignment (demographic, remediated status, PTI) between legacy systems and NDB	Lippincott/ Guisinger	RIMS non-CA EPDE deployed for OR 10/1/07. Additional states will follow. War room in place to manage emergent issues.
6. Claim provider selection logic alignment	Lippincott/ Guisinger	Provider selection logic review completed and PTI rules of the road published; leverage UAT test results and GRI findings for improvement.
7. Claim pricing operations team (inquiries and audits) staffing levels	Verrilli	Staff hired to handle 07 volume. Official volume increase notice given to FiServ (manual pricer).
8. PHS (Uniprise) claim issue resolution realignment	Verrilli/ Vonderhaar	Finalizing workflows, documentation preparation and training plan for all operations areas.
9. Overall end-to-end claim process owner & mgmt. processes	Vonderhaar	Key resources secured and engaged. Process workflows currently being finalized. Training in progress 9/17 – 11/12.
10. Communications (member id cards, notification of leased network change)	Haben	HMO will transition from PHCS on 1/1/08; PPO transition date under review due to operational complexity and readiness.



EPDE Update

Ross Lippincott

Criteria

- ✓ Completion of 90 test scenarios in UAT by joint Network Mgmt/Net Ops team. Successful resolution of all UAT issues
- ✓ 178 CA War Room issues reviewed for possible programming logic issues – none found
- ✓ 119 CA returned checks reviewed for possible programming logic issues – one found and remediated.
- ✓ All Parameter tables for E2E process validated and updated.
- ✓ Process for all fall-out reports confirmed and in place.
- ✓ Network process to ID issues with key providers post “Go-Live”
- ✓ Monitoring Metrics identified
- ✓ Database Reconciliation reporting in place; all identified data discrepancies resolved for OR pilot providers
- ✓ Network Training implemented

Result:

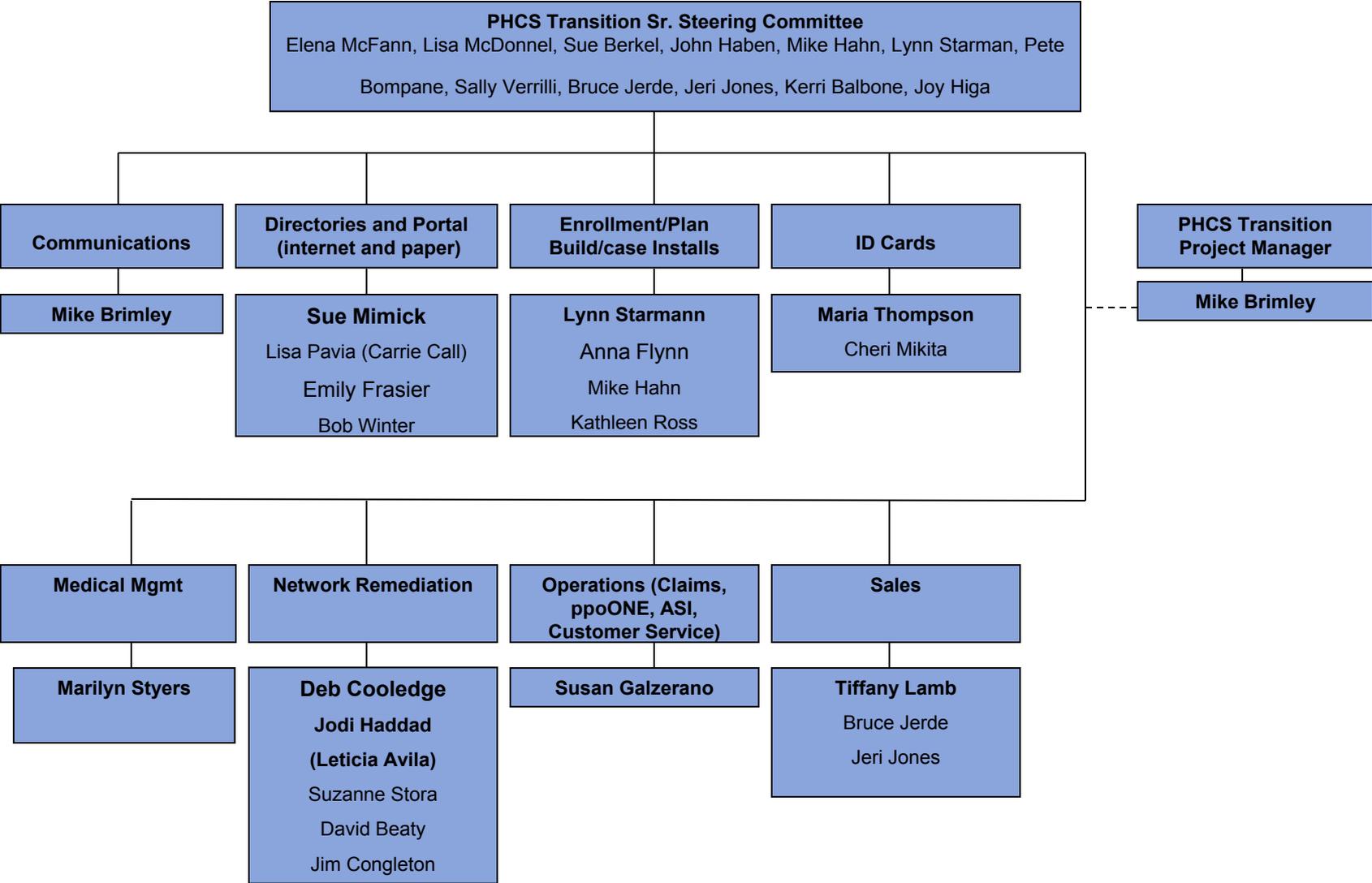
- Approx. 1,000 OR providers loaded with IPA 700
- Full-file process to synchronize these OR providers on 10/1.
- Incremental files subsequent to ensure data remains in synch.
- Expansion dependent upon success.

- Network review identified 3 possible issues:
 - **“EOR” Network type not being created for added suffixes.**
 - About 3,400 members on impacted Networks.
 - About half the EOR Network of 3,800 providers could be impacted.
 - 400 provider records identified and corrected to date.
 - Process in place to immediately identify and correct errors going forward.
 - 4 day exposure to possible claims issues for 3,400 members.
 - **“Extra” suffixes created unnecessarily**
 - All examples to date have resulted from incorrect NDB data.
 - Process in place to catch and resolve these error types.
 - **Provider “Pay-to” being changed.**
 - Change is to NDB Corporate TIN owner.
 - Change in accordance with UHC policy for these remediated providers.
- Non-CA War Room in place and operational
 - 3 meetings held the week of 10/1
 - 11 issues identified – 4 issues unrelated to E2E, 4 related to EOR issue, remaining 3 being investigated.



PacifiCare - PHCS Transition Project

John Haben



PPO members on RIMS

- Replace PHCS with UHC Choice Plus network nationally for PPO members effective 1/1/08
- CA members in Monterey County who use PHCS as primary network will transition off of PHCS effective 1/1/08

NOTE: The replacement of PHCS nationally, including Monterey County, could be delayed to 2/1/08 or 4/1/08 due to resource constraints on both the Case Install side and Claims UAT team.

- TX, WA, and OK members who use PHCS as primary network will transition off of PHCS on or after 4/1/08 pending regulatory review and in-area ppoONE launch success

HMO members on NICE/ILIAD

- We will terminate PHCS access for HMO members effective 1/1/08.
- These members already have access to the Choice Plus network for covered services outside the PacifiCare service area

First Health Group (FHG) as Shared Savings vendor

- FHG will be added as the Shared Savings vendor when the membership above transitions from PHCS as noted above
- Members on the PPO products Limited Fee Schedule and Maximum Allowed Fee will not have access to the Shared Savings Program
- Claims will be manually repriced until full EDI solution is in place in mid to late 2008
- Very rough savings estimates show a material opportunity
- A final medical cost savings estimate will be completed by mid-November

SDHP members on ASI

- Replace PHCS with UHC Choice Plus nationally for OOA access
- Date TBD pending claims volume analysis and manual claims processing capability
- For all members who use PHCS as primary network, we will follow the same rule as the members on RIMS

Indemnity and Medicare members out of scope

1/1/08 Focus
Could be delayed to 2/1 or 4/1/08
4/1/08 or later Focus

	Owner	HMO	PPO (all except TX/WA/OK)	PPO (TX/WA/OK)	SDHP / ASI
Members (to be validated)		1,442,585	143,769	79,073	31,410
Remove PHCS Logo	Haben	X	X	X	X
Add FHG	Haben	X	X	X	NA
Add UHC Choice + logo	Haben	NA	NA	Only WA	NA
Signature Elite name change	Stitt	NA	X	X	NA
Stacked Logo	Difonso/Thomas	X	X	X	X
Regular Plan Change	Hahn/Starman	X	X	X	X

Assumptions/Additional requirements:
* Oct 15th is the Drop dead for card changes to be finalized and turned over for production in order to hit the 1/1/08 date.
* Add in Shared Savings Network logo (FHG) except for LFS and MAF
* Many of the Choice Plus logos already added last year except for WA PPO members
* Move the Choice Plus logo to upper right corner of PPO card (preferred)
* We will change the signature elite name for approved 5 states first OK, OR, TX, AZ, NV. It will be 2/1 for CO and 3/1 for CA.

