

Interviews for Summit County Service Area No. 5

Wednesday, April 10, 2019

Sheldon Richins Building Rm# 133, 1885 West Ute Blvd, Park City UT 84098

2 vacancies; 1 applicant

Wednesday, 4/10/2019

1:05 PM Jessica Taylor

The two vacancies are a result of Jessica Cartwright resigning, and Steve Sady's term expired 12/31/2018. He did not reapply.



**SKI &
SNOWBOARD**

SUMMIT COUNTY RESTAURANT TAX GRANT

**2019 FIS SNOWBOARD, FREESTYLE & FREESKI WORLD
CHAMPIONSHIPS MARKETING REPORT**

EXECUTIVE SUMMARY

- Summit County Restaurant Tax Grant awarded U.S. Ski & Snowboard \$200,000 to market the 2019 FIS Snowboard, Freestyle and Freeski World Championships
- The funds were allocated thus:
 - \$65,000: video production by Good Company, using athletes to showcase Summit County as a year round destination for a range of sports activities
 - \$135,000: promotion of the videos to three distinct audiences, primarily ex-Summit County to drive awareness of the events in February 2019 and to drive tune-in to those events on TV in the US and internationally, and to engage in conversations about the events online
- The audiences targeted were:
 - m/f under 25 across USA and internationally to join conversation online
 - m/f 25 – 35 across USA and internationally to join conversation online and tune in to TV broadcasts
 - m/f 35 – 65 across USA and internationally who are fans of Olympic sport to tune in to TV broadcasts

EXECUTIVE SUMMARY

Event Highlights

- 1,400 athletes from 45 nations took part
- Biggest winter sports event in Utah since 2002 Olympic Winter Games
- USA dominated medal table, winning 14 to Canada's 9 and Switzerland's 7
- 300 media and broadcasters from 20 nations provided global coverage, the biggest media attendance ever for these World Championships
- 6,000 fans braved the cold for the Opening Ceremony and Freeski Big Air at Canyons
- 480 volunteers gave up their time to staff 2,750 shifts
- 18,900, 572 digital impressions were generated by a dedicate event marketing campaign, funded by Summit County Restaurant Tax Grant, using athletes, competition venues and Summit County as her figures to promote events
- Core marketing asset was a long-form video shot in Summit County with 11 athletes which was viewed on Facebook alone 232,676 times with 58.34% of the audience watching the entire video. This is unprecedented. The average watch time of a Facebook video is 10 seconds and any video watched for over 15 seconds is considered strong. This tells us people want to engage with snowsports athletes, filmed in their home environments

EXECUTIVE SUMMARY

- Good Company filmed with 11 athletes across Summit County in summer / fall 2018 and produced one long form video (and teaser cuts) and 11 athlete focused edits, for use on the official World Champs channels and for athletes to share across their own channels
- In addition, U.S. Ski & Snowboard produced multiple ads for placement across a range of digital channels to:
 - create awareness among target audiences
 - educate those audiences
 - Direct calls to action to those audiences to generate tune in (to digital channels and broadcast output)
- Over the course of the campaign 20.9 million impressions were delivered in target territories across digital, social and outdoor reaching approximately 6,535,893 people an average of 2.2x
- The campaign outperformed industry benchmarks across the board and generated awareness and excitement for the events

EXECUTIVE SUMMARY

- Much of the online traffic was directing people to 2019worldchamps.com, the dedicated event website
- The campaign helped generate:
 - 335,000 page views from 151,000 unique visitors
 - The world tuned in:
 - USA 63.3%
 - Switzerland 7.59%
 - Austria 3.83%
 - Australia 3.51%
 - Canada 3.09%
 - Germany 2.19%
 - UK 1.92%
 - Norway 1.44%

ADVERTISING OVERVIEW // JAN-FEB 2019



18,794,041
Impressions

79,323
Spend

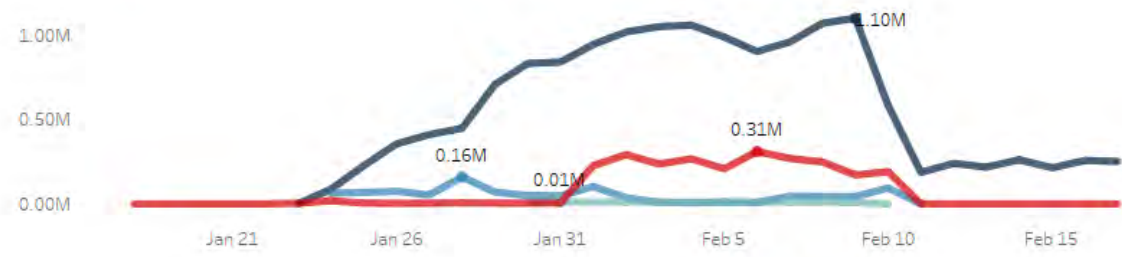
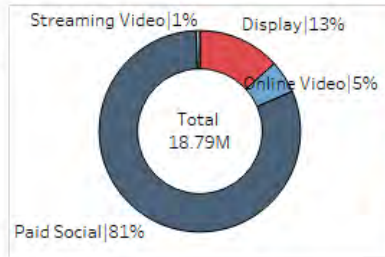
31,887
Clicks

\$2.49
Cost per Click

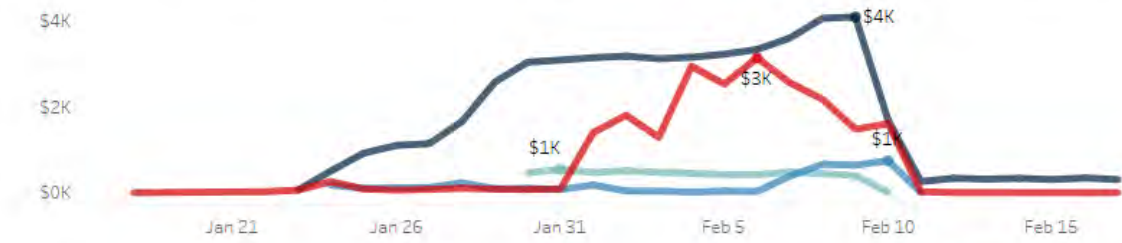
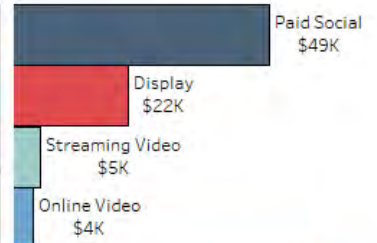
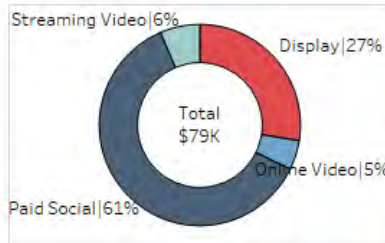
0.17%
Click Through Rate

2,408,020
Video Views

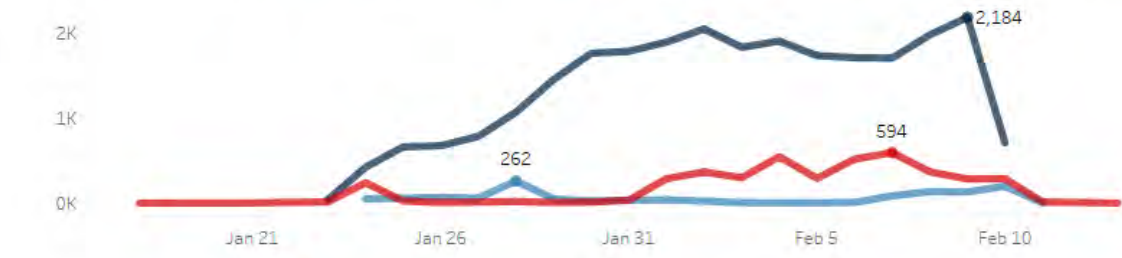
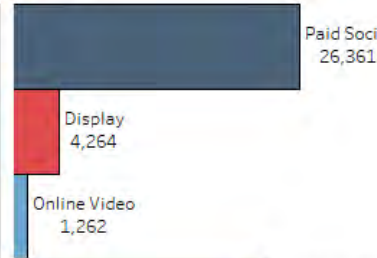
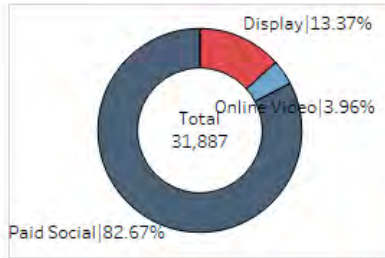
Impressions



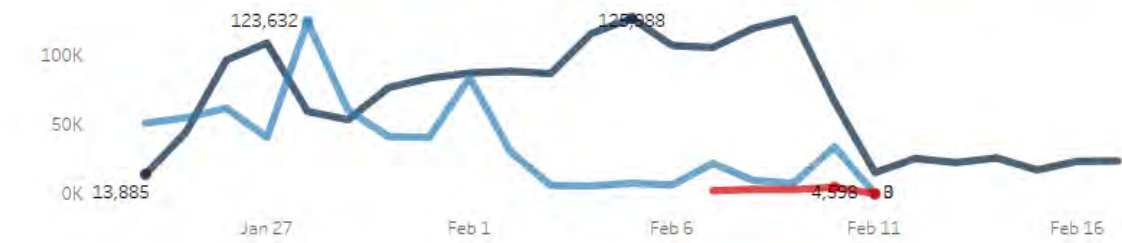
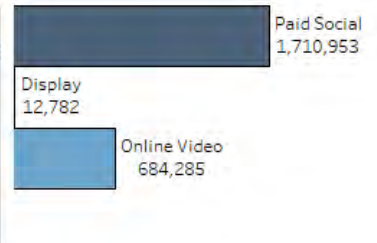
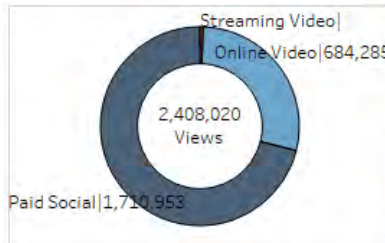
Spend



Clicks



Video Views



*Doesn't include Streaming, Snapchat or OTT views

Video Content



Long form video

McRae Williams

David Wise

 **U.S. Ski & Snowboard Team**
Sponsored · 

This February snowboard, freestyle and freeski athletes from 40 different countries will compete to be crowned World Champion. Check out all the action from the 2019 FIS World Championships on NBC.








Utah Welcomes the World!
February 1-10, 2019
2019 FIS World Championships [Learn More](#)

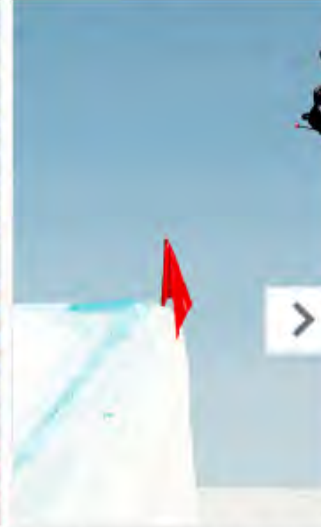
Utah Welcomes the World!
February 1-10, 2019
2019 FIS World Championships

   Rob Van De Langenberg, Toni Borg and 70 others 1 Comment 2 Shares

 **U.S. Ski & Snowboard Team**
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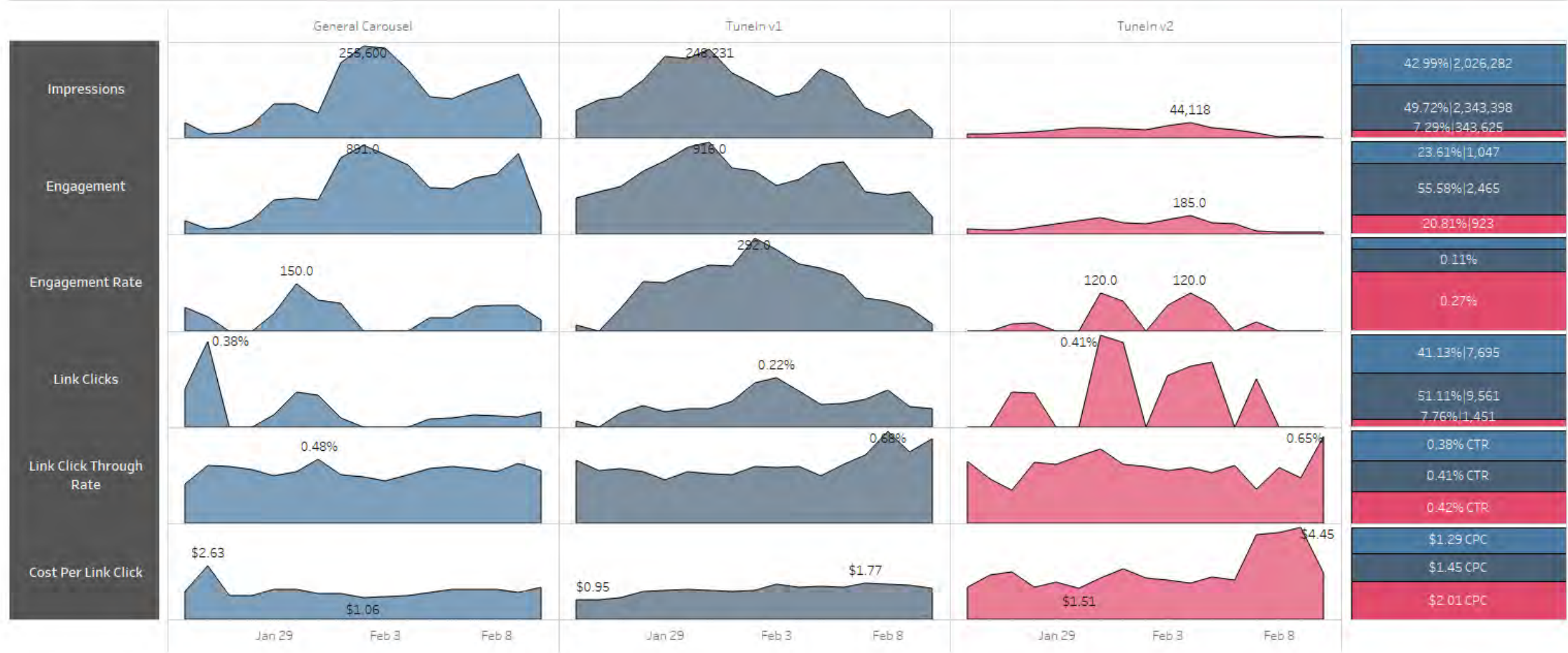


Utah Welcomes the World!
February 1-10, 2019
2019 FIS World Championships [Learn More](#)

Utah Welcomes the World!
February 1-10, 2019
2019 FIS World Championships

 Grant Duffey, Sally Beeton and 5 others

General Carousel	2,026,282 Impressions	\$9,946 Spend	1,047 Engagement	0.05% Engagement Rate	7,695 Link Clicks	0.38% Link Click Through Rate	\$1.29 Cost Per Link Click
TuneIn v1 & TuneIn v2	2,687,023 Impressions	\$16,726 Spend	3,388 Engagement	0.13% Engagement Rate	11,012 Link Clicks	0.41% Link Click Through Rate	\$1.52 Cost Per Link Click




 **U.S. Ski & Snowboard Team**
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The world's best snowboard, freestyle and freeski athletes will compete to be crowned World Champion. Check out the 2019 FIS World Championships on NBC this February.




2019WORLDCHAMPS.COM
Utah Welcomes the World! February 1-10, 2019 [Learn More](#)


  Brad Zeman, Jeremiah Top and 4 others 1 Comment 1 Share 652K Views

 **U.S. Ski & Snowboard Team**
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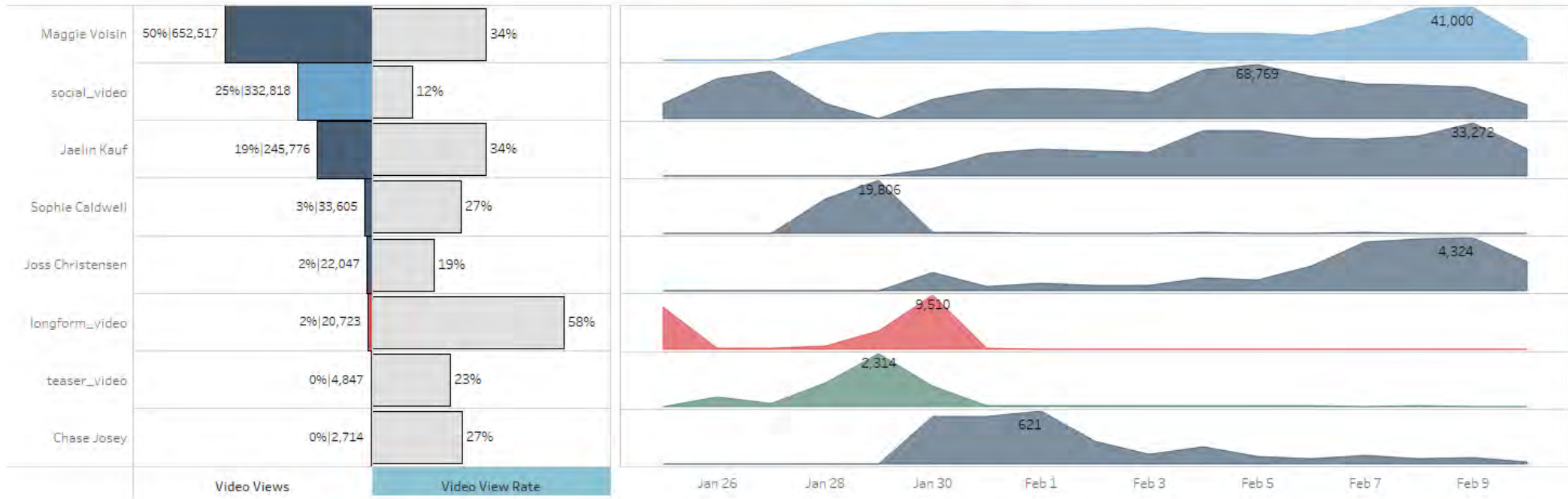
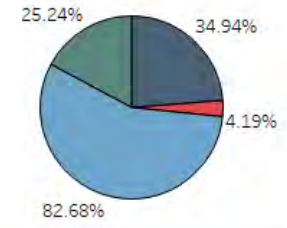
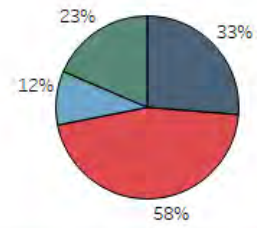
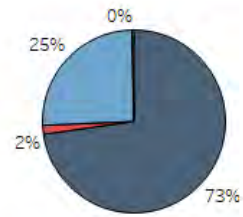
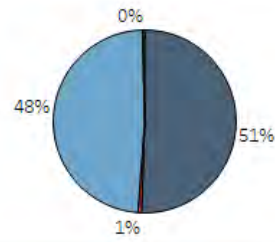
The world's best snowboard, freestyle and freeski athletes will compete to be crowned World Champion. Check out the 2019 FIS World Championships on NBC this February.



2019WORLDCHAMPS.COM
Utah Welcomes the World! February 1-10, 2019 [Learn More](#)

 Val Geist and Michele Gleich Roepke 4.9K Views

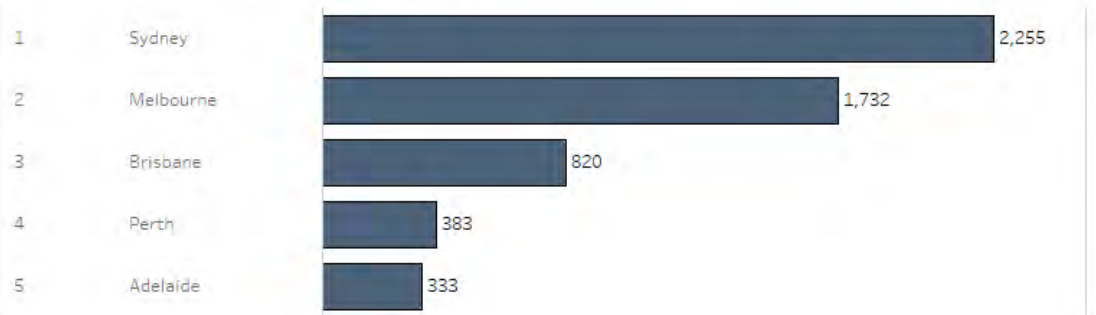
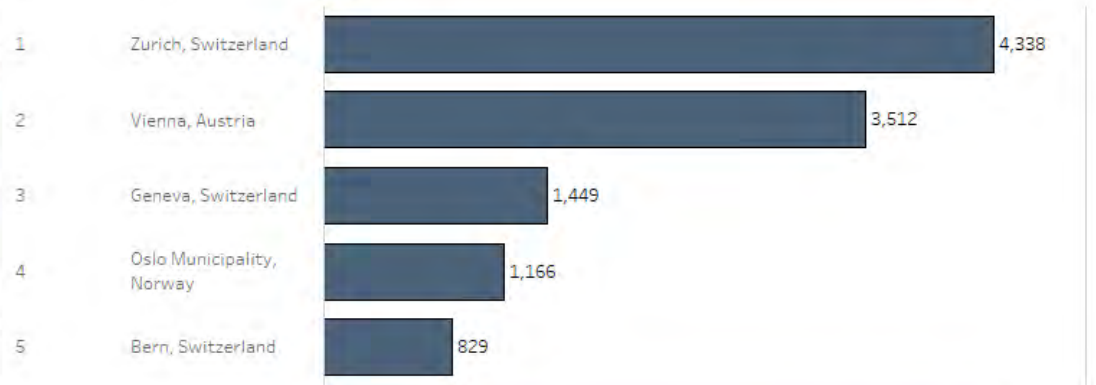
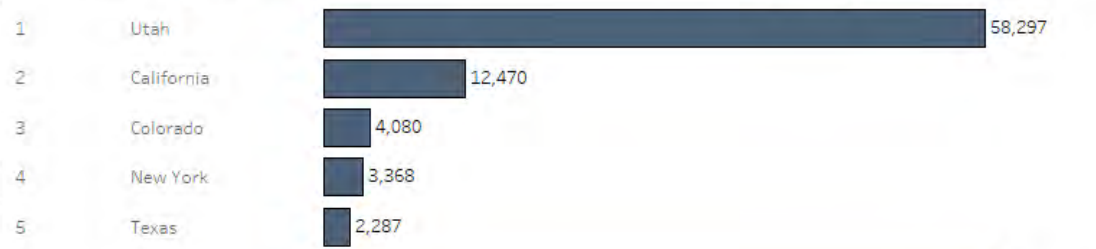
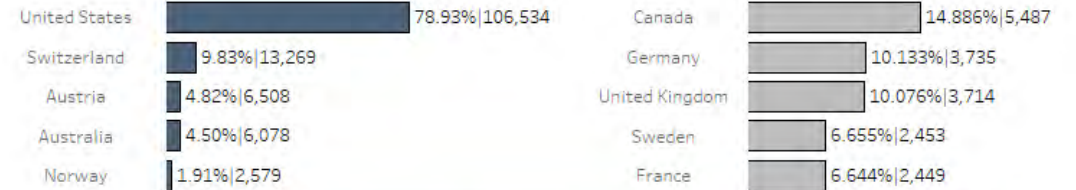
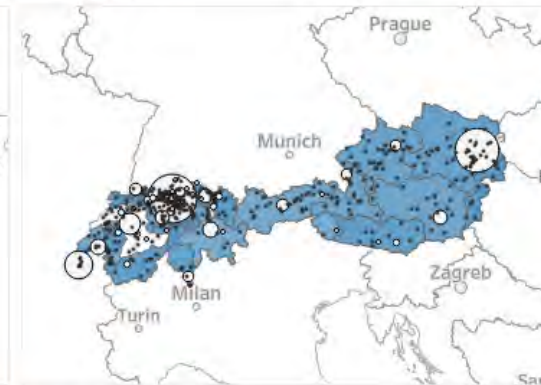
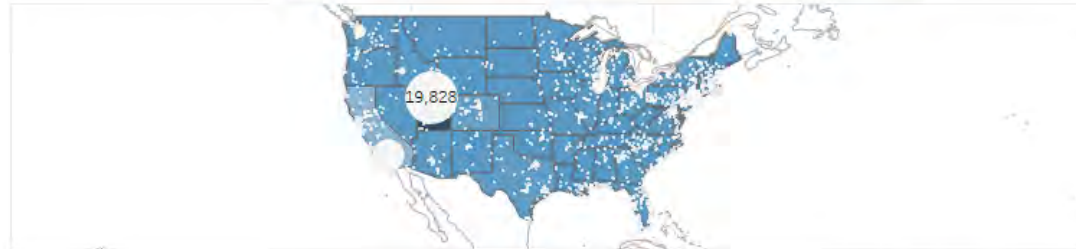
Grand Total	5,706,757 Impressions	1,315,047 Video Views	23% Video View Rate	36.77% Video Quartile 75 Rate
Athlete Video	2,884,244 Impressions	956,659 Video Views	33% Video View Rate	34.94% Video Quartile 75 Rate
Social Video	2,765,901 Impressions	332,818 Video Views	12% Video View Rate	82.68% Video Quartile 75 Rate
Longform Video	35,934 Impressions	20,723 Video Views	58% Video View Rate	4.19% Video Quartile 75 Rate
Teaser Video	20,678 Impressions	4,847 Video Views	23% Video View Rate	25.24% Video Quartile 75 Rate





SESSIONS BY GEOGRAPHY // JAN-FEB 2019




Traffic by Location (paid and organic)




 **U.S. Ski & Snowboard Team**
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Utah Welcomes the World! February 1-10, 2019 [Learn More](#)

 Ed Nickel, Liz Hallen and 15 others 2 Shares 35K Views



 **usskiteam**
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FEBRUARY
1-10, 2019

LIFE ON THE EDGE

  
PARK CITY / Solitude / DEER VALLEY

2019worldchamps.com



SUMMIT COUNTY RESTAURANT TAX

Ad - 3:16 © 2019 worldchamps.com/schedule

Like Dislike

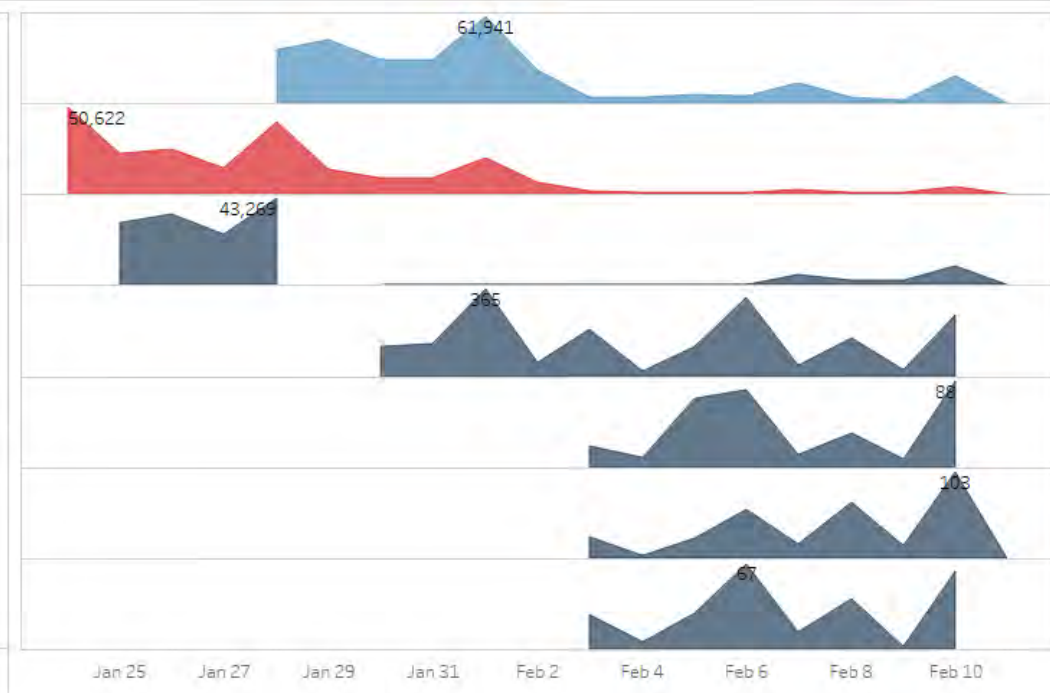
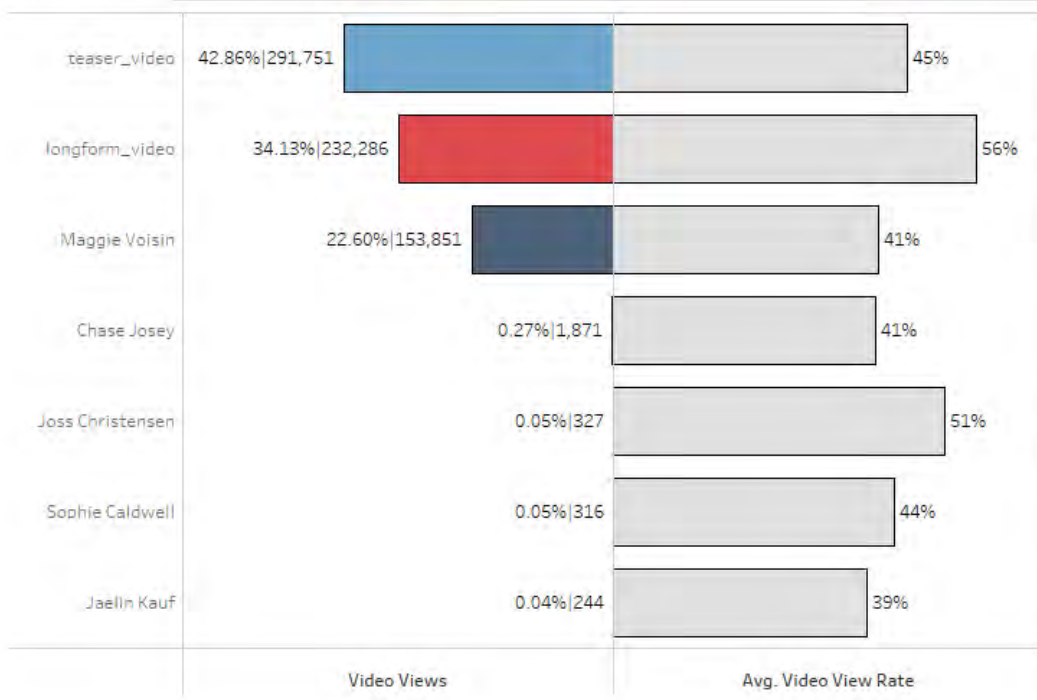
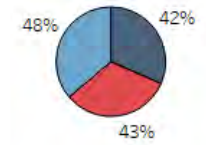
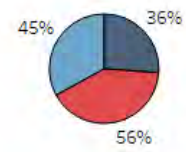
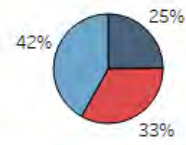
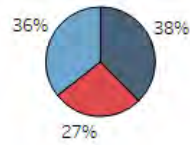
Skip Ad

Up next

AUTOPLAY

- 洋楽 ヒットソング BGM 名曲メドレー || みんなが知っている...
Pop Music
2.5K views
- Morning Coffee JAZZ & Bossa Nova Music Radio - Relaxing...
Relax Music
843 watching
LIVE NOW
- Sade Greatest Hits Full Album - The Best of Sade
Music Collection
Recommended for you
- Hawaiian Cafe Music - Relaxing Guitar Music - Background...
BGM channel
Recommended for you
- Ramsey Lewis featuring Earth, Wind & Fire - Sun Goddess
DaBigMotor
Recommended for you
- Jazz Hip Hop VS Trip Hop "Gramatik Style" (Funk, Jazz,...)
Groove Companion
Recommended for you
- The 100 Greatest Soul Songs of