Member/Employer Impact:

PPO Membership outside the 8 core states:

- 6.5k members reside outside the 8 core states
- 5 states contain 2.3k of these members (FL, UT, IL, NM, and GA)
- 5 clients with more than 100 members impacted (largest with 340 members)
- 60 clients with 20-99 members

Communications:

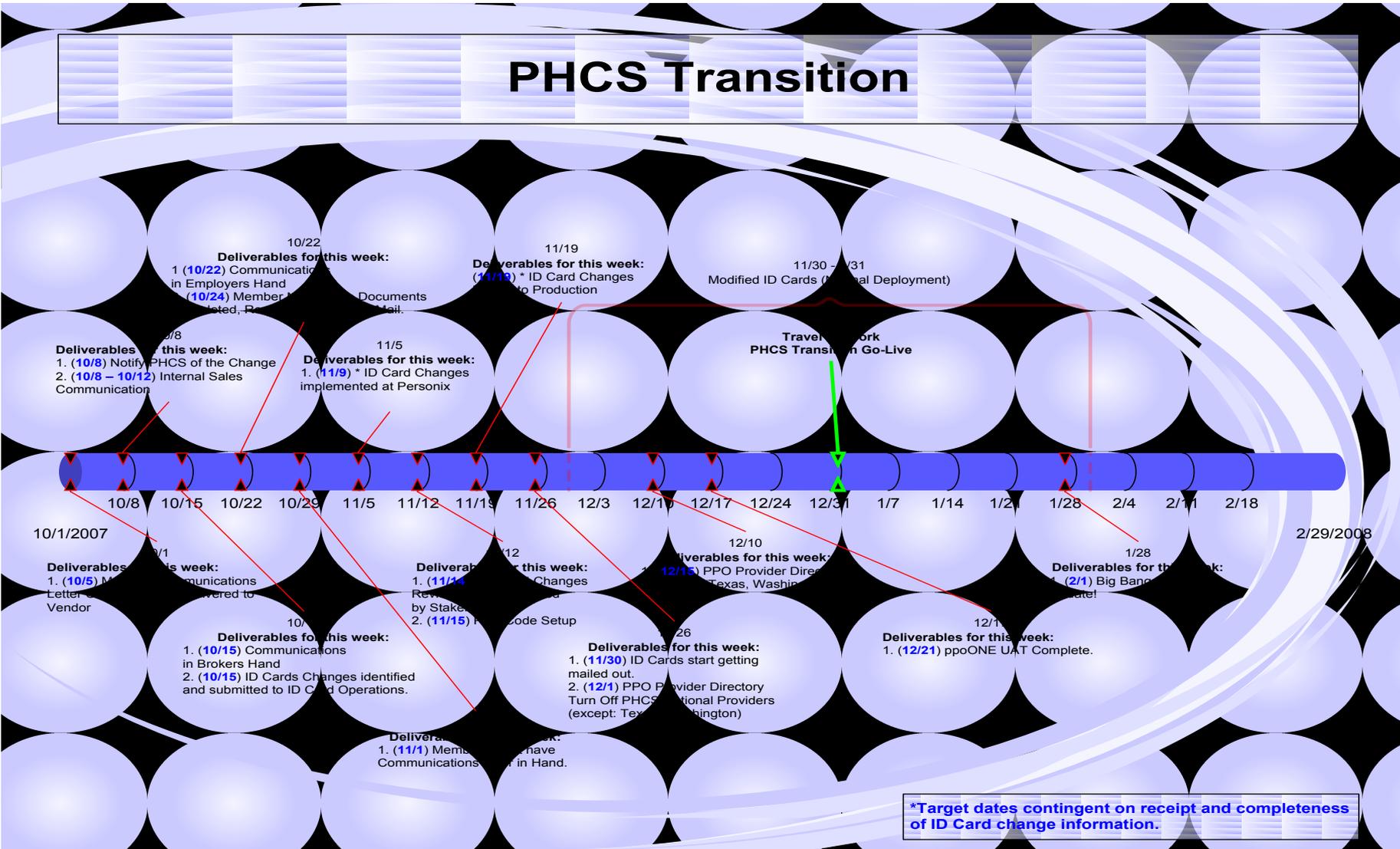
- Member Letters – final with legal to review
- Employer Letters – final with legal to review
- Brokers – eUpdate document has been drafted and with Sales for review
- Internal Communications - drafted and out for review
- Member mailing lists will be solidified early this week

Communication date will hinge on the finalization of the Go-Live date currently under review by Case Install/Member Services

These dates will change based on the potential delay from the 1/1/08 date ...

- New requirements will be incorporated for cards produced in December effective on 1/1/08 or after; "Big bang" to capture all remaining cards will be by 2/1/08.
- Oct 15th is the drop-dead date for all card changes.
- New card vendor (Personix) can accommodate the "big bang" for a 2/1 update so long as we issue through the month of January 2008. *Verified by Pete Bompane (9/28/07)*
- Cards ordered in Mid-Nov to the beginning of Dec may not have the changes. These members will need to be caught up in the "Big-Bang" update no later than 2-1.
- Jeanne Stitt to send Signature Elite Logo and messages on the carrier or Buck Slip to Maria Thompson and Mike Brimley.
- David Bowyer will provide the FHG logo and rules.
- Team to draft overall message on the carrier or Buck Slip.
- Pete Bompane to validate whether card print date will be on the cards.
- 60-day advanced member communication for PPO only; we will not conduct HMO member communication. (PPO member letters need to be submitted by 10/5/07) We will do two separate letters (one for PPO members residing in PHS legacy states, one for members outside legacy states)
- We will hold off the mailing and ID cards for TX/WA/OK PPO members.
- Employer, broker and internal sales communication will be completed.
- We need to understand by employer the aggregate member disruption volume (target to be delivered by this Friday)
- MI, FL are two states outside PHS legacy states that have specific Continuity of Care languages... need to work with PHS care management and service to define Continuity of Care approval process (leverage CTN)
- Validate minimum disruption for 1,180 HMO members residing outside PHS legacy states as result of the transition

PHCS Transition



*Target dates contingent on receipt and completeness of ID Card change information.



Contract Control & Installation

Contract Load Readiness Efforts for 1/1/2008

- The contract submission period for new and renewing ancillary and facility contracts with effective dates of 1/1/2008 through 1/31/2008 is 60 days prior to the effective date. Included below is a change in submission period for December effective date contracts. This does not apply to physician contracts.
 - Submissions to be effective on any date in December need to be submitted BEFORE November 1.
 - Submissions to be effective in January need to be submitted BEFORE November 1.
- *Exception: 100% standard contracts can be submitted through Emptoris 30 days prior to the effective date

- It is important to note that in our earlier announcement for submission of year-end rate changes, for FIXED RATE ESCALATORS we indicated that those with effective dates effective in December or January need to be submitted BEFORE October 1.

HOWEVER, Due to the impact of the new MS DRGs on the existing FIXED RATE ESCALATORS it was necessary to change the original submission date .

- For FIXED RATE ESCALATORS ONLY this date has changed (no date change for provider Contracts for Dec. or Jan. – Still 11/1 due date). – The new DUE DATE for FIXED RATE ESCALATORS has been moved 31 days later to 11/1.