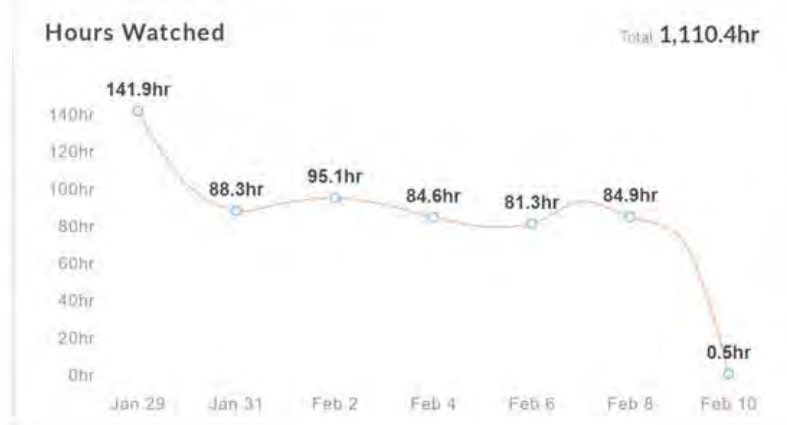
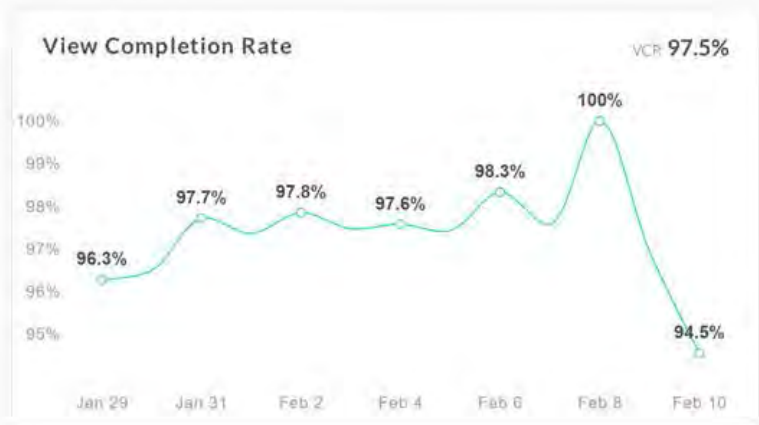
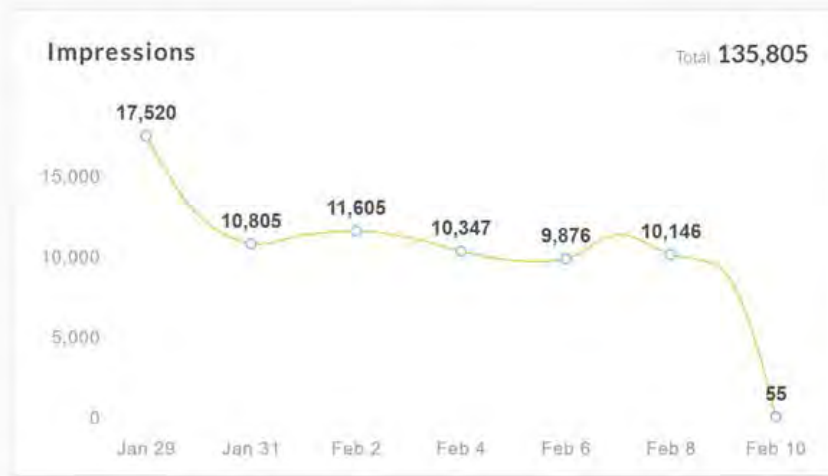
Athlete Video	257,414 Impressions	156,609 Video Views	42% Avg. Video View Rate	47.48% Avg. Video Quartile 75 Rate
Longform Video	282,930 Impressions	232,286 Video Views	56% Avg. Video View Rate	42.55% Avg. Video Quartile 75 Rate
Teaser Video	378,052 Impressions	291,751 Video Views	45% Avg. Video View Rate	47.73% Avg. Video Quartile 75 Rate



115,082
Impressions

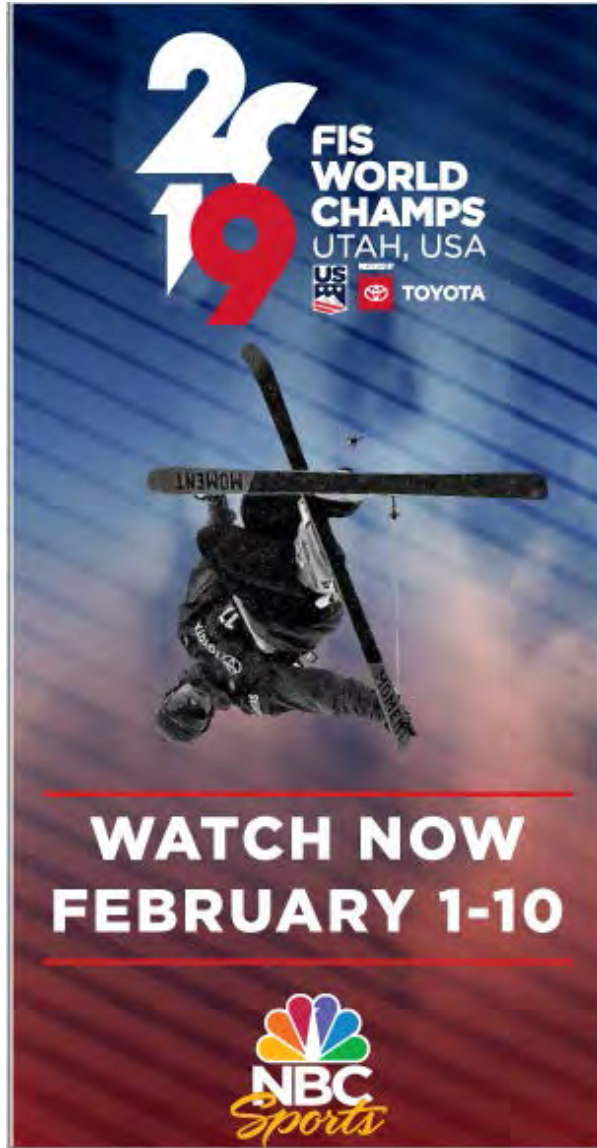
\$5,064
Spend

\$44.00
CPM




Top Premium Publishers


Publisher	Impressions
sling	28,059 (20.66%)
xumo	16,957 (12.49%)
ROKU	12,441 (9.16%)
A&E	11,505 (8.47%)
PLUTO TV	10,136 (7.46%)
Discovery	8,644 (6.37%)
CRACKLE	6,277 (4.62%)
FOX	4,605 (3.39%)
HGTV	3,637 (2.68%)
Outside	2,424 (1.78%)
newsy	2,074 (1.53%)
vudu	1,274 (0.94%)
en	1,208 (0.89%)
fubo TV	799 (0.59%)
WATCH ESPN	474 (0.35%)
tubitv	355 (0.26%)
scripps	326 (0.24%)
VIZIO	314 (0.23%)
Bloomberg	228 (0.17%)
CBS	25 (0.02%)
VH1	12 (0.01%)
SCRIPPS	6 (0.00%)
VH1	3 (0.00%)
SCRIPPS	2 (0.00%)
FILMRISE	1 (0.00%)
Others	24,019 (17.69%)



2019 FIS
WORLD
CHAMPS
UTAH, USA

  TOYOTA

WATCH NOW
FEBRUARY 1-10



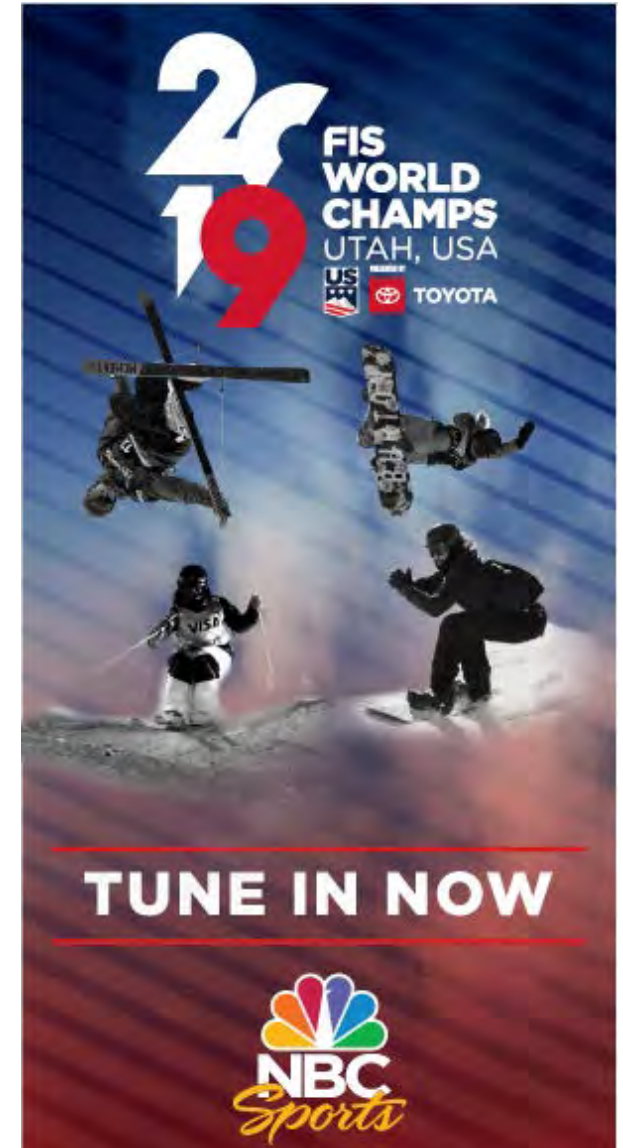


2019 FIS
WORLD
CHAMPS
UTAH, USA



  TOYOTA

TUNE IN NOW






2019 FIS
WORLD
CHAMPS
UTAH, USA

  TOYOTA

TUNE IN NOW



REFERENCE SHEET

Session - a group of interactions one user takes within a given time frame on your website.

Pageview - A pageview is recorded every time a page is viewed. Or, more technically, a pageview is recorded every time the Google Analytics pageview tracking method is executed.

Session Duration - This is the sum of the time on page for all pageviews in a visit. Or, more accurately, it is the difference between the time they viewed the first page and last page in a visit.

Bounce Rate - Bounce Rate is the percentage of single-page sessions (i.e. sessions in which the visitor only visited one page on a site without interacting with the page).

Pages Per Session – The average number of pages viewed during a session on your website.

Impression - Counted each time your ad is shown on a search result page or other site on the Google Network.

Click - When someone clicks your ad, like on the blue headline of a text ad.

Click through Rate - A ratio showing how often people who see your ad end up clicking it.

Engagement – The total number of reactions, comments, and shares a social post earns.

Engagement Rate - The rate at which users engage with your content. Total Engagements/Reach.

View Rate – The percentage of users who either clicked on a video ad or watched at least 30 seconds of the video.



To: Summit County Council
From: Aaron W. Newman, Mental Health & Substance Abuse Programs
Date: April 2nd, 2019
Item: RFP for the Mental Health and Substance Abuse Local Contracted Provider
Process: Presentations for Consideration of Contract Award, No Action Required This Meeting

Introduction:

Pursuant to Utah Code Ann. (“UCA”) §§17-43-201 & 301 et. Seq., the Summit County Council serves as the Local Mental Health Authority and the Local Substance Abuse Authority. In this capacity, **the Council is charged with the selection and contracting of the Local Contracted Provider or Providers (LCP)**. Since 1996, Valley Behavioral Health has served as the LCP for Summit County. The current contract with Valley Behavioral Health ends on August 31st of this year (entered into in 2003), the decision was made to engage in a Request For Proposal (RFP) process and explore options of providing services to Summit County residents. A committee was formed to examine the needs and gaps in services within Summit County this past August.

Working with the Utah Division of Substance Abuse and Mental Health (DSAMH) and the Utah Behavioral Health Council, the RFP was released in January of 2019. After reviewing the submissions, the committee selected the University of Utah Health Plans and Optum as the two finalists to present to the Council on April 10th. At the April 17th Council Meeting, the Committee will present their recommendation to the County Council for approval in their capacity as the Local Mental Health Authority and the Local Substance Abuse Authority.

Change in Service Model

For the past 24 years, Summit County has contracted with Valley Behavioral Health (VBH) to provide services to the Medicaid and unfunded residents through a Primary Mental Health Provider (PMHP). This model served as a “one stop shop” with VBH providing all services mandated by the state and relied on its own ability to provide staff and services to meet the needs of Summit County. It was determined due to the increased demand for services that the County needed to explore other means of

service delivery. After reviewing several models, it was determined that the best means of providing quality services to the residents of Summit County was to utilize a provider which operated in a network model. This would allow for an increased number of providers which would reduce wait times and expand service offerings by no longer relying on one entity to provide all services. This is accomplished through a Managed Care Organization (MCO) or an Accountable Care Organization (ACO). The additional advantage of utilizing these organizations is the increase ability to coordinate behavioral health care with physical health care and primary health physicians (PHP).

Mandated Services

The Utah Legislature has mandated in UCA Title 17, Chapter 43, Local Human Services Act, that all Local Authorities provide directly, or through an LCP, local substance abuse services (UCA §17-43-201) and local mental health services (UCA §17-43-301) to adults, youth, and children within its boundaries. The selected LCP will be expected to meet all of the services as mandated by statute and DSAMH directives (the “Mandated Services”). During the bidding process, should a bidder not be able to provide a service at this time, they were to indicate so and explain why. **Please note, it was explained to the bidders that should they not have a provider who could perform a mandated service, they would be expected to work with a provider identified by the County.** The Mandated Services include:

1) UCA §17-43-201 (Substance Abuse Services)

- (a) For persons convicted of driving under the influence in violation of UCA §41-6a-502 or §41-6a-517, conduct the following as defined in UCA §41-6a-501:
- (i) A screening;
 - (ii) An assessment;
 - (iii) An educational series; and
 - (iv) Substance abuse treatment.

2) UCA §17-43-301 (Mental Health Services)

- (i) A screening;
- (ii) Inpatient care and services;
- (iii) Residential care and services;
- (iv) Outpatient care and services;
- (v) 24-hour crisis care and services (Pending MCOT & Crisis-Line Change);
- (vi) Psychotropic medication management;
- (vii) Psychosocial rehabilitation, including vocational training and skills development;
- (viii) Case management;
- (ix) Community supports, including in-home services, housing, family support services, and respite services;
- (x) Consultation and education services, including case consultation, collaboration with other County service agencies, public education, and public information; and

- (xi) Services to persons incarcerated in the County jail or County correctional facility.
- 3) In addition to the Mandated Services, DSAMH, through authority granted in UCA §17-43-201 and §17-43-301, provides additional directives each year in which the County and LCP must abide. Those directives for FY19/20 are as follows:
- A) DSAMH FY19 Directives: Combined Mental Health & Substance Abuse Directives**
- 1) LCP shall perform a strength-based assessment on each client, which complies with the Medicaid Provider Manual and current Administrative Rule as described in R523.
 - 2) The LCP's Clinical Records shall be maintained using the approved protocol as defined by the DSAMH checklist and the Office of Licensing chart monitoring tools.
 - 3) The LCP shall participate with key community partners. (Alliance, CONNECT Summit County, Summit County Clubhouse, school districts, local practitioners, local governmental agencies, local non-profits, etc.) Participation will be evidenced through stakeholder feedback and applicable records (minutes, written communication, such as letters or email, etc.).
 - 4) The LCP shall establish and/or expand Adult, Youth, and Family Peer Support Services within Summit County. Certified Peer Specialists and Family Resource Facilitators who are employed by the LCP are to be integrated meaningfully into all levels of agency process and service, effectively utilizing peer and family voice. The LCP shall seek ways to maximize effective on-going training for peers and peer supervisors specific to the unique make-up, resources and structure of each local area or demographic group. The LCP shall develop appropriate policies and procedures consistent with DSAMH standards to provide guidance and support for Certified Peer Support Specialists and Family Resource Facilitators.
 - 5) The LCP shall promote integrated programs that address an individual's substance use disorder, mental health, intellectual/developmental disabilities, physical health, and criminal risk factors as described in UCA §62A-15-103(2)(vi). The LCP shall use a Holistic Approach to Wellness by:
 - (i) Identifying tobacco use in the assessment,
 - (ii) Providing services in a nicotine free environment,
 - (iii) Providing appropriate smoking cessation services and resources (*including medication*),
 - (iv) Implementing a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB, and
 - (v) Training staff in recognizing health issues often seen in the behavioral health population, and provide information and referrals as appropriate.
- B) DSAMH FY19 Directives: Suicide Prevention, Intervention and Postvention**
- 1) During FY20, the Department and LCP shall continue to implement, monitor and report on the County's prevention, intervention, and postvention efforts. (*QPR, Hope Elevated, etc.*)
 - 2) LCP records must contain a safety/crisis plan when clinically indicated which can be quickly and easily accessed and updated as needed.
 - 3) The LCP shall develop a plan for coordination of follow-up care based on best practices with inpatient and emergency department services for clients being treated for a suicide related event.

- 4) LCP shall ensure that all individuals within the care of the Summit County jail or a correctional institution (together, the “**County Jail**”) will have the appropriate safety plan in place before being turned over to the County Jail.

C) DSAMH FY19 Directives: Drug Testing Program Requirements

- 1) All drug testing conducted by the LCP shall comply with the requirements outlined in Administrative Rule R523-15.
- 2) The LCP will be required to perform, either directly or through a subcontract, all Regular Urinalysis (“**UAs**”), related to the Summit County Drug Court (the “**Drug Court**”).
- 3) All UA testing shall be completed within 72 hours. Unless extraordinary circumstances are at play, as determined by the Summit County Attorney, failure to meet this deadline may be considered grounds for termination of the LCP contract.
- 4) LCP shall ensure that all Drug Court related UA test results are transmitted to the appropriate Drug Court or Probation staff member.

D) DSAMH FY19 Directives: Justice Reinvestment Initiative

- 1) The LCP shall participate, with the Department, in all State and Local justice reform efforts.
- 2) The LCP shall adhere to Evidence-Based Practice in Community Treatment.
- 3) The LCP shall provide ongoing training to Drug Court staff on criminogenic risk, need, and responsivity.

E) DSAMH FY19 Directives: Juvenile Justice Reform

- 1) In accordance with the Juvenile Justice Amendments (*2017-HB 239*) changes to the Juvenile Justice System, the LCP will participate in all State and Local Juvenile Justice Reform efforts.

F) DSAMH FY19 Directives: Recovery Support Services

- 1) The LCP shall provide Recovery Support Services (“**RSS**”), which include culturally and linguistically appropriate services that assist individuals and families working toward recovery from behavioral health problems. The LCP shall incorporate a full range of social, legal, and other services that facilitate recovery, wellness, and linkage to and coordination among service providers, and other supports shown to improve quality of life for people in and seeking recovery, as well as for their families.
 - (a) RSS includes access to evidence-based practices such as:
 - (i) Supported Employment,
 - (ii) Education,
 - (iii) Housing,
 - (iv) Assertive Community Treatment,
 - (v) Illness Management, and
 - (vi) Peer-Operated Services.
 - (b) RSS may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment, but seek support services. If the LCP needs to supplement its RSS with community partners, it will do so in coordination with the Department.
- 2) All RSS services provided by the LCP shall be documented and reported in the Substance Abuse Mental Health Information System (“**SAMHIS**”), recovery support data specifications file as indicated in the data specifications and as approved and directed by DSAMH.

G) DSAMH FY19 Directives: Billing Requirements

- 1) Services rendered by the LCP shall be reimbursed based on the approved service rates listed in the most current RSS manual located on the DSAMH website at <https://dsamh.utah.gov/provider-information/patr-org-program-manual/>
- 2) Services that are provided outside of the approved list of services will not be reimbursable. Services that are submitted under “billing contracts” through SAMHIS will be billed automatically through the DSAMH KiSSFLOW system. All other invoices submitted for billing must be submitted monthly through the DSAMH KiSSFLOW system. Each RSS funding program must be submitted separately and in accordance to the appropriate funding program code.
- 3) Pass-through State and Federal funds run through the Department are to be invoiced on a date to be determined by the LCP to the Department.

H) DSAMH FY19 Directives: Mental Health Services Directives

- 1) The LCP shall use the “unfunded” State General Funds when no funding is available.
- 2) The LCP will utilize the Outcomes Questionnaire (“**OQ**”), or the Youth Outcomes Questionnaire (“**YOQ**”), and will share the results of the OQ/YOQ with the client and incorporate such into the clinical process, as evidenced in the chart (*excluding children age five and under*).
- 3) The LCP shall collaboratively work with other agencies and local non-profits to provide Supported Employment services that assist an eligible recipient in obtaining and retaining competitive, integrated, and meaningful permanent employment.
- 4) The LCP shall utilize Wraparound Facilitation (*as defined by the Utah Family Coalition and/or nationally accepted evidence based Wraparound Facilitation Definition*) and Multi-Agency Collaboration in the provision of services for Children, Youth and Families. The LCP shall participate in USH Adult and Children Continuity of Care meetings.
- 5) The LCP shall provide Adult Outplacement services which provide wrap-around supports and recovery enhancement to the patient. The LCP shall document such within the plan of care.
- 6) The LCP shall oversee all written requests for Children’s Outplacement Funds and shall ensure that such are submitted to DSAMH for each individual client.
- 7) The LCP shall provide Mental Health Early Intervention services (“**MHEI**”), for children and youth who may or may not have a Serious Emotional Disturbance (“**SED**”) designation, but are at risk to become so without early intervention services. Service provision is limited to Family Resource Facilitation, MCOTs, and School-Based Behavioral Health. Temporary Assistance for Needy Families (“**TANF**”) funds focused on School-Based Behavioral Health for counties with the highest rates of intergenerational poverty shall be allocated according to the previous schedule and tracked by the LCP and submitted to DSAMH.

I) DSAMH FY19 Directives: Substance Use Disorder Treatment Services Directives

- 1) The LCP, with the Department and Park City Hospital, shall provide Naloxone education, training and assistance to individuals with opioid use disorders (“**OD**”), and when possible to their families, friends, and significant others.
- 2) The LCP and Department shall ensure clients are allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program (“**OTP**”), and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual’s OUD.

- 3) The LCP and Department shall ensure medications available by prescription or office-based implantation shall be permitted for treatment if it is appropriately authorized through prescription by a licensed prescriber or provider.
- 4) In all cases, the LCP shall allow medications to continue for as long as the prescriber or treatment provider determines that the medication is clinically beneficial.
- 5) The LCP and Department shall ensure that clients will not be compelled to taper or abstain from medications as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

J) DSAMH FY19 Directives: Drug Court Program

- 1) The LCP will serve as the primary therapist for the Summit County Drug Court Program (the "**Drug Court Program**").
- 2) The LCP, along with support from the County, shall be certified by the Administrative Office of the Courts in accordance with Utah Judicial Council Rule 4-409, and retain certification throughout the contracted period. This rule is available online at: <http://www.utcourts.gov/resources/rules/ucja/ch04/4-409.htm>
- 3) The LCP shall serve Drug Court participants identified as High Risk/High Need by using a validated criminogenic risk tool.
- 4) The LCP shall oversee documentation of High Risk/ High Need and shall ensure that said documentation is placed/ maintained in each participant's clinical record.
- 5) The LCP shall submit annually to DSAMH all Drug Court Service Reports or any alternative data collection system adopted by DSAMH and as requested to the DSAMH Justice Program Manager.
- 6) The LCP shall disclose any and all participant fees related to Drug Court participation (*Treatment, case management, drug testing, court fees etc.*) to individuals prior to their admission.
- 7) The LCP and County shall have no prohibitions against Medication Assisted Treatment ("**MAT**"), or a requirement to be abstinent from medications used in addiction treatment in order to enter the Drug Court Program, or to progress or complete the Drug Court Program.
- 8) The LCP and County shall ensure each Drug Court Program team member, who interacts or has decision-making authority regarding the participants of the Drug Court Program attend a minimum of eight hours of continuing education per year. The continuing education shall have a focus on substance use disorders.
- 9) The LCP shall use Drug Court funds for treatment, case management, recovery support and drug testing expenses only.
- 10) The LCP's case managers shall ensure that Drug Court participants meet with the Department of Workforce Services and/or to determine eligibility for Medicaid, other public insurance or commercial insurance.
- 11) The LCP shall ensure that Drug Court participants receive assistance throughout their episode of care with Medicaid enrollment.
- 12) The LCP shall ensure that public funds are the payor of last resort for Drug Court participants.
- 13) The LCP acknowledges that Drug Court funding shall be determined in accordance with statute by the Director of the Department of Human Services, the Director of the Department of Corrections and the State Courts Administrator.
- 14) The LCP shall notify the Department of Corrections and the State Courts Administrator of any court changes including court closures, changes in judges, drug court staff, or court coordinators.

K) DSAMH FY19 Directives: Women's SAPTBG set aside

- 1) The LCP shall provide services to pregnant women, and women with dependent children in need of substance use disorder treatment through SAPTBG funds.
- 2) SAPTBG funds shall be used by the LCP used to provide treatment services at the I.0, II.1, II.5, III.1, III.3, and III.5 American Society of Addiction Medicine Levels of Care, as defined in the American Society of Addiction Medicine's Criteria 3rd Edition;
- 3) SAPTBG funds shall be used by the LCP to provide any of the following services:
 - (a) Gender-specific substance use disorder treatment and other therapeutic interventions for women that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting,
 - (b) Child-care while the women are receiving services,
 - (c) Therapeutic interventions for the children which may address their developmental needs, potential for substance use disorders, and issues of sexual and physical abuse and neglect,
 - (d) Sufficient case management to ensure the women and their children have access to the services listed above,
 - (e) Regular Urinalysis testing, and
 - (f) Ongoing assessment of the children who are in the mothers and children's programs that will include, but not be limited to: developmental adjustment; motor skills; cognitive skills; health, including immunization history; interaction with mother and other adults; language and general affect.

L) General Funds for children living with parents receiving residential substance use disorder treatment services

- 1) The LCP shall provide the following services to children living with parents receiving residential substance use disorder treatment services:
 - (a) Room and board.
 - (b) Therapeutic day care to address developmental needs, the potential for substance use disorders, and issues of sexual and physical abuse and neglect.
 - (c) Case Management and transportation for behavioral and physical health care services.
 - (d) Ongoing assessment that will include, but not be limited to:
 - (i) developmental adjustment,
 - (ii) motor skills,
 - (iii) cognitive skills,
 - (iv) health, including immunizations history,
 - (v) interaction with mother and other adults, and
 - (vi) language and general affect.

M) DSAMH FY19 Directives: Women's Funds

- 1) The LCP shall provide evidence-based treatment and/or recovery support services for women. Priority shall be given to women referred or involved with the Utah Division of Child and Family Services.

N) DSAMH FY19 Directives: Opioid Treatment and Recovery Support Funds

- 1) The LCP shall provide evidence-based treatment and recovery supports services for individuals with OUD.
- 2) The LCP shall submit, with the Area Plan, a local needs assessment, detailed description of planned OUD services and a budget.

- 3) The LCP shall be able to provide OUD using MAT.
- 4) The LCP shall support innovative telehealth in rural and underserved areas to increase the capacity of communities to support OUD prevention and treatment.
- 5) The LCP shall implement or expand access to clinically appropriate evidence-based practices for OUD treatment, particularly, the use of MAT, i.e., the use of FDA-approved medications (*e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine*) in combination with psychosocial interventions.
- 6) The LCP shall provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings.
- 7) The LCP shall enhance or support the provision of Peer Support and other RSS designed to improve treatment access and retention, and support long-term recovery to include relapse and suicide prevention efforts.

O) DSAMH FY19 Directives: Substance Use Disorder Prevention Services Directives

Affective September 1, 2019, the Department will incorporate these services into Local Authority operations and as such, are not a part of this RFP.

P) DSAMH FY19 Directives: School-Based Programs

- 1) The LCP shall provide School-Based Behavioral Health services within the North Summit School District, South Summit School District, Park City School District and the Weilenmann School of Discovery at a capacity to meet the current demand for service. The LCP will be free to contract with any private school located in Summit County on its own terms so long as no funds associated with this RFP are utilized.
- 2) The LCP shall provide school-based behavioral health programs and services for youth 18 years of age and younger who are currently enrolled in the public-school system. The goal of these coordinated services will be to prevent youth who may be at-risk for developing a mental illness from disrupting his or her school placement. The programs and services shall be focused on maintaining the youth/child in their regular school setting, providing services in the school (described below), and collaborating with school staff. The LCP is expected to work with all three Summit County school districts and the Weilenmann School of Discovery to provide services in as many schools as possible.
- 3) As services are provided at school locations, many of the outcome measures will come from the district's or school's metrics (i.e.; attendance rates, office referrals, academic measures, on track for graduation, and teacher reports). The LCP shall be required to utilize the YOQ to demonstrate client progress with the goal of decreasing symptomology that in turn will support the student having increased access to academics.
- 4) The LCP shall work to penetrate into the community and reach families who do not have or have limited access to behavioral health services. Additional services can be leveraged through the LCP's system of care which could include:
 - (i) off/on-site medication management,
 - (ii) psychological assessment, and/or
 - (iii) access to a continuum of behavioral health services including,
 1. in- home services,
 2. partial day-treatment,

3. day-treatment, and/or
4. respite services.

Summit County Priority Needs

Of the Mandated Services listed above, the County has identified five critical needs for improving behavioral health in Summit County. The LCP will be expected to focus on improving the quality of care for these priority needs while ensuring all Mandated Services are provided for. The selected LCP will work with the Summit County Health Department and the Summit County Mental Wellness Alliance to develop community relationships to supplement the delivery of these selected services. The five priorities are, in descending order:

- 1) Outpatient Care
- 2) Case Management
- 3) Psychotropic Medication Management
- 4) Incarcerated Services (Including Drug Court)
- 5) Crisis Care

In addition to these mandated services and Priority Needs, the Committee has identified 6 additional services for the selected LCP to provide.

- 1) The LCP shall provide a minimum of 1 clinician (Ph.D. or Psy.D) to provide school-based psychoeducational consultation, and education services, including assessments of school aged youth.
- 2) The LCP shall provide mental health and substance abuse services in Spanish through a minimum of two clinicians with a preference of four.
- 3) The LCP shall have a minimum of two days a week in which office hours conclude at 8:00pm. Starting times for these days will be at the discretion of the LCP.
- 4) The LCP shall provide access to a psychiatrist or psychiatric APRN to consult on treatment, medications, and diagnosis within the County Jail.
- 5) LCP shall have a commitment to the Strategic Plan and its success. This will be demonstrated by participation and membership on the following Strategic Plan committees (*Committee Descriptions can be found beginning on page 18 of the Strategic Plan*):
 - (a) Local Director
 - (i) Mental Wellness Executive Committee
 - (b) Staff
 - (i) Alliance Steering Committee
 - (ii) Alliance Access & Capacity Committee
 - (iii) Communities That Care Committee
 - (iv) Latino Mental Health Committee

The LCP shall provide, as part of its crisis care, in partnership with the Department, a plan to participate in the Summit County Stabilization Team. This team is used to supplement the services of the state Mobile Crisis Outreach Team program.

Selection Process

Beginning in August of 2018, the RFP Selection Committee was established to create the RFP document and to participate in the selection of two finalists. Committee Membership included:

- i. Beth Armstrong, *People's Health Clinic*
- ii. Roger Armstrong, *Summit County Council*
- iii. Nann Worel, *Park City Council*
- iv. Margaret Olson, *Summit County Attorney*
- v. Ed Rutan, *CONNECT*
- vi. Dusty Frisby, *Summit Pediatrics*
- vii. Ellen Silver, *Jewish Family Services*
- viii. Shad Sorenson, *South Summit School District*
- ix. Lizeette Zurita, *Holy Cross Ministries*
- x. Aaron Newman, *Summit County Health Department*
- xi. Rich Bullough, *Summit County Health Department*
- xii. **DSAMH Advisor:** Brent Kelsy, *DSAMH*
- xiii. **RFP Advisor:** Brandon Hatch, *Davis Behavioral Health*

Of the members listed above, Roger Armstrong, Ellen Silver, and Ed Rutan recused themselves from the selection process due to possible conflicts of interests. Brent Kelsy from DSAMH served to guide the committee on what the State's expectations and requirements would be for the new LCP. Brandon Hatch also served as an advisor to the committee. Brandon is the CEO of Davis Behavioral and an Oakly native.

The role of the Summit County Council will be to make the final decision on who will be selected as the Summit County Local Contracted Provider for Behavioral Health Services. On April 10th, the Council will hear two 30-minute presentations from both Optum and the University of Utah Health Plans followed by 15-minutes for Council questions. Should the RFP Committee have any new questions for the bidders those questions will be funneled through the Summit County Attorney, Margaret Olson or her designate.

After the presentations, the RFP Committee will convene on April 12th to develop a recommendation for the Council to Consider. This recommendation will be presented to the Council at the April 17th meeting for possible adoption. At that point, the Council may elect to accept the recommendation of the RFP Committee or choose the other bidder. Once a decision by the Council has been made, a resolution will be required to begin the awarding and contracting of the LCP contract. Once a contract has been finalized, the Utah Division of Substance Abuse and Mental Health will need to review the contract before either party may enter into it. It is expected that this will be concluded during the month of May, with the selected LCP taking overall operation on September 1st.

Attachments

Attached to this report, in an order determined by a coin toss, are:

- 1) Submitted Bid for Optum
- 2) Additional Questions from the RFP Committee and Optum's Response
- 3) Submitted Bid for the University of Utah Health Plans
- 4) Additional Questions from the RFP Committee and University of Utah Health Plans' Response
- 5) Committee's Overall Score Sheet from the Submitted Bids
- 6) A Copy of the RFP

- END OF REPORT -



**Substance Use Disorder Treatment
& Mental Health Services for
Medicaid, Uninsured, and Non-
Medicaid Summit County Residents**

RFP #SUCO20197552

Date

March 13, 2019

Contact

Blaine Bergeson
VP, Business Development
Optum
T: (602) 821-4631
Blaine.bergeson@optum.com

**Optum’s Response to Summit County Request for Proposals
Substance Use Disorder Treatment & Mental Health Services for Medicaid, Uninsured,
and Non-Medicaid Summit County Residents**

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- Attachment – Section II.6 Summit County Business License (Optum)

Cover Letter



March 13, 2019

Clay Coleman

Summit County Procurement Office

RE: RFP #SUCO20197552 for Substance Use Disorder Treatment & Mental Health Services

Dear Mr. Coleman:

United Behavioral Health, Inc. (hereafter referred to in our proposal as "Optum Summit County" or "Optum")¹, is pleased to submit a response to the Request for Proposals (RFP) #SUCO20197552 for Substance Use Disorder Treatment & Mental Health Services for Medicaid, Uninsured, and Non-Medicaid Summit County Residents. This letter serves as notice of our intent to provide services as outlined in this RFP upon selection. We confirm our ability to meet the minimum qualifications as demonstrated in our responses to the questions in Form A – Governance & Oversight Narrative. Furthermore, we affirm our willingness to enter into an agreement with the County and agree with all County Assurances should the County offer a service contract. In compliance with the requirements of this RFP, please see the following information below:

Full Name	United Behavioral Health, Inc. (Optum Summit County or Optum)
Legal status	Corporation
Business Address	11000 Optum Circle Eden Prairie MN 55344 (Corporate) 2525 Lake Park Boulevard, West Valley City UT 84120 (Local)
Phone Number	(602) 821-4631

Optum has been a leader in providing specialty substance use disorder (SUD) and mental health services for more than 30 years and across 32 states and the District of Columbia. We currently serve approximately 35.2 million individuals in both commercial and publicly funded behavioral health programs through our provider network of approximately 186,000 providers nationwide. Since July 2011, Optum Salt Lake County has partnered with the Salt Lake County, Division of Behavioral Health to manage the Salt Lake County Medicaid Plan for Behavioral Health Services including the management of SUD Medicaid Services.

In the proposal that follows, we describe our program design and our experience, both of which support Optum as the organization best qualified to become the Summit County Local Contracted Provider serving the mental health and substance use disorder needs of individuals and families. We welcome the opportunity to provide additional information or respond to questions.

I affirm that as Vice President, Optum Finance, I am an officer of the company and have the authority to commit our proposal to the requirements of this RFP. My signature reflects our wholehearted commitment to providing the services outlined in this RFP to meet the needs of Summit County residents. If you would like clarification or have any questions regarding our proposal, please reach out to Blaine Bergeson, Vice President, Business Development, Public Sector at (602) 821-4631 or blaine.bergeson@optum.com.

Sincerely,

Paul M. Miller
Vice President, Optum Finance

¹ The legal name of the Offeror is United Behavioral Health, Inc. and has adopted the brand "Optum" as part of a leading health services business, and references to the experience of Optum include the experience of the Offeror and its affiliates.

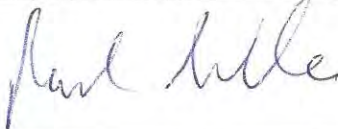
Attachment A

Agency Confirmation

Attachment A
Agency Confirmation
Mental Health & SUD Contract 2019

Legal Name of Agency:			
United Behavioral Health, Inc.			
Doing Business As (if applicable):			
NA			
Address:	City	State	Zip Code
1100 Optum Circle (corporate)	Eden Prairie (corporate)	MN (corp)	55344 (corporate)
2525 Lake Park Boulevard (local)	West Valley City (local)	UT (local)	84120 (local)
RFP Contact Person		Telephone Number	
Blaine Bergeson, Vice President, Business Development, Public Sector		(602) 821-4631	
E-Mail:			
blaine.bergeson@optum.com			

I certify that to the best of my knowledge the information contained in this proposal is accurate and complete and that I have the legal authority to commit this organization to a contractual agreement. I realize the final funding for any service is based upon funding levels and the approval of the Summit County Council.

Agency's Authorized Representative	Date
Paul M. Miller	03/13/2019
	Title or Position with Agency
	Vice President, Optum Finance
Signature of Authorized Representative	
	

Additional Individual to keep informed of the RFP Status.	
RFP Contact Person	Telephone Number
Ronnii Shelby	317-698-1664
E-Mail:	
ronnii.shelby@optum.com	

Executive Summary

Executive Summary

We are pleased to present this proposal in response to Summit County’s RFP # SUCO20197552 for and on behalf of United Behavioral Health, Inc. (UBH), hereafter referred to by the brand name “Optum Summit County” or “Optum”. As a managed care organization (MCO), our mission is to help people live healthier lives and to help make the health system work better for everyone. We know that helping people live healthier lives requires understanding the capabilities, needs and goals of each individual, family and community, then working collaboratively to develop local systems of care that are effective, efficient and sustainable. We recognize the commitment and significant progress Summit County has made in addressing the behavioral health needs of its residents. We look forward to adding our experience and resources to support the County in its stated goal, fostering an “accessible, efficient, client centered, and integrated system of care for uninsured (Medicaid) individuals residing in Summit County.”

Selecting an MCO as the LCP...Expanding Access, Choice, and Accountability

Optum is offering to become Summit County’s Local Contracted Provider (LCP) and to work in partnership with the Health Department and local stakeholders to transform the County’s public mental health and substance use disorder (SUD) services into a comprehensive, integrated system of care. Having an MCO as the LCP will bring significant changes, because services will no longer be provided and managed by a single organization. The same inpatient and outpatient services will still be available, but a whole network of highly qualified behavioral health professionals will provide the treatment. Optum will ensure that the right services are available, accessible and appropriate when clients need them, monitor and oversee the progress of individual clients, and be accountable for the overall quality and effectiveness of Summit County’s behavioral healthcare delivery system.

The new system design will:

- Allow all qualified Summit County behavioral health providers to serve the County’s clients
- Offer Summit County clients a choice of treatment providers and where they go for services
- Improve the County’s ability to hold its LCP accountable for system improvements and ensure transparency in system oversight of the LCP’s operations
- Eliminate constraints and potential conflicts by separating clinical treatment and financial management, laying the foundation for reinvesting savings and expanding the array of services
- Increase the voice, choice and involvement of Summit County clients and stakeholders in the evolution of their mental health and SUD services delivery system

A Brief Summary of the RFP Submission

To more fully understand Optum’s responses to questions posed in the Request for Proposals (RFP), it is important to have a “big picture” understanding of how managed behavioral healthcare would work in Summit County. In this Executive Summary we will provide an overview of our proposal. In the next section, we will describe in more detail the benefits Summit County can expect from selecting Optum as its LCP.

In reading the proposal, it is important to understand that while Optum has broad-based experience in managing mental health and SUD services across the country, those who are part of Summit County’s delivery system today are the experts about its unique strengths, needs and challenges. Therefore, the *ideas discussed throughout this proposal are suggestions*—a starting point for change. Local input is critical, and we look forward to adapting our program to best serve Summit County. One other key point is that *change will be incremental*. A true system of care evolves over time, reflecting the priorities of local stakeholders.

Optum Summit County

If awarded the contract, Optum will establish Optum Summit County (OSC), a team of experienced behavioral health clinicians and administrative staff. Most of the OSC team will be based in Salt Lake County, traveling to Summit County to meet with clients, providers, County staff and other stakeholders. The OSC Director will be headquartered in Summit County and have three key responsibilities: ongoing

collaboration with the Health Department and other key stakeholders; supporting Summit County providers; and coordinating the work of the OSC team. Upon contract award, we will hire a licensed behavioral health professional with significant Utah-based experience to fill the Director position.

Recruiting and Supporting a Provider Network

Optum staff will not provide direct treatment services to clients. Instead, Optum Summit County will recruit and contract with all qualified and willing behavioral health providers in the County, creating a network that will offer Summit County clients and families a choice between more providers than ever before. We have already contacted all Summit County's behavioral health providers, some of which are already contracting with Optum to serve people with UnitedHealthcare insurance. With the approval of the Health Department, we also can expand the Summit County network to include providers in adjacent counties, including Salt Lake, which will give local residents even more choice.

Overseeing the Treatment Services Provided

Optum's most important responsibility is to ensure that clients treated by our provider network receive effective and appropriate mental health and SUD services, and that those services help them move forward in their recovery journey. Our Utilization Management team provides a bridge between clients and their outpatient treatment providers through individualized care coordination to ensure the client is linked to appropriate step-down services upon discharge. Quality Management staff generate and analyze an array of monthly reports designed to identify clients who are not progressing well in treatment; clients at risk of admission/readmission; providers whose outcomes are not as good as those of their peers; over/under utilization of particular treatment services; regional variances in service utilization; and similar data. OSC Quality Management Committees will offer stakeholders an opportunity to review QM data reflecting our performance and that of the delivery system and offer ideas for improvement.

For clarity, in our proposal we differentiate between work that will be the responsibility of our direct employees [Optum Summit County (OSC) team] and work (generally direct treatment services) delegated to our network providers.

Technology and Reporting Infrastructure

OSC will introduce NetSmart, an integrated information technology platform that has been customized to support clinical and administrative managed care functions in Utah, including service authorizations and referrals, complaints and grievances, quality and financial tracking and claims payment. We will create a dedicated OSC website where, following review by the County, stakeholders will be able to view selected reports and access Optum's award-winning on-line library of health and wellness materials for clients, families and professionals. We also will introduce virtual visits, which will enable clinicians to offer therapy to their clients using secure video-based technology.

Financial Considerations

Optum is proposing to contract with Summit County on a full-risk basis, which means that that OSC will be responsible for ensuring that all eligible Summit County clients receive the mental health and SUD services they need, for reimbursing providers for treatment services provided to clients, and for covering our own administrative costs—even if actual costs exceed the funding that Optum receives from Summit County. The funds budgeted for provider reimbursement are called the medical budget.

An MCO often changes the way in which services are utilized, resulting in medical budget savings, especially in the initial contract years. For instance, typically inpatient and residential bed days decrease and the number of outpatient services increases. In most risk-based arrangements, medical budget savings remain with the MCO. However, our experience shows that savings come not only from the work of the MCO, but also through the collaborative efforts of the entire behavioral health community. Therefore, Optum believes in reinvesting savings to strengthen local systems of care.

As part of our proposal to Summit County, Optum is offering to invest 100% of any medical budget savings into a Community Reinvestment fund that can only be spent with the County's approval on the expansion of behavioral health treatment services or supports in Summit County. Specifics on determining savings and approving Community Reinvestment Fund expenditures will be incorporated into our contract. In other Optum public sector contracts including Salt Lake County, Community

Reinvestment dollars have played a major role in expanding services. Examples of Community Reinvestment projects are highlighted throughout our proposal.

Optum: Committed to Summit County

Optum has been administering mental health and SUD services in Salt Lake County since July 2011. We believe that our experience, expertise, and infrastructure will enable Optum Summit County to make measurable changes that support the goals of the Summit County Mental Wellness Strategic Plan. In partnership with local stakeholders, we will endeavor to meet or exceed the following objectives:

- Goal I: Expand community access to mental health & substance abuse programs and services in Summit County: By the end of the first contract year, Summit County clients will have access to a network that has expanded to *more than 50 outpatient behavioral health professionals*, assuring clients access to expanded diversity, choice, and continuity (decreased clinician turnover) in programs and services.
- Goal II: Increase prevention and education around mental health & substance abuse in Summit County During the first contract year, Optum Summit County staff, in coordination with the Department, Summit County Connect and the Mental Wellness Alliance, will offer at least six training sessions for clients, families and the general public that focus prevention and education about mental health and substance abuse, including areas such as suicide prevention, Mental Health First Aid, and how to access publicly funded behavioral health benefits in Summit County.
- Goal III: Ensure success and sustainability of mental health & substance abuse programs and services in Summit County. Optum Summit County will deposit 100% of any medical budget savings into a restricted Community Reinvestment account which will be used only with approval of the Health Department to fund behavioral health initiatives in the County, such as mobile crisis outreach services, jail diversion or other identified service priorities.
- Goal IV: Establish systems to support life during recovery and reintegration into the community. Optum's Peer Support Specialists will work with local advocacy groups, providers and County staff to expand the availability of peer support services. By the end of the first contract year, network providers will have established at least five new peer support positions, including one Family Resource Facilitator.
- Goal V: Ensure equity of mental health & substance abuse programs and services for Latino Community members. Optum Summit County currently has letters of intent (LOIs) with four agencies that include Spanish-speaking therapists. To further ensure ongoing equity of programs and services, our staff will meet quarterly with the Latino Committee Workgroup of the Summit County Mental Wellness Alliance to request feedback and share data on the service utilization of Spanish-speaking clients.

As your LCP, we will work with you to significantly improve the health and wellbeing of Summit County clients. We welcome the opportunity to clarify any questions about our proposal.

Additional Services

Additional Services

What Does It Mean to Contract With Optum?

Every state, every county, every contract is different. At Optum, we take great pride in our ability to customize each of our programs so they become an integral part of their local healthcare delivery systems. For instance, even though Summit County and Salt Lake County would be supported by the same infrastructure and many of the same staff, the programs would be different, reflecting different county priorities, different covered benefits, different network providers, different community resources, different ethnic and cultural groups...and on and on.

We are committed to transparency and accountability in our public sector programs. Our determination to work with local stakeholders and implement an individualized program for every contract is the foundation for our successful public/private partnerships across the country.

However, even though we do customize key components of the way in which we interact with each delivery system, our internal operations remain much the same. Those key functions—the essence of how we manage care—are a big part of what a state or county gets by contracting with Optum. And yet sometimes it is difficult to provide a clear picture of how we do what we do...and what it means to our contract partners and their constituents.

So we have pulled together a few of the questions we most frequently receive about Optum's approach to managing mental health and substance use disorder services. We hope the answers will provide additional background information and context for our responses to the Summit County Request for Proposals, which follow. We look forward to responding to additional questions from Summit County's Selection Committee.

Managed Care from the Clients' Perspective

Everyone is legitimately concerned about what introducing Optum into a delivery system will mean to clients and their families. The simple answer is that it allows clients enrolled with Optum to access treatment the same way that people do when they have healthcare insurance through their employer:

- How can I get outpatient mental health or substance use disorder treatment: A client or family member has three choices:
 - Call Optum's toll-free number and ask for assistance in selecting a treatment provider. A clinician will help you decide what kind of service is most appropriate and which network provider you prefer. If you want help making the appointment, the clinician will contact the provider and help you select a convenient time.
 - Go online to Optum Summit County's dedicated website. You can pull up the list of network providers and call your preferred provider directly to make an appointment.
 - Call or walk into the behavioral health provider of your choice. First, you should ask if the provider is part of the Optum public sector network. If the provider is in network, you can make an appointment.
- **What if the provider I want to see is not part of the Optum network?** You can ask the provider to call the Optum toll-free number and enroll as a network provider or you can call the Optum toll-free number and ask the Optum Provider Relations staff to recruit the provider into the network.
- **What if I need a provider with special services, special training or special credentials?** You can always call Optum's toll-free number and ask for assistance in finding a provider that offers what you need, such as a particular treatment modality like cognitive behavioral therapy, an expert in helping with people who have a particular condition like dually diagnosed developmental disabilities and mental illness, or therapists who specialize in serving children and adolescents. To facilitate appropriate referrals, Optum tracks the specialties of each network provider. If we do not have an in-network provider with the appropriate specialization, we will work with you to find a provider that can provide the necessary treatment and execute a contract (called a Single Case Agreement or SCA) with that provider specifically for you.

- **Do I have to get approval before receiving treatment?** Not many services require prior authorization, but if you need a service that requires authorization by one of Optum's utilization managers (such as inpatient or residential care), the provider will submit the request.
- **What if I am no longer satisfied with my current provider?** You typically get better only when you have a strong, trusting relationship with your provider. If you are dissatisfied with your therapist, you should first try to resolve the issue with the therapist. If that doesn't work, you can call Optum's toll-free number and request referral to another provider or just make an appointment with the network provider of your choice.
- **What kind of contact will I have with Optum?** Optum clinicians will reach out telephonically to you if you are identified as being at risk of needing crisis intervention, hospitalization, re-hospitalization or some other intensive treatment service. Optum clinicians also may contact you if you have just been discharged from a hospital or residential care facility. Through these calls, the clinician will help you get an appointment with a behavioral health professional or deal with other issues, such as a need for food or housing. Our goal is to help you avoid hospitalization or other negative experiences. Unless you are at risk or call Optum, most contact will be either through printed materials or information posted on the dedicated Optum Summit County website.
- **What can I do if I am dissatisfied with the way I am being treated?** Optum provides comprehensive complaint and grievance system that is tracked and monitored to ensure that all issues are addressed in a timely manner. Responses are shared with the client who registered the complaint or grievance. The entire process is explained in the Member Handbook which will be available on the dedicated Optum Summit County website and provided in writing if you call the Optum Summit County dedicated toll-free number and request one.
- **What will I be charged for services?** Your services will be reimbursed by Medicaid or other county, state or federal funds. While you have no responsibility for paying for your treatment, you do have certain rights and responsibilities. They are clearly outlined in the Member Handbook. Perhaps most important, you have an obligation to keep appointments you make, to participate in developing your treatment plan, and to complete the steps you agree to as part of that plan.
- **Why should I use mental health or substance use disorder services?** If you find yourself wondering whether treatment services are worthwhile, you should talk with a peer support specialist. You can ask your provider to refer you to a peer on staff or you can call the Optum Summit County toll-free number and ask to talk with one of our peer support specialists. A peer support specialist is a person who has real life, personal experience with mental illness and/or substance use and has improved through appropriate treatment services and supports. Using that life experience, a peer support specialist can help you understand treatment from a different perspective. The peer support specialist also can offer advice on how to deal with daily challenges. Summit County's program is built on a recovery philosophy, which means that we know people can and do control their mental illness and substance use disorders, learn to manage their symptoms, and live independent, healthy and productive lives.

Managed Care from Behavioral Healthcare Providers' Perspective

In many ways, being part of a public sector behavioral health network is very similar to being in the network of a health plan that has contracted with a major employer to provide coverage for its employees and their families.

- **What is the biggest adjustment that providers must make as they become part of an Optum public sector network?** If providers have always been reimbursed on a lump sum monthly basis, they have to learn how to submit claims, but most providers have contracts to serve people with insurance through their employer, so they are already familiar with claims processing. Providers who have never before worked with Medicaid clients may have to learn how to comply with documentation requirements and other regulations that are unique to Medicaid. Optum provides training online and in classroom settings and also offers on-site support for new providers when necessary.
- **How is prior authorization done?** Typically only 24-hour levels of care and a few other intensive treatment services require prior authorization (a request for approval of reimbursement submitted before care is initiated) or concurrent review (a request for approval of reimbursement for continued stay or an extension of ambulatory services). To request prior authorization or

concurrent review, providers can either (a) submit required information online via our provider portal or (b) call our toll-free number and share required information with an Optum clinician. Service authorizations are required as part of many different kinds of healthcare reimbursement arrangements, not just managed care. For example, state Medicaid agencies often contract with specialty companies to review authorization requests for inpatient and other specific services for clients who are not in managed care plans.

- **What if a provider disagrees with a decision made by Optum?** All network providers, and any out-of-network provider treating an enrolled client, have access to our complaint and grievance process. We will share information about complaints, grievances, and their resolution regularly with Summit County.
- **What about reimbursement rates?** Optum's policy is to pay providers at a level at least equal to the state's Medicaid reimbursement. In some instances, such as single case agreements or difficult-to-find specialties, we may reimburse at a higher level. We do negotiate rates with some providers, especially 24-hour facilities such as inpatient hospitals and residential treatment facilities.

What are the key elements of a successful managed care program?

People who are not part of Optum's day-to-day operations may not realize the variety and complexity of skills, strategies and resources that must come together in an effective managed care program. It's important for a contract partner like Summit County to understand the full scope of diverse components because County staff may be able to leverage Optum's expertise in additional ways. Key elements of Optum's approach to managed care include:

- Individualized Needs Assessment
 - Empower each client and their family to define goals and priorities
 - Consider each client and evaluate their individual behavioral, social, and functional needs
 - Understand cultural preferences and specialized benefits/resources available
 - Help clients choose and connect with providers to receive needed services and supports
- Personalized Care Management
 - Enable providers and community based partners to serve each client with a holistic approach
 - Ensure complex/high risk individuals receive personalized, consistent, and efficient care management
- Provider Network
 - Based on covered services and those needed to improve client health and wellbeing, contract with qualified providers that offer convenient access to needed services and supports
 - Recognize provider capabilities and work to address their strengths and challenges in providing unified behavioral health services to their patients
 - Incentivize providers to collaborate and communicate with their patient's care teams in order to direct individual patient care that is clinically, socially, and culturally appropriate
- Operational/Administrative Infrastructure
 - Employ qualified and experienced staff
 - Ensure staff is trained on the unique aspects of the program, population served, benefits covered, local system of care, providers, regulatory agencies and community partners
 - Ensure development and use of policies and procedures to meet all requirements of the program
 - Information Technology and related resources to support operations and meet reporting and analytic needs
- Technology, Data, and Resource Support
 - Use technology, data and specialized resources to support an internal/external multidisciplinary care team that unifies the delivery system to support holistic care
 - Streamline and simplify the provider experience and be seen as a preferred partner in care delivery, coordination, management and system transformation
 - Provide reporting and analytics to regulatory agencies, the County, providers, health plan staff and the community at large to identify successes and areas for improvement
- Stakeholder/Community Collaboration and Engagement

- Identify and collaborate with people or organizations that are aware of community needs, provide services or supports that help residents live healthier lives, understand the local system of care and are willing to help assess, plan or participate in programs or activities that improve the health of the community

What are the differences between managed care models?

The term “managed care” covers a variety of organizational structures and reimbursement arrangements. Each managed care approach has its own characteristics and a different impact on the delivery system, including the clients and families who access treatment services and supports. The process of changing between models also has some implications for a delivery system. As they consider the options available to Summit County through this procurement process, it’s important that the Selection Committee, Health Department staff and County Commissioners understand the difference between their current model and Optum’s proposed approach as well as how the transition between the two can be accomplished smoothly.

A Staff Model versus a Network Model

In a staff model of managed care, the same entity employs the clinical professionals who deliver treatment services and supports as well as the staff who provide managed care administrative functions. Valley Behavioral Health (VBH) has provided a staff model of managed care in Summit County for a number of years. One of the major impacts of this program design is that it typically requires that clients receive services only from clinicians employed by the managed care organization. The staff model limits client choice and also can be a barrier to timely access to necessary services.

The network model of managed care separates managed care administrative functions from care delivery by developing a contracted network of qualified providers. A network model requires the managed care entity to credential providers to ensure they have the required training and licensing.

MCOs like Optum, that operate using network models usually recruit and contract with as many qualified providers as possible, especially when they are new to a delivery system. A well populated provider network ensures that clients have timely access to services, have access to the most appropriate level of services needed, and can select a provider in their home community.

In addition to providing clinical treatment services and supports, network providers also are contractually responsible to provide information the MCO can use to monitor provider performance using parameters such as: length of time between the time a client requests an appointment and receives it; improvement in client functioning; sharing information with other providers serving the client, including primary care practitioners; and following a recovery-oriented approach to treatment planning and service delivery. Network providers also agree to comply with Optum’s policies and procedures, including utilization management protocols, orientation and in-service training, documentation standards, record audits, and claims submission requirements.

In a network model, the MCO works collaboratively with providers to address concerns about access, quality and cost. We provide regular reporting to providers comparing their performance to others that provide similar services, and we work together to improve their performance and our own. This collaborative approach helps ensure we meet the needs of our clients and have an effective working relationship between the provider agency and their staff, the clients they serve, and Optum.

How will Optum collaborate with Valley Behavioral Health (VBH) to ensure a smooth transition?

VBH has been part of Optum’s provider network in Salt Lake County since July 2011. The two organizations have learned how to work together well, which should facilitate the transition from Valley as the Local Contracted Provider (LCP) to Optum.

Because VBH has been both the managed care entity and the direct treatment provider, Optum—or any other organization selected to become Summit County’s next LCP—will require a significant amount of information to ensure a smooth transition for clients. County staff may be required to encourage VBH to provide the required documentation, including:

- An electronic file containing a record of all services provided to all enrolled clients since September 2017
- A list of all clients receiving services as of July 1, 2019
- A list of all clients who have received crisis support services or inpatient care since July 1, 2019 which will serve as the first list of at risk clients
- Clinical discharge summaries for all clients receiving services as of August 1, 2019, which will be given to each client's selected future provider

The change from VBH to Optum may require clients in treatment to select a new provider. The number of clients impacted will be determined by how many, if any, VBH-employed providers open a private practice in Summit County and participate in our network.

On contract award we will review our transition plan with VBH and outline the steps necessary to ensure a smooth transition. We completed a similar transition process with VBH when Optum became Salt Lake County's LCP in 2011. In addition, in the years since 2011 when a staff member who was carrying a high caseload left VBH or VBH terminated services for a large number of clients, we have implemented similar transition plans.

Additional Insight into Key Questions

Choosing Optum as a new partner for Summit County raises a number of questions which are not fully addressed in responses to the RFP due to page limitations. To make the best decision, the Selection Committee may need a more comprehensive understanding in a number of key areas.

How will Optum develop a comprehensive provider network to serve Summit County clients?

Optum currently contracts with hundreds of behavioral health providers across Utah. Most of our contracted providers live and practice in counties contiguous to Summit County. The contracts that Optum executes with its network providers are specific about the population to be served, clients' coverage type (Medicaid, Medicare, Commercial/Employer Sponsored or Tricare), regulatory requirements and the fee schedule paid for each coverage type.

Since release of RFP #SUCO20197552, Optum staff have been recruiting providers to treat Summit County residents who are covered by Medicaid or who are uninsured. We typically offer providers the same fee schedule for the uninsured as we do for Medicaid. Because of our contract with Salt Lake County, many of our Utah providers are already registered with the Department of Health, and most of them are located in Salt Lake or nearby counties. We are explaining the opportunity in Summit County to all these providers so they know Summit County clients may come to one of their offices for service. A number of these providers have expressed an interest in providing services in Summit County, either in the space offered by the county or opening an office(s) in the county. Those providers have the ability to provide a broad array of services and are among the largest, most effective providers in the state. Many pointed out that because VBH used their own employees to provide treatment services in Summit County, there has been little incentive for other providers to open offices there. However, a change in LCP offers significant opportunities for them as well as for Summit County clients.

Today, we contract with 32 behavioral health providers in Summit County who treat people whose services are not reimbursed through Medicaid or other county funds. For almost 24 years, they have had no opportunity to serve Medicaid clients because of VBH's staff model program. We are recruiting these providers to serve clients for which the Summit County LCP is responsible.

We also are talking with Optum network providers located in the counties contiguous to Summit. They do not have a contract with us to serve Medicaid or other public sector clients, but we are encouraging them to consider the feasibility of opening their practices to Summit County clients.

Finally, our network staff are continually identifying and contacting mental health and substance use disorder service providers located in Summit and nearby counties that are not currently contracted with us. We are encouraging them to consider the benefits of joining our Summit County network if we are selected as the LCP.

We have provided our most current provider list in Attachment E of our to the RFP and we are confident that, through our continued engagement with potential providers, we will be able to offer the largest, most

accessible and stable network of behavioral health providers that Summit County has experienced in many years.

Will clients need better transportation to access an expanded provider network?

Transportation has been a long-standing challenge for Medicaid and the uninsured in both urban and rural communities. Overall, individuals who live near the poverty level –in addition to being older, less educated, single parents, fluent in a primary language other than English—or have a combination of these characteristics—are very likely to require transportation support. Children, older adults, and veterans are in particular need of transportation assistance to help them overcome social isolation, multiple chronic medical conditions, and greater need for frequent clinician visits.

On contract award Optum will engage with the County, Alliance, Connect, local transportation companies and other stakeholders to better understand Summit County specific transportation barriers, current or past initiatives to address the issue and collaboratively develop a plan to provide transportation assistance to eligible clients.

Who will lead Optum’s Summit County program?

Optum has provided a comprehensive behavioral health program for Salt Lake County since July 2011. Just as in Summit County, Optum Salt Lake took over for Valley Behavioral Health who had operated a staff model managed care program in Salt Lake for a number of years.

Today Optum Salt Lake is responsible for approximately 100,000 clients, contracts with hundreds of providers, employs 35 experienced team members, and is an integral part of the local health and social services delivery system. The team works with regulatory agencies, law enforcement, schools, the Justice System, the Utah Division of Child and Family Services, community organizations and Salt Lake County leadership and staff, to ensure the behavioral health needs of county residents are addressed. If Optum is selected as the LCP, the Salt Lake County leadership team will be responsible for designing and executing the transition plan and then for providing management of behavioral health services for Summit County. The leadership team consists of seven experienced professionals who together have more than 120 years of experience in the health care industry. Brief bios for our leadership team are provided below.



Tracy Luoma has served as the Executive Director for Optum for the last three years and has a total of 17 years of Utah-specific health care experience including six years with the Utah Division of Substance Abuse and Mental Health where she served as the Administrative Services Director, five years with the Utah Department of Health-Division of Medicaid and Health Financing where she served for two years as the Finance Director and three years as the Deputy Director. Ms. Luoma also worked for a year with the Molina Utah Medicaid ACO.



Satish Annadata, MD, MPH, MBA has served as the Optum Senior Medical Director for the last year and previously worked in public service for the U.S. Department of Veterans Affairs. Dr. Annadata is board-certified in Psychiatry and Brain Injury Medicine by the American Board of Psychiatry and Neurology. He has over 18 years of field experience in healthcare operations and strategy focused on achieving the best patient outcomes at the lowest cost.



Connie Mendez, LCSW, MBA has served as the Optum Deputy Director of Utilization Management and Care Coordination for the last eight years and has a total of 17 years of clinical experience in quality assurance, compliance and operations of programs that offered residential and day treatment services for youth and families covered by Medicaid programs.

- **Randy Dow, LCSW** has served as the Optum Medicaid Network and Contracts Director for the last year and has 31 years of community mental health experience serving both as a provider and

as Children’s Services Director and in various other roles in Salt Lake, Tooele and Uintah counties.

- **Susann S. Nowels, LCSW** has served as the Optum Clinical Director for the last eight years and has 29 years of Utah community mental health experience serving as both a direct care provider and as a Manager/Director of a variety of public sector behavioral health programs.
- **Jason Norwood** has served as the Optum Finance Manager for the past eight years and has more than 10 years of healthcare industry experience.
- **Gina Attallah, LCSW** has been with Optum for the last seven years and was recently promoted to the position of Director of Compliance and Quality Assurance/Performance Improvement. Prior roles at Optum were as the Clinical Supervisor and Clinical Quality Manager. Prior to joining Optum, Ms. Attallah worked as a clinician serving Medicaid covered youth and families for 12 years.

The Optum leadership team and other members of the Optum Salt Lake County team have been very involved in evaluating the system of care in Summit County, meeting with providers to discuss opportunities in Summit County, reviewing the RFP and preparing our response, and developing implementation and transition plans to ensure a smooth transition should we be selected as the LCP. We will hire an experienced Director who will be fully dedicated to working with and for Summit County. Our ideal candidate is a behavioral clinician who lives in Summit County and has a clinical background and experience working with providers, clients, community organizations, the justice system, law enforcement, schools and other stakeholders in Summit County.

The Summit County Director (SCD) will report to Ms. Luoma and be part of the Optum senior leadership team. The SCD will have day to day responsibility for ensuring that Optum’s services meet the needs of clients and their families, the County, providers and all other stakeholders.

Upon contract award, the Optum leadership team and key Optum corporate leaders will work with the Health Department and other key stakeholders to develop a shared implementation strategy and plan to: educate the community about the change in LCPs, including: identify participating providers, knowing how to access services, knowing how to obtain more information about the transition, understanding what clients and their families can do to ensure continuity of care and identifying the necessary steps to ensure a smooth transition.

The Salt Lake County leadership team is supported by regional and national Optum employees who, over the last several years, have implemented new network model managed care programs or transitioned populations and programs to an Optum managed care program for more than 600 states, counties, provider entities or employers.

Both locally and corporately, Optum has the resources, experience and commitment needed to partner with Summit County and its stakeholders to transition smoothly into a managed care program that will significantly improve the quality, appropriateness and cost effectiveness of those eligible for publicly funded mental health and SUD services.

Additional Services

LCPs bidding on this RFP may elect to add (up to, but not to exceed 15 pages) information related to services they wish to provide, in addition to the mandated services outlined in this RFP. All additional programs must include cost estimates and estimated number of individuals to be served.

Developing and Delivering Effective Value-Added Programs that Impact Clients

Behavioral health needs and challenges impact more clients of the community than we often realize. Too many times, we are only made aware of these needs and challenges when they reach a crisis point in our lives, our families, or in our community. However, to truly build a thriving community, it is essential that we address these unmet needs and the issues surrounding them such as lack of resources, lack of funding, and most importantly, how to effectively communicate and provide education to create a more holistic environment.

Optum’s programs are developed keeping the following core elements in mind. We **listen** to the community, including residents, health care professionals, and individuals who affect the lives of the

individuals with these needs such as criminal justice representatives, social workers, government agencies, and organizations that deliver services to these individuals. From there, we **create** programs and services, most which are built on the foundations of successful programs proven over our 30 years of providing mental health and substance use services. Throughout the program, we **assess** its effectiveness and determine what changes can or need to be made to increase access, effectiveness, and success leading to long-term sustainability. Finally, we assess the **impact** our programs have on the community to determine if programmatic adjustments need to be made and how we can replicate these services across other programs and/or develop best practices.

All the value-added programs and services we are proposing are customized to meet the specific needs of Summit County. Our proposed value-added services will:

- Expand community access to mental health and substance use services by bringing needed services to the community such as **non-emergency transportation** to increase accessibility to services and support.
- Offer additional support services to complement Summit County’s landscape such as **Seeking Safety**, providing ready access to individuals seeking assistance with substance use disorders and/or refuge from trauma.
- Increase education and information to provide early identification and treatment of substance use through **Narconon’s Truth About Drugs Video program** bringing these video resources into schools to give children and young adults the information they need to understand all sides of the drug debate and how to identify, understand, and seek help for themselves, their friends, and/or family members.
- Access to online educational tools and resources to learn how to **LiveandWorkWell**, (our member portal), providing a variety of tools and resources with 24/7 access to help individuals learn how to live healthier and happier lives.
- Providing resources such as the **SUD Helpline** to help build systems to support the individual throughout the recovery process and assist in their reintegration into their families and community. The SUD Helpline provides education, support, and assistance in seeking help, learning harm reduction techniques, and perhaps how to live a substance free life.
- Too often, communities fail to address the needs of youth, especially in a setting that allows them to receive treatment but still remain at home to reinforce the social and familiar supports that are critical to recovery. To respond to this need, Optum will provide **Youth Day Treatment Services** as a value-added service offering therapeutic behavioral skills training and reinforcement, cognitive behavioral therapy, and wraparound client and family support by trained social workers and clinical staff for clients 12 to 17 years old.