	1/1/08 Effective Projected Receipts	Comparative 1/1/07 Effective Volumes	Comparative 1/1/06 Effective Volumes
Diamond	20	15	20
Facets	20	17	10
Harvard Pilgrim	149	109	149
MAMSI Live	120	30	12
Medica	61	53	15
Oxford Pulse	168	146	80
RIMS / NICE / Illiad	345	300	300
UNET / COSMOS / ppoOne	960	835	406
Total	1843	1505	992

Strategy - Model previous years success around volume/capacity match with accelerated timelines for submission to smooth volumes

- Escalators due 11/1/2007
- All 1/1 contracts due 11/1/2007
- Limited reserved capacity in December for late loads
- Resource Balancing across CCI teams
- Staff OT & Incentives



California Regulatory Update and PacifiCare Reintegration

Susan L. Berkel



**Acquired PacifiCare States
Regulatory Relationship Summary**
last updated October 5, 2007

	AZ	CA	CO	NV	OK	OR	TX	WA
Regulatory relationship	G	R	R	Y	G	Y	Y	R

Transaction Processing/Disputes

<i>NICE/ILIAD</i>	Y	R	Y	Y	Y	Y	Y	Y
<i>RIMS/ASI/TPA</i>	Y	R	R	Y	Y	Y	Y	Y
<i>UNET</i>	G	Y	Y	G	G	Y	Y	R
Inpatient Transformation Initiatives	G	Y	R	G	G	G	Y	Y
Dividends	G	G	Y	G	G	G	G	R

Audits

HMO Claims/Provider Disputes	R							
PPO Claims/Disputes/Contracting	R	R						
Migration of services outside state	R							
Undertakings - pricing audit	R							
Individual Policy Recission	Y							
Financial Examination						G		R

Other

<i>Sierra undertakings</i>			Y					
<i>Provider network/contracting</i>								R
<i>Undertaking compliance</i>	R	R						

Fines 1/1/07 - 10/5/07		\$7,500	\$46,000			\$34,000	\$4,100,000	
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California Department of Managed Healthcare PacifiCare of California Regulatory (HMO and Point of Service Product) Claims and Provider Dispute Audit

- Preliminary Audit Report was issued Friday, September 28, 2007.
- PCC is required to self-report new issues impacting claims accuracy and timeliness to DMHC.
- Monthly DMHC corrective action reporting begins November 1, 2007.
- Our response is due Wednesday, November 14, 2007.
- Public document in 10 days – with holidays, probably Monday, November 26, 2007. Public Relations coordination began Friday, October 5th.
- Publicity expected to miss open enrollment window
- Enforcement, press release and fine expected with website posting .
- DMHC has used the words “unprecedented fine.”
 - Fine is intended to send a message to MN – pre-acquisition promises have not been kept. PCC largest fine is \$250,000.
 - Largest DMHC fine is \$5.0 million over patient transplant services (not audit or claims processing based).
 - Accrued \$1 million fine in September close – commercial January 2006 to May 2007
- Other Publicity Implications
 - California Medical Association
 - Sierra implications on Nevada undertakings
 - MAWG
 - Stock Options
 - UHG leadership changes

Non Audit Issues with other DMHC representatives

- Los Angeles and Orange County ambulance claims payment accuracy rework project
- Member Appeals & Grievances – recently received three separate enforcement actions for late responses – fined \$2,500 each.

California Department of Managed Healthcare PacifiCare of California Regulatory (HMO and Point of Service Product) Claims and Provider Dispute Audit Findings

1 Provider Dispute Resolution

- Inappropriate determination of claim dispute – 30% error rate.
- Inappropriate request for information to resolve dispute – 22% error rate.
- Non-timely resolution of provider disputes (45 working days).
- Our corrective action is a cradle to grave review of processes, procedures and policies. Leadership, resource changes proposed.
- Ineffective handling of customer service calls from providers inquiring about previously submitted claims disputes - providers were simply instructed to resubmit the dispute

2 Inappropriate denial of health plan risk claims

- NPI functionality to NICE broke the out of area determination tool on February 9, 2007 and fixed on May 31, 2007 but rework has not been defined. **Potential 100k claims impacted – all PHS products and states on NICE. Rework project has not been started as we are seeking automated approaches.**
- Capitation contracts have inherent complexities in the adjudication decision tree. The Lason implementation requires retooling of document routing to prevent claims initially group returned (denied as capitated risk) from being group returned again when it really is health plan risk (misdirected claims).

3 Retro contract loads – claims payment accuracy

- 46% percent of sampled retro contracts had no rework project initiated.
- **Required to provide detailed claims rework by provider for all January 1, 2006 through November 15, 2007 California HMO fee for service retrocontract changes.**
- Integration role clarity issue. CCI owns facility rework initiation. Network management owns physician, ancillary rework initiation for retro contracts.
- **NICE claims payment accuracy - examiner errors**
- **an audit trail is needed to document the dates when new or revised contract provisions are loaded into the system**

4 Claims Timeliness Failures Q4 2006 to present and inaccurate interest and penalty

- AB1455 requirements not met.
- **Required to rework all late paid claims from January 1, 2006 through November 15, 2007 to accurately pay interest and penalty.**

5 Point of Service Claims Processing

- Self-disclosed late of POS payment when service rendered out-of-network.
- RIMS OON POS claims payment accuracy issues.
- 79,000 claims reworked by May 31, 2007.
- Centralizing POS claims processing in Cypress, CA.
- Initial estimates of FTEs may be light. Trying new ideas to prevent additional FTEs.
- **Focused audits have been implemented – still indicates claims payment and interest payment accuracy issues.**
- **inappropriate denials (claims examiner errors, unrelated to rework project)**

6 Lason/DocDNA causing late claims payment, inappropriate denials, inappropriate requests for information already received

- Document routing rules provided to Lason not robust.
- Lason reconciliation/routing issues.
- DocDNA management of queues and inventory poorly managed.
- Secondary document indexing was in a black hole.
- Need to implement functionality within Lason to accurately search for secondary documents.

7 Other issues

- Claims received date stamping.

Administrative Capacity Allegations

- Insufficient controls over claims operations
 - Lason correspondence routing
 - Ireland claims processing
 - San Antonio POS claims processing
 - MedPlans - POS claims processing
- Insufficient staffing to manage claims inventory
 - RIMS resources for POS rework project

What Administrative Capacity Looks Like

- Ability to exercise independent control over its operations
 - third party vendor oversight - plan specific information
 - hiring decisions
 - technology improvements
 - Sufficient financial resources
 - Compliance with the law

Administrative Capacity Personnel

- VP, Transactions
 - Oversight of controls and metrics for:
 - Lason
 - EDI processing
 - PCC claims processing quality metrics including dollar and financial accuracy
 - PCC claims turn around time metrics/AB1455 compliance
 - Claims reprocessing metrics - number of second+ touches, interest/penalty
 - Provider Dispute Resolution inventory reporting, quality metrics
 - DocDNA queues reporting - focus on turn around time, aged inventory
 - Supported by other ACME staff (need to designate project manager and reporting person) that prepare summary information and provide overview
 - Directs corrective actions, as necessary - self-reports to DMHC
 - Leads monthly reporting to DMHC

California Department of Insurance

- 2007 Certificate of Coverage filed Q4 2006 approved for UHIC/Unet.
- Failed undertakings – auto adjudication, justified complaints. (See next page.)
- Undertaking calculations for first call resolution not California specific. (See next page.)
- Undertaking pricing audit may be issued by October 31. No issues to date.
- CDI July 23, 2007 data claims, provider dispute and contracting audit is ongoing. General Counsel is also requesting separate data.
 - REVA – closure letters are not consistently sent out informing the provider of the outcome of the PDR.
 - Creation of bi-weekly report to validate a closure letter has been created for PDRs where an acknowledgement letter has been sent.
 - New day claims – for claims that are not processed within 15 days, an acknowledgement letter is supposed to be sent out the provider. The system does not pick up the claims that enter the system after day 15.
 - EOBs – missing information informing the provider of the DOI website and the PHS website.
 - Create mechanism to retrieve archived claims from Claims Exchange.
 - CTN late contract loads and claims rework completeness and accuracy.
 - Preexisting condition claims adjudication.
 - RIMS claims payment accuracy.