Every program we offer is assessed to determine long-term sustainability and to ensure the programs and services can evolve with the needs of the individuals and communities they serve. It is also important that our programs and services reflect the cultural needs of the community including providing materials, resources, and support for clients of Hispanic cultures and other diverse populations. We are pleased to provide information on our proposed value-added services below.

Non-Emergency Transportation Initiative

Currently, Medicaid can provide reimbursement for non-emergency medical transportation for eligible clients for traditional Medicaid services using Medicaid providers. However, behavioral health providers are not required to provide transportation assistance for Medicaid clients, which can create a substantial barrier to access these services. This lack of transportation can be especially challenging for youth. To overcome this challenge and create a bridge to resolve this problem of lack of resources and funding, we are proposing to offer cab vouchers for individuals needing outpatient services. Transportation companies like Uber and Lyft offer Non Emergent Medical Transportation (NEMT).

On contract award and agreement from the County and other stakeholders, Optum will reach out to Uber, Lyft and

Narconon Drug Education Program Success

At a six-month follow up, youth receiving Narconon drug education curriculum experienced reduced drug use compared with controls across all drug categories tested. The program also produced changes in knowledge, attitudes, and perception of risk.

- Substance Abuse Treatment, Prevention, and Policy (2008)

local cab companies like City Ride and 649 Taxi to determine their interest, performance standards and pricing to identify their fit to function as our NEMT solution.

Medical budget savings accumulated in the Community Reinvestment Fund may be used to pay for the cost of NEMT program.

In Optum's other contracts across the country, we have used several innovative strategies to solve similar transportation issues that might provide some insight into best practices for future solutions in Summit County including:

- In several states where lack of transportation created a barrier to care, including those states with significant rural populations, we encouraged co-location and collaboration between health care providers to increase access points and make services more accessible. For example, many rural areas have federally funded transportation systems to serve the elderly or those with disabilities. It is sometimes possible to expand their charter to transport those with serious mental illness (SMI) to and from their treatment or employment sites. In the same way, communities may organize volunteer drivers who could help transport those with SMI as well as others who need to get to medical appointments.
- Identifying providers with offices along public transportation routes such as buses/trolleys, and incorporate them into our referral process allowing us to guide clients as to which route to use to best access services.
- In our Pennsylvania program, we employed a rural access team to address the challenges clients face in outlying communities related to access to services and transportation needs. The team was made up of a Care Coordinator, Provider Representative, and Community Outreach Representative serving as resources to our call center teams to document and expedite effective solutions for rural provider access challenges such as transportation and homelessness. They also gained experience through conducting outreach in rural and frontier areas and helped to devise solutions to solve specific member access issues.

We look forward to working with Summit County stakeholders to develop and deploy innovative and effective solutions to remove transportation barriers.

Narconon's Truth About Drugs Video Program

Statistics show that we are losing the "War on Drugs."¹ As of 2015, more 12th graders are smoking marijuana than cigarettes². Narconon®, an international non-profit drug rehabilitation and prevention organization has developed a comprehensive drug education curriculum that educates young people about the real effects of the decision to use drugs. In their 40 years of experience delivering drug rehabilitation and prevention services, they found that individuals who gain knowledge and understanding in this area more often make the decision to stay away from drug use. If the school district agrees, we will purchase the video programs and make them available for use in the three Summit County school systems for middle and high school students. These Substance Abuse and Mental Health Service Administration (SAMHSA) recognized best practices could be used in classrooms, after school activities, or through the behavioral health services provided within the schools.

The Narconon program has been proven to provide educators with information students can relate to and easily demonstrate in their real lives. Information is presented in a way that audiences are willing to receive. Facts are presented, but the audience is allowed and encouraged to arrive at their own conclusions. The video curriculum includes ways to help young people find alternative solutions to social situations instead of using drugs. The Narconon Drug Education curriculum has been delivered to hundreds of thousands of school children of all ages and in countries all over the world. Every presentation is designed to be highly interactive to keep the audience fully engaged and includes video of live classroom presentations and interviews with students and recovered addicts who tell the real story.

¹ Porter, Eduardo, "Numbers Tell of Failure in Drug War," *New York Times*, July 3, 2012.,

<https://www.nytimes.com/2012/07/04/business/in-rethinking-the-war-on-drugs-start-with-the-numbers.html>

² NIH's 2015 Monitoring the Future Survey, <https://www.drugabuse.gov/news-events/news-releases/2015/12/drug-use-trends-remain-stable-or-decline-among-teens>

The program is evidence-based and was developed after analyzing where previous drug education efforts failed. The “scare tactic” approach was used for years but never worked and in many cases perpetuated drug use because it presented information that could be easily discredited. Later, the opposite approach was used – the “harm reduction method.” It took a more apathetic approach that no matter what, people are going to use drugs, and they should be taught how to use them safely. However, Narconon found that once a young person or adult truly understands the consequences of drug use in relation to their life and those around them, they usually make the rational decision not to use drugs. Their approach has experienced decades of success with youth around the world. The key to success is both in the content and delivery of the program. Interactive presentations and practical sessions contain simple, true information about the physical and mental effects of drugs, as well as other related social issues. Program delivery includes a hands-on demonstration of the material with plenty of real-life applications. They don’t just tell kids to “say no,” but instead educate them to come to that conclusion on their own, and more importantly, show them how to say no and what exactly they are saying no to.

The Narconon drug education presentations are divided into several subjects geared to the appropriate age groups and focus on the real life situations that often lead to drug use including:

- The physical effects of drugs on the body
- How drugs affect the mind
- Marijuana – The Myth
- The Truth About Ecstasy
- The Truth About Methamphetamines
- Drugs and Alcohol; How the Media Affects Young People
- Tobacco, smoking and your health
- LSD – one of today’s most dangerous drugs
- Establishing and achieving goals in life – how this eliminates the desire for drugs
- Peer pressure and resisting drug use
- Addiction – how it starts and what keeps a person addicted
- How emotions play a role in drug use

Seeking Safety

Individuals who have experienced trauma in their lifetime are at a higher risk of developing significant health problems including mental health, substance use, and chronic physical health conditions. Exposure to childhood trauma can include physical, emotional, and sexual abuse; violence; neglect; and family instability and divorce. Later in life, trauma can include many similar events including domestic abuse, accidents and traumatic injury, and workplace violence or job-related accidents. People who experience trauma can have a lower sense of security and personal perceptions of threats to their safety, and also have challenges to their resiliency and wellbeing. Many people diagnosed with behavioral health illnesses have experienced trauma from the stigma and disenfranchisement associated with conditions.³

Seeking Safety Success

“I am a 62-year-old man who has hated himself vehemently all his life. Seeking Safety has given me a place to know that I am not alone, new tools and creative ways to feel safe with no limits and empowered lifestyle changes. Along with leadership from Rhonda, our Peer Group Facilitator, I have learned respect, empathy and agape love.”

“Seeking Safety topics empower me with knowing that I can make better choices, gain skills to cope with my addiction and anger. The anger topic was very powerful and eye opening. Seeking Safety and Rhonda, our Peer Group Facilitator, make us look deep into ourselves and ask the hard questions.”

Optum recognized that covered clients who have experienced trauma often face special challenges to their recovery and resiliency and uncovered the need to provide specialized programs that address these challenges in a safe and empowering environment. Recognizing and addressing the impacts of trauma is often an important component of behavioral and physical health care, and essential for engagement and activation that supports improved wellbeing and resiliency.

Seeking Safety (www.seekingsafety.org) is a program designed to help people who have experienced trauma and/or substance problems to develop and sustain recovery goals. Seeking Safety is a present-

³ 1. Chartier MJ, Walker JR, Naimark B. Separate and cumulative effects of predicting adult health and health care utilization. Child Abuse Negl.2010;34(6):454–64.

focused, coping skills therapy to help adults, children, and youth including those suffering from sexual abuse and domestic violence. Unfortunately, for many women (ranging from 15% to 25%) have suffered from a lifetime of sexual abuse. The prevalence of domestic violence ranges from 9% to 44% and disproportionately affects women and girls with an estimated cost of \$8.3 billion. Seeking Safety is an evidence-based care model, backed by over 20 outcome studies.

Optum has implemented Seeking Safety programs in ten states for individuals who have experienced trauma and may also have substance use and post-traumatic stress disorder (PTSD). Working with local community-based, consumer-led peer organizations, Optum has developed and implemented this program as a service that is provided by peer specialists. Optum is the only MBHO that has an arrangement with Seeking Safety's creator to certify peers to render Seeking Safety groups and to date, Seeking Safety will be used as a peer-to-peer service in Summit County once we train peers to facilitate these groups.

Seeking Safety is a structured group model focused on developing present-day coping skills in a safe environment. Each session follows a structured format that includes one of 25 topics that include areas such as Safety, Taking Good Care of Yourself, Compassion, Coping with Triggers, Asking for Help, Setting Boundaries in Relationships, and Honesty, among others. Optum has pioneered the use of peers to lead Seeking Safety groups. By offering groups that are peer-led, the Seeking Safety program is able to reach people that have previously had difficulty engaging in traditional clinical services due to issues of trauma and safety. The core concepts of Seeking Safety encourages people (adults, youth, and children) who have suffered trauma to find a safe environment to engage with their peers, respect themselves, and develop and use healthy coping techniques to achieve their recovery goals.

Optum clients credit the program with a unique opportunity to develop socialization and problem solving skills in a safe environment. Having a peer group facilitator creates an opportunity to safely engage in group activities without fear of external judgment or instability. Participants can review different topics each week to improve health and recovery. Setting a safe place helps participants engage and accept support from others. The group provides socialization in a structured environment, and provides encouragement to learn and try new skills. The peer-run Seeking Safety programs are also demonstrating effective clinical outcomes.

A claims review from a pilot sample of peer-led Seeking Safety program participants suggested that the program could lead to lower utilization of costly behavioral health services, as well as reduced inpatient readmission rates.⁴ Real-life success stories have proven that Seeking Safety programs make a difference where it matters the most, in the lives of the clients we serve.

"Sara" completed 12 weeks of Seeking Safety classes that were held at a homeless shelter in Des

Moines, Iowa, where she resided. She had many obstacles that prevented her from moving forward in her recovery including substance use and lack of support from family and friends. During the time Sara attended Seeking Safety groups, she began to have hope that things could get better. She developed a plan to find her own housing, learned about case management and support, and increased her knowledge of how to obtain and maintain housing, and decrease substance use. After the 12th group, Sara was beaming with pride when she shared with the group that she had obtained affordable housing, and was substance free. She also began giving back at the shelter by helping others in similar situations to obtain case management and how to obtain housing.

LiveandWorkWell.com Client Portal is a nationally recognized leader in the development and implementation of recovery-focused tools. Our recovery, resilience, and wellbeing services are supported by robust web-enabled resources such as **LiveandWorkWell.com** which provides information on a variety of topics, including recovery, well-being support, and health management. A screenshot depicted

⁴ Based on a sample of 77 clients who enrolled in the Seeking Safety Program between March 2014 and August 2015. Clients included in the analysis were required to have behavioral health claims 90 days before and after program participation (N=61). Optum Consumer Solutions Group Healthcare Analytics, June 20, 2016.

below shows the entry page to the LiveandWorkWell.com site. We will offer access to this comprehensive website to clients in Summit County.



In 2016, we received URAC’s website accreditation for the LiveandWorkWell.com site. The site has also achieved National Committee for Quality Assurance (NCQA) and URAC Health Utilization Management accreditation.

The translated website, MenteSana-CuerpoSano.com (Healthy Mind - Healthy Body), is the Interactive Media award-winning affiliated site to **Liveandworkwell.com** for Spanish-speaking Clients. LiveandWorkWell.com and the Spanish translated site offer the following recovery and resiliency resources:

Whole Health Tracker: We partnered with Consumer Leader Larry Fricks to develop a wellness tracking tool based upon the Whole Health Action Management (WHAM) program called the Whole Health Tracker to assist clients in setting and tracking progress toward their goals. This is available on our award-winning LiveandWorkWell.com site.

Empowerment Toolkit: The *Empowerment Toolkit* offers clients a range of recovery and resiliency tools including information and encouragement to create an advance directive. Staff is trained to ask if a member has an advance directive, request a copy, and place it in the member’s file for use if he/she is experiencing a crisis. If there is no advance directive, our trained staff will send clients the *Empowerment Toolkit* and urge them to create an advance directive. The *Empowerment Toolkit* includes suggestions and links to recovery tools like attending a support group, using meditation tools, setting up recovery activities through a game-like website, using a graphic novel approach, and other tools designed to offer “something for everyone.”

Question, Persuade, Refer (QPR) Training: We offer QPR training, a suicide prevention approach that has proven outcomes. QPR is an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. It is an evidence-based practice recognized by SAMHSA and is available through our website, LiveandWorkWell.com. QPR can be presented in person or via WebEx on the LiveandWorkWell.com site.

Resiliency, Engagement, and Activation Choices (REACH): Clients can access this web-based tool on LiveandWorkWell.com. This tool considers where an individual falls within a “stage of change” as determined by their “engagement” and “activation.” These two key elements are terms often used synonymously, but they are two different aspects of a continuum of health and well-being management. Engagement is the process by which an individual and a health care system can establish the connections that link health, illness, and wellbeing to a system of care. Activation occurs as an individual becomes empowered to improve and sustain their own health and wellness. The individual’s responses are then used to populate results. The results page brings materials and self-care tools to the member at the right time based on their level of activation and stage of recovery.

The website offers a wealth of additional information and resources for overall health and wellness. These additional resources include:

- Self-paced Cognitive Behavioral Therapy
- Recovery Toolkits for SUD, mental health, and family
- A recovery and resiliency center, inclusive of peer videos
- Addiction Recovery Applications
- Psychiatric Advance Directives that are state specific
- *Daily Strength* online support groups for teens and adults

LiveandWorkWell.com

In 2018, 2.4 million unique visitors used our LiveandWorkWell.com website for resources almost 4 million times. Our portal contains administration tools that enable our Web team to update/customize the site without added costs and maintain more than 1,400 customized, customer-specific websites efficiently and accurately.

SUD Helpline

Based on Helpline follow up data, of the clients who self-identified and then sought and received care within 30 days of their SUD Helpline intervention, 90 percent utilized in-network services.

Clients also will have confidential access to information and tools developed by internal professional staff, doctors, clinicians, industry experts and respected external content providers (including Truven Health Analytics and Healthwise®) through our member website.

Our LiveandWorkWell.com website is fully mobile responsive—Clients can view and navigate the website on any smartphone, desktop/laptop or tablet.

The website features assessments (such as depression, alcohol, and tobacco), health calculators, financial resources, searchable provider database, important communications (such as special alerts for disasters) and links to expert resources. It contains centers focused on relevant behavioral health topics, such as resilience, addiction, recovery and stress that combine resources including articles, videos, screeners, guides and links to expert information onto one page.

Substance Use Disorder (SUD) Helpline

Clients and families/caregivers will have free access to our Substance Use Disorder Helpline. The Helpline provides a toll-free number that enables people with substance use disorders and their loved ones to have direct contact with a Substance Use Recovery Advocate. The SUD Recovery Advocates explain the nuances of the complex health care system, including the benefits of in-network, community-based services and evidence-based care. Callers can choose to remain anonymous, or be identified by program if they want to know their specific benefits or take additional steps to access care.

Additionally, clients and their families have access to LiveandWorkWell.com to find a variety of resources on behavioral health, alcohol, drugs, binge drinking, other addictions, and tobacco use (e.g., Addiction Recovery Toolkit) on this site. Each of these centers for substance use disorders provides clients access to articles, guides, recovery videos, self-assessment tools, personal empowerment programs (i.e. online cognitive behavioral therapy) and other resources they can utilize in their own recovery.

Whole Health Coaching through Optum’s Peer Support Program

Optum can effectively addresses the needs of the whole person through our existing Peer Support program, which utilizes the skills, life experience, and the power of peer support to work with clients to assist them with mental health and wellness challenges they may face. A Peer Support Specialist is an individual who has progressed in his or her own recovery from mental illness and/or substance use and is working to assist other people with a similar experience. They provide peer support services, serving as an advocate, and providing information and assistance in emergency, outpatient or inpatient settings. The Peer Support services are designed to integrate with behavioral health treatment services and to help people live healthier lives. A Peer Support Specialist is assigned to clients who have been or are currently hospitalized to work with them for about six months to provide guidance and assistance as they work their way through the Peer Support Program.

We propose to expand the current peer support services available through Peer Support Specialists and Family Resource Facilitators to include whole health peer coaching. Whole health peer coaching expands the scope of impact beyond mental health and substance use to include engagement with clients in their total health needs, inclusive of medical care.

The Whole Health Peer Support Specialist works with the client to help set and work on their wellness goals such as diet, exercise, taking medication consistently, etc. They provide education about their illnesses and the various treatments available in the wellness plan. The coach helps connect the member to primary care services if they are not already engaged and local support groups. They aid the client to identify questions and learn how to advocate for themselves with their providers. They promote practices anchored in the belief that people with behavioral health conditions are able to live, act, work, and



Addiction
Recovery Tools



participate productively in their communities and are resilient and able to rebound from trauma, stigma and other stresses with a sense of mastery.

The Whole Health Peer Support Specialist meets with the client in their home or community setting of choice to **begin developing supportive relationships and help connect with local peer support groups. They work with the** client to create and implement a plan, such as the Whole Health Tracker, to assist in setting and achieving their wellness goals and strategies. Most importantly, the Whole Health Peer Support Specialist empowers the client to help them prepare for provider visits and to learn how to effectively educate and assist them in communicating their needs and wishes to the health care professionals to support their treatment adherence and connect their treatment to recovery goals. They can offer tips and tricks the client can use to remember to take their medications. One goal of the program is to help the client identify and work toward their recovery goals based on what is meaningful to each individual and help eliminate the internal stigma many individuals live with. Each week, the Whole Health Peer Support Specialist meets with a clinical supervisor to identify concerns and brainstorm solutions to help support the clients/peers they serve.

Peer Support Specialists are certified paraprofessionals and receive Whole Health Certified Peer Specialist training to equip them with the skills they need to be effective. Optum’s Peer Coach Support program has been proven to be successful in programs across the country. In Michigan, a total of 16 clients participated through completion of their plans in the Whole Health Peer Support program in 2017, which resulted in increased utilization and adherence to outpatient and professional service visits as well as reduced costs. Annualized cost reductions for clients receiving Peer Support services in 2017 are outlined below.

Type of Treatment/Service	Annualized Cost Reduction for Clients Receiving Peer Support Services in 2017
Outpatient Medical Services	\$102,112
Inpatient Medical Services	\$578,490
TOTAL COST SAVINGS	\$680,602

Youth Day Treatment Services

Optum’s network provider, Hopeful Day Treatment located in Valley City, Utah, provides a short-term, intensive day treatment program Monday through Friday from 9:00 a.m. to 3:30 p.m. MST. The day treatment program provides therapeutic behavioral skills training and reinforcement, cognitive behavioral therapy, and wrap around client and family support provided by social service workers, licensed therapists, and other trained staff. Medication management is also provided when indicated. Hopeful Day Treatment serves clients 12 to 17 years of age who are in need of behavioral health treatment and support.

The goal of the day treatment team is to address acute behavioral health concerns in a supportive and therapeutic environment. Wraparound services, including skills training and family therapy, can also be provided in the member’s home, if needed. Clients and their families will work collaboratively with the treatment team to identify treatment goals, review treatment effectiveness, and develop a step-down plan from day treatment to less intensive services when indicated. Interventions utilize evidenced-based practices developed through years of research and evaluation.

On average, most clients participate in the day treatment program for a period of eight weeks. Program completion will be decided by the treatment team, which includes the client and their family. All of the additional services included in this section will be offered to eligible Summit County residents at no cost to the County or the client.

One Final Note: What are the benefits of contracting with Optum?

Based on our experience, a contract between Optum and Summit County will bring major improvements to the Summit County behavioral healthcare delivery system. Here are the ones we consider most significant. Keep this list, and upon renewal, see how many of them we have been able to accomplish by working together.

- Increased client voice, choice, and satisfaction
- An expanded array of services and supports, including a much stronger role for trained peer support specialists and client-delivered and operated services
- A greater percentage of eligible clients accessing mental health and SUD services
- A greater number and variety of behavioral healthcare providers located in Summit County, benefitting all the County's residents
- Improvements in clinical effectiveness and expanded application of evidence-based practices because of improved provider training and support
- A reduction in the use of 24-hour facility-based services and an increase in mobile crisis response services as well outpatient and community natural supports; this brings an overall reduction in costs while increasing consumer independence and community reintegration
- Increased focus on improved performance throughout the system through expanded quality management programs based in national standards, expanded and flexible reporting, and performance-based incentives
- Significantly increased stakeholder involvement in the oversight and administration of the delivery system
- Increased transparency into the LCP's operations and greater LCP accountability for client outcomes and system improvement
- Greater flexibility in responding to changes in funding levels, increasing enrollment and changing regulatory environment
- Introduction of new technology for providers, consumers and families

Optum looks forward to the opportunity to partner with you in making these—and many other improvements—happen in Summit County.

Form A

Governance & Oversight

Narrative

RFP # SUCO20197552

FORM A - GOVERNANCE & OVERSIGHT NARRATIVE

Submitting Agency (LCP): United Behavioral Health, Inc. (Optum or Optum Summit County)

Instructions:

The following form is modeled off of the annual Area Plan the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County and the RFP process. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form A is limited to a maximum of 40 pages.** Refer to Section VII of the RFP to ensure all required services and metrics are provided in your provided responses. FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for the fiscal year. Funding contracts are for July 1st to June 30th.

1) LCP Qualifications

Is the LCP a licensed non-profit or governmental agency (Special Service District) eligible to receive Medicaid funding?

The legal entity responding to this Request for Proposals (RFP) is United Behavioral Health, Inc. (UBH). UBH has adopted the brand “Optum” as part of a leading health services business and is referred to as “Optum Summit County (OSC)” or “Optum” throughout our proposal. Although UBH is not a non-profit or governmental agency, it is established as a Managed Care Organization (MCO) per the LCP minimum qualifications criteria in Section II) question 4 of the RFP and is eligible per federal regulations to handle Medicaid funds as evidenced by our federal, state, and county contracts. Optum is required to meet financial solvency requirements under its current Salt Lake County contract and has established a compliance program and operational areas structured to support regulatory and contractual compliance. We will build upon this foundation to meet the financial solvency requirements of this RFP as well.

We have the honor of serving Clients in a variety of roles such as a primary contractor, subcontractor, and delegated entity inclusive of Medicare Advantage, 1876 Cost Plans, Medicaid Managed Care, and Commercial Plans. More specifically, Optum has direct contracts with federal, state and county agencies, which are inclusive of serving as a Medicaid Plan (PIHP, PAHP, MCO), performing independent assessments applicable to HCBS Authorities and servicing our Veterans through various contracts.

Does the LCP have at least ten years of experience providing mental health services?

Optum has been a leader in providing specialty behavioral health care, including mental health services, to culturally diverse populations for more than 30 years and in 32 states plus the District of Columbia. We currently serve approximately 35.2 million clients in both commercial and publicly funded behavioral health programs through our provider network of approximately 186,000 providers nationwide. Some of our contracts

are carve out programs that cover only mental health and substance use disorder (SUD) services and in others, behavioral health services are part of a fully integrated program covering both behavioral and physical health care benefits. Regardless of the contract structure, we emphasize a comprehensive approach to identifying behavioral health treatment needs and delivering comprehensive treatment services and supports because integrating care is the most effective way to help clients move ahead in their recovery journey.

This depth and breadth of experience serving in both large metropolitan areas as well as rural and frontier communities makes clear that collaboratively building systems of care with local clients, families, providers, and agencies delivers the best value for everyone. We understand healthier truly happens one person, one family, and one community at a time.

Our success in managing behavioral health programs is due to our philosophy of recovery, resiliency, and reintegration; the strength of the working relationships we establish with clients, our government partners, providers, and the community; and our ability to drive transformation and innovation in behavioral health delivery systems. Because we have learned through many opportunities how best to support system reform efforts, we are skilled in creating and adopting new best practices, innovations (including technology) for better service delivery, and stretching available funding for maximum benefit.

Below are two examples of our successful, innovative mental health programming.

Optum Public Sector San Diego, California, since 1997: We deliver a broad array of administrative services to support the County of San Diego Behavioral Health Plan, including a county-wide Access and Crisis Line available to all county residents; utilization management for Medi-Cal (Medicaid) funded inpatient and outpatient services; provider network development and management; claims processing and payment to fee-for-service providers and full management information system support for the county’s behavioral health electronic health record, including required reporting to the State and Federal government. We also provide behavioral health screening of individuals released from prison and review of treatment plans and psychological reports that are presented to the dependency and delinquency courts.

Salt Lake County Behavioral Health Medicaid Services, since 2011: We manage the Salt Lake County Behavioral Health Medicaid Services Mental Health and Substance Use Disorder Services. Covered under the contract are: inpatient-mental health only, outpatient, and residential. We perform utilization management, network development and support, quality assurance and claims payment. By reinvesting savings from our full-risk contractual arrangement, our Salt Lake County team has developed a mobile crisis outreach team and a county-wide Crisis and Access Line/Warm Line operated by peers.

Does the LCP have at least ten years of experience providing substance abuse services?

As part of our behavioral healthcare contracts, we have also managed SUD services in 11 states over the last ten years for the following public sector contracts:

<ul style="list-style-type: none"> • Healthy & Well Kids of Iowa, now included in Medicaid plan 	<ul style="list-style-type: none"> • Florida Statewide Medicaid Managed Care and Healthy Kids
<ul style="list-style-type: none"> • Ohio Covered Families/Children and Aged, Blind, and Disabled (ABD) 	<ul style="list-style-type: none"> • Wisconsin BadgerCare Plus/Medicaid Supplemental Security Income (SSI)
<ul style="list-style-type: none"> • Nevada Medicaid 	<ul style="list-style-type: none"> • Optum San Diego, California
<ul style="list-style-type: none"> • Rhode Island RiteCare and Adult SSI 	<ul style="list-style-type: none"> • Tennessee TennCare
<ul style="list-style-type: none"> • Texas STAR, STAR PLUS, and CHIP 	<ul style="list-style-type: none"> • Massachusetts Senior Care Options
<ul style="list-style-type: none"> • Hawaii QEXA Expanded Access 	

Below we present two examples of our innovative initiatives in two of these states.

Tennessee: We have served the SUD needs of Tennesseans since the state carved behavioral health benefits into managed care entities in 2007. In recent years, Tennessee has been hard hit by the opioid

epidemic. To respond to this epidemic, we initiated an effort to build a “Medication Assisted Treatment (MAT) network of distinction” to verify access to evidence-based treatment. This initiative assesses GeoAccess standards and actual capacity, leveraging the availability of behavioral health providers. We have also developed alternative payment models to expand the delivery of comprehensive MAT services and are working with the state to develop a set of metrics to measure the quality of the treatment clients are receiving (e.g., continuous MAT treatment, relapse rate). From 2017 to 2018, we have seen a 62% increase in our Tennessee MAT network because of these efforts.

Ohio: In Ohio we implemented several initiatives to verify that clients with SUD are receiving the right care, at the right time, and in the right amount. For example, our hotspotting data tool allows us to quickly identify at-risk clients and reach out to them with support, such as referral to treatment.

The pharmacy lock-in and a field-based care team in Ohio are two care management strategies that also are contributing to our positive results. Over 400 clients are enrolled in our Coordinated Services Program (CSP, pharmacy lock-in), which provides specialized care management to clients with concerning prescription and utilization patterns, such as four or more potentially misused drugs. Clients enrolled in CSP are restricted to one pharmacy or one provider or both for 24 months and are assigned to a case manager. The case manager works with the assigned provider to address the needs underlying the inappropriate utilization behaviors whether they are chronic pain, SUD, or other health-related resource needs, such as housing. More than 250 clients have successfully completed CSP, meaning there was no evidence of current medication misuse or inappropriate emergency department or medical use. Our field-based care team directly engages with high risk clients through a team-based approach, inclusive of registered nurses, behavioral health clinicians, and peer support specialists.

Does the LCP have at least five years of experience providing case management to children, youth, adults and families

We have provided case management through our direct staff to children, youth, adults, and families in over 20 states for more than five years. Our use of network providers to render case management as a Medicaid service spans over 30 years of experience. This service has been provided within the context of our experience managing behavioral health care to diverse populations. We recognize the critical nature of these activities to verify that services are provided appropriately and effectively and take into account the unique needs of each client. In addition, these services are helpful in making service provision as cost effective as possible.

Case management, as a unique service within the behavioral health care continuum, is important to help clients stay on track with their treatment. Case managers encourage clients to engage in and remain active in treatment programs. They assist in the monitoring and management of medication therapies and can also provide a linguistic bridge between clients (especially those for whom English is not their first language) and their treatment providers. In addition, case managers can be helpful in making service provision as cost effective as possible. Perhaps most important, the best case managers help clients to make good informed decisions and take responsibility for their own recovery process.

To demonstrate our experience in the provision of case management, we provide the following examples:

Case Management for Children and Youth – Mississippi Children’s Health Insurance Program (CHIP), since 2010

This state-funded program provides high quality, accessible health care throughout the state of Mississippi for CHIP eligible populations. Medical coverage provides a broad range of services, including inpatient and outpatient hospital care, rural health clinic and federally qualified health center visits, case management, laboratory and x-ray, behavioral health services, ambulance/medical transportation, pharmacy services, and vision and dental services. Optum staff recruits and manage a behavioral health provider network, perform utilization management and case management, provide after-hours crisis response, conduct quality oversight, and perform administrative services including reporting and claims payment.

Case Management for Adults – Kansas KanCare Managed Care, since 2013

This Medicaid program provides health care coverage throughout the state for the Aged, Blind and Disabled (ABD); CHIP; Long-Term Care, and Temporary Aid to Needy Families (TANF) populations. It also includes multiple waiver populations, including frail elderly, physically disabled, and developmentally disabled/intellectually disabled. Case managers, such as registered nurses, community health workers, and behavioral health clinicians, deliver hands-on case management, including risk assessments and individualized plans of care with monitoring and oversight. Enrollment is mandatory for most populations; however, it is voluntary for Native Americans. We manage a behavioral health network and provide utilization management and case management, after-hours crisis response, quality oversight, reporting, claims payment and other financial management.

Case Management for Families – Ohio Covered Families/Children and ABD, since 2005

This state-funded program provides health care coverage throughout the state of Ohio for ABD, CHIP, expansion, and TANF beneficiaries. The Medicaid program encompasses ABD, Ohio’s Healthy Families eligibles (i.e., TANF-related Medicaid clients), Ohio’s Healthy Start eligibles (CHIP clients)—referred to as Covered Families and Children—and Medicaid expansion beneficiaries. It involves the delivery of all Medicaid-covered physical health services, including retail pharmacy, vision, and dental, to eligible recipients.

Behavioral health services are fully integrated into this plan, and Optum manages a provider network that offers counseling and psychotherapy, physician/psychologist/psychiatrist services, outpatient clinic services, general hospital outpatient psychiatric services, pre-hospitalization screening, diagnostic assessment (clinical evaluation), crisis intervention, psychiatric hospitalization in general hospitals for all ages, and laboratory services. For SUD, it facilitates access to Alcohol and Other Drug (AOD) urinalysis screening, assessment, counseling, physician/psychologist/psychiatrist AOD treatment services, outpatient clinic AOD treatment services, general hospital outpatient AOD treatment services, crisis intervention, inpatient detoxification services in a general hospital, and laboratory services. The program covers short-term nursing facility stays (under 100 days), except in the case of the expansion population where the entire stay is covered. We provide a behavioral health network, utilization management and case management, after-hours crisis response, quality oversight, claims payment and other administrative support services.

LCP will provide evidence of being licensed in the State of Utah, Department of Human Services and Office of Licensing to provide the requested services.

Optum intends to provide services as a MCO through a network of licensed providers that it will oversee. In accordance with the County’s response to a bidder’s question dated January 30, 2019, Optum will meet the financial solvency standards described in Section VI, P) of the RFP and established by the State in accordance with 42 CFR 438.116(b). As a MCO providing behavioral health services in Salt Lake County, Optum must comply with 42 CFR 438.116(b) and has demonstrated its ability to provide services in compliance with requirements established by its county contract, the Utah Department of Human Services and Office of Licensing requirements. Optum (United Behavioral Health, Inc.) also has a TPA license (6581) with the Utah Insurance Department.

Registered in Summit County

As required in the RFP, Section II) LCP Minimum Qualifications, question 6, Optum is registered to do business in Summit County. Our business license application was approved on March 6, 2019 and we have provided proof of our license as Attachment – Form A.1.e – Summit County Business License. We are also registered with the Utah Division of Corporations (Entity Number 1208692-0143 for United Behavioral Health, Inc.).

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

2) Experience and Capability

Provide your mission statement and describe how it supports the community behavioral health model of service.

Our Mission Statement

The Optum mission statement: "To help people live healthier lives and to help make the health system work better for everyone," summarizes our approach to the community model of behavioral health service.

Supporting the Community Behavioral Health Model of Service

Optum's public sector programs are all built on a philosophy of recovery and resiliency that relies on client and community engagement, quality services and stakeholder collaboration. Driven by the goals incorporated into the Summit County Mental Wellness Strategic Plan, we will leverage the strengths of the County's current delivery system and the community's strong support and advocacy for the ongoing transformation of Summit County's behavioral health system of care. Together we will implement more proactive policies that focus on access to care; prevention and education; recovery, resilience, and reintegration; success and sustainability; and health care equity for Latino community members and other underserved populations.

Optum Summit County (OSC) will embody the principles that guide all of Optum's behavioral health programs – principles that fully align with the Department's vision for enhanced quality of life for Summit County community members who are struggling with mental health issues or SUD.

- Our policies and procedures, materials and training, professional and personal interactions will exemplify the principles of recovery, resiliency, and reintegration. This demonstrates our conviction that people can and do manage their mental illness and SUD and live healthy, productive lives in their communities.
- We will promote voice, choice, and active involvement of clients and their families in every part of OSC operations and will encourage expanded peer support services. This client and family involvement will be particularly critical to prevention and education efforts.
- We will work with Summit County providers and provider organizations to expand access to services through expanded capacity and innovative techniques to get care to clients in alternative locations.
- We understand the need for equity in provision of behavioral health services to the Latino community. The Optum provider network will include providers who represent the Latino community, speak their language, and understand the cultural issues involved when a Latino client reaches out for behavioral health care. Our staff will include a diverse mix of cultural and ethnic representation and we will provide qualified interpretive services to effectively communicate with Latino clients.
- We will share our experience, expertise, and recommendations to support the long-term success of the behavioral health programs in Summit County.

Describe, in detail, your experience with providing the services outlined in this RFP.

Optum is experienced in developing and implementing mental health and SUD services for some of the most vulnerable populations, including clients in urban and rural / frontier areas. Some of our contracts are carve-out programs that cover only mental health and SUD services and in others, behavioral health services are part of a fully integrated program covering both behavioral and physical health care benefits. Regardless of the contract structure, we emphasize a comprehensive approach to identifying treatment needs and providing fully integrated services that most effectively help individuals move ahead in their recovery journey. We have worked with numerous state and county partners to transform public sector behavioral health delivery systems that better meet the needs of the clients whose care has been entrusted to us. Accountability and continuous quality improvement are basic tenets in the way we conduct all aspects of our operation and are key in maintaining positive long-term relationships. Below, we have provided a brief overview of our experiences providing the services outlined in this RFP.

Mental Health Services

Optum has more than 30 years of experience providing behavioral health services in the public arena. Within each of the contracts, we focus on making sure that clients have access to necessary mental health services

and we work collaboratively with our clients to continuously evaluate and enhance the service delivery process. Summaries of our experience managing mental health contracts and some examples of our capabilities are below:

Salt Lake County: In 2011, the County instituted a new vision for mental health services and as the selected MCO, Optum has participated in the transformation of the Salt Lake County behavioral health system from a single provider run system to a comprehensive network model. Our Optum Salt Lake County program is built on a philosophy of local presence, client and community engagement, quality services and stakeholder collaboration. Through a structured process with the County and key stakeholders, Optum Salt Lake County partnered to complete a system-wide planning effort to redesign systems of care in order to focus on client empowerment, service coordination, and partnerships with emphasis on early intervention, community and home-based care and recovery principles.

Oregon: Over the past several years, we have launched reimbursement approaches that promote whole person care by addressing both medical and behavioral health outcomes. In Oregon, we funded a behavioral health specialist to support primary care practices as a means of improving the identification and access to behavioral health treatment for clients with comorbid conditions. The specialist helped the medical homes create a process which identified and stratified clients needing services through the use of patient questionnaires, screening tools and registries. Efforts were focused on increasing the capacity of the primary care team through skill building, implementing best practices in care coordination, linking patients to community resources and self-management tools as well as expanding psychiatric capacity directly and through telehealth. Our key learnings from this effort include: the need for development of formal workflows to assure integration of services, identifying a physician/clinical champion from the medical home that works with the behavioral health specialist and the development of meaningful incentives.

San Diego County: Optum has been providing administrative services for San Diego County since July 1997. Under that program, we administer behavioral health services including crisis line services, utilization management, network development, claims processing, and full information management support for the County's electronic health record. As part of our contract, we provide care coordination to further integrate care between the behavioral health provider network, primary care and managed care plans, ensuring continuity of care for Medi-Cal (state Medicaid) beneficiaries. In an effort to enhance the clinical management of enrollees with multiple psychiatric hospitalizations, we designed and implemented the Special Help for At-Risk Individuals (SHARI) program, a partnership between the County, hospital representatives, community providers and enrollees. The SHARI program has won awards from both the National Association of Counties and the California State Association of Counties. An analysis of our efforts to coordinate, integrate and manage services demonstrated savings of \$11.2M from July 1, 2009, to June 30, 2015, while the quality of behavioral health services continued to improve.

Idaho: Optum implemented the Idaho Behavioral Health Plan in September 2013. Under this contract with the Idaho Department of Health and Welfare, we manage outpatient benefits for the Idaho Behavioral Health Plan for Idaho Medicaid clients. In collaboration with DHW, our mission is to transform the Medicaid outpatient mental health and substance use system to help people in their recovery. We have built and expanded the state behavioral health network and offer peer services and other programs that support clients and families. We also provide transitional services, which help individuals make a smooth transition back to the community after discharge from a hospital or other inpatient facility. In addition, we operate a Member Access and Crisis Line, a free 24-hour, seven days a week service that provides support and referrals to people experiencing a mental health or substance use crisis. The line also serves as a central access point for Idaho Behavioral Health Plan clients to obtain provider referrals and information about the Plan.

Innovative Telehealth Solutions: Optum has been leveraging technology to increase access to mental health and SUD services, especially in rural and frontier areas. Examples are described below.

Online cognitive behavioral therapy: This service is available through our LiveandWorkWell.com client portal. It provides clients with immediate access to support that can assist them in managing their behavioral health, medical, and social support needs. Clients have used our online cognitive behavioral therapy module to

move through such issues as depression, calm anxiety symptoms, manage everyday stress, and recognize and address at-risk drinking and drug use.

Telehealth: Virtual visits provides clients residing in rural/frontier areas and in medical settings with faster, convenient access to behavioral health care, which results in higher levels of engagement and better treatment outcomes. Optum has the largest “telehealth” network, with contracted arrangements based on our proprietary network terms and quality standards. What differentiates our network is that it is unlike those of our competitors, who often subcontract with a virtual visit vendor and are subject to the vendor’s standards of quality control. We maintain full control of our program and network, thus ensuring the quality and accessibility of these services. For example, in rural Kansas, we implemented a telehealth consultation program paying psychiatrists to provide consultation and direct services in two federally qualified health centers and since 2016 more than 400 consultations have occurred, improving access to specialty behavioral health care that would not otherwise be accessible.

Optum’s Experience Delivering SUD Services

Optum has extensive experience providing SUD services. The experience includes introducing substance use services into contracts that formerly covered only mental health services as well as introducing new substance use services to expand the existing array of covered SUD services. Our experience also includes providing fully integrated services for persons with co-occurring mental health and substance use problems and working with states that have received Section 1115 Medicaid demonstration or other waivers in the successful deployment of services. Our SUD network and capabilities include a wide spectrum of services, each customized to meet the needs of our contracts and clients and follow the American Society of Addiction Medicine (ASAM) guidelines. The type of services we provide include:

- Early intervention (ASAM Level 0.5)
- Initial evaluation and assessment
- Intensive case management services
- Mobile crisis response services
- Peer-based crisis services
- Outpatient MAT
- Care coordination
- Outpatient services (ASAM Level 1)
- SUD intensive outpatient services (ASAM Level 2.1)
- Partial hospitalization services (ASAM Level 2.5)
- Ambulatory withdrawal
- Clinically managed low-intensity residential services (ASAM Level 3.1)
- Clinically managed population-specific high-intensity residential services (ASAM Level 3.3)
- Clinically managed medium-intensity residential services for adolescents (ASAM Level 3.5)
- Clinically managed high-intensity residential services for adults (ASAM Level 3.5)
- Medically monitored high-intensity inpatient services for adolescents (ASAM Level 3.7)
- Medically monitored intensive inpatient services withdrawal management for adults (ASAM Level 3.7)
- Medically managed intensive inpatient services for adolescents and adults (ASAM Level 4.0)

Below we have provided examples of contracts where we currently provide SUD services.

Salt Lake County: Optum Salt Lake County staff has worked to develop effective partnerships in the community, as well as with the Utah Department of Mental Health and Substance Abuse. Medicaid funded SUD services were added to Optum Salt Lake County’s contract in July 2012 a year after mental health management began. Optum Salt Lake County is responsible for managing approximately \$6 million in Medicaid-funded substance use services while the County continues to manage the Non-Medicaid funds. Using ASAM Patient Placement Criteria – 2nd Edition, Revised (ASAM PPC-2R) criteria to establish most appropriate level of care placement, Optum Salt Lake County provides prior authorization, concurrent and retrospective review of requested substance use services. Before Optum Salt Lake County became involved in the management of these funds, the ASAM criteria were not fully utilized and concurrent reviews were not consistently applied. Since July 1, 2012, to align increased accountability, Salt Lake County has implemented

a process closely mirroring Optum Salt Lake County's policy of prior authorizations and concurrent reviews utilizing ASAM criteria as a guideline for services. This partnership has resulted in Medicaid savings, along with increased accountability, ensuring that Medicaid and Non-Medicaid dollars are appropriately used. Additionally, Optum Salt Lake County made every effort to see that the transition to this partnership also included an emphasis on establishing a positive relationship with the current substance use providers including reaching out to support an improved understanding of ASAM criteria; use of concurrent reviews; and on time payments.

Peer Support Services

Optum uses peer support specialists and peer support services in many of our contracts. Peer support specialists are individuals with lived experience of mental illness and/or SUD who are able to develop strong relationships with clients because of their similar experiences. We contract peer support services in the markets where permitted or seek to add peer support specialists to our staff for our Medicaid programs whenever possible and we actively encourage providers to hire peer support specialists as well. Peer support specialists help clients navigate the health care system, assist with transition from inpatient or residential services back into the community, link clients to community supports within their region, engage clients with clinical services they might not otherwise accept, encourage clients to stay in treatment by sharing their stories of recovery, and attend appointments with partners when geographically possible. In addition, they may work with clients to complete a Wellness Recovery Action Plan (WRAP) or the Whole Health Tracker tool for self-management. They train participating providers and community advocacy groups how to facilitate group Seeking Safety sessions. They also offer telehealth options for non-clinical conversations to clients and family members and assist clients in using free mobile recovery applications and other tools offered through Optum.

Over the years, peer support has been found to improve the quality of life, increase treatment engagement, and increase self-management and whole health among clients. A study conducted by Mental Health America in May 2018 used results of many of Optum's peer support programs to demonstrate the efficacy and benefits of peer support services. Some of the outcomes reported by Mental Health America's study include:

- Recovery Innovations in Arizona saw a 56% decrease in hospital readmission rates.
- Participants assigned a peer mentor had significantly fewer re-hospitalizations and fewer hospital days.
- Peer support services provided through a federally qualified health center in Denver achieved a return on investment of \$2.28 for every \$1 spent.

The Peer Bridger Program is a peer support program that serves individuals being discharged from a community or state hospital by teaming them up with a "Peer Bridger" for two weeks or longer post-discharge. Clients receive in-home and community support in the transition into community life to help decrease the need for readmission and use of crisis services. We have implemented the program in our Salt Lake County contract and have seen a reduction in recidivism among clients using this service.

School-based Services

According to the U.S. Department of Health and Human Services, one in five children and youth experience a mental health problem during their school years. Stress, substance use, and a number of other behavioral health issues are resulting in self-injury and even suicide. School-based services are an essential component of helping communities reach children/youth in need of services and creating a resource for students and their families to get the help they need, when they need it. Optum has successfully contracted with Hopeful Beginnings to provide school-based behavioral health services for Medicaid clients. Today, the organization offers services in approximately 20 schools throughout the Salt Lake County.

Justice-involved Services

In collaboration with local governments, Optum has helped implement programs designed to reduce the time people with mental health or SUD spend in jail. In Salt Lake County, the State found that over 75% of the jail population had mental health or SUD issues, which lead to higher social services, health care, and criminal justice costs and lower patient outcomes. Optum has worked with the County to augment the County's existing

Alternatives to Incarceration (ATI) programs of Jail Diversion Outreach Team (JDOT) and Co-Occurring Re-entry and Empowerment Program (CORE) by implementing crisis outreach and intervention services in March 2012 for individuals in mental health crisis that faced incarceration. Services include Mobile Crisis Outreach Teams (MCOT) that provides rapid-response crisis intervention and immediate onsite assessment and intervention. We also established a Receiving Center in July 2012, located at the University of Utah Neuropsychiatric Institute, where individuals can stay for up to 23 hours to receive crisis intervention services. In its first year of operation, 691 individuals in behavioral health crisis were referred to the MCOT or Receiving Center by law enforcement. Based on cost analysis done by Optum, the two crisis services alone saved the County over \$650,000. This is in addition to savings from the County's other ATI programs. Optum and Salt Lake County's coordinated crisis services reflect nationally recognized best practice models for effective jail diversion programs.

Although ATI programs were in existence within Salt Lake County prior to Optum's involvement, we have partnered closely with the contracted provider since 2011 to ensure that quality evidenced based intensive outpatient and residential services are available to Medicaid eligible consumers with justice involvement. All services are provided in community settings, with appropriate supervision, and have proved to be less expensive and more effective than housing those with these mental health conditions and substance use disorders in jail.

Other Initiatives and Innovations

Our medical, clinical, quality management, network management and technology departments work collaboratively and constantly to identify innovative programs and services that address the needs of our state and county customers. Our subject matter experts, many of them leaders in the behavioral health field, are at the forefront of advancement in mental health and SUD service delivery and use this expertise to identify, recommend, and develop programs that meet the unique needs of the markets we serve. We are committed to providing clients with access to quality care and the best client-centered outcomes. Some of the innovative treatment and engagement services we endorse and offer are outlined below.

Medication Assisted Treatment (MAT): Optum was one of the first behavioral health companies to pursue the use of MAT in treating individuals with opioid addiction. We first implemented the program in 2013 and since then have increased our MAT network locations by over 75%. Today, we have over 2,000 MAT providers in over 4,000 locations nationwide.

Seeking Safety: Seeking Safety is a present-focused, coping skills therapy to help adults, children and youth attain safety from trauma and/or SUD. The treatment is available as a book, providing both client handouts and clinician guidelines, but may also be conducted in group or individual format for adolescents (both females, and males) in various settings (e.g., outpatient, inpatient, residential, home care, and schools). Optum is the only managed care entity approved to train and certify peers to facilitate Seeking Safety groups by its creator. We currently offer over 40 peer-led trainer certification courses for peer support specialists per year nationally.

Mental Health First Aid: This course provides training on how to assist someone experiencing a mental health or substance use-related crisis. In the Mental Health First Aid course, clients (i.e. teachers, parents, counselors, family members, care givers, etc.) learn risk factors and warning signs of mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Topics covered include anxiety, depression, psychosis, and addictions. The adult course is available in both English and Spanish. The Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. While Mental Health First Aid as an evidence-based practice is becoming more utilized, Optum's commitment to educate as many first responders, school personnel, family members, and other stakeholders in our markets has us providing over 75 trainings per year.

Association for Behavioral Health and Wellness (ABHW) Stamp Out Stigma Campaign: An all-electronic program where we provide information and links, via our member/provider websites and social media outlets, to information about stamping out stigma. Optum has sponsored this campaign offered by the ABHW and

additional information can be reviewed at StampOutStigma.com.

INAPS Training Webinars for Peers: In 2009, the National Association of Peer Specialists (NAPS) was awarded a contract, as one of five professional disciplines in mental health care, to develop tools and training for working peer specialists under the Recovery to Practice initiative. [NAPS was later renamed the International Association of Peer Supporters, iNAPS.]. In partnership with Optum, free webinars are made available online. Continuing education is an important factor for Certified Peer Specialists to maintain their certification. The website advertises our assistance with the development of these webinars, which positively impacts how Optum is seen in the mental health community. See available courses at <https://www.inaops.org/webinars>.

If you currently serve as an LCP in a Mental Health or Substance Abuse District contiguous to Summit County, how does this lend to improving services in Summit County?

Optum has contracted with Salt Lake County since 2011 to provide behavioral health services in accordance with the Scope of Work, Utah Public Mental Health System Practice Guidelines, and the Salt Lake County Area Plan. In five of the last seven years, Optum Salt Lake County has realized Medicaid savings and has worked in partnership with Salt Lake County to subsequently reinvest these savings in the community. Early on, Medicaid savings were used to help fund behavioral health crisis services such as the Wellness Recovery Center, a mobile crisis outreach team (MCOT), and the Receiving Center in Salt Lake County. Prior years' savings also have been reinvested jointly by Optum and Salt Lake County to help fund behavioral health outreach services for community's homeless population as well as expansion of housing availability for county residents diagnosed with severe and persistent mental illness.

Optum has administered mental health and substance use disorder services in Utah since July 2011, and this experience offers a number of benefits to Summit County. As the Summit County LCP, we will leverage the synergies and efficiencies resulting from our current Utah contracts to improve service delivery in Summit County, including:

- Broader availability of Optum expansive resources for Summit County
- Existing contracts with multiple providers in the area for services that are not readily available in Summit County
- Optum's familiarity with the area, population demographics, and state regulations
- Optum's experience in working with DSAMH and the Utah Department of Health, Division of Medicaid and Health Financing in meeting contract deliverables
- Optum's knowledge of the Utah state, regional and local community cultural needs and expectations
- Optum's ability to leverage the capabilities of our virtual visits platform (telemental health) to facilitate Summit County clients receiving services at or close to home

Local and Regional Experience, Knowledge, and Relationships

One of the most important benefits that Optum can offer Summit County is our **relationships with area behavioral health providers**: As an MCO in Salt Lake County, we have contracted with over 140 providers in the Wasatch Front. These providers offer all levels of care across the behavioral health care continuum and we will leverage their availability to serve Summit County clients. We will also seek to contract additional providers in Summit County that are not already part of our Summit County network, and pursue expansion of existing Salt Lake County providers into Summit County, as needed to establish a full continuum of care and client choice of providers. This will be especially true for levels of care, such as inpatient and residential services which are not available today in Summit County.

Our team also knows how to **work in partnership with county staff and build collaborative relationships with the local community**, including our clients and their families, providers, community organizations and resources, and governmental agencies. We rely on them as the experts in the community to identify needs and to build an effective, comprehensive care continuum that addresses the health care needs of clients. We also have learned how to best support existing community initiatives, such as the Summit County Mental Wellness Plan and incorporate their goals into our program.

We know that effective partnerships rely on open communication, so we will participate in regular meetings with Summit County staff, Summit County Connect, the Summit County Mental Wellness Alliance, medical and behavioral health providers and other key stakeholders. In addition, we will be adding the Summit County Quality Improvement Committee. These standing commitments allow us to receive feedback from providers and the larger community and to discuss any issues or concerns. We have learned how important it is for the community to understand our program, so we will provide a dedicated website, training, monthly provider newsletters, and provider email blasts as needed to keep stakeholders informed. Online resources are available to clients, families, providers, and other stakeholders to receive information about the program.

Summit County also will benefit from our **familiarity with Utah's Local Mental Health and Substance Use Disorder system**. We can provide experienced support to the Summit County Health Department because we have assisted Salt Lake County to complete the Department of Substance Abuse and Mental Health (DSAMH) Area Plan for the past seven years.

Optum also has built **strong relationships with DSAMH staff** over the last eight years. In addition, we have relationships and contacts with staff at the Department of Health and have developed a deep understanding of Medicaid regulations. We also have an in-depth knowledge of related state and federal regulations including those other funding streams that support services for the clients we serve. We are highly experienced in generating and providing required client data to county, state and federal agencies and have ongoing conversations with representatives of those agencies for process improvements and programmatic oversight.

Our broad array of experience and knowledge will be valuable to during both initial implementation as well as ongoing operations in Optum Summit County. We will not lose time developing relationships, and we will not have to research regulations and requirements as these, already form the foundation of our programs, policies, procedures and training.

Connecting our Experience and Relationships to Summit County

Based on our experience with Salt Lake County, we are uniquely positioned to leverage the strong relationships we have built in northern Utah with providers and other stakeholders in the region to further enhance the service delivery system in Summit County. We have mechanisms in place to communicate effectively with system stakeholders, coordinate care across systems in the region by sharing documents and information and respond to the needs of the community. Based on our strong relationships with the community and our proven track record in the adjacent county, Optum can support Summit County in meeting its goal to be the healthiest county in Utah.

Our contractual relationships with providers in Salt Lake County and the region will support and enhance those contracted providers we have already secured in Summit County. We have reached out to several of our providers in the Wasatch Front and many have expressed an interest in contracting with OSC to provide services in the Summit County area. This expanded network will benefit clients in Summit County when it is necessary for them to seek or receive services in Salt Lake County. Having the availability of a provider network offering all levels of care across both counties will allow us to offer behavioral health care in the right place, at the right time, and in the right amount with a focus on reduction of acute care and goals that will result in cost containment and fiscal responsibility.

Currently, the Department will provide space for clinicians in the Kamas (*2 offices and a private waiting area*) and Coalville (*1 office space and shared waiting area*) Health Department Offices. Space in Park City will be available, located at a central transit hub, the Summer for 2020. During the interim, temporary space has been secured for 12 months. Will you require this Park City space, or will you plan on finding your own Park City / Kimball Junction offices?

If we are selected as the LCP, Optum Summit County will utilize all the office space that has been made available in Kamas, Coalville, and Park City. We will work with our contracted providers to establish predefined office hours at these three locations and will share the times with the health departments and local medical

providers so they may refer clients in need of behavioral health services, coordinate care for clients with comorbid medical/behavioral health conditions, and promote health care integration across the provider community. The OSCteam also will use the space, when available, to meet with clients, families, providers and other Summit County residents.

Describe LCP's experience and capability to deliver, track, and bill Medicaid services and manage operations.

Experience and Capability to Manage Operations

Optum has supported county-based Medicaid health systems for over 30 years with customized solutions, services, and supports. Today, Optum serves nearly 6 million clients insured through Medicaid and CHIP in 32 states and the District of Columbia through our behavioral health public sector programs, under contracts with states, counties, and managed care plans. We have developed and maintain the nation's largest behavioral health network to meet the needs of these clients with over 186,000 performance-tiered contract providers.

This extensive experience has provided us the knowledge and expertise to effectively manage the operations of a large Medicaid behavioral health care system. We have experienced staff, including leadership positions, clinical management expertise, information technology systems, provider relations processes, and education/training programs to support a system of care.

Experience and Capability to Manage the Delivery of Medicaid Services

We recruit, credential and contract with qualified and experienced behavioral health providers. To ensure effective treatment services, we monitor and oversee the quality of their work, using a variety of strategies including data analysis and performance standards. We support providers with orientation, ongoing training and with tools such as free online continuing education, online report capabilities to track performance, and online claims submissions. Our Network Management Team exists to provide monitoring, feedback, clinical consultation, and training as well as:

- **Provider Handbook:** All network providers receive a printed copy of the provider training manual upon request. The Provider Handbook will include information about the Optum Summit County program benefits and our policies and procedures, and information regarding payment terms and utilization review.
- **Optum Summit County Website:** All providers will have access to the dedicated OSC website and the wealth of information that is provided there specifically for our providers. The website will include our provider portal, which will contain:
 - Online versions of the Provider Handbook and Provider Directory
 - Clinical practice guidelines
 - Quality and utilization requirements
 - Training materials, recorded webinar presentations, and other educational content
 - Cultural competency information
 - Monthly provider newsletters and copies of recent email blasts
 - A link to the Optum Integrated Care Coordination System for Community Care Management
 - County-specific guides and regulations
 - Accessible level of care guideline, along with a link to the online versions of these
- **OptumHealth Education:** This website, accessible through a link on the OSC website, offers over 100 hours of free on-demand continuing medical education/continuing education units accredited education on a variety of topics, including MAT and trauma-informed care. OptumHealth Education has a strong basis for determining training that will have an impact on provider practices with access to de-identified medical, pharmacy, and laboratory claims data on approximately 30 million lives. Trained educators design and implement programs that enhance clinician knowledge and lead to productive behavioral changes and improving patient and public health outcomes.

Experience and Capability to Track and Bill Medicaid Services

Because Optum operates a managed care network model we don't directly deliver or bill for Medicaid services. However, we track and process prior authorization requests, claims payments to our providers and report encounters for more than nearly 6 million Medicaid members nationwide. Our electronic data warehouse collects millions of pieces of data relevant to each of our managed health care systems. This wealth of data

allows our data analytics staff to generate standard and ad hoc reports to track performance to targets and manage all aspects of our interactions with the provider network. Provider survey results demonstrate that timely and accurate claims payments are a top priority for providers. Our national data for 2018 claims received year to date shows that we have achieved:

- Payment accuracy of 99.87%
- Claims processed within 10 business days at a rate of 95.55%
- Claims paid within 30 calendar days at a rate of 99.04%

Managing Operations

Optum operates a number of public sector programs that are similar to the one in Salt Lake County. Management teams in those local operations have significant autonomy, but operate with the oversight, support and resources of Optum's corporate clinical and administrative leaders. Our internal policies and procedures for managing public sector mental health and substance use disorder services were developed and have been refined by the dedicated teams responsible for those public sector programs. Because each public sector program is different, one of the most important responsibilities during implementation is to adapt the policies so they are aligned with the local delivery system and contract terms. One of the most critical documents we produce for each contract is a compliance document that serves as a checklist for our local Director and team to ensure that each local team remains in compliance with Optum's internal operational standards as well as all additional requirements imposed by our contract partner.

One of the most significant lessons we have learned through our public sector contracts is the importance of transparency—of sharing data on our performance and system change with our contract partners and stakeholders. Our quality management committees and the OSC website will both be used to share information with interested Summit County citizens and also to request their input and feedback.

Describe LCP's experience with Quality Management, including a plan capable of adhering to DSAMH documentation standard and requirements.

- Staffing, supervision, training, retention, and leadership,
- Systems of quality assurance as it relates to clinical chart documentation and compliance,
- Capacity and plan to perform quality improvement activities, data entry, data and outcome tracking and program evaluation

The core goal of our Quality Management (QM) Program for providers is straightforward: improve quality of care, services, and outcomes for individuals through the application of evidence-based best practices. To evaluate the impact and effectiveness of our program, we include clearly defined goals related to both clinical and administrative effectiveness that will directly align with the County's strategic goals, DSAMH documentation standards and requirements and Medicaid requirements. This includes measurable objectives, data feeds, responsible parties, frequencies of activities, and target completion dates as part of our Quality Improvement (QI) Work Plan. Optum's corporate quality management staff and resources are available to provide consultation and assistance to our local team, which ensures that all our QM efforts are done in compliance with applicable national standards.

As a part of our oversight of network provider performance, we conduct routine clinical monitoring audits of treatment records. These audits, conducted by independently licensed behavioral health clinicians, evaluate whether providers meet Optum and community standards for assessment, diagnosis, treatment planning, coordination of care, and ongoing documentation of services.

We provide additional information on our QM experience below.

Describe LCP's experience with Quality Management, including staffing, supervision, training and leadership.

Experience with Quality Management

Quality management—and continuous quality improvement—are at the core of our approach to managing behavioral healthcare delivery systems. Quality activities are not siloed as a standalone function – they are

embedded in all our processes, from clinical functions to technology and reporting. During our seven years of experience in Salt Lake County, we have managed and organized all DSAMH and CMS/Medicaid audits in partnership with the County; as a result, we are familiar with DSAMH mandates and Medicaid regulations. We audit our providers on an ongoing basis to verify that they fulfill these requirements and, based on outcomes from audits, we design our trainings to address areas for provider improvement and development. Some training examples in Salt Lake County include:

- The Golden Thread: an approach related to treatment planning, service delivery and documentation in which assessments and diagnoses are the foundation for client-centered treatment plans with progress notes outlining the interventions implemented to meet identified goals and objectives
- Suicide Prevention and Safety Planning
- Treatment planning and documentation
- Cultural Responsiveness
- Contractual requirements to include timely access and LEIE/SAM exclusion checks
- OQ[®] Measures (administering questionnaires and incorporating into treatment planning)

Our audit tools (a site tool and a record tool) assess for compliance with DSAMH mandates and Utah Medicaid requirements. With these tools, we will be able to effectively monitor staffing, supervision, training, and leadership in Summit County. Claims validation is another component of our provider monitoring process. Additionally, in situations where we identify specific concerns related to Fraud, Waste, and Abuse (FWA), the auditor will notify the Optum Program and Network Integrity department for further review.

Staffing

Our Quality Management Team includes our Medical Director, Director of Compliance and Quality Assurance and Program Improvement, Senior Clinical Quality Analysts, Compliance Manager, and Clinical Appeals Reviewer. However, we expect all our staff to be active participants in the QM Program by:

- Reporting on and monitoring key quality metrics for their department on a routine basis
- Attending and actively participating in QM committees and subcommittees
- Promoting recovery, resiliency, and reintegration in the selection of QM activities and studies
- Adhering to policies, procedures, and workflows approved by our customers and any appropriate external review organizations
- Providing documentation/data for external reviews and site visits, as needed
- Looking for ways to improve our performance in service to clients and our customers

We will continually monitor multiple areas of our performance and our impact on clients, families, and providers and constantly look for ways to improve to facilitate QM success.

Supervision and Leadership

The Medical Director and Executive Management Team play key roles in facilitating and managing QM and the Executive Director oversees the quality committee structure.

Training

All our staff are trained on the QM Program and their role in quality activities at the time they are hired and at regular intervals thereafter. We expect staff to continually look for areas of improvement in the performance of the organization and our providers, as well as to suggest innovative ways to improve our service and to promote recovery, resiliency, and reintegration.

Annual trainings include: Cultural responsiveness, Fraud Waste and Abuse, privacy and security, Health Insurance Portability and Accountability Act (HIPAA), code of conduct, and the special needs plan model of care, amongst others. We also conduct an annual review of all our local policies and procedures.

Describe LCP's experience with Quality Management, including systems of quality assurance as it relates to clinical chart documentation and compliance.

We regularly review our internal clinical processes, including compliance with clinical guidelines, policies and procedures, and clinical documentation. We describe clinical chart documentation and compliance of our contracted providers in the previous section under Experience with Quality Management. We use the following to monitor internal Optum activities.

Care Advocate Quality Reviews. We monitor and review random sample of calls monthly to verify:

- Consistency and compliance with Optum policy and procedures
- Consistent application of the clinical criteria and other clinical guidelines required by contract or regulation
- Compliance with any delegated Level of Care Guidelines related to Utilization Management

We complete individual-centric call reviews to assess customer service and call handling skills. Supervisors then report the results to the Care Advocates to facilitate improvement in the quality of customer service and decision-making by clinical staff. We also review additional records should a Care Advocate demonstrate a pattern of deficiency. Scores are reported monthly to senior clinical leadership who implement corrective actions as needed.

Inter-Rater Reliability: We perform Inter-Rater Reliability reviews based on Care Advocate audits and report the results on an annual basis. Care Advocate audit tools contain a question that measures the consistency with which staff apply our clinical guidelines. This question is applicable to all staff who make Utilization Management decisions based on application of Level of Care Guidelines, Behavioral Clinical Policies, the Coverage Determination Guidelines, or other guidelines required by contract or regulation. Our experience is that using this question on actual calls is much more meaningful to our staff than providing a separate test using scenarios.

Auditing Clinical Charts of our Network Providers: An important part of our responsibilities as an MCO is auditing records of our provider network to ensure that they are in full compliance with standards related to documentation of the services provided to and on behalf of clients enrolled with OSC. As described in more detail in responses related to our Quality Management program, we audit our providers on an ongoing basis to verify that they fulfill all requirements related to the provision and documentation of treatment. Based on outcomes from audits, we design our trainings to address areas for provider improvement and development. Our audit tools (a site tool and a record tool) assess for compliance with DSAMH mandates and Utah Medicaid requirements. With these tools, we will be able to effectively monitor staffing, supervision, training, and leadership in Summit County. Claims validation is another component of our provider monitoring process. Additionally, in situations where we identify specific concerns related to Fraud, Waste, and Abuse (FWA), the auditor will notify the Program and Network Integrity department for further review.

Describe LCP's experience with Quality Management, including capacity and plan to perform quality improvement activities, data entry, data and outcome tracking and program evaluation.

Capacity and Plan to Perform Quality Improvement Activities

Optum has embedded a continuous quality improvement (CQI) process within the structure of our QM Program both nationally and within each local public sector program. The CQI process provides the mechanism by which barriers to delivering optimal behavioral health care and services are identified, opportunities are prioritized, and interventions are implemented and evaluated for their effectiveness in improving performance.

In addition to conducting our own quality management and CQI activities, Optum currently manages the Performance Improvement Project on behalf of Salt Lake County Division of Behavioral Health Services (DBHS), which was implemented to increase suicide risk assessment and safety planning. This included administration of the Columbia Suicide Severity Rating Scale (C-SSRS) upon admission and other times when individuals demonstrate suicide risk. When indicated, providers work with the client to develop a safety plan on

the same day.

Data Entry, Data and Outcome Tracking

When performance measures do not meet expected standards, we conduct a barrier analysis to assess the reasons for the identified deficiencies. Techniques used to determine the barriers may include the collection of additional data, stratification of the data, or analysis of subgroup data to sufficiently understand the reasons for the results. We apply common CQI techniques (e.g., brainstorming, diagramming, and identification of key factors) to identify barriers to improvement. We assess, select, and implement appropriate interventions to overcome the barriers, and then select an applicable timeframe to evaluate the results. Once the interventions have been in place for the recommended timeframe, an evaluation of results occurs to see if the interventions resulted in the intended effect and improved performance. If so, the selected interventions continue until we reach the goal and performance is stable. If the interventions are not effective, we select and implement alternative interventions until the goal is reached and performance is stabilized.