Reporting period: Q1 2006 through 2007 Q2

Metric	Standard	Tolerance Threshold	Performance					
			2006 Q1	2006 Q2	2006 Q3	2006 Q4	2007 Q1	2007 Q2
Member Related Metrics								
First Call Resolution	90%	87%	91%	87%	90%	90%	89%	81%
Net Claims adjustment volume	96%	93%	96%	93%	96%	96%	96%	92%
Provider Related Metrics								
First call resolution rate	90%	87%	98%	87%	96%	96%	81%	88%
Percent of appeals resolved within 15 calendar days of proper receipt	90%	87%	74%	87%	89%	83%	66%	67%
DOI Related Metrics								
Number of Justified Complaints received per 1,000 members	0.00805	0.00829	See (Note 1)	See (Note 1)	0.091	0.01183	0.03574	0.04219
Claims Payment Related Metrics								
Percent of claims auto-adjudicated	50%	47%	45%	47%	49%	50%	52%	51%
Claims processed within 30 calendar days	95%	92%	98%	92%	98%	98%	98%	98%

(Note 1) The Company was awaiting approval from CDI on the standard and tolerance threshold as a result nothing was filed during this period for number of justified complaints received per 1,000 members for 2006 Q1 and Q2.

The exit conference was held, September 24, 2007.

Preliminary Survey Findings:

- Inconsistencies in pre-enrollment individual HMO underwriting and applying of guidelines.
- Lack of documentation and rationale for rescission decisions.
- Inconsistencies in the rescission process, no clear guidelines for willful misrepresentation.
- The appeals process, acceptance of verbal/telephonic appeals, notification to enrollee of investigation, and lack of documentation.

Other related issues:

- The need for clarification in certain customer application questions.
- The need for clinical input in underwriting and rescission process.
- Documentation of activities and rational/written criteria.
- Assistance for enrollees with limited English language skills.
- Capitated vs non-capitated data inputting into the NICE system.
- Tracking, auditing and oversight of decisions.

Next Steps

- The company will have 45 days to respond to the preliminary report. No release date for the report at this time, however, affected areas should begin implementation of changes, corrective action plans and/or gathering documentation of changes implemented as soon as possible so that we will be ready to respond upon receipt of the report.

California Department of Managed Healthcare

- PacifiCare Behavioral Health of California and United Behavioral Health of California and USBHPC – surprise non routine claims and provider dispute resolution audit.
- On July 16, DMHC examiners started unannounced exams at PBHC, UBH and USBHPC offices in CA.
- Purpose of audit was to verify compliance for claims processing and provider dispute resolution processes, related to pending PBHC filing seeking approval to move claims functions to TX and India.

On October 1, DMHC shared preliminary findings:

- PBHC moved claims operations to TX/India without regulatory approval.
- Inaccurate claims payment denials
- Deficiencies with provider dispute resolution processes
- All findings have been referred for enforcement action. A fine is anticipated.

- Numerous compliance issues
 - UHIC Member notification requirements viewed as pre-authorization
 - UHIC Claims for OON providers at par facilities not processed correctly
 - PLAC desk audit -- \$46,000 fine
 - Claims denied within 31 days of term date for members who were terminated for non-payment of premium – Group Services has the CAP, transactions will provide self audit
 - Benefit maximum denials – RIMS system is set to deny claims for participating providers associated with benefit maximums at the billed charge amount. The EOB reflects the member owes billed charges. DOI is requiring the denial be at the provider contracted amounts. This will reduce the member responsibility amount appearing on the EOB. Requesting a system fix from Trizetto.
 - FI auto-adjudicated metric failure is ILIAD driven (per merger undertakings for all UHC companies in Colorado)
 - **80% target (3% tolerance) – reported 43.9% First Quarter**
- Ongoing regulatory scrutiny
 - Noticed exams for PLAC, PCCO, UHIC (on hold)
 - Affordability initiatives
 - **DOI critical of roll-out, concerned about fairness to providers**
 - Proposed \$10.1M extraordinary dividend (UHIC)

- TDI compliance issues
 - UHT Complaint log tracking member complaints (2006)
 - Improper complaint categorization and inclusion of HMO and PPO complaints into HMO log.
 - Potential \$1.5M fine per 2005 Consent Order requirement.
 - UHIC Prompt pay violations (Q3 2006)
 - Failure to meet 98% metric for timely claim payment
 - Potential \$3M fine per 2005 Consent Order requirement.
 - PCTX/PLAC prompt pay penalties and interest have increased substantially
 - Ex: 2006 Total penalties (HMO/PPO combined) \$500K vs. 2007 penalties thru July „07 (HMO/PPO combined) **\$2.6M**
- 2007 Certificate of Coverage
 - TDI challenging our ability to impose member notification requirements
 - Transition to Texas UR appeal guidelines is likely solution
- MAWG update – TDI did not join per UHC

Office of Insurance Commissioner Concerns

- Meeting with Puget Sound, OIC and UHC together to resolve discrepancy in OIC perception of UHC's handling of issue/consumers on September 6th. All requirements of this meeting have been completed.
 - 2005 settlement agreement allows for consumers to pay higher coinsurance based on UHC paying billed charges. OIC wants UHC to make consumers and ASO groups whole without having PSG to do this in the settlement process.
 - PSG has sent 90 day termination notice on ASC contract. If claim payment issues are not resolved, termination will proceed.
 - PSG has dropped ASC claims to paper. OIC expects dedicated and fully trained analysts for accurate Puget Sound claims adjudication.
- Provider contracts
 - Network impact of ITI roll out and future affordability initiatives - alleging not supported by contracts
 - WSMA complaint regarding Labcorp protocol - requests OIC take action to remove penalties
 - Provider Contracts in Market not current with WA regulation - possible specific Market Conduct forthcoming
- Provider relations/Network operations
 - Continued complaints by providers and consumers regarding service levels - "basics aren't being done right"
- Network adequacy
 - OIC concerned about network adequacy – providers terminating contracts due to new initiatives, other problems
 - Monthly Form A filings fail to correspond with public provider network listings
- Contentious provider issues
 - Swedish termination by PHS - OIC is questioning violation of Undertaking Agreement by PacifiCare contract being aligned with UHC contract termination
 - Secure Horizons contracting – contentious provider negotiations and threat of providers competing directly are strongly impacting our regulatory position and pose a public affairs threat
- Commissioner voiced concerns about signing MAWG due to issues and recommendation by his staff
- The UHC Provider EOP does not itemize payment from the billing statement that is processed. The payment to the provider only identifies a combined total payment. As a result, the providers are complaining that they are unable to reconcile their receivables to determine whether or not the claim was in fact adjudicated correctly. UHC technology is indicating that this a very low priority and of which they are unable to make any type of commitment due to the development/programming requirements. OIC has been very vocal on what they believe is our deficient provider dispute process and the amount of provider contract/dispute issues that are coming to their attention

Plan Concerns

- Dividends on hold
 - Threat of public hearing
 - Approval of OIC to integrate PHS/UHC systems (Undertaking Issue)
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Oregon DOI

- \$34,000 fine for untimely response to certificate of creditable coverage member complaints.
 - Includes failure to timely and accurately respond to DOI complaints
 - Annual Claims Prompt Payment report submitted with incorrect data. DOI is accepting signature of PCW and PLAC acknowledging next year enforcement fines will result if data submitted incorrectly.

Recent Accomplishments

Q4 Goals

3,500 Iliad AZ professional claims impacted by UFE Emdeon change have been reworked.	Develop UFE control framework for recent issues.
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Overall Status Yellow for August/September issues:

1. Emdeon (and other vendor) files not received by UFE.
2. ENS files not received by UFE.
3. Inaccurate UFE routing.
4. UFE files not processing.
5. Technology issues - imaging servers not responding.
6. Emdeon through ENS process - inaccurate load of member information for AZ professional claims.