We created a tool for providers to submit data related to screening using the C-SSRS and subsequent safety planning in Salt Lake County. We repeatedly offered training to providers related to screening, clinical documentation, and data submissions. The Optum IT Reporting Team compiles and analyzes the data to complete the Health Services Advisory Group (HSAG) Performance Improvement Plan (PIP) submission materials. Optum then uploads required information to the HSAG portal on behalf of Salt Lake County DBHS.

Program Evaluation

Under the direction of the Quality Committee, key metrics are monitored at regular intervals through the Quality Work Plan. For local public sector programs, these key metrics are specific to the contract requirements and County Strategic Goals. In addition to this monitoring, we complete a formal written annual evaluation of our QM Program with the following information:

- A description of completed and ongoing QM activities that address quality and safety of clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- Analysis of the results of QM initiatives
- Evaluation of the overall effectiveness of the QM Program

Optum leadership, Quality, and Network Department staff review the data findings with the IT Reporting Team to identify barriers and to develop plans each year to increase participation and reporting of the interventions.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

3) Staffing and Administration

Describe, in detail, LCP's Organizational Structure, including:

1. Staffing capacity to perform all functions in this RFP,
2. Mental Health Treatment Staffing Plan showing proposed treatment FTEs by profession and where reporting structure, clinical supervisor to staff ratios, staff to client ratios, professional credentialing and staff specialization.
3. SUD Treatment Staffing Plan showing proposed treatment FTEs by profession and where reporting structure, clinical supervisor to staff ratios, staff to client ratios, professional credentialing and staff specialization.
4. QM Staffing Plan including staff for QI activities, data entry, data and outcomes tracking, and program evaluation functions.
5. Staff Supervision Model that includes a description of the role of the clinical supervisor(s) in staff coaching, client care, and QI and service utilization activities.

6. Treatment Services Staff Training Schedule and Technical Assistance Plan

Staffing Capacity to Perform all RFP Functions

As an MCO, Optum Summit County will incorporate two major resources for meeting our contractual requirements: a contracted provider network to provide direct treatment services and supports to Summit County clients; and Optum staff and infrastructure in Salt Lake County and in corporate locations across the country.

We rely on geo-access reports and access standards to ensure that we have an adequate number and array of network providers to make appropriate and timely services available to clients. Those access standards replace the ratios mentioned in this question. We will discuss our recommendations with Summit County. For instance, today in Salt Lake County, appointment availability is measured as follows:

- Routine Appointment (non-urgent): Within 10 business days of the request for services, unless the client requests a later time
- Urgent Care Appointment: Within 5 business days
- Emergent: Within 30 minutes by phone, one hour face-to-face

The OSC team will be comprised of a subset of the experienced clinicians and administrative staff based in Salt Lake County. Their work with Summit County clients and providers will be coordinated by the Summit County Director. The Executive Director ultimately will be responsible for ensuring that services are provided in compliance with industry standards, contractual requirements, state, federal and county regulations. Both the Director and Executive Director will meet regularly with Summit County officials to ensure that the OSC team is meeting the County's expectations.

Staffing Capacity

We will ensure that sufficient staffing is provided to effectively perform the functions of the contract. Our organizational structure is under the supervision of the Executive Director, Medical Director, Deputy Director of Utilization Management and Care Coordination, and Director of Compliance, Quality Assurance and Performance Improvement. Complementing this top tier of oversight, our organization includes managers who oversee and supervise our recovery and resilience activities, clinical activities, clinical quality assurance and performance improvement, data analytics, finance, and claims. The Executive Director will be ultimately responsible for contract compliance. The Summit County Director will be the key liaison with providers, stakeholders and the Department and for coordinating with staff to ensure all Summit County clients and providers receive the support they require.

Mental Health/SUD Treatment Staffing Plan

The Mental Health/SUD Treatment Staffing Plan is illustrated in the Organizational Chart reflected in Attachment D – Proposed Organizational Chart. As noted above, our provider network will be responsible for all direct treatment services and support. Our clinical and quality management teams provide monitoring and oversight.

Quality Management Staffing Plan

The Quality Management Team includes the Medical Director, Director of Compliance, Quality Assurance and Program Improvement, a Senior Clinical Quality Analyst, a Care Advocate, a Compliance Manager, and a Clinical Appeals Reviewer. Summit County specific reports and quality-related initiatives will be developed and implemented by the QM Team.

Staff Supervision Model

Our staff supervision model includes management staff who monitor and manage the functions of a team of Care Advocates who provide utilization management and care coordination. Experienced clinical supervisors provide guidance to the team, resolving problems, and driving recovery, resiliency, and reintegration principles into the team functions. The team, in turn, translates those principles into meaningful processes and offerings for clients with the assistance of the manager. The manager provides coaching and mentoring to the team to support their professional growth and provision of the most effective services possible to clients.

Staff in clinical management roles are also responsible for direct case management and utilization review of

mental health and SUD services, including authorization, concurrent review, and coordination and assurance of appropriate levels of care to clients. Management staff will provide case management services through review and evaluation of inpatient and outpatient behavioral health treatments for medical necessity, emergency status, and quality of care. These staff members will also facilitate resolution of client issues and concerns.

Staff Training and Technical Assistance Plan

Staff training includes initial and comprehensive orientation as well as ongoing training on a variety of topics. Our training team will plan and conduct a wide array of training, which will be geared to expanding staff understanding of mental health and SUD treatment services, including evidence-based practices and recovery-based services and supports. Additionally, we provide training to all Care Advocates, Peer Specialist and care management staff regarding recovery, resiliency, and reintegration.

As noted in other responses, we also will provide a comprehensive orientation and training program for our network providers. The training offered will be directed in part by our quality management findings and CQI processes.

Optum Staff Training

Everyone on our Salt Lake County team will receive basic orientation and training about our new responsibilities as the LCP for Summit County. New employees will receive five weeks of training that covers their job responsibilities as well as details about Summit County operations. Training for existing staff will focus on unique aspects of the Summit County contract, local providers, county staff and community resources.

Training will include, among others, topics such as:

- Orientation to Summit County policies, procedures, network and resources
- Applicable Utah regulations and policies
- Recovery, Resiliency, Reintegration, and Self-Directed Care
- Client Rights and Responsibilities
- HIPAA Privacy rules
- Appeals, Grievances, and Complaints
- Compliance requirements regarding Federal, Commonwealth, and county laws and regulations
- Evidence-based Practices, including treatment of co-occurring disorders
- Level of Care Guidelines, including ASAM criteria
- Cultural Competencies
- Social Determinants of Health
- Peer Staff and Peer Provider Roles and Responsibilities
- Developing Comprehensive Care Plans for Clients (WRAP Plans, Advance Psychiatric Directives, Personal Medicine)
- Adverse Events
- Quality of Care Complaints
- Data-driven Intensive Care Management

In addition to comprehensive client services training, we will provide our Provider Relations team and clinicians with Summit County-specific training that addresses the unique system requirements and community resources.

These resources will include:

- Benefit information
- All mental health and SUD assessments
- Provider information, including specialties, location, and contact information
- Information regarding drop-in centers
- Information regarding resources to address social determinant of health needs, such as housing authorities, food banks, and shelters
- Information on support groups, such as Alcoholics Anonymous and Narcotics Anonymous, and other community centers and resources

- Family support information, including the National Alliance on Mental Illness and the Depression and Bipolar Support Alliance along with local resources such as those available via the Summit County Department of Health, school based programs like Communities that Care, Summit County Connect, Summit County Mental Wellness Alliance and other community organizations and programs.

Each team member will also complete annual training in cultural competency, with an emphasis on the unique needs and characteristics of the Latino and Spanish-speaking communities, and Mental Health First Aid. Mental Health First Aid is an in-person training that teaches clients how to help people who are developing a mental illness or in a crisis. It teaches staff to recognize signs of addictions and mental illnesses, offers a five-step action plan to assess a situation and help a client, and informs those who take the training about local resources. Referrals for clinical care are provided by a licensed clinician.

Training Methods

We also will use a variety of training strategies, especially those leveraging technology, to enable staff members to take part via computer or telephone. These include:

- Classroom based training
- Client face-to-face, mentoring-type training
- Web-based training via webinars and self-paced modules which can be accessed via a desktop computer, tablet, or smartphone

Describe, in detail, LCP’s communication plan and ability to inform and communicate with the public and beneficiaries regarding services.

We work to ensure Summit County clients, the community, and other stakeholders receive detailed information regarding behavioral health care and services that are available in Summit County. We will coordinate with Summit County Health Department, behavioral health and physical health providers and other stakeholders to develop and disseminate appropriate materials for a seamless transition, including those for initial start-up and materials for ongoing care.

We will also work closely with the Summit County Mental Wellness Alliance and CONNECT Summit County and collaborate with additional identified community organizations and stakeholders to verify that we are including the most current and relevant information for Summit County clients. The Alliance and CONNECT maintain comprehensive resource databases and we will coordinate to cross reference their resources on our available materials and through our website. We will submit our information and resources to the County Health Department, Alliance and CONNECT so that this content can be included in their resource database. These organizations will be valuable partners as we work to educate clients and the community about how to connect with needed services and supports.

Client Orientation, Development, and Ongoing Communication

Upon contract award, we will work with County staff to finalize our training and communication plan. Strategies for outreach and education will include community forums, webinars, client and prospective client informational materials, our dedicated OSC website, which includes the educational resources accessed through LiveandWorkWell.com. Information will include a description of the MCO’s responsibilities and our partnership with the Health Department, an overview of changes including the expansion of available treatment providers, how the MCO will support goals of the Strategic Plan, and system of behavioral health care, cultural competency, implementation timeline, key personnel, contact numbers, and other critical information such as how to access services and assurances that services will not be interrupted during the transition.

Orientation

Orientation for clients and their families will be offered initially during the implementation period, and will continue to be provided regularly throughout the contract period or as long as the client is enrolled with Optum Summit County. After written materials have been approved by Summit County Council members, we will notify clients of material availability. When a client calls to request written materials, we will provide them using mail, email, or another process requested by the client.

All client materials are written at a 6th-grade reading level or less using a font size of 12-point (minimum). To accommodate non-English-speaking clients and clients with different communication styles, we offer translated materials and interpretive services and can provide information in Braille, large print (18-point minimum) for hard copies, and voice recorded CD formats. We will work closely with our Summit County QM committees, community organizations such as the Alliance, CONNECT, and county staff to develop materials that are current, Summit County-specific and reflect the principles of resiliency, reintegration, and recovery.

Optum uses a variety of methods to help clients get behavioral health services. For the most individualized support, we encourage clients with questions to call our HIPAA-compliant toll-free telephone line and speak with our licensed clinical staff.

In addition to the availability of Spanish-speaking staff in our Client Services Call Center, we offer a language line to provide interpreter services in over 200 languages for clients with limited English proficiency. We will focus on providing sufficient resources for Spanish-speaking clients in Summit County. Clients who are hard of hearing or deaf will be able to use Utah Relay 711.

We will use a variety of ways to communicate with Summit County clients and introduce OSC as the new LCP, including:

- Welcome Letter: We will send a Welcome Letter to all clients explaining the change. If the Department prefers, we also can support County officials' in producing and mailing a letter explaining the upcoming system expansion
- Direct outreach to clients receiving treatment services in the weeks just prior to the transition to Optum as Summit County's MCO/LCP to assist them select and make appointment(s) with providers of their choice as necessary
- Forums in various communities which will provide details to help clients get the most out of their health plan
- Client Handbook: All clients will receive a Client Handbook via the Utah State Mail procedure. This same handbook will also be available online
- Additional resources and materials, as described below in Education and Ongoing Communication, will also be available to all transitioning and new clients

Education and Ongoing Communication

When clients understand their rights and responsibilities, they are more apt to have good outcomes from their treatment programs. Therefore, we have developed a range of client materials — both printed and electronic — to support the client in his or her goals for better health. Our client materials and resources are designed to help clients understand all their covered health care services and how to access them as quickly as possible. We provide many opportunities for clients to engage with us via mail, phone, or via our website.

For non-English speaking clients, our website will include information on how to obtain program information in a variety of languages. The website also will include information for clients who are vision- or hearing-impaired. For clients who are hearing-impaired, we will include information about how to access Relay Utah 711. For clients who have impaired vision, our Care Advocates will assist them or connect them to our Care Management Team for assistance.

We will work with Summit County, as well as the Alliance, Connect and other stakeholders, to test and approve the format of the website, as well as its functionality at varying bandwidths. We will update our website monthly with new program information or other information, as available.

The variety of materials and resources available to clients to support them in their self-management of behavioral health conditions and to improve their communications with treating providers is described below:

- Client Portal: LiveandWorkWell.com, our online client portal, provides clients with a wealth of information and resources on overall health and wellness. The site is available in Spanish by selecting

language preference on the home page

- LiveandWorkWell.com also includes a broad selection of educational material that is of interest to caregivers and family members. It is accessible without a password and at no charge.
- In addition to information of interest to clients, LiveandWorkWell.com also offers educational material and other resources for caregivers as well as network providers and the general public
- Website: Our website will contain an online version of our Client Handbook and educational materials that a client may need in order to navigate available resources. We also will post notifications regarding legal changes, regulations, bulletins and alerts regarding important program changes. An example of one of our client websites can be found at <https://optumidaho.com>
- Resiliency, Engagement, and Activation Choices (REACH): Clients can access this Web-based tool on LiveandWorkWell.com. This tool helps a client determine where he/she falls within a “stage of change” as determined by their “engagement” and “activation”. These two key elements are terms often used synonymously, but they are two different aspects of a continuum of health and well-being management. Engagement is the process by which an individual and a health care system can establish the connections that link health, illness, and well-being to a system of care. Activation occurs as an individual becomes empowered to improve and sustain their own health and wellness. The individual’s responses are then used to populate results. The results page brings materials and self-care tools to the individual at the right time based on the individual’s own level of activation and stage of recovery
- Mobile Applications: Optum will help clients connect with mobile applications such as:
 - **AA Big Book and More, by Rob Laltrello** (iOS) (<https://itunes.apple.com/us/app/aa-big-book-and-more/id513779578?mt=8>), an easy to use app which helps clients keep track of their sobriety and offers encouraging daily messages
 - **SuperBetter** (<https://www.superbetter.com/>) a gaming application, which helps clients build resilience, set personal goals, and do simple things every day to move toward well-being
 - **Mindful Meditation** (<https://www.uclahealth.org/marc/app>), an online meditation tool to help maintain good mental and physical health
 - **DBSA Wellness Tracking** (<https://tracker.facingus.org/>), a system for tracking on a daily, weekly, and monthly basis, your mood, symptoms, lifestyle, medications, and overall health to facilitate better interaction with treating providers
 - **WhatsMyM3** (<https://itunes.apple.com/us/app/whatsmym3/id515945611?mt=8>), a private 3-minute mental health tool to screen for depression, anxiety, bipolar disorder, and post-traumatic stress disorder (in English and Spanish).
- Whole Health Tracker: The Whole Health Tracker is available via LiveandWorkWell.com (<https://www.liveandworkwell.com/content/en/public.html>) and Provider Express (<https://www.providerexpress.com/content/ope-provexpr/us/en.html>) to support clients’ management of health conditions, including behavioral and physical health conditions, such as Attention-Deficit/Hyperactivity Disorder, pregnancy and obesity. The Tracker focuses on domains of wellness, including healthy eating, physical activity, restful sleep and stress management. The Tracker follows a person-centered planning approach to help clients reach whole health, wellness, and resiliency goals through self-management
- Customer Service Team: Each time a client calls the dedicated toll-free number, the caller will speak with an experienced Care Advocate who has been thoroughly trained in customer service processes and the Summit County program
- Client Events: We will collaborate with providers, state agencies, community-based organizations, and the Provider associations to participate in events and community forums in the county and will publish a calendar of these events for clients. This will enable us to provide education and information to Summit County clients
- Peer Support Services: We will provide information regarding Peer Support Specialist services through identified Providers who will provide outreach, communication, and support to clients and their families in a number of ways
- Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Client Support: We provide information through LiveandWorkWell.com regarding resources to support clients identifying as LGBTQ. This includes specialty areas noted in the Provider Directory to address LGBTQ client needs and peer support resources and groups

- **Seeking Safety:** We will direct clients to Seeking Safety groups facilitated by trained Peer Support Specialists, described more fully below.

Training

Optum provides a variety of training opportunities appropriate for clients, families, caregivers, community members, and civil servants, as well as providers.

- **Question, Persuade, Refer (QPR) Training:** We will offer QPR training, a suicide prevention approach that has proven outcomes. QPR is an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. It is an evidence-based practice recognized by SAMHSA and is available through our website, LiveandWorkWell.com. QPR can be presented in person or on the LiveandWorkWell.com site.
- **Mental Health First Aid:** Mental Health First Aid is an in-person training that teaches clients how to help people developing a mental illness or in a crisis. It teaches communities at large to recognize signs of addictions and mental illnesses, offers a five-step action plan to assess a situation and help a client, helps communities recognize the impact of mental health disorders and SUD, and informs clients of local resources where they can turn for help. The program can be specifically configured for unique populations such as first responders, long term care providers, nursing home staff, youth populations, etc. Targeted populations include youth under 18 years and adults 18 years and older.

Potential Client Resources

We will provide information on the dedicated OSC website explaining how clients can use virtual visits, Optum’s approach to telehealth. To access virtual visits, clients will download an app from the OSC website which will allow them to make an appointment with a Utah-licensed behavioral health provider who is enrolled in the virtual visits program. Using a cell phone, computer or tablet, clients will be able to participate in a therapy session with their selected provider.

Describe, in detail, LCP’s plan and ability to recruit and retain quality staff members, including those able to provide competent, culturally aware, and linguistically accurate care in Spanish.

Optum will use a multi-pronged approach to recruit candidates for the position of Optum Summit County Director and also to fill vacancies in other positions that also will be responsible for providing clinical management or administrative support to the County’s clients, providers and stakeholders:

- Upon contract award, we will begin screening applications from qualified applicants who may be interested in joining OSC and who meet our requirements for education and experience. We will particularly recruit candidates who can provide excellent references, preferably from local stakeholders and Summit County staff. If necessary, we will use corporate recruiting support and resources to identify potential candidates both outside and within Optum who may be interested in working with the OSC team
- We also will leverage our recruiting strategies and relationships in Utah to identify, recruit, and fill available positions, whenever they occur

Because we value the expertise of staff who are employed by the current LCP, we will encourage them to apply for available positions, and we also will encourage our network providers to look to those experienced staff as they expand their teams to serve the influx of new Summit County clients.

Retention

We work hard to retain quality, high-performing staff members. Currently our turnover rate is less than 10% annually. Our methods to retain staff include:

- We offer a comprehensive benefit package that includes medical, dental, and vision insurance coverage; paid time off, short-term and long-term disability coverage, matching 401k benefits; access to credit union services, and the UnitedHealth Group, Incorporated Employee Discount Program.
- We reward staff for performance results, including recognizing staff as “super heroes”
- We regularly measure employee satisfaction, including checking in to confirm that staff are trained to do

what they are hired to do and that they are provided opportunities for professional development and advancement

- We monitor the staff turnover rates across the organization and our human capital team is preemptively engaged in any areas where retention appears to be an emerging issue
- We promote from within and provide tools for an employee to develop their professional career to advance within our organization. This continued support and focus on advancement is a key factor in our retention of staff

Culturally Competent Staff – Spanish, Latino, and Hispanic

We are an Equal Employment Opportunity/Affirmative Action employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, age, national origin, protected veteran status, disability status, sexual orientation, gender identity or expression, marital status, genetic information, or any other characteristic protected by law.

We know that diversity creates a healthier atmosphere and we value our diverse workforce. In those markets where one particular cultural or linguistic group needs particularly attention, we seek out members of our workforce to serve those clients. In Summit County there is a need for both staff and providers who are able to communicate effectively and accurately in Spanish. This need will drive our efforts to seek out qualified staff members from the Spanish-speaking Latino and Hispanic communities. By targeting our recruitment strategies there, we hope to engage interested individuals. We will also focus on collaborating with community and governmental agencies that serve these groups to identify those who may wish to explore employment opportunities with Optum. Our goal is to increase the number of our employees and network provider staff who are linguistically fluent in Spanish and who can converse accurately in Spanish about health care issues.

Describe, in detail, LCP’s support programs located outside of the District

Optum Summit County will provide two services located outside of the district that includes Summit County – inpatient and residential care. Both of these services will be provided in Salt Lake County, contiguous to Summit County.

Inpatient care: These services will be provided by St. Mark’s Hospital in Salt Lake City, Jordan Valley Medical Center in West Jordan, and the University of Utah Neuropsychiatric Institute (UNI). These services will be available in Salt Lake County for children, youth, and adults. Provided that medical necessity is met, adult inpatient services will be available at all three facilities and services for children and youth will be available at UNI. Additionally, if these facilities are not available due to capacity issues or the individual is not in the area at the time inpatient care is needed, Optum will develop a Single Case Agreement (SCA) with the facility that will be accepting the client.

Residential care: Residential care will be made available on an as needed basis to meet the individualized needs of the adult, youth, or child.

In addition, we will contract with out-of-network facilities on a client-by-client basis using a single case agreement (a contract specifically related to services for that individual) if a client is admitted to a hospital outside our network.

Describe, in detail, LCP’s ability to ensure that all services outlined in this RFP are provided by staff with required credentials and licenses.

Staff Credentials and Licenses

We hire independently Utah-licensed behavioral health clinicians to perform utilization and care management functions, and during the recruitment process, we verify that they have the appropriate licensure, credentials, education, and experience applicable to their position and in compliance with Utah State requirements. We have provided detailed descriptions of our staffing plans in Question 3, “Staffing and Administration,” of this Form .

Provider Credentials and Licenses

Through our credentialing and re-credentialing processes, as well as through ongoing monitoring, we verify that direct service providers are qualified to provide the treatment services and supports for which we contract with them. We also verify that providers who are providing specialty care have obtained the appropriate training and certification, if required.

Our Credentialing Plan follows NCQA accreditation standards and will be modified to include the following additional Utah requirements:

- Verification of enrollment in good standing with Medicaid (Providers of Supplemental Services must be enrolled in the Medicaid program)
- Verification of an active Medicaid Provider Agreement

We do not delegate these functions. They are conducted within Optum.

- We perform primary source verification for: license, Drug Enforcement Administration (DEA) certificate or furnishing number, malpractice insurance, education, and breaks in employment greater than six months
- The National Practitioner Data Bank is queried for any disciplinary actions and Providers are reviewed monthly against the federal Health and Human Services, Federal Office of Inspector General, and State Disbarment databases
- Optum contracts and credentials Providers in accordance with Title 9 requirements and National Standards

We re-credential providers every three years in accordance with NCQA guidelines. Based on expiration dates, we monitor, document and verify professional licenses, DEA and malpractice insurance. During re-credentialing, any complaints received in the prior three years as well as the resulting response/escalation/resolution are presented to the Credentialing Committee for consideration and recommendation for action as appropriate. Optum recognizes that Providers often supplement staff with non-independently licensed employees to render care to clients. To confirm that quality of services being rendered, the provider will be required to comply with our supervisory protocol and state guidelines. The non-licensed individual would be under the supervision of a psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which services are provided, who practices as an employee of a group and has been credentialed or formally rostered and approved by Optum, in writing, as a Participating Supervising Provider.

Through the breadth of our public sector experience, we recognize that many clients are supported through a complex web of services to meet their behavioral health, social, and functional needs. We understand the roles these providers play in supporting recovery-based services. We place a priority on the recruitment of providers with special skills and abilities as well as culturally and linguistically appropriate providers. Our provider credentialing and re-credentialing process includes the collection and updating of provider demographic and specialization data to facilitate matching of clients to appropriate providers whenever possible. Critical specializations we capture include autism spectrum disorders, co-occurring disorders, intellectual and developmental disabilities, children with special needs, comorbid medical conditions, trauma-informed care, and SUD services.

Building a Stable Provider Network

Optum is focused on building stable provider networks in all of our markets, including Utah. Our goal is to provide sufficient network capacity, using a network model, to close any potential gaps or vacancies. This model, which relies on multiple independent providers, provider groups, and facilities, is much more stable than that of a single provider agency.

We also plan to build redundancy into our network, as we have in for other areas. Redundancy means that wherever possible, we have more than one provider offering the same services or supports. By doing this we are able to offer clients choice of provider. We also can maintain continuity of care by transitioning clients to another provider should their regular provider move or leave the network for another reason. Our network policies do allow us to execute Single Case Agreements (SCAs) with providers for specialty services until we

can come to an agreement with other network providers who can fill that need or recruit the specialty provider into the network. This type of network model will provide stability for clients and for Summit County. Optum currently has contracts and Letters of Intent (LOIs) with 20 Summit County-based behavioral health providers and are actively recruiting other Summit County providers.

A key part of our plan to build a stable, redundant network is to leverage the existing provider contracts we have in place in our Optum Salt Lake County contract. We will also use our network providers in Summit County that are contracted to serve our other health plan business.

Since 2011, Optum has participated in transforming the Salt Lake County behavioral health system from a single provider-run system to a comprehensive network model. This new model increased the provider network from a single provider agency to over 600 providers (mental health and SUD), expanded specialty provider expertise, increased client choice, addressed service gaps and increased the focus on recovery and resiliency for peers and families. This has resulted in an increase in the number of people served, significantly reducing the reliance on inpatient services through expanded crisis response resources; redirected those savings to greater community-based resources and significantly increased the role and participation of peers and clients in direct service delivery, as well as system planning.

We currently have providers in Salt Lake County. In addition to the community behavioral health center, this includes:

• 18 facilities	• 16 psychiatrists
• 437 social workers	• 39 psychologists
• 49 registered nurses	• 56 provider groups

LCP meets the minimum General Insurance requirements of this RFP as outlined in Section 2-IV-G: Yes/No

Yes. We look forward to clarifying certain insurance requirements during contract negotiations. For example, we wish to clarify it is acceptable in Section G.1.(b)(i)c to have a standard professional liability policy limit based on a per claim basis instead of per occurrence which would be consistent with the “claims made” statement in Section G.1.(a)(i) and standard insurance industry practice.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) LCP’s Audited Financial Statement

Describe, in detail, LCP’s overall organizational structure, including:

- LCP’s audited financial statements as Attachment H and provide written explanation of any of the following findings:
 - Auditor presents a qualified audit opinion,
 - Balance sheet liability exceed assets,
 - There are overdue payments due to a State or Federal agency,
 - There is a Federal or State account currently in collections,
 - There is current pending litigation for fraud, misrepresentation, errors or omissions involving one or more current or former employees of the organization,
- Auditor notes or footnotes that indicate:
 - Organizational instability or uncertainty as to its ability to continue in its current business,
 - Overdue State/Federal amounts,
 - Pending litigation involving organizations’ employees, management, director or Board of Directors.

As stated above in our response to Form A, Question 1, the legal entity responding to this RFP is United Behavioral Health, Inc. (“UBH”). UBH has adopted the brand “Optum” as part of a leading health services business. UBH is established as a managed care organization per the LCP minimum qualifications criteria in Section 2 II) 4) of the RFP and eligible to receive Medicaid funding. We are part of UnitedHealth Group, Incorporated, a fully independent organization that does not provide direct clinical services and we intend to provide services as an MCO through a network of providers that we will oversee.

Optum’s legal bidding entity, UBH, is a wholly owned subsidiary of United Healthcare Services, Inc. (UHS), which is a subsidiary of UnitedHealth Group, Incorporated. United Behavioral Health is a privately held company and does not have or maintain and is not otherwise legally required to have or maintain separate audited financial statements. UBH’s financial information is consolidated into UHS. Therefore, we have included the most recent UHS and Subsidiaries consolidated financial statements in Attachment H.a, Audited Financial Statements (UBH Consolidating Supplemental Schedules), with UBH included in the Consolidating Schedules. In addition, the most recent 10-K for UnitedHealth Group, Incorporated is included as attachment H.b Audited financial Statement (UHN-Q4-2018Form 10K).

Our independent auditor, Deloitte & Touche LLP, who have served as the company’s auditor since 2002, have issued an unqualified audit opinion as noted in the attached financial statements. There were no unfavorable findings with respect to the bulleted items above noted in the auditor’s opinion. In fact, please note that within the attached UHS financials, total assets at \$119,573 million exceed total liabilities at \$52,899 million, with \$65,373 million in total equity. The accompanying notes to the financial statements contain additional disclosures regarding regulatory capital and dividend restrictions as well as commitments and contingencies (note 13), such as performance guarantees, legal matters, and government investigations, audits and reviews.

The following ratings for UnitedHealth Group, Incorporated, our parent company, provide an appropriate basis for measuring the financial strength for UnitedHealth Group, Incorporated and individual entities, including UBH.

Credit Ratings. Our credit ratings as of December 31, 2018 were as follows:

	Moody’s		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt.....	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper.....	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

5) Access & Eligibility for Mental Health and/or Substance Abuse Clients

How will you inform the public on what services are available?

As described above in our response to Question 3, we will complete and implement a comprehensive communication plan to inform clients, families, providers, and the larger community about the services that will be available through Optum Summit County and changes that will happen, especially the expansion of clients’ choice of providers. Our goal is to see that Summit County clients and other stakeholders receive adequate information regarding the behavioral health services available to them, how to access them, and where to direct questions.

Before September, we will work with the Department to create a news release (or a series of releases) that they can share with all media that cover Summit County to provide key information about available behavioral health services, impending changes, and contacts within the Department and OSC for additional information.

Leveraging the public involvement and support for the Mental Wellness Strategic Plan, we also will support the Department in providing the media with data and de-identified examples of the impact of the new approach to delivering behavioral health services.

Summarized from Question 3, highlights of our overall communication plan for informing all stakeholders, including the public, about available services includes:

Orientation:

The general orientation program will include community forums at various locations in the county prior to beginning operations. These forums will be aimed at educating Summit County clients and other residents of the change in the LCP effective September 1, 2019. During the community forums we will provide information regarding the services that will be available and answer any questions regarding the transition. Our orientation will also include welcome letters mailed to all clients prior to the start of operations with information on the services that are available and how they can access our provider directory through contact with our Client Services Call Center or on our client portal. Optimally, we will receive information on all the clients who used behavioral health services within the past year. If that information is available, we will conduct targeted outreach to those clients via letter and telephonically for those who are high risk to introduce our health plan and discuss their transitional needs and to educate them about the services available.

During orientation we will also provide additional materials in a variety of formats and offer our toll-free phone line where clients can speak with our Care Advocates and licensed clinical staff to receive service information. We will also provide a client handbook and additional resources described below.

Education and Ongoing Communication:

A variety of resources will be available to clients, including our Client Portal, LiveandWorkWell.com, which includes our provider directory. This website provides information on how to obtain program information in a variety of languages, including Spanish, and for clients who are vision- or hearing-impaired.

Briefly, the variety of resources is listed here, with more detailed descriptions above in Question 3.

- Client Portal, LiveandWorkWell.com
- REACH (Resiliency, Engagement, and Activation CHOICES) and other self-assessment tools
- Mobile Applications to support recovery, including:
 - AA Big Book and More, by Rob Laltrello (iOS), helps clients track their sobriety
 - SuperBetter, with which clients can build resilience, set goals, and progress
 - Mindful Meditation, to maintain good mental and physical health
 - DBSA Wellness Tracking, documenting daily client status
 - WhatsMyM3, a 3-minute mental health screening tool
- Whole Health Tracker
- Care Advocate Team who are knowledgeable about the provider network, services available, and how to access treatment.
- Client Events, such as health fairs
- Peer Support Services
- LGBTQ Client Support

Training:

We will provide a variety of training opportunities appropriate for clients, families, caregivers, community members, and civil servants, as well as providers. For detail on these training opportunities, please see above in Question 3.

- QPR Training
- Mental Health First Aid
- Seeking Safety Facilitator Training

What are your projected days and hours of operations, including holidays?

Our days and hours of operation, when staff will be available to assist clients and providers, will be Monday and Thursdays from 8 am to 8 pm Mountain Time and Tuesdays, Wednesdays, and Fridays from 8 am to 5 pm Mountain Time. Our crisis call center operations will be available 24 hours a day/365 day a year to assist clients and providers with urgent or emergent behavioral health needs. Additionally, we will work to contract with providers who are available for evening and weekend in-person appointments to accommodate various client schedules. Currently, we have crisis services and community outreach providers who can also serve Summit County.

Describe LCP's format or scheduling appointments, including any triage measures used to reduce wait-times.

Format for Appointment Access Standards

Optum develops and maintains a provider network with adequate numbers and types of clinicians to support client choice and requires that the network adheres to specific access standards, which are outlined below. These access standards are defined within our Salt Lake County provider manual and we monitor their adherence regularly. We are developing a similar provider network for Summit County, which will include local providers and will be required to meet the access standards.

Our access standards for Summit County will be as follows:

- Routine Appointment (non-urgent): Within 14 business days of the request for services, unless the client requests a later time
- Urgent Care Appointment: Within 5 business days
- Emergent: Within 30 minutes by phone, one hour face-to-face

Triage Measures to Reduce Wait Times

Aligned with our recovery-oriented care approach, we empower clients to take responsibility for their own health care and understand that sometimes clients with behavioral health conditions require additional supports. When this occurs, our Client Services Call Center operations and clinical staff assist clients who require appointments timelier than is required of providers and engage with providers to accommodate walk-in appointments. We will also engage additional innovative resources to accommodate clients quickly, such as:

Express Access Network: Our Express Access Network is a sub-group of our contacted network providers that agree to offer clients appointments up to five days sooner than required by the access standards described above. In markets, such as Summit County, where we are responsible for directly contracting with providers and setting reimbursement rates, we develop a unique sub-network of providers who contractually agree to see individuals up to five days sooner than the industry standard of 14 days. We typically offer incentives to providers to encourage participation in this network. Approximately seven percent of Optum's outpatient visits for behavioral health services are delivered by an Express Access provider. Optum's Provider Relations Team will develop and administer the program for Summit County. We will promote and attempt to contract with providers willing to participate in this program.