Area	Status/Recent Issues	Recent Accomplishments	Q4 Goals
Lason Reporting	Daily reconciliation reports are not in place. Lason reconciles on a weekly basis. Batches not fully processed not identified quickly.		Daily reporting to be implemented 10/15/2007. Full review of Lason reporting to be completed with Transaction and PHS management by 10/31/2007.
Lason - paper claims	Inaccurate policy/procedure is causing Lason to key units on superbills incorrectly (decimal placed inappropriately). Estimated claims impact is 7k - believe both over and underpayments. More robust reporting is pending.		Correct fractional unit issue in Lason education, policy/procedure. Rework underpaid claims. Send overpayments to ARO.
Doc DNA queues - inventory management	Continue to experience inappropriate aging of documents, lack of turn around reporting	Down to 4 problematic queues, 3 with large aged inventories.	Define turn around time reporting (complex because documents move from DocDNA queue to other queues).
Lason - secondary documents - indexing and routing to DOC DNA queues	9,000 secondary documents require indexing by Lason for proper matching to claims. Also PHS imaging has size limitations; certain Lason files are rejected. PHS imaging has page capacity of 999 pages. Lason files are truncated and balance is never sent.	Weekly meetings with DOC DNA owners have reduced aged inventory.	Index secondary documents, link to claims, reprocess. Redocument routing instructions with Lason. Resolve page space and page limitation protocols. Design single Lason/Doc DNA weekly reporting format. Host Lason summit by mid October.
Doc DNA search ability	Lack of search functionality. Matching documents not systematic to identifiers.		Incremental cost is \$40,000. Implement functionality. Cost of a single late claim reverting to billed charges because of missing documents pays for this.

Contract Loading and Network Management Issues Impacting Transaction Processing



Area	Owner	Status/Recent Issues	Recent Accomplishments	Q4 Goals
Emptoris	Kaja	Emptoris expertise in Pacific region network management is limited. Access to PDLTs requires Lotus Notes access. Four systems have to be touched.		Emptoris superusers need to be identified to support Network Management.
EPDE - the human intervention	Kaja		Training completed.	Superusers need to be identified to help non NDB, EPDE network management personnel ensure that contracts are configured correctly for CCI in the first submission.
EPDE - the technology	Kaja	EOR network type not being created for added suffixes. Extra suffixes created unnecessarily. Provider pay to being changed.	Bugs continue to have manual workarounds or fixes implemented. War room addressing - 3 open issues.	Resolve EPDE errors as identified. Launch rework project.
NDB to RIMS comparison	Kaja		Reconciliation reports have been productionalized. Errors are being corrected.	Implement reconciliation trend reporting.
Capitated Contract Configuration	Kaja	PHS had a team that reviewed the CCI load of capitated contracts to ensure that there were no errors and that claims would adjudicate between health plan risk and capitated group risk correctly. Team does not exist for January 1, 2008 contract loading.		Reinstate team, controls. Transfer knowledge to CCI.
Skilled Nursing Facility contract load accuracy	Evercare/Guisinger	Inaccurate claims payments for skilled nursing facilities paid on PHS claims engines. Root cause not known, 4 potential causes being researched.	Team assembled 10/4 to research.	Correct defects confirmed. Reprocess claims.
Fee Schedule Loading	OM	35,000 MSPS fee schedules updated with overlapping dates in NICE and RIMS. Caused by partial load.	Root cause identified. Partial load MSPS will require different approach.	Quantify rework prioritize with all rework projects.
Fee Schedule Maintenance	McKinley	2006 and 2007 NMSPS maintenance not completed timely.	Inventory of NMSPF completed. Fee schedule builder enhanced.	Continue to monitor inventory and maintenance dates.
Retro contracts - role clarity on rework project initiation	McKinley/Kaja	DMHC is requiring documentation that all CA commercial HMO fee for service claims received between effective date and late load date have been reprocessed under the updated contract terms.		CCI launches facility only. Network management is accountable for physician and ancillary. Role clarity, updated policies and procedures to be defined. Control procedures to be implemented to ensure all rework is initiated.
Late contracts - retro	McKinley	RIMS retro contracts from CCI, expected January 1, 2008 retro contracts - HMO and PPO.		Network management to provide realistic delivery date. Retro contracts to be approved now or avoided with pushed out effective dates.



Ask – Resources, overtime

Area		Findings	Recent Accomplishments
CA Point of Service Claims	Raynee Andrews and Jan Wold	Out of compliance with CA law turnaround times, inaccurate application of interest and penalty, inappropriate denials.	Cypress, CA POS claims processing for new day claims began July 9, 2007. 4 additional FTEs approved for hire to replace third party vendor. POS claims processing training held in August. Quality team has completed focused audits to measure our progress.
CA NICE out of area denials and misdirectd claims	Padraig Monaghan	DMHC audit reveals 20% error rate in claims denied for payment by capitated medical group were out of area claims to be paid by Plan. Estimated number of claims currently at 100k.	Out of area determination tool fix implemented May 31, 2007. Error began on February 9, 2007 with NPI functionality launched in NICE. Impacts all states, all products.
CA NICE indemnified claims	Melinda Dysinger/Anne Harvey	Large inventory of arbitration and new day claims for capitated groups with carve out claims (e.g. Sutter). Technology to load these claims requires enhancements.	Network Management increased FTEs to assist in claims triage. Sanity check of IBNR reserve indicates we are adequately reserved. Rework claims still unidentified.
CA HMO Prompt Pay AB1455	Padraig Monaghan	Point of service claims plus increased NICE rework claims caused Q2 failure of prompt pay laws which is likely to repeat in Q3.	CA Prompt Pay reports have been rewritten to conform to new DMHC definitions and to ensure data agrees to other inventory reporting.
CA NICE interest and penalty	Padraig Monaghan	DMHC audit is requiring all late paid claims from January 1, 2006 through November 15, 2007 be reworked for accurate interest and penalty	
CA NICE claims payment accuracy - emergency room/ambulance claims	Padraig Monaghan		Training bulletin issued.
Rework Not Yet Received	Padraig Monaghan	OOA claims - GIS broken Other misdirected claims Late paid claims Retrocontract claims MSPS overlap claims	
CMS DRG 10/1 change	Padraig Monaghan	Holding claims	



Area	Findings	Recent Accomplishments	Q4 Goals
CA Point of Service Claims	Out of compliance with CA law turnaround times, inaccurate application of interest and penalty, inappropriate denials.	Cypress, CA POS claims processing for new day claims began July 9, 2007. 4 additional FTEs approved for hire to replace third party vendor. POS claims processing training held in August. Quality team has completed focused audits to measure our progress.	Achieve CA required turnaround times. Reduce errors noted in focused audits. Complete recruiting. Transition POS rework claims to Cypress team.
CA RIMS interest	DMHC interpretation of law around prompt pay of Point of Service claims is updated. We have been overpaying interest on RIMS.	Correct number of days updated on August 25, 2007.	Implement quality review of sample of POS late paid claims for interest calculation.
CA RIMS claims payment accuracy	CDI is finding significant accuracy errors. DMHC found significant errors in POS claims processing by vendor MedPlans	Cypress, CA POS claims processing for new day claims began July 9, 2007. # additional FTEs approved for hire to replace third party vendor. POS claims processing training held in August.	Implement focused audits. Conduct complete training including Med Plans. Continue POS corrective action. MedPlans work will cease by 11/1/2007.
Rework Not Yet Received	MSPS overlap claims		Quantify projects, resources, timelines. Minimize risk, penalties.
EOB/EOP	Noncompliant EOB/EOP for member/provider dispute process.	New EOB/EOP implemented June 2007	
RIMS Interest	When claims are entered into RIMS without a Claims Exchange batch process, the automated interest application is bypassed.	CDI requiring 5,400 claims be reworked for interest. 3,300 completed.	Complete project.

Area	Status/Recent Issues	Recent Accomplishments	Q4 Goals
PHS Wide ORS - Marty Sing	Inventory at acceptable levels	ORS inventory reduction initiative completed.	Track member calls from provider calls for undertaking reporting. Enhance customer call categories to track root causes.
PHS Wide ORS - Marty Sing	ORS does not interface with the PHS provider dispute resolution tracking tool. PHS' customer service connected to PDR tool. Team must manually search ORS data to define claim issue.		ORS upgrade required for technical solution. PHS on weaker version of ORS. Understand upgrade timing/prioritization.
CA etrack - Jeff Larsen	Inventory at acceptable levels		Track root cause of reopened issues. Improve turnaround time. Continue to reduce aged inventory.
Returned Checks Douglas Tonto, Lori Wolf	Significantly higher returned checks EPDE since integration. Root cause not adequately defined and is hampered by lack of trail of changes between NDB and PHS engines.	Single EPDE root cause related to 10% of 109 returned checks analyzed.	Define root causes. Continue to manage inventory requiring reissuance.