Virtual Visit Network: Optum is expanding access to virtual visits, which enable clients to receive needed services in convenient locations through the use of a computer or Smart Phone. Optum was the first behavioral health organization to offer an independently contracted virtual visits network that is fully integrated with our face-to-face clinicians. Currently, more than 4,800 of our Providers in all 50 states offer virtual visit services to their clients, from initial evaluations to ongoing treatment, psychotherapy, and medication management. Clients can search for Providers, schedule, reschedule, and attend virtual sessions through our real-time, HIPAA-secure, video-based technology platform. We look forward to discussing this possibility with Summit County upon contract award. Today we have three agencies, contracted to provide virtual visits. The agencies are Summit County – Summit Community Counseling, Silverado Counseling Services, and The Lotus Center. These practices provide virtual visit services through our Salt Lake County agreement and are accessible and prepared to serve Summit County residents through virtual visits.

What are the criteria used to determine who is eligible for a public subsidy?

As described above, we expect clients who either have the ability to pay or have adequate insurance to pay for as much of their treatment as possible. However, for the underinsured and uninsured client proof of income must be provided. When determining the appropriate fee for services, providers are encouraged to take into account other financial responsibilities the client has, such as mortgage or rent, paying of fines, child support, etc., which demonstrate they are a contributing member of society and working toward recovery. For those who are indigent a history is obtained which shows the need for treatment and the lack of ability to pay for treatment. All providers are educated that the lack of ability to pay for treatment cannot be a barrier to treatment. The sliding fee scale applies to anyone who enters treatment under a public subsidy.

All qualifying residents of Summit County are eligible for services regardless of their ability to pay subject to availability of funds. We do expect residents with insurance, adequate wages, or other forms of payment to pay for as much of their care as possible, but payment is based on our Local Authority approved sliding fee schedules.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Subcontractor Monitoring

Describe how subcontractors are selected and what criteria is utilized.

Optum sometimes utilizes providers as subcontractors to fulfill contract requirements and to enhance our service offerings in a variety of markets as we do in Salt Lake County today.

Criteria for Selection of Subcontractors

There are a variety of criteria we utilize to select subcontractors which include:

- If they are already rendering services within the market
- What their performance has been in providing the service(s)
- If they are identified as a minority, women, and/or veteran-owned business
- If they have the requisite license(s) and insurance requirements to perform the service(s)
- If they are in good standing with federal, state, and local government to perform work through government funded programs
- The cost of their service(s)

Once a potential subcontractor or a specific service is identified that we would like to explore by establishing a business relationship, we engage our Enterprise Sourcing & Procurement team to outreach to the potential contractor, verify that all requirements to serve as a subcontractor for Optum are met, and negotiate and execute a contract that includes the scope of work.

Describe how monitoring will be conducted, what items will be monitored, and how required documentation will be kept up-to-date for subcontractors.

Our oversight of subcontractors is both ongoing and at regularly defined intervals, depending on the work delegated to the subcontractor.

Monitoring Subcontractors

For the call center operations subcontracted to ProtoCall, Optum Summit County will receive monthly call reports that indicate the volume of calls received, speed of answer, abandonment rate, and handle time.

Our telephony platform includes NICE Uptivity Call Recording software so every call can be recorded. Samples of calls will be reviewed quarterly for quality assurance and appropriateness of disposition.

Required Documentation

Reporting will be reviewed monthly and incorporated into our regular Quality Assurance and Performance Improvement program reporting.

What services outlined in this RFP will you require subcontractors for?

We plan to use ProtoCall Services, Inc. for our after-hours call center operations for providers. ProtoCall is a nationally recognized and accredited provider of specialized behavioral health call center services. Optum has successfully partnered with ProtoCall since 2008 to support behavioral health call center-related contract needs in Washington, New Mexico, Utah, and Idaho. If a provider contacts ProtoCall after hours and needs prior authorization for client care, ProtoCall will assess care needs against the appropriate program utilization guidelines and render the care determination. ProtoCall is utilized for provider calls received after 5 pm MST on weekdays and on weekends and holidays.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

7) Transition and Implementation Plan (Unless current LCP)

Describe your plan for hiring and on-boarding staff to serve Summit County. Include details on any plans to retain current clinicians and case managers to maintain continuity of care.

Recruitment and Hiring of Optum Summit County Staff

We have started identifying potential candidates to fill new and vacant positions and will continue these efforts until Summit County announces its contract award. We will fill all positions if we are the selected bidder. As described in our previous response, we will use a variety of methods to publicize available positions in our recruitment efforts.

Optum Summit County Staff Onboarding and Training

All Salt Lake County-based staff will receive training about our new responsibilities in Summit County. New employees begin five weeks of training upon hire, much of which is completed on the job, concurrently with their job duties. This on-the-job training for onboarding staff may include activities such as shadowing experienced staff and then being shadowed during client calls by tenured staff to identify teachable moments and to confirm compliance with policies, procedures, HIPAA Privacy and client rights.

Training will include, among others, topics such as:

- Orientation to available Summit County and Local Resources
- Recovery, Resiliency, Reintegration, and Self-Directed Care
- Member Rights and Responsibilities
- HIPAA Privacy rules
- Appeals, Grievances, and Complaints
- Compliance requirements regarding Federal, State, and county laws and regulations
- Evidence-based Practices, including treatment of co-occurring disorders
- Level of Care Guidelines, including ASAM criteria
- Cultural Competencies
- Social Determinants of Health
- Peer Staff and Peer Provider Roles and Responsibilities
- Developing Comprehensive Care Plans for Clients (WRAP Plans, Advance Psychiatric Directives, Personal Medicine)
- Adverse Events
- Quality of Care Complaints
- Data-driven Intensive Care Management

Current employees who will be assuming some Summit County responsibilities will participate in contract-specific training, especially related to local resources, services offered in Summit County, local providers and Summit County policies, procedures and contract terms.

Initially and throughout the contract period, we will make employment opportunities available to all local qualified candidates, including those who have been employed by the current LCP. We value the experience that these professionals possess and will consider them fully for available positions on our team. We make it a practice to consider local talent in each market that we enter, realizing that these individuals know their communities and can bring this knowledge to effectively serve the clients in their regions.

Retention of Optum Summit County Staff

As discussed above in our response to Question 3, our goal is to recruit and retain quality, high-performing staff members. We do that by rewarding performance, measuring employee satisfaction and addressing opportunities for improvement, and monitoring staff turnover rates to identify any trends for staff leaving positions. We also believe in promoting from within, which provides incentive for employees to develop their professional skills to advance their careers within our organization. Our continued support and focus in this area are key factors in our retention of staff.

It also is likely that many of our network providers will be recruiting additional clinicians and case managers to serve Medicaid clients that will be coming onto their caseloads. We will encourage our providers to provide interviews to staff of the current LCP to retain their knowledge, experience and expertise within the public sector delivery system.

Describe your plan for transferring of all files related to the care of clients, including IT Infrastructure development.

Upon award of the Summit County BH contract, Optum will coordinate with Summit County for the ingestion of all go-live files, including an initial file of current member data including their current authorization data, including dates, diagnoses and additional necessary data to initiate operations and to identify high risk members for care management outreach and ensure continuity of care.

Provider credentialing will also be initiated with provider information being loaded via the Optum OPTICCS portal for providers' licensure information, Provider Express. For any other file transfers at go-live, a secure file transfer protocol will be followed for file ingestion. After go-live, for continued file transfers, the data would be transferred via one of the following methods as applicable to Summit County and the data exchange partner:

- sFTP – secure file transfer protocol
- UHIN – Utah Health Information Network electronic file transfer gateway, standard EDI file transfers
- myAvatar ProviderConnect – for non-EDI electronic claims submissions
- OPTICCS Portal – Provider Express for provider credentialing
- Utah DHS SAMHIS Portal - for SAMHIS data submissions as required
- USMail, Fax, Secure Email – for the rare occasion that claims are submitted by providers preferring or unable to use UHIN or Provider Connect.

Implementation:

For transfer of files to Optum at go-live, we can ingest the following historical files for the care of clients at implementation:

Via sFTP

- Reports and other confidential files not being transferred via UHIN or PConn, can be sent or received through our secure file transfer protocol methodology.
- 834 eligibility files – 834's are received from the State of Utah via sFTP in standard 834 industry format.
- Initial Client Demographic Load Files – at implementation we would accept a file of member

authorization data to include authorization dates, diagnoses, and associated demographic data which we would use to start operations and to identify high risk members for care management outreach and ensure continuity of care.

Via Optum OPTICCS Portal

- Providers – Credentialing providers into the Optum network would occur via the Optum OPTICCS Portal, Provider Express, which would capture the credentialed information into our internal systems.

On-Going File Transfers:

Upon implementation, regular file transfer processes will be enacted. The files that will be transferred for the care of clients post-implementation are:

Via UHIN

- 837 files – 837 is a standard industry format for plan member claims sent by providers to Optum.
- 999 files – File level acknowledgements sent to providers to confirm receipt of 837s.
- 277CA files – Claim level acknowledgements sent to providers to advise which claims were rejected (not ingested) vs. accepted into our system for adjudication.
- 835 payment advice files – 835 files are sent to providers when claims are processed and paid.
- 837E files – encounter files which are submitted from Optum via UHIN to the State of Utah.

Via NetSmart ProviderConnect

Claims submitted via the PConn Portal – While many files that are transferred into and out of the Optum are handled by our EDI team via UHIN, for providers not able to participate with EDI transactions, myAvatar also has a secure portal (Provider Connect, a.k.a. PCONN) that can be used for submitting information related to the care of the clients such as authorization requests and treatment information. We assume the same approach could be used for Summit County file transfers.”

Via sFTP

Reports and other confidential files not being transferred via UHIN or PConn, can be sent or received through our secure file transfer protocol methodology. For example:

- 834 eligibility files – These files are received from the State of Utah via sFTP in a standard 834 industry format.

Via Optum OPTICCS Portal

- Providers – Ongoing new credentialing of providers into the Optum network would occur via the Optum OPTICCS Portal, Provider Express, which would capture the credentialed information into our internal systems.

Via SAMHIS Portal

Data is uploaded to the Utah Department of Human Services/Division of Substance Abuse and Mental Health. Mental Health Event Records (MHER) contains certain demographic and service information for mental health consumers served with a Utah county network.

Via Non-Electronic Submissions

Optum encourages the use of secure electronic means for transfer of data related to the care of clients. However, some providers are unable to participate in EDI processes for claims and they might not choose to enter claims into the Optum OPTICCS myAvatar PConn portal. In those rare instances, claims can be sent via US Mail, fax or secure email.

Describe your plan for mitigating client attrition due to LCP change.

Continuity of care and working with clients through the transition is critical to mitigate attrition and make them feel comfortable with the changes in the service delivery system. We would appreciate the support of the Summit County Health Department in two ways:

- Helping us get electronic files from the incumbent LCP so we can import key utilization information and easily identify clients who are currently receiving services; and
- Discharge and transfer summaries provided by the current LCP clinicians to the clients' newly selected treatment provider(s)

Both kinds of data are critical to providing a smooth transition for clients and minimizing the number of clients who fail to select or keep appointments with a new provider.

After the award is made and we have received historical utilization information, we will begin contacting clients to help them understand the upcoming transition. First, a welcome letter will be sent providing our contact information. Our customer service team Care Advocates will answer clients' questions and assist them in selecting a new provider and making an appointment, if they request help. Our care management and peer support staff will directly contact clients who have been in active treatment relationships to assist them during the LCP change. We will monitor claims data for the first three months of the contract period and follow-up with any clients who were receiving treatment services prior to September 1 and have not received services since.

We have been contacted by a few clinicians who are working for the current LCP who have let us know that they intend to become independent practitioners and continue to serve Summit County clients. However, all clients will have the opportunity to select the provider of their choice from our network, and the OSC team will make a focused effort to ensure that clients and families understand their opportunity to establish new relationships and how to do that.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

- END OF FORM A -

Attachment B

Staffing/Budget

Attachment B

For this attachment, each LCP is required to create a spreadsheet with the following information pertaining to estimated staffing in Summit County:

- Position Classification
 - Administration
 - Staff
 - Clinicians
 - Spanish Service Clinicians
 - Case Management
 - Peer Support
 - Lab
- Position Title
- Position Licensure and/or Certification
- FTE
- Benefit Percentage
- Average Pay for the Position
- Salary Funds Support from the Summit County Contract
- Percentage of Total Salary and Benefits Supported by the Summit County Contract
- Salary Funds Support From the LCP
- Percentage of Total Salary and Benefits Supported by the LCP
- Totals for the Above

Classification	Title	License / Certification	FTE	Benefit Percentage	Funded from Contract	Percentage	Funding from LCP	Percentage	Position Total
Clinician	Director Summit County	LCSW/LPC/RN/LMFT	1.00	36%	\$ 158,500	100%	\$ 0	0%	\$ 158,500
Case Management	Care Management – UM	LCSW/LPC/RN/LMFT	0.10	38%	\$ 10,000	10%	\$ 74,500	90%	\$ 84,500
Clinician	Psychiatrist	MD	0.03	9%	\$ 10,100	3%	\$ 268,000	97%	\$ 278,100
Case Management	Recovery/Resiliency Manager	LCSW/LPC/RN/LMFT	0.05	21%	\$ 7,800	5%	\$ 123,500	95%	\$ 131,300
Case Management	Peer Support Specialist	LCSW/LPC/RN/LMFT	0.05	45%	\$ 4,300	5%	\$ 68,700	95%	\$ 73,000
Case Management	Family Support Specialist	LCSW/LPC/RN/LMFT	0.05	45%	\$ 4,300	5%	\$ 68,700	95%	\$ 73,000
Staff	QI Manager	BA	0.05	21%	\$ 7,800	5%	\$ 123,500	95%	\$ 131,300
Staff	Appeals & Grievances Coordinator	BA	0.05	45%	\$ 4,300	5%	\$ 68,700	95%	\$ 73,000
Staff	Benefit Analyst	BA	0.05	45%	\$ 4,300	5%	\$ 68,700	95%	\$ 73,000
Staff	Group Analyst	BA	0.05	45%	\$ 4,300	5%	\$ 68,700	95%	\$ 73,000
Staff	Network Manager	BA	0.10	32%	\$ 10,600	10%	\$ 79,500	90%	\$ 90,100
TOTAL			1.58		\$ 226,300		\$ 1,012,500		\$ 1,238,800

Form B

Mental Health Narrative

RFP # SUCO20197552

FORM B - MENTAL HEALTH BUDGET NARRATIVE

Submitting Agency (LCP): United Behavioral Health, Inc. (Optum or Optum Summit County)

Instructions:

The following form is modeled off of the annual **Mental Health Area Plan** the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

If you are unable to provide a service, please indicate the reasons why. If you feel you need to amend your ability to meet the service, provide detailed rationale along with the proposed amended delivery.

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form B is limited to a maximum of 40 pages.** Refer to Section 1-VII of the RFP to ensure **all required services and metrics are provided in your provided responses.** FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for FY20. Funding contracts are for July 1st to June 30th.

The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. Final numbers will be known by July, 2019.

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

Projected FY20 Mental Health Funding from Contracted Sources: \$1,300,000

Inpatient Services: *Inpatient services refer to inpatient hospital services overseen by a psychiatrist for includes treatment for serious mental disorder. Inpatient psychiatric services vary from short-term or outpatient therapy for low-risk patients to long term care or permanent care such as routine assistance treatment, or a specialized and controlled environment.*

1) Adult Inpatient:

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$84,500	Form A1 - Projected Clients Served in FY19 Area Plan	7
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$90,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	7

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Adult Inpatient Services

Our network of qualified inpatient providers will be available for these services. They will provide medically necessary, post-stabilization services as required by Optum’s Level of Care Guidelines. Our Utilization Management (UM) team will provide utilization management (UM) services to ensure quality of care and patient engagement, to monitor treatment, and to manage to the appropriate level of care. The UM team will also provide a bridge between clients and their outpatient treatment providers through individualized care coordination to ensure the client is linked to appropriate step down services and supports upon discharge. Our UM team is made up of experienced, licensed clinicians who work in tandem with our Psychiatrist.

Where and How Services Will be Provided

Optum Summit County (OSC) will contract with University Neuropsychiatric Institute (UNI), University of Utah Medical Center, Jordan Valley Medical Center- West Valley , and St. Mark’s Hospital for Adult Inpatient Care. Should our in-network facilities be at capacity or an out of network facility is the right choice for the client, we will implement a Single Case Agreement (SCA) with a qualified provider.

Provider Qualifications

Through our NCQA-certified credentialing, recredentialing and contracting standards and guidelines, Optum will validate that all providers have the proper education, qualifications, licensure, and experience to render care and services appropriate to their provider type and specialty. Any provider that does not hold national accreditation (e.g., the Joint Commission, Utilization Review Accreditation Commission (URAC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other governing body) must pass a site visit before joining our network and then every three years during routine recredentialing. Please see Form A, Question 3 – Staffing and Administration for more detail on our credentialing process and standards. We promptly investigate quality of care complaints and suspected quality concerns, which may result in additional onsite visits outside the credentialing process. OSC will also partner with the County to conduct any additional audit or outreach as required. Optum will validate that all inpatient hospital services for our clients are overseen by a psychiatrist for serious mental disorder treatment.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the

uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

2) Children/Youth Inpatient

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - FY19 Amount Budgeted:	\$85,250	Form A1 - FY19 Projected clients Served:	5
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$86,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	5

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Address Children/Youth Inpatient Mandated Services

Our qualified inpatient provider will be available for these services. They will provide medically necessary, post-stabilization services as required by Optum’s Level of Care Guidelines. Our Utilization Management (UM) team will provide utilization management (UM) services to ensure quality of care and patient engagement, to monitor treatment, and to manage to the appropriate level of care. The UM team will also provide a bridge between clients and their outpatient treatment providers through individualized care coordination to ensure the client is linked to appropriate step down services and supports upon discharge. Our UM team is made up of experienced, licensed clinicians who work in tandem with our Psychiatrist.

Where and How the Services Will be Provided

We work with providers and families to promote community-based treatment as a less restrictive alternative whenever possible. While our preference is to provide inpatient services close to the child’s home, currently there are no child/youth inpatient facilities in Summit County. We work primarily with UNI and 5 other out-of-network facilities that offer inpatient services to children/youth. Initial hospitalization assessments will be performed either in the primary care unit or by crisis staff in the ER at any hospital. Should our in-network facility be at capacity or an out-of-network facility be the right choice for the child/adolescent, we will implement a single case agreement with a qualified provider.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. All inpatient hospital services for our clients are overseen by a psychiatrist with experience in treating serious mental disorders.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Residential Care: Residential Care is a structured service setting or program that provides short-or long-term overnight care delivered in a specialty facility/hospital/center/clinic, specifically for the treatment of behavioral health clients. It is an intensive treatment setting or program distinct from a hospital inpatient setting or program, and provides supervised living coupled with supportive mental health services. Residential Habilitation is a bundled service which includes personal care, homemaker services, nutritional meals and snacks, medication oversight (to the extent permitted under state law), social and recreational activities and 24-hour onsite response to ensure the care, well-being, health and safety needs of the residents are met at all times.

3) Adult Residential Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,000	Form A1 - Projected Clients Served in FY19 Area Plan	1
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$10,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	1

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and means to provide Adult Residential Care Mandated Services

Our network of qualified residential providers will be available for these services. They will provide medically necessary, post-stabilization services according to Optum’s Level of Care Guidelines. Our Utilization Management (UM) team will provide utilization management (UM) services to ensure quality of care and client engagement, to monitor treatment, and to manage to the appropriate level of care. The UM team provides a bridge between clients and their outpatient treatment providers through individualized care coordination to ensure the client is linked to appropriate step down services and supports upon discharge. Our UM team is made up of experienced, licensed clinicians who work in tandem with our Psychiatrist.

Where and How Services Will be Provided

We will use the Highland Ridge Sub-acute Residential Treatment unit which is located in Midvale. We will use providers in our network for an Intensive Outpatient Program (IOP) model that is inclusive of client and group therapy, case management, Medication Management, recreation, and peer support.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. For Adult Residential Care Mandated Services, we will make sure short-or long-term overnight care is delivered in an appropriately credentialed specialty facility, hospital, center, or clinic, specifically for the treatment of behavioral health clients.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) Children/Youth Residential Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$20,000	Form A1 - Projected Clients Served in FY19 Area Plan	2
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	0	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	0

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Provide Children/Youth Residential Care Services

Our network of qualified residential treatment providers will be available for these services. They will provide medically necessary, post-stabilization services in accordance with Optum’s Level of Care Guidelines. Our Utilization Management (UM) team will provide services to ensure quality of care and client engagement, to monitor treatment, and to manage to the appropriate level of care. The UM team provides a bridge between clients and their outpatient treatment providers through individualized care coordination to ensure the client is linked to appropriate step down services and supports upon discharge. Our UM team is made up of experienced, licensed clinicians who work in tandem with our Psychiatrist.

Where and How Services Will be Provided

Optum Summit County Team will work with providers and families to support community-based treatment in a less restrictive alternative whenever possible.

We will partner with the following providers that currently provide treatment in Salt Lake County:

- **The Family Assessment and Stabilization Team (FAST)Program** – Division of Youth Services (DYS)– provides short-term out of home placement with an emphasis on family therapy, communication and coping skills. Youth reside at Youth Services usually while attending day treatment, while remaining in the custody of their guardian. Length of stay is 30 days or less. Services provided are individual therapy, family therapy and case management. A Family Resource Facilitator is available to support parents throughout this process.
- **New Beginnings** – New Beginnings is a 10-bed residential facility for male and female youth, located in West Jordan. Youth have access to school services along with therapeutic services, including medication management..

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. For Child/Youth Residential Care Mandated Services, we will make sure

short-or long-term overnight care is delivered in an appropriately credentialed specialty facility, hospital, center, or clinic, specifically for the treatment of behavioral health clients.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Outpatient Care: *Outpatient Care is a structured service setting or program that provides ambulatory (not overnight) care specifically for the treatment of behavioral health clients. Care is generally provided for visits of 3 hours or less in duration and 1 or 2 days per week or as needed.*

5) Adult Outpatient Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$365,241	Form A1 - Projected Clients Served in FY19 Area Plan	460
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$386,031	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	468

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Provide Adult Outpatient Care Services

Our network of qualified outpatient treatment providers will be available for these services. They will provide individualized medically necessary services focused on an ongoing strength based assessment and evaluation of risk, using a treatment/recovery plan to facilitate recovery at the lowest level of care needed.

Adult Outpatient services include but are not limited to, individual client and group therapy, medication management, family therapy, peer support services and case management. We will contract with various agencies to provide all services allowed by the client benefit plan and Medicaid BH fee schedule.

Where Services Will be Provided

Outpatient services will be made available in clinics, in-home or community based settings. Our network will include Summit Community Counseling (which is looking to add a location in Summit County), Psychiatric and Behavioral Solutions (PBS), Hopeful Beginnings (which is also looking to add a location in Summit County), SunDance Behavioral (which is also looking to add a location in Summit County), VOA (Cornerstone), Multi-Cultural Counseling, and other contracted group and solo providers.

Qualifications to provide this service

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is

comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Describe programmatic approach for serving individuals in the least restrictive level of care who are civilly committed. *(Civil Commitment is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment in a hospital (inpatient), or in the community (outpatient). All citizens have civil liberties that need to be protected under both federal and state laws, so following “due process” is of paramount importance. Treatment is not punishment! The state may need to deprive someone of their civil liberties because they pose a danger to self or others due to mental illness.)*

Our provider network will include providers such as VOA and Psychiatric Behavioral Solutions that focus on, and work closely with, the treatment needs of civilly committed clients. Our Care Advocates will authorize care in the most appropriate, least restrictive setting. If we encounter clients resistant to treatment, we will collaborate with our provider partners and engage case management and peer services to address the resistance and work towards treatment re-engagement. We take a recovery-oriented approach to client care and recognize that clients who are resistant to treatment often have not had an active voice in the services and supports they prefer to meet their health care needs. We use motivational interviewing, peer support and other evidence-based practices to re-engage hard to reach clients in their care.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Children/Youth Outpatient Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$262,725	Form A1 - Projected Clients Served in FY19 Area Plan	319
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$268,053	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	344

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Provide Children/Youth Outpatient Care services Our network of qualified outpatient treatment providers will be available for these services. They will provide individualized medically necessary services based on ongoing strength based assessments and evaluations of risk, guided by a treatment/recovery plan to facilitate recovery at the lowest level of care needed.

Child/Youth outpatient services include but are not limited to, individual client and group therapy, family therapy, medication management, respite and case management. Our providers address issues and have specialties in assessing high risk behaviors such as suicide risk, self-harm, substance use, trauma, and domestic violence. We recognize the impact that environment and systems have on youth; therefore our providers coordinate with schools, Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), the court, law enforcement, medical providers and other programs.

Where and How Services Will be Provided

Optum currently contracts with Summit Community Counseling, Psychiatric and Behavioral Solutions, SunDance Behavioral, Multi-Cultural Counseling Center and Hopeful Beginnings, among other group and solo providers. Summit Community Counseling and Hopeful Beginnings and SunDance Behavioral have shown strong interest in setting up a site and delivering services in Summit County.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers that render children/youth outpatient care. This currently includes 11 outpatient providers comprised of one psychiatrist, seven MSWs, and three PhDs.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

24-Hour Crisis Care: *Crisis Care is defined as a 24-hour, 365-day service available during a personal or social situation where mental distress is a significant contributing factor. Crisis is a behavioral change that brings the user to the attention of crisis services and this for example might result from relapse of an existing mental illness. The crisis is the impact of the change on the user and the disruption it causes to their life and social networks.*

For this RFP, the LCP is required to have full and timely coverage, 24/7, for crisis incidents in the Summit County Jail. For all other incidents, the LCP is required to respond during business hours. Incidents outside of these hours will be handled through the State Crisis-Line, Mobile Crisis Outreach Teams (MCOTs), and the Summit County Stabilization Team. Please note, once the LCP is selected, they will work with the Department to greater define their role with Crisis Care. The current expectation is a 60/40 split between the County and LCP for FY20. Per Crisis-Line and MCOT legislation passed in 2018, a local crisis-line is not required, but a plan for warm handoff is. The local director of the LCP will play a critical role in the oversight of this service and will serve on the Crisis Care Committee comprised of first responders, law enforcement, the Department, and the Park City Hospital.

7) Adult 24-Hour Crisis Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$11,392	Form A1 - Projected Clients Served in FY19 Area Plan	47
Form A1 - Actual FY18	\$21,501	Form A1 - Actual FY18	75

Expenditures Reported by Current LCP (VBH)		Clients Served as Reported by Current LCP (VBH)	
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Describe access to crisis services during daytime work hours, after hours, weekends, and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify proposed activities and where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Access to Crisis Services During Daytime Work Hours, After Hours, Weekends, and Holidays
 Our network will include a multidisciplinary team of mental health professionals, including Peer Specialists, providing a combination of crisis services including crisis intervention, assessment, psychiatric emergency care, stabilization, and follow-up. Crisis services and supports will be available 24/7/365. We will have coverage 24/7 for crisis incidents in the Summit County Jail, and we will respond during business hours for all other incidents. The State Crisis-Line, MCOTs, and the Summit County Stabilization Team will handle incidents outside normal business hours. The OSC Director welcomes the opportunity to participate actively on the Crisis Care Committee.

How Crisis Services Divert Clients From Higher levels of Care
 Crisis services provide rapid assessment of the factors that caused the crisis (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) The client’s condition is then stabilized, allowing many clients to be treated in a less intensive level of care. In Salt Lake County 90.41 percent of those receiving an outreach visit have been diverted from inpatient and ER visits in the past year.

Proposed Activities and Where Services are Provided
 OSC will contract with a crisis outreach provider that will respond to a crisis call within 30 minutes and arrive at the scene within one hour depending on location and weather. A clinician will assess the situation and make a determination regarding disposition, using the least restrictive alternatives to meet the client’s needs. This array of services includes telephone crisis-line services; warm-line telephone services, an in-person, strength-based assessment.

We will educate clients and the community about the following crisis access points:

- SafeUT Crisis Text and Tip Line – UNI: a statewide service that offers real-time crisis intervention to youth through texting and a confidential tip program available to users on their smart phone.
- Crisis Line – UNI: The crisis line is a phone line answered 24/7 by licensed mental health therapists. Staff will triage the call to determine if an immediate referral to one of our providers is needed. If immediate referral to MCOT is not necessary, crisis line staff work with the caller in an attempt to deescalate the client. If not truly a crisis, staff can also immediately connect the caller with the Warm Line.
- Warm Line – UNI: The warm line is a confidential anonymous phone line answered by Peer Support Specialists trained to provide support to callers between 3:00 and 11:00 PM, seven days a week, 365 days a year. Staff is trained to connect with, share, and provide support, hope, and a listening ear for individuals in times of stress and uncertainty. Callers are connected with someone who can truly understand their struggle because they have “been there before” and can provide a needed local resource or referral.

Providing Services through Contracted Providers
 Optum is in discussions with Hopeful Beginnings, an experienced crisis provider contracted for crisis services with Optum in Salt Lake, is interested in expanding to Summit County.

Provider Qualifications
 Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. UNI MCOT is an existing provider and has the experience and qualifications to perform these services.

Provide specifics, including timeline, of crisis services for incarcerated individuals.

When jail staff believes an incarcerated person is in crisis they will call our 24/7 client service line. Our staff will determine whether the client has a life threatening emergency, in which case they would instruct the jail to transport the client to the local emergency room or call 911. If determined to be non-life threatening, our staff will call our provider to arrange an in person assessment within 5 hours. If an in person assessment is not possible our local provider will do a tele-assessment. If the local provider can't do the tele-assessment within 5 hours, our staff will contact UNI to perform the tele-assessment. Based on the results of the crisis assessment, our local provider will deliver emergent care within 5 hours, urgent follow up care within 5 business days and routine follow up care within 10 business days.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

8) Children/Youth 24-Hour Crisis Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,620	Form A1 - Projected Clients Served in FY19 Area Plan	39
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$14,308	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	41

Describe access to crisis services during daytime work hours, after hours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify proposed activities and where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Access to Crisis Services

Optum will work with the County, clients and their families, providers, the Alliance, Connect, law enforcement, the schools and other stakeholders to ensure the community is able to recognize when someone is in a behavioral crisis and what to do when they are. During normal business hours crisis calls will be directed to the Optum client service line. Our staff will determine whether the client has a life threatening emergency, in which case they will keep the caller on the line while connecting with 911 for immediate assistance. If non-life threatening and the caller had their own transportation, they will be directed to our nearest provider location. If they don't have their own transportation, our provider will come to them within one hour of the call, weather and location permitting. Once connected, our provider performs an assessment, stabilizes the client and arranges for follow up care within 5 business days for urgent care and 10 business days for routine care.. The State Crisis-Line, MCOTs, and the Summit County Stabilization Team will handle incidents outside normal business hours. The OSC Director will welcome the opportunity to participate actively on the Crisis Care Committee.

How Crisis Services are Used as a Diversion from Higher Levels of Care

year.

Optum will provide an interdisciplinary team of mental health professionals, including Peer Specialists, through our network providers to provide a combination of crisis services including crisis intervention, psychiatric emergency care, and crisis follow-up for Summit County clients. The team will respond to a call within 30 minutes and arrive at the scene within 1 hour depending on location and weather.

The staff assesses the situation and makes a determination regarding disposition using all available resources to provide the best outcome possible using the least restrictive alternatives. At our Salt Lake affiliate, 90.41 percent of those receiving an outreach visit were diverted from inpatient and ER visits in the past year.

Proposed Activities and Where the Services are Provided

For Summit County, the OSC team will implement an approach similar to the one used in Salt Lake County, which utilizes contracted providers, including:

- **The OSC Team will work with a designated Provider(s) to assure crisis services are accessible in Summit County within the required timeframes.** This will include collaborating with local key stakeholders including the Summit County Health Department, Summit County and local jurisdiction police departments, and local School Districts. OSC also will work with key community partners like the Summit County Mental Wellness Alliance and Connect Summit County to educate the community on services and access to this care.
- **SLCo DYS–Juvenile Receiving Center (JRC):** This program offers screening, evaluation and referral services to youth, families and law enforcement 24/7. Services are for youth ages 8 to 17 who are runaway, homeless, and ungovernable or youth who have committed minor offenses. It is currently serving two locations: Salt Lake and West Jordan.
- **SLCo DYS–Crisis Residential:** Offers 24/7 crisis timeout service to run away and ungovernable youth ages 10 to 17.
- **Hopeful Beginnings** offers Crisis Services (FASTer Program) in Salt Lake County and will offer these services in Summit County. This includes going where the client is and providing in-home crisis services as needed.

The location where services are provided depends on the nature of the incident, where the incident occurred, and severity of the incident. While some of the above providers are based in nearby communities outside of Summit County, these and many of our providers have agreed to go where the clients are so services will be provided at the level of care and preferred location indicated by the clients and their parents/guardians.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Provide specifics, including timeline, of crisis services for youth during school hours.