Corrective Action	Accountable	Issue	Recent Accomplishments	Key Milestones-November
CA Claims Returned to Medical Groups for payment	Dysinger Calvin	TAT	Staffing: 1 FTE Hired	Staffing: 1) Fill 2 FTE (interviewing) and 1 Temp positions (approval) 2) Ensure appropriate knowledge and tools in place to make accurate decisions timely.
		Inventory Volume		
CA HMO Provider Disputes	Dysinger Calvin	TAT	Staffing: 2 PDR and 1 Misdirected FTEs hired, 1 Misdirected FTE Hired 1 Auditor-Interviewing, 4 Temps, Approval Process	Staffing: Fill 1 Auditor FTE (interviewing) and 4 Temp positions (approval)
		Reporting	Weekly (manual) report to identify ackn letter issuance	1) Automate weekly report of ackn letter issuance 2) Develop automated & consistent daily/weekly/monthly reporting for PDRS
		Determination Accuracy	1) Agreement for dedicated claim rework team in Ireland (roll out 12/1) 2)PDR team using Infolink to flag rework disputes for Ireland 3) Weekly rework team btwn PDR and Ireland	1) Roll-out process by 11/30 between PDR & Ireland to manage PDR determinations-daily meetings with knowledge share and training feedback 2) Finalize quality audit program 3) Finalize Root Cause codes, reporting & action plan 4) Roll out of new determination letters 5) Roll out escalation process for receipt of repeat (second) PDR on same issue
		Inappropriate Request for Additional Information	1) Process for Medical records & other secondary documents to be identified in San Antonio, fill out fields in Doc DNA queue and route to REVA (roll out in Oct)	
		Technology	REVA enhancement request approved: 1)Dedicated service 2)Staff to support upgrades/reports 3) Elimination of claim records not matched to dispute 4) Archive old REVA records 5) Create batch job pull eligibility & claim data 6) Eliminate old tables	1) Monitor delivery of REVA enhancements 2) Ensure L&T support of reporting requests
CA HMO/PPO Claim Projects (not disputes or indemnified claims)	Dysinger Calvin	Inventory Volume-35% Increase	Staffing: 4 FTEs hired	Staffing: 1) Fill 3 FTE positions

Reintegration Update

- Non-Migration Capital
- Open Enrollment

- **The legacy PacifiCare platform still processes over \$15 billion in premiums and over \$12 billion of health care costs**
- Historical data provided by former PacifiCare IT Finance resources documents a 2005 IT spend (9+3 Forecast) of over \$138 million
 - Total investment includes all labor / non-labor costs (both capital and expense)
 - Discretionary dollars are difficult to isolate but even the removal of easily identifiable discretionary programs still rendered a total IT **spend of over \$80 million**
- 2005 IT spend was reduced after the UHG-PacifiCare merger announcement
- 2006 and 2007 IT spend was significantly limited given the desire to immediately recognize synergies between the two organizations
- Unfortunately, plans to migrate the PacifiCare business off of this platform have slowed significantly
- As a result, the legacy PacifiCare platform has not been adequately maintained over the last 2+ years to support ongoing operations, including regulatory requirements
- The Individual & Employer Markets Group (IEMG) segment is supposed to fund a majority of the capital requirements to support this platform and current **2008 allocation is being proposed at only \$10 million**



PHS Business At-A-Glance

as of 10/05/07

Company	Revenue	Primary Products	Total Membership	Portals	Platforms	IT Spend
2005 (PHS) (8 States)	\$ 14.3 B	* ASO (CM Only) * HMO (CM and SH) * PPO (CM only) * PFFS * PBH * PDV * Rx Solutions	2,942,994	* Broker * Employer * Member (CM & SH) * Provider * PBH * PDV * Rx Solutions * Latino Health * African-American * Chinese * Korean * Vietnamese	* NICE * RIMS * Iliad * Approx. 350 - additional applications	\$ 85 M (Medical ONLY, excluding the following and the cost for Specialty Companies): * AMS Acquisition efforts (-\$5.2M) * Cabernet (-\$10.7M) * ILIAD Conversion (-\$10.5M) * IT Internal Operations (-\$7.2M) * Medicare Part D (-\$9.2M) * Pacific Life Acquisition (-\$1.7M) * PERFORM (-\$2.8M) * PPMO (-\$1M) * Security Management Services (-\$4.9M)
2008 (PHS/UHG)	\$ 14.3 approx.	* ASO (CM Only) * HMO (CM and SH) * PPO (CM only) * PFFS * Medicare Part D * PBH * PDV * Rx Solutions	2,579,190 YTD 07/07	* Broker * Employer * Member (CM & SH) * Provider * PBH * PDV * Rx Solutions * Latino Health * African-American * Chinese * Korean * Vietnamese	* NICE * RIMS * Iliad * Approx. 350 additional applications * UHG Systems/Platforms impacted due to Migration	\$ 10 M (Medical Only)

Capital Summary

- **Total Capital - 2008 IT Labor: \$14,066,356; 2008 Non-Labor \$950,000**
- Capital dollars on the following slide represent capital requests submitted jointly by the business and IT that have been initially approved / screened by S. Berkel & G. Ahwah
- Excludes an estimated \$3.8M in Operations Maintenance (OM) owned work orders confirmed by the OM team as included in the 2008 OM Expense budget (although potentially under revised estimates)
- Excludes \$865K in Software License fees which are assumed to be covered in 2008 Segment Expense budgets
- **Excludes additional 2008 regulatory requirements still being scoped / estimated (CA Senate Bill 853)**

- **SB 853 affects CA fully insured commercial members of 12 United subsidiaries:**
- DMHC Licensed Entities: PCC, PacifiCare Dental, PBHC, Spectera of CA, DBP, Pacific Union Dental, U.S. Behavioral Health, A C N of CA
- DOI Licensed Entities: AMSLIC, Golden Rule, PLHIC, UHIC
- National Compliance Implementation Team is coordinating implementation activities across 12 United subsidiaries affected by SB 853 –
 - West Region Regulatory Affairs is leading implementation efforts for PCC and PLHIC
 - SCS Regulatory Affairs is leading implementation efforts for PD, PBHC, Spectera, DBP, Pacific Union Dental, U.S. Behavioral Health, AC N
 - National Compliance Implementation Team is leading implementation efforts for UHIC
 - AMSLIC and Golden Rule have self contained implementation teams, who have recently reached out to West Region
- Plans are required to develop a Comprehensive Language Assistance Program which will:
- Assess Threshold Languages
 - Translate Vital Documents into Threshold languages*
 - Provide timely access to interpreter services*
 - Ensure competency of interpreters and translators*
 - Provide info to regulators annually on several cultural competency measures

* *These items also pertain to health care or administrative providers that are delegated to provide services for SB 853 related functions*

Renewal Volume

- 10,239 January 1, 2008 renewals expected to be received for all three platforms: NICE, RIMS, ILIAD.

• Open Enrollment Readiness Plans

- Commercial Plan codes approved and submitted **(OE Milestone)**
- Case Installation started processing 1/1/08 Renewals in PHS Systems 10/1/07
- 2008 Open Enrollment Guide (Quick Hits) for Sales & Underwriting finalized and distributed 10/5/07
- Final listing of 2008 Confirmed groups with Performance Guarantees and Special Handling group listing completed 10/5/07
- ID Card Kick off meeting with the new vendor (Personix) scheduled on Oct 15-16
 - **Overview of PHS renewal process since this is Personix' first OE experience with PHS**
 - Present PHS expectations, renewal volumes, etc.
 - Understand Service Level Agreements (SLAs), process, control
 - ID Card Production Process walkthrough

• Competing 2007 Projects and Impact to OE Readiness

- PHCS transition – impacting ID card production
- PPO Name Change (SignatureElite) – impacting ID card production

• OE Communication Plans

- Weekly Cross Functional Meetings
- Group Retiree weekly touch points
- Bi-weekly Sales Forum
- OE Core Team Weekly Planning
- ID Card Production Meeting (will start soon)
- PHS OE SharePoint <http://unitedteams.uhc.com/Uniprise/GroupServices/default.aspx>
- Connect. COM
- Weekly Executive Summary
- OE Flash Report (Renewal Case Status)

• Group Retiree

- Group Retiree Renewal Process presented to Sales/UW and other key areas on September 21 and 26
- Plan Codes entered into PMT and NICE as of today **(OE Milestone)**
- **Identified top 50 retiree accounts that will be included in OE's Special Handling/VIP Group listing**
- In process of streamlining OE tracking reports
- Group Retiree Leadership Team meeting with Sales and OE Project Lead next week to discuss ongoing OE readiness plans and reporting

Initiative Description



Implementation of a Small Business Service Model for PHS Platform Broker and Employer issues.

Progress this Period

Implement Small Business service model

- ✓ Continued to develop training curriculum to cross train the BSU's
- ✓ Designed consistent eTrack workflow between San Antonio/Phoenix BSU's and Ireland and the Network Operations Team
- ✓ Graduation of new hire class- 9/28
- ✓ Kicked off Quality Assurance plan formation

Planned for Next Period

Implement Small Business service model

- ✓ Continue eTrack rollout planning for all other PHS markets
- ✓ Implement workflow between San Antonio/Phoenix and Ireland and the Network Operations Team
- ✓ New hires to augment service team starting 10/1
- ✓ Finalize QA plan
- ✓ Finalize Internal IVR requirements- kick of IT coding effort
- ✓ Create PHS Platform Health Plan Reports

Key Issues/Risks/Dependencies

- BSU assessment resulted in significant training and systems access gaps that need to be addressed
- Resources were diverted last period to address several systems access and curriculum issues with current new hire training class. Impacted overall BSU cross-training schedule. Working with training leadership to determine options other than pushing schedule out dramatically
- Supply/Demand issues with trainers and training resources

Key Action Items & Milestones

Item	Date	Status	Comments
Consolidate BSU tracking system (eTrack)	9/14	Complete	eTrack rolled out to San Antonio and Phoenix BSU
Train new hires	9/28	Green	Training on schedule
Consolidate three BSU's into one cross-trained team	TBD	Red	Trainers cannot accommodate training until early November. Working with leadership to bring that date in.
Rollout eTrack to all PHS Markets	11/23	Yellow	Dependant on BSU cross-training schedule

Initiative Description		Implementation of the Dedicated Service Model for Key Account and Platinum Brokers
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Progress this Period
<p><u>Implement Dedicated KA & Platinum service model</u></p> <ul style="list-style-type: none"> ✓ Began recruiting activities for 15 FTE's ✓ Remaining 10 FTE's in final approval process ✓ Finalized PHS Platinum "Stop Gap" Approach ✓ Communicated PHS Platinum "Stop Gap" Approach to SB Leadership ✓ Continued creation of new hire curriculum

Planned for Next Period
<p><u>Implement Dedicated KA & Platinum service model</u></p> <ul style="list-style-type: none"> ✓ Start interviews for Platinum/DSCM positions ✓ Determine necessary steps to transfer headcount budget to ECS ✓ Finalize communication approach for existing Account Managers re: DSCM role ✓ Finalize logistics for new hire training class (identify trainer's, classroom, location, etc)-first class scheduled for 11/12

Key Issues/Risks/Dependencies
<ul style="list-style-type: none"> • Supply/Demand issues with Trainers and Training Resources • Communication to existing Sales Account Managers regarding DCSM roles prior to open enrollment • FTE Transfer logistics still need to be finalized (compensation approach, budget transfers, etc)

Key Action Items & Milestones			
Item	Date	Status	Comments
Implement Platinum "Stop Gap" Approach	9/28/07	Green	
Post, Recruit & Hire Resources for Platinum and DCSM model-2007	11/9/07	Yellow	Timeline for interviewing and hiring candidates
Finalize Platinum/DSCM Training Curriculum/Approach	10/26/07	Green	
Train New Hire Platinum/DSCM reps- Wave 1	1/7/08	Green	Based on 11/12 new hire training date

High Level Milestones:

- Determine number\names of brokers needing support- COMPLETE
- Determine number of SRT resources that can support Platinum brokers-COMplete
- Develop issue intake approach-COMplete
- Assign SRT resources to Platinum Brokers-COMplete
- Communicate Model to SB Leadership-COMplete
- Account Mgmt Communicates Model to Brokers-9/28

The short term Platinum approach will be implemented for PHS platform effective 10/1.

The UHC platform Platinum approach is still in early planning stages.

The UHC West Coast Service Improvement Plan is underway:

- SME's continue to travel to Cypress to cross train and observe the DCSM's
- The entire West Coast DCSM team will be in a three week UHC training program starting on 10/8
- Active recruitment for a new DCSM Team Lead to replace Lisa Pezzuto is underway

In an effort to increase on site exposure and accountability, Jeff Larsen will assume ownership for the UHC DCSM Team effective 10/1. Amy Fisher will continue to support Jeff in this new capacity.



Dedicated Service Model – PHS Major Accounts (National)

Kerri Balbone



To create a better overall service experience in support of our largest, more sophisticated customers in the PHS Major Accounts space.

- Multiple work teams in place working on similar objectives in this space.
 - Duplicative efforts in motion to resolve service pain points raised by Major Accounts Sales
- Confusion exists on organizational ownership from Major Accounts
 - Major Accounts customers cross multiple segments. Consistent definition of Major Accounts is unclear
 - There may be opportunity for tighter coordination between segments
- UHC models for implementation and client service managers are in place today, but not extended to include Major Accounts customers
 - Implementation Manager model in place for key accounts
 - Dedicated Client Service Manager in place for small business
- Quantification and organizational direction missing on service pain points raised by Major Accounts Sales
 - Greater facts needed to determine new vs. old, single vs. global issues to address

- Confirm correct participants and key decision makers to engage in discussions
- Determine what projects overlap or coincide, and what needs to continue within this space
- Identify where we can leverage existing process and models, and where gaps exist with different work streams
- Obtain tangible data on service pain points raised that include the following:
 - List of Major Accounts customers impacted by service – who has experienced repeat issues
 - List of customers who have dual platform (PHS and UHC) implementation vs. PHS only platform implementation
 - List of reoccurring issues – how many are repeating more than 2x a month
 - Open/close status on issues to determine new vs. old, single events vs. global issues to address
 - Need current examples of pain points with customers impacted



PHS Migration Program Update

Jason Greenberg

- Program Budget & Timeline
- Functional Status Summary
- Key Functional Updates
- SPRF Status
- Work Package Execution Status (WP1 R1 & R2)
 - WP1 Provider Update
- Voluntary Migration Volumes
 - Membership
 - Customers

- 2007 Spend On Target: Budget \$52.1M, Forecast at \$49.1M
- 2008:\$46.8M currently approved. Forecast with current scope at \$61.3M
- Total Program Spend (2007-2009): Forecast \$137.9M
- Upon reviewing the current forecast and associated risk for estimate growth, UCMG requested that the team provide execution options based upon different levels of capital expenditure in 2008
 - Team has identified 4 options and developed recommendation
 - Working with ACME leadership to finalize scope & timeline based upon 2008 capital allowance
- Executing toward the following timeline:
 - WP1 Q1 & Q2 2008 Delivery

		Q2 07			Q3 07			Q4 07			Q1 08			Q2 08			Q3 08			Q4 08			Q1 09			Q2 09			Q3 09			Q4 09			Q1 09			
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
PHS Commercial	WP1 R1	BRDs 7/13		Sys Deployment																																		
	WP1 R2	BRDs 9/28/07			Sys Deployment									Ops Ready			9/1/08 ACIS			4/1/09 ACIS																		
	WP2 R1	BRDs 9/28/07		Sys Deployment																																		
	WP2 R2	BRDs 1/25/08									Sys Deployment									Ops Ready			1/1/09 PRIME			4/1/09 PRIME												
	WP3 R1	BRDs 1/25/08									Sys Deployment																											
	WP3 R2	BRDs ~7/08												Sys Deployment									Ops Ready			6/1/09 Case Eff												
	WP 8	BRDs ~9/1/08												Sys Deployment																								
																			Voluntary Migration									Forced Migration										

Functional Area	Overall	Scope	Budget	Resource	Timeline
Analytics (Galaxy/Downstream Data)	Green	Green	Green	Green	Green
Analytics (PacifiCare Regional Data)	Green	Green	Green	Green	Green
Billing	Green	Green	Green	Green	Green
Broker & Commissions	Green	Green	Green	Green	Green
Broker Portal	Green	Green	Green	Green	Green
Calls	Yellow	Yellow	Yellow	Yellow	Yellow
Capitation	Green	Green	Green	Green	Green
Care Management	Yellow	Yellow	Yellow	Yellow	Yellow
Case Installation (ACIS)	Green	Green	Green	Green	Green
Case Installation (PRIME)	Green	Green	Green	Green	Green
Claim Transactions	Green	Green	Green	Green	Green
Client Migration	Green	Green	Green	Green	Green
Conversion Tools - UP	Green	Green	Green	Green	Green
Employer Portal	Green	Green	Green	Green	Green
Enrollment/Eligibility	Green	Green	Green	Green	Green
Exante	Green	Green	Green	Green	Green
Financial Configuration	Yellow	Yellow	Green	Green	Green
Member Portal	Green	Green	Green	Green	Green
Network Management (Fee For Service)	Yellow	Green	N/A	N/A	Yellow
Network Management (HMO Cap)	Green	Green	N/A	N/A	Green
Network Operations (HMO Cap)	Yellow	Green	Green	Yellow	Yellow
Network Operations (ppoONE Migration)	Yellow	Green	Green	Yellow	Yellow
PMO	Green	Green	Green	Green	Green
Pricing and Policy Initiatives	Green	Green	Green	Green	Green
Product_Regulatory	Yellow	Yellow	Green	Green	Green
Provider Portal	Green	Green	Green	N/A	Green
Rx Solutions	Yellow	Green	Yellow	Yellow	Yellow
Sales	Green	Green	Green	Green	Green
Specialty Care Services	Yellow	Green	Green	Green	Yellow
Testing	Green	Green	Green	Green	Green
Underwriting	Yellow	Yellow	Yellow	Yellow	Green

Health Care Analytics

- Significant increase in program forecast has been addressed for the Ingenix work for the RIMS and RX Solutions Data Migration projects
 - Decision was made to continue Galaxy and Gopher portions of the projects as this will deliver usable business functionality and has minimal work left to completion.
 - Downstream application development (eCR, UCAP, TADM) immediately deferred out of 2007.
 - This work has not been scheduled and will require new project to migrate the legacy RIMS/RX data to these marts.
 - A formal program budget Change Control illustrating the total impact of these decisions will be finalized in mid-October.
- PRDS is on track for a "go live" date of March 2008. UAT is in progress. Estimate is now in "lock down" status.

ECap

- 5/2008 deployment date for ECap remains unchanged
- We are currently in round 4 of system testing
- System testing is slightly behind schedule, but no impact to the deployment date-
 - Build of interface file feeds from CES, ACIS, PRIME and NDB have been completed
 - 21 of 25 post-implementation defect fix have been fully deployed
 - 2 NDB post-implementation defect fixes have been completed awaiting production check-out in December
 - 2 NDB defects remain open at this time
- Payment Management on track.
- Settlements Plus slight delay in the start of Unit Testing, but now back on track with milestones

Rx Solutions

- Go live date shifted 1 month to 4/1/08 due to realignment of RxSol & UT testing
 - Risk that delays to IDT desktop certification may delay go-live by one month (worst case)
- UHPS/RxS and Uniprise have agreed to a call model for Rx calls. Uniprise will take pharmacy calls for all PHS customers who voluntarily migrate to UNET. RxS call center application being reviewed. Operational model in progress.
- Completed Operational Model deep dives for all functional areas.
- Team recommending UHPS to assume ownership of strategy and execution of work package approach (enablement of Rx Solutions as PBM for PHS products on UP).

Total SPR Count - Active Projects Only

Baseline - SPRF Status	Total	%of Total
Green	48	84%
Yellow	7	12%
Red	2	4%
Grand Total	57	100%

Total SPR Count - All Projects

Baseline - SPRF Status	Total	%of Total
Blue	9	10%
Green	48	51%
Yellow	7	7%
Red	2	2%
Cancelled	15	16%
In Estimating	3	3%
On hold	10	11%
Grand Total	94	100%

- **Red:**
 - Provider Requirements for WP Approach (see subsequent slides)
 - Routing of PBH Claims via UFE

- **Yellow:**
 - Rx Solutions Connectivity & Rebate Accounting (Timeline)
 - Re-pricing SPRFs PacifiCare ASI -HCFA ppoONE Repricing (Timeline)
 - Work Package SPRFs (Timeline)
 - PHS Feeds to FSDB

Work Package	Overall Confidence Level	Scope	Budget	Resource	Timeline	Overall Status Comments	Yellow / Red Status Mitigation Plan
Work Package 1 - Release 1	Yellow	Green	Green	Green	Yellow	NDB IT has not signed off due to outstanding decisions around approach for provider contract loading.	JAD session scheduled week of 10/8
Work Package 1 - Release 2	Red	Yellow	Green	Green	Red	Provider requirements significantly delayed. Outstanding decisions/ approach around contract load in NDB have potential to increase scope & cost of program and require additional releases in NDB.	1) Alternative approach to remove NDB from day 1 critical path being assessed. 2) JAD session week of 10/7 to resolve outstanding items.
Work Package 2 - Release 1	Green	Green	Green	Green	Green	On Target	N/A
Work Package 2 - Release 2	Green	Green	Green	Green	Green	On Target	N/A
Work Package 3 - Release 1	Yellow	Green	Yellow	Green	Yellow	Capital constraints in 2008 may cause delay	Finalize 2008 budget, revise scope & timeline.
Work Package 3 - Release 2	Yellow	Green	Yellow	Green	Yellow	Capital constraints in 2008 may cause delay	Finalize 2008 budget, revise scope & timeline.
Work Package 8	Yellow	Green	Yellow	Green	Yellow	Capital constraints in 2008 may cause delay	Finalize 2008 budget, revise scope & timeline.

WP1, R1: All aspects on target except for Provider (related to issue with 4-19681)

WP1, R2:

- 4-20307 Install & Admin: Items Included: Structure Correlation Service, Member Data Mapping, Process State Identifier, Data feed requirements, Network Management Reconciliation Report, Branding
 - BRDs submitted 9/28 in PROMPT- open issues (1) being actively worked
- 4-19683 Service: Items Included: Portal enhancements, Service requirements to support the various call centers, Branding
 - BRDs submitted 9/28 in PROMPT- open issues (4) being actively worked will be identified
- 4-19681 Provider: Items Included: Provider Crosswalk, Items from WP R1 realigned to R2
 - Status- (see following slide):

Issues

- Resources: Competing priorities delayed initial involvement. Same resources working on WP1 R1 & R2
- Delivery of Requirements: Approach and corresponding requirements are delayed
 - Outstanding decisions around business strategy and software to be used delaying progress- impact WP1 R1 also
- Work Effort: Enhanced understanding of requirements and potential changes to NDB are larger and more complex than anticipated

Impact

- Q2 08 delivery may not be achievable. Multiple releases in Q3/Q4 08 would delay migration by 6 months

Mitigation

- JAD sessions being scheduled for week of 10/8 in NJ
 - Team to develop business & technology timelines
- Team assessing feasibility of a non-NDBN solution for day 1
 - Assessment to be completed 10/12
 - Decision to execute by 10/19
 - If viable, UT PMO to determine if it can be delivered in Q2

Business Area	Business Model Impact	Business Rqmt Impact	FTE Impact	Bus/Tech Impact	Risks and Issues
Behavioral Health	Low	Low	Low	Low	Low
UPCT	Medium	Low	Low	Low	Low
Cap	Low	Medium	Low	Low	Low
UPCT	Medium	Low	Low	Low	Low
Analytics	High	Medium	Low	Medium	High
Call	Low	Low	Low	Low	Low
PRDS	High	Medium	Low	Medium	High
Eligibility	High	Medium	High	High	High

Technology Area	Estimate Reduction Impact	Timeline Delivery Impact	Work Effort Impact	FTE Impact	Tech Area Impact	Delivery Schedule Risks
NICE	High	Low	Medium	Low	Low	Medium
EEMS	High	Medium	Low	Medium	High	Medium
eCap	Low	Low	Low	Low	Low	Low
UPCT	Medium	Low	Medium	Low	Medium	Low
CES	Medium	Medium	High	High	High	Low
Employer Portal (EeS)	High	High	Medium	Low	Medium	Medium