We will contract with Hopeful Beginnings to run all school-based systems, programs and services, including crisis services, during school hours. We describe our approach to school based services in Form B-Question 24.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Psychotropic Medication Management: *Psychotropic Medication Management is the level of outpatient treatment where the sole service rendered is by a qualified psychiatrist or psychiatric APRN (Advanced Practice Registered Nurse), who is the initial evaluator of the patient's need for psychotropic medications, the provision of a prescription and as-needed, ongoing, medical monitoring/evaluation related to the patient's use of the psychotropic medication. Interactive psychotherapy is not being rendered at this time by the physician/prescriber, but may be provided by another clinician. The LCP is expected to provide a minimum of 40 hours of access a week to a psychiatrist and/or psychiatric APRN for Psychotropic Medication Management.*

9) Adult Psychotropic Medication Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$122,815	Form A1 - Projected Clients Served in FY19 Area Plan	213
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$147,260	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	215

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. Address how the LCP plans to expedite wait-times for appointments.

Activities and Means to Meet the Mandated Service

Optum clients will access our providers including Psychiatric and Behavioral Solutions, Hopeful Beginnings, SunDance Behavioral, Odyssey House, and other providers that offer psychiatric/APRN coverage. All clients will have access to a prescriber to adjust, change, or maintain their medication. We have APRNs in the commercial network. The contract requires other lines of business so we may have to pay these providers a higher rate than what is on the Medicaid fee schedule to meet the requirement of having enough providers for 40 hours a week and expedite the wait-times for appointments. Medicaid timely access standard is 30 minutes by phone and within an hour onsite if emergent, if urgent 5 business days – non-urgent is 10 business days. (based on level of acuity and risk the time to access, applies). We will meet monthly with Summit County Mental Wellness Alliance to collaborate on concerns and resolve issues.

Where and How Services Will be Provided

We will provide adult outpatient medication management services via our contracted network providers in Summit County or nearby communities. Additionally, we will evaluate the need for virtual visits to increase access to clients all across Summit County.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. Those who provide Adult Psychotropic Medication Management will be licensed psychiatrists, APRNs, and RNs. To increase access to care, Licensed Practical Nurses (LPNs) may provide this intervention where possible.

How We Will Expedite Wait-Times for Appointments

Our Utilization Managers will work with individual providers to expedite the appointments in a crisis situation. We have one Express Access provider located in SLCo who will provide medication management services to our Summit County clients. Express Access providers agree to see clients up to five days sooner than the Utah timely access standards. Lastly, we have four physicians and one nurse contracted to provide virtual visits in Summit County,

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

10) Children/Youth Psychotropic Medication Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$30,583	Form A1 - Projected Clients Served in FY19 Area Plan	47
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$46,503	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	48

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. Address how the LCP plans to expedite wait times for appointments.

Activities and Means to Meet the Mandated Service

Optum will access in network providers including Psychiatric and Behavioral Solutions, Hopeful Beginnings, SunDance Behavioral, Odyssey House and other providers that offer psychiatric/APRN coverage. All clients will have access to a prescriber to adjust, change, or maintain their medication. We have APRNs in the commercial network. The contract requires other lines of business so we may have to pay these providers a higher rate than what is on the Medicaid fee schedule to meet the requirement of having enough providers for 40 hours a week and expedite the wait-times for appointments. Medicaid timely access standard is 30 minutes by phone and within an hour onsite if emergent, if urgent within 5 business days – non-urgent is 10 business days (based on level of acuity and risk the time to access, applies). We will meet monthly with Summit County Mental Wellness Alliance to collaborate on concerns and resolve issues.

Where and How Services Will be Provided

Optum will contract with Psychiatric and Behavioral Solutions, Hopeful Beginnings, SunDance Behavioral, Odyssey House and other providers that offer psychiatric/APRN coverage. If chosen, Optum will evaluate the use of virtual visits to ensure increased and timely access for medication management appointments.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. Those who provide this service will be licensed psychiatrists, APRNs, and RNs within the scope of their license. LPNs may provide intervention where possible and within their scope of practice to increase access to care.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Psychoeducational Services & Psychosocial Rehabilitation: *Psychoeducational Services & Psychosocial Rehabilitation focuses on a patient's current life and relationships within the family, social, and work environments through one-on-one conversations with a therapist. The goal is to identify and resolve problems with insight, as well as build on strengths.*

11) Adult Psychoeducation Services & Psychosocial Rehabilitation

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$20,071	Form A1 - Projected Clients Served in FY19 Area Plan	165
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$25,357	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	167

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Adult Psychoeducation Services & Psychosocial Rehabilitation

Optum will contract with providers who have experience offering psychoeducation services to clients with Severe Mental Illness (SMI) that will help clients achieve goals of remedial and/or rehabilitative vocational adequacy necessary to restore a client to his/her best possible functioning level. We understand Summit County is working on an International Clubhouse Model program and we will work closely with them to include the program in our network and fully support the program.

Where and How Services Will Be Provided

Optum will partner with the identified providers to ensure that services will be provided in a setting designed to maximize the success of the client. This may include but is not limited to individualized or group based services in an office or community setting. For example: Psychosocial Rehabilitative Services may be provided in a group setting where the provider models positive interactions with a store clerk and then cues a client in a store setting to help him/her understand when it is appropriate to initiate the engagement. As needed, we will also seek to expand existing contracts such as Alliance House, an International Certified Clubhouse model program, in Salt Lake City to provide skills development programs for adults who reside in Summit County.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

12) Children/Youth Psychoeducation Services & Psychosocial Rehabilitation

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$5,080	Form A1 - Projected Clients Served in FY19 Area Plan	21
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$7,724	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	38

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Children/Youth Psychoeducation Services & Psychosocial Rehabilitation

Optum will contract with providers who have experience offering psychoeducation services to those children/youth identified with Serious Emotionally Disturbance (SED). The intent of the services will be to aid these children and youth to help the achieve goals of remedial adequacy necessary to restore a client to their best possible functioning level.

Where and How Services Will be Provided

The OSC team will partner with the identified providers to ensure that services will be provided in a setting designed to maximize the success of the client. This may include but is not limited to individualized or group based services in an office, community setting, or in the home. Additionally, Optum will explore the implementation of these service types in the school based setting.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Case Management: Case Management is an intensive service that is a key part of the continuum of mental health care and supports for persons with serious mental illness. Case management involves building a caring, trusting relationship with the client, promoting independence through the coordination of appropriate services, and providing on-going, long-term support as needed to function in the least restrictive, most natural environment and achieve an improved quality of life. Case management emphasizes frequent contact, small caseloads (<100 cases) and high intensity of care designed to improve planning for and responsiveness to the consumer's multiple service needs. The case manager coordinates required services from across the mental health system as well as other service systems (e.g., criminal justice, social services) as the consumer's service needs change. Intensive case managers fulfill a vital function for clients by working with them to realize personal recovery goals and providing the support and resources that the consumer needs to achieve goals, stabilize his/her life and improve his/her quality of life.

13) Adult Case Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$70,525	Form A1 - Projected Clients Served in FY19 Area Plan	375
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$84,048	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	389

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Offer Adult Case Management

Our network of qualified, treatment providers will assess for case management needs, in alignment with the requirements of the Utah Medicaid Targeted Case Management manual. Case Managers in our network are required to be certified in accordance with the Division of Substance Abuse and Mental Health (DSAMH) requirements.

Case Management Services will be provided to those clients classified with Severe Mental Illness (SMI) throughout the service continuum.

- Specific Case Management services include the following: Educate clients and their families in how to navigate the behavioral health care and social system
- Empower clients by enabling them to access new roles and responsibilities (e.g. gainful employment)
- Integrate clients into normalized community living: housing, activities and friends with whom to socialize
- Educate and support clients and their families in learning how to manage their resources

Where and How Case Management Services Will be Provided

Depending on the nature of the service and client need, services could be rendered in the provider office or where clients live, work, or in another location as appropriate. Optum has a continuum of providers who will provide case management services including: Silverado, Psychiatric and Behavioral Solutions, Volunteers of America, and Asian Association of Utah, among other contracted providers.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change). Provide the expected number of case managers to be provided.

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

14) Children/Youth Case Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$54,408	Form A1 - Projected Clients Served in FY19 Area Plan	104
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$61,979	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	104

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Offer Children/Youth Case Management

Our network of qualified, treatment providers will assess for case management needs, in alignment with the requirements of the Utah Medicaid Targeted Case Management manual. Case Managers in our network are required to be certified in accordance with the Division of Substance Abuse and Mental Health (DSAMH) requirements. The Optum Care Advocates assist in coordinating services as youth transition between levels of care and actively support our network of providers in linking youth and family to community resources.

Case Management will include coordinating care, accessing and linking clients to needed services in the community then monitoring, progress and the ongoing needs of the clients. Culturally responsive services will be provided to those youth classified with Serious Emotional Disturbance (SED) throughout the service continuum, including children who are at risk for development of a substance use disorder.

Specific case management services could include the following:

- Educate youth and their families in how to navigate the behavioral health care and social system
- Empower youth by enabling them to engage in school and age appropriate activities
- Educate and support youth in social and emotional learning
- Address the social determinants of health impacting the youth and their family

Where and How Services Will be Provided

Services could be rendered in the provider office or where clients live, schools or other locations as appropriate. Optum currently contracts with Summit Community Counseling for case management services. Hopeful Beginnings will also offer these mandated services and have made a commitment to locate services within Summit County.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change). Provide the expected number of case managers to be provided

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Adult Community Supports: *Adult Community Supports is independent, normal housing with flexible, individualized supportive services that allow individuals to maintain as much independence as possible.*

15) Adult Community Supports

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$509	Form A1 - Projected Clients Served in FY19 Area Plan	2
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$509	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	2

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Meeting Mandated Services and Where Services Will Be Provided

Based on the individualized needs of each client, Optum will work with our network and key community partners to develop a plan to maximize successful community tenure and promote independence in the least restrictive setting. Our utilization management and case management staff will coordinate with network services to either create a plan utilizing appropriate wraparound services or access housing support. Currently, Optum partners with subsidized housing units in Salt Lake County. Although the preference is to maintain a person in his/her community, it is also understood there are times when a higher level of routine supervision is needed to maintain safety and promote success. If needed, the OSC team will seek housing supports in contiguous counties. Supports will be local to where the client lives and he/she will have inputs into preferred services approach and provider(s) to the extent it is possible while still addressing the need(s).

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Respite Services: *Respite Services are services are designed to prevent unnecessary hospitalizations or out of home placements for those receiving mental health services. These services are provided by highly trained staff and licensed foster care providers.*

16) Respite Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$9,916	Form A1 - Projected Clients Served in FY19 Area Plan	25
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$9,421	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	24

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Respite Mandated Services

Respite is available for children and youth through our Optum network of providers. This program provides planned respite to offer relief to parents and other caregivers who are raising children with emotional/behavioral challenges. Respite services are provided by highly trained staff to help alleviate stress in the family, thereby increasing a parent's or other caregiver's overall effectiveness. Respite care may be brief (for a couple hours a week) or extended for several hours or several days a week. Services usually are provided outside the child's home. The Division of Youth Services can provide overnight respite at their facility. This type of respite is provided for cases determined to need a longer period of time out, to address behaviors, health and wellbeing of the family and/or the youth. Overnight respite is limited to no longer than two weeks. We will provide bilingual respite care as appropriate or requested. We will also provide referrals to community partners who can address social determinants factors such as babysitting services, transportation and social support groups.

Where and How Services Will be Provided

Optum will contract with Hopeful Beginnings (which has bilingual providers), Summit Community Counseling and Salt Lake County Division of Youth Services (DYS), to provide respite services. Both Hopeful Beginnings and Summit Community Counseling will provide respite services in Summit County.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Peer Support Services: Peer Support Services are provided by mental health individuals and include mental health treatment and/or support services, such as social clubs, peer-support groups, and other peer-organized or consumer-run activities.

17) Adult Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$11,054	Form A1 - Projected Clients Served in FY19 Area Plan	223
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$12,643	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	223

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Adult Peer Support Services

Peer Support Specialists are critical to supporting the strategic goals of Summit County including increasing access, education, success and sustainability, and recovery and integration. Our network providers will employ Certified Peer Support Specialists (CPSS) who will provide a bridge for support, advocacy, and skill building through individual client contacts. CPSS will offer linkage to behavioral health, physical health, and social supports such as social clubs, peer-support groups, and other peer-organized activities. The goals of peer support include decreasing the need for hospitalization by engaging people prior to entry into the inpatient facilities; identifying the barriers to success when being discharged from hospital settings; and decreasing the need for hospital readmissions.

Optum’s CPSS role includes supporting Peer Navigation programs, working with providers to develop and expand peer support resources within agencies, and encourage participation in DSAMH’s peer support certification training program. Our Peer Support Specialist will also collaborate and coordinate with stakeholders to make available the evidenced based group practice models Seeking Safety and Double Trouble.

Where and How Services Will be Provided

We will offer peer support services through our contracted network. Peer support services will be provided in the community, at a facility or other location where the client is receiving treatment/services.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

How is adult peer support supervision provided? Who provides the supervision? What training do supervisors receive?

Providing Peer Support Supervision

Our provider network will provide supervision to CPSSs as identified in paragraph A.1, A.2 or A.3(b) of Chapter 1-5. Optum will provide oversight to ensure that all CPSS supervisors are in compliance with supervision requirements and must show evidence of participation in DSAMH sponsored supervision trainings. Optum’s Recovery and Resiliency Team Manager will provide supervision to Optum’s CPSS. Additionally, Optum’s CPSS will be fully integrated into the Optum Care Coordination team which will be available for consultation on complex individuals.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

18) Children/Youth Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$18,965	Form A1 - Projected Clients Served in FY19 Area Plan	23
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$6,322	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	15

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Mandated Services and Where Services Are Provided

Working in partnership with the Utah Family Coalition, a designated provider specializing in complex treatment of children/youth and their families will provide Children/Youth Peer Support Services through a Family Resource Facilitator (FRF). FRFs provide referrals to local resources; advocacy for culturally appropriate services; links to information and support groups; and family wraparound facilitation. These services encourage increased family involvement at the service delivery, administration and policy levels, which help lead to improved outcomes for families and the communities. We will provide FRF services through our network partners and other entities

throughout Summit County.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

How are Family Resource Facilitator (FRF) peer support supervision provided? Who provides the supervision? What training do supervisors receive?

Providing FRF/Peer Support Supervision

In compliance with the DSMAH website, each FRF receives standardized training, coaching, and supervision by members of the Utah Family Coalition (Allies with Families, NAMI Utah, and New Frontiers for Families) who work together to:

- Train, coach, and support the FRFs
- Verify fidelity to the program and the wraparound model
- Promote family engagement
- Promote systems of care values and principles statewide

Who Provides the Supervision

While the Utah Family Coalition provides administrative oversight and close monitoring of each FRF, the clinical supervisor of the designated agency will provide direct supervision for the FRF.

Supervisor Training

The Utah Family Coalition FRF Policy and Training Manual can be found on the DSMAH website at <https://dsamh.utah.gov/education/certification/family-resource-facilitators>. It includes materials on new employee orientation, wraparound, and advocacy. Please see Form B, Question 17 for detail on Training our Recovery and Resiliency Manager will receive.

Has the LCP met the services and metrics of this required service?

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Consultation & Education Services: *Consultation and Education Services address specific behaviors by assessing and address the client’s needs by developing an individualized plan with providers and additional support team members (Parents, teachers, employers, friends, etc.). A plan includes specific strategies for addressing the concerning behaviors.*

19) Adult Consultation & Education Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	No Data – Mandated Service Currently Not Provided	Form A1 - Projected Clients Served in FY19 Area Plan	No Data – Mandated Service Currently Not Provided

Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	No Data – Mandated Service Currently Not Provided	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	No Data – Mandated Service Currently Not Provided
<p>Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>Activities and Means to Provide Adult Consultation & Education Services Optum’s Certified Peer Support Specialist (CPSS) will facilitate adult consultation and education services with our network providers. Our CPSS will provide education and consultation to clients, consumer run organizations, contracted providers, community partners and stakeholders, and centers of learning. The CPSS will work with an Optum clinical team to provide input into clients’ individualized service plans and support utilization reviews. Clients and their parents/guardians, teachers, employers, friends, or others, as authorized by the client, will participate in the development of the individualized service plan. Optum will also work with Summit County Connect, the Mental Wellness Alliance and other community stakeholders to determine educational priorities and how to address identified needs.</p> <p>The Optum Recovery and Resiliency Team has experience in presenting training topics for community groups, centers of learning, providers, and other stakeholders on topics such as:: Suicide Prevention, Recovery, Peer Support, Power of Language, Wellness Recovery Action Plans, Communication and Language, Discharge Planning, Mental Health First Aid, and Question Persuade and Refer. Our team will educate clients and providers on the resources available through our Client Portal to educate and support clients in their recovery, including our REACH tool and Whole Health Tracker. REACH is a web-based tool that asks clients four questions then the results page brings materials and self-care tools to the client at the right time based on the client’s own level of activation and stage of recovery. Whole Health Tracker is a tool that clients can use to self-manage their health care.</p> <p>Where and How Services Will be Provided Optum will provide educational services in a variety of locations (provider offices, schools, community settings, or other facility) and meet the client where they are. We will provide services either directly through our Recovery and Resiliency team or in concert with our provider network.</p> <p>Provider Qualifications Optum Summit County will develop community and allied partners throughout the County as described throughout this section. Many of these providers/service organizations already actively participate with the Summit County Mental Wellness Alliance and have the experience and qualifications needed to provide these services for our clients.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).</p>			
<p>Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			
<p align="center">- COMMITTEE USE ONLY -</p>			

Consultation and Education Services address specific behaviors by assessing and address the client's needs by developing an individualized plan with providers and additional support team members (Parents, teachers, employers, friends, etc.). A plan includes specific strategies for addressing the concerning behaviors.

20) Children/Youth Consultation & Education Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	No Data – Mandated Service Not Provided	Form A1 - Projected Clients Served in FY19 Area Plan	No Data – Mandated Service Not Provided
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	No Data – Mandated Service Not Provided	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	No Data – Mandated Service Not Provided
<p>Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>Activities and Means to Provide Child/Youth Consultation and Education Services Optum has a Recovery and Resiliency team that includes a Family Support Specialist who will help facilitate child/youth consultation and education services with our network providers to best serve the children/youth, their families, and the community. We will provide education and consultation to clients, consumer run organizations, contracted providers, community partners and stakeholders, and centers of learning.</p> <p>Our Family Support Specialist will meet with clients where they receive services, promoting the recovery model and whole health person wellness. They will work with our Clinical Operations Team on care team meetings to provide input into the clients' individualized plans and support utilization reviews. Additionally, we will include the clients and their parents/guardians, teachers or others as authorized by the client to help inform the individualized plan of care and develop specific strategies to address concerning behavior.</p> <p>Optum will also work with Summit County Connect, the Mental Wellness Alliance and other community stakeholders to determine the educational priorities for children/youth in the community.</p> <p>Where and How Services Will Be Provided Optum will provide educational services in a variety of locations (provider offices, schools, community settings, or other facility) and meet the client where they are. We will provide services either directly through our Recovery and Resiliency team or in concert with our provider network.</p> <p>Provider Qualifications Please see Form B, Question 1 for detail on how we verify—and regularly validate—the qualifications of our contracted providers. In addition, as described in our response to provide “Adult Consultation & Education Services,” We will develop community and allied partners throughout the County. Many of these providers/service organizations already actively participate with the Summit County Mental Wellness Alliance.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).</p>			
<p>Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			

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Services to Incarcerated Persons: *Services to Incarcerated Persons include access to a psychiatrist or psychiatric APRN to consult on treatment, medications, and diagnosis within the Summit County Jail along with general mental health services.*

21) Services to Incarcerated Persons

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,187	Form A1 - Projected Clients Served in FY19 Area Plan	237
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$12,150	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	242

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Address Services to Incarcerated Persons

Optum will contract with a local network provider to deliver crisis services for jail-based behavioral health services. We will provide all non-emergent mental health care onsite, including providing consulting on treatment, medications, and diagnosis. Our provider will visit the jail as needed; the number of hours and times will be scheduled based on need and in consultation with jail leadership. We will work closely with Summit County and the jail system to consider options, including the feasibility of telehealth. To implement a telehealth solution, OSC would establish the processes and procedures; secure appropriate space within the facility that would ensure client confidentiality for the visit; verify that we can access clinical records for services rendered to incarcerated clients; and install equipment to deliver telehealth visits in the selected space.

In cooperation with the Summit County Jail, Optum will collaborate with both the jail and our provider to develop an individualized release plan to behavioral health services, which includes an assessment of transportation needs. It is our intent that this collaboration occur prior to individual's release from jail. When it is determined that transportation is necessary to provide linkage to treatment, Optum will make transportation arrangements that can occur directly between jail and the agency.

Where Services Will be Provided

Services will be in the jail unless otherwise indicated due to urgent or emergency conditions.

Provider Qualifications

Please see Form b, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers. For Services to Incarcerated Persons, we will use contracted providers with experience serving these clients including a psychiatrist or psychiatric APRN.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

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Outplacement Services: *Outplacement Services include assisting individuals with finding work; assessing individuals' skills, attitudes, behaviors, and interest relevant to work; providing vocational rehabilitation and/or other training; and providing work opportunities.*

22) Outplacement Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$18,591	Form A1 - Projected Clients Served in FY19 Area Plan	4
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$18,617	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet Outplacement Services Mandates

The Optum Care Advocate/Hospital Liaison ensures a smooth transition from USH, other inpatient and residential facilities back to the community using Optum’s qualified network of providers to continue ongoing treatment, medication management, case management, and peer support specialists. These outplacement efforts will include locating stable housing, community supports and family supports as needed. We will help coordinate housing placement in the community by identifying and connecting clients to housing support programs or independent living with wraparound support services. We will collaborate with the Alliance, Connect, Clubhouse and other stakeholders to assist clients with skills assessment finding work, providing rehabilitation or training, and connecting client to work opportunities. We will maintain a comprehensive database of resources to which we can refer our clients and coordinate with other agencies. See also our response to Form B – Question 11, Adult Psychoeducation Services & Psychosocial Rehabilitation for related outplacement initiatives.

Optum’s Care Advocate/Pediatric Liaison for Summit County will provide coordination for discharges from the Utah State Hospital or other inpatient or residential facilities. They will work with the State Continuity of Care committee, and the DSAMH representatives, to secure any needed outplacement funding to ensure access to services for step down, regardless of the youth and family’s payer source. These funds can be used for community supports for the entire family (recreational passes), or individualized support to fund co-pays, treatment or educational services (art classes, guitar lessons, football) , and for arranging any discharge planning and coordination for the Summit County population. The OSC team will work with providers to ensure case management and support are provided to all youth and their families for at least 12 months post discharge.

Where Services Will be Provided and Who Will Provide Them

Services will be provided at a variety of locations including USH, inpatient facilities, offices of our network providers, community offices, vocational/school sites, and others depending on the client’s situation and individual needs. Clinical reviews for those receiving treatment at USH will be conducted monthly either in-person or via conference call.

Provider Qualifications

Please see Form b, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Describe how you will collaborate with the Division of Workforce Services and the Summit County Clubhouse to meet this Mandated Service.

The OSC team will identify a liaison at the Division of Workforce Services (DWFS) and work with them on outplacement services, such as the Summit County Clubhouse and the employment opportunities available. The Recovery and Resiliency Manager will explore opportunities for mutual education on Clubhouse International employment models, such as transitional employment, supported employment, and independent employment according to fidelity guidelines. We will work collaboratively with DWFS to coordinate and follow up on referrals for services. Our Recovery and Resiliency Manager, in collaboration with Summit County Clubhouse, will train providers and facilitate appropriate referrals to the Summit County Clubhouse. The Recovery and Resiliency Manager, in concert with representative of the Clubhouse and DWFS, will hold a yearly job fair to inform community, clients and their family members on transitional, supported, and independent employment models, opportunities at the Summit Clubhouse, and services available through DWFS.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

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Unfunded Clients: *Unfunded Clients are those individuals covered under the State’s General Fund which do not qualify for Medicaid, have insurance, or are able to self-pay.*

23) Unfunded Clients

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$41,569	Form A1 - Projected Clients Served in FY19 Area Plan	36
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$43,053	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	59

Describe the activities and means you will undertake to ensure full access to the Mandated Services listed in this RFP are made available to Unfunded Clients.

Activities and Means to Provide Full Access to Mandated Services

Optum will use the limited State General Funds only when no other payment source is available. We will work with our providers and other organizations to assist clients in obtaining funding from all other sources for which they are eligible, such as; Medicaid, Medicare, private insurance, or federal grant funding. We work with Take Care Utah, a statewide network of trained enrollment specialists, to assist clients enroll in Medicaid.

They are able to assist the Spanish speaking population as well. We will carefully prioritize the funding to make certain unfunded clients have full access to mandated services. We will contract with several different agencies for services for unfunded clients such as the UDOH, VOA, and DYS. Additionally, the OSC team and our network providers will:

- Work with the Utah Family Coalition to provide Family Resource Facilitators in Summit County to work with youth and families regardless of funding.
- Collaboratively work with other agencies, local non-profits and key community stakeholders to provide supported employment services that assist an eligible recipient in obtaining and retaining competitive, integrated, and meaningful permanent employment.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

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School-Based Services: *School-based mental health services are those delivered by the LCP in the three school districts. (North Summit School District, South Summit School District, and Park City School District). School-based mental health programs will provide services for youth 18 years of age and younger who are currently enrolled in the public-school system. For purposes of these monies, state regulated charter schools are considered to be part of the public-school system. The goal of these coordinated services will be to prevent youth who may be at-risk for developing a mental illness from disrupting his or her school placement. The services will be focused on maintaining the youth/child in their regular school setting, providing services in the school and collaborating with school staff.*

24) School Based Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	Service Provided but Data Not Available	Form A1 - Projected Clients Served in FY19 Area Plan	Service Provided but Data Not Available
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	Service Provided but Data Not Available	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	Service Provided but Data Not Available

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Meet School-Based Services Mandates

In compliance with RFP Section VIII.S, we will provide school-based behavioral health services within the North Summit School District, South Summit School District, Park City School District, and the Weilenmann School of Discovery. We will leverage and will build upon Summit County's Communities that Care initiatives related to the Youth Prevention Program initiatives to inform our approach to school-based services; the development of a parent education program; and other existing programs. OSC will seek to participate in or connect with the Youth

Advisory Council and we support the Council's priorities.

Optum's network provider(s) will offer an array of services including assessing students, identifying interventions, offering training, making referrals, and coordinating care. Our contracted school-based provider will receive referrals from school personnel for assessment and interventions, based on identified at risk behaviors exhibited by students. We will offer trainings on Youth Mental Health First Aid and QPR suicide prevention within the schools for personnel and parents so they may better understand, observe, and intervene when problematic behaviors first emerge, which will result in earlier interventions. These activities support the County's goal to increase prevention and education around mental health and SUD programs and services. We will also provide each district with curriculum copies of Narconon's Truth About Drugs Video Program for middle and high school students. These videos are a SAMHSA recognized best practice for prevention and early intervention of substance use and can be used through health services, after school programming, or another forum that best fits the school district's preferred approach for deployment, if desired for use. We will use outcome measures such as attendance rates, office referrals, academic measures, graduation rates, and teacher reports to determine the efficacy of our program. See below for additional information on how we will coordinate care with local school district personnel and guardians.

Where and How Services Will be Performed

Optum will contract with Hopeful Beginnings and/or Odyssey House to work with the school districts to arrange schedules to be onsite at the school to render services to students and be available when needed to address any urgent student need that may arise.

Provider Qualifications

Both Odyssey House and Hopeful Beginnings are recognized as high quality providers with a number of licensed clinicians offering a comprehensive array of services for children and youth. Both provide services today for Optum in Salt Lake and have clinicians with school based counseling experience. As both provide services to adults and families, as well as children, when needed and appropriate, they are available to address the needs of the entire family. Hopeful Beginnings has signed a LOI to perform school-based services and will designate a school liaison/student consultant to serve the Summit County school districts. Hopeful Beginnings staff have previously run school-based programs. Discussions with Odyssey House are ongoing.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Describe how you will coordinate care with local school district personnel and guardians.

The OSC Director will oversee the program. We will contract with Hopeful Beginnings and are exploring opportunities to contract with Odyssey House, to run all school-based systems. Our Director will work closely with our contracted provider(s) school liaison/student consultant to verify that contracted services are provided. At a minimum, the Director and school liaison/student consultant will meet monthly or as needed to discuss caseloads, issues, progress, and process improvement opportunities. Our collective goal is to foster seamless continuity of care, and have a comprehensive, well-communicated process in place so that students receive care on a timely basis. Our Director and our contracted school liaison/student consultant will regularly collaborate with school district leadership on ways to improve access, refine current programs that the schools and the County have developed, and partner to improve the health and wellbeing of students, their families, and communities.

Has the LCP met the services and metrics of this required service?

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25) Other Services (Refer to section 1-VII-N)

Describe how you will insure that services are delivered in Spanish by means of a qualified and culturally competent clinician. How will you recruit and retain a minimum of 2 Spanish speaking clinicians and additional support staff?

Delivering Services in Spanish By Culturally Competent Clinicians

Optum shares the County's goal to promote equity of mental health and SUD programs and services for Latino community members. We are committed to building comprehensive awareness of the cultural differences among the clients we serve and it is important, to make sure our staff respects these differences in each interaction. We require employees, client-facing vendors, and network providers to complete online cultural proficiency training. Employees must complete the course within 90 days of hire and annually thereafter. Currently, we employ bilingual team members and our provider network will include a minimum of two bi-lingual clinicians. We also offer competent interpreters for provider visits and health-care-related services along with translated written materials in languages spoken by those we serve. In addition, our interpretation services vendor is always available and provides clients access to more than 240 languages to meet their communication needs. Providers can arrange for these services on an individualized basis and at no cost to the client. Across the contract period, it will be our goal to increase the number of bi-lingual/Spanish speaking providers and support staff.

Contracting with Providers With Bilingual Staff

We will contract with providers that have bilingual staff and track their language capabilities in our provider database. We will also track client languages (when known) to connect bilingual providers and clients, when available. Optum's current network includes Multicultural Counseling Center, Hopeful Beginnings, and Asian Association (Refugee and Immigrant Center), who all have bilingual staff. Thanks to a donation from Rob Katz and Elana Amsterdam, the Christian Center of Park City will add a Spanish-speaking clinician to their staff in order to better serve our Spanish-speaking community. These resources will be available to our Summit County clients. [Optum also has policies and procedures that focus on provider recruitment. Activities include but are not limited to, offering quality reviews, on-site visits and continuing education credits for training activities.](#)

Describe how you will insure collaborative efforts with other community partners. (*Summit County Health Department, CONNECT Summit County, Summit County Mental Wellness Alliance, Summit County Sheriff's Department, Summit County Jail, Summit County Attorney's Office, Park City Police Department, IHC, UNI, School Districts, Non-Profits, and local government*)

Optum recognizes the value of community collaboration. We are already connected with a number of community partners, including Summit County, Connect, Summit County Jail, IHC, UNI, North Summit County School Superintendent Jerre Holmes, Park City Community Foundation, the Peoples Clinic and a number of providers. We look forward to, and welcome the opportunity, to further enhance these relationships in support and advocacy of Summit County clients.

Describe how you will insure clinician and case manager retention to maintain continuity of care.

As the current LCP is a staff model managed care program employing its own clinical staff and case managers, most clients will likely need to select a new provider from our network.

On award announcement we will reach out to the current LCP to begin transition planning and discuss continuity of care requirements to ensure all clients maintain convenient access to needed services. At that time and as agreed by the current LCP and the Optum leadership team, we will work to identify any of their clinical staff that plans to continue to practice in the area and recruit them to join our network or existing contracted providers. As part of our efforts to ensure continuity of care we will:

- Assign clients to their current provider (if available in our network) when they transition from the former LCP to Optum Summit County.
- Encourage our network providers to hire the former LCP's provider and case managers.
- Accept referrals and recommendations for providers outside our network, and evaluate any requests to

use these providers on a case-by-case basis for inclusion under our single case agreement process.

How will LCP will provide Peer Specialists/Family Resource Facilitators for Peer Support Services.

Peer Support Specialists and FRFs are an integral part of our organization and are included in all aspects of our work. Our Recovery and Resiliency team will work closely with Summit County clients to link them to Peer Support Specialists and FRFs within our provider network, and other community partners/agencies as appropriate. Peers attend all clinical staffing meetings to be “the Voice” of the client in the recommendations we make. As part of our ongoing network access oversight, we assess the demand for peer support services and FRFs to ensure clients have access to these important resources.

Describe how you will insure that any transition in LCPs will minimize the effects on the continuity of care of current LCP clients. Have you a plan to incorporate current LCP clinicians /staff into your organization.

Minimizing Impact on Clients During a LCP Transition

Please see the answer to the question above labeled, “Describe how you will insure clinician and case manager retention to maintain continuity of care”, and Form A Question 7-Transition and Implementation Plan for additional detail.

Incorporating Current LCP Clinicians/Staff into Our Organization

Please see the answer to the question above labeled, “Describe how you will insure clinician and case manager retention to maintain continuity of care”, and Form A Question 7-Transition and Implementation Plan for additional detail.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

26) Quality & Access

Describe how LCP will provide open and timely access to services while maintaining the highest quality of care. Include specifics for services provided in Park City, Kamas, and Coalville. (Current levels in Kamas are 1 fulltime and 2 part-time clinicians, and 1 part-time clinician in Coalville. Space for both locations provided by the Department.)

Providing Open and Timely Access to Services While Maintaining the Highest Quality of Care

To make sure that all clients have access to appropriate treatment, we will develop and maintain a network with appropriate numbers and types of clinicians and require that the network adhere to the Medicaid Timely Access standards for emergent, urgent and non-urgent care, and they must submit related data for review on a monthly basis. If a provider is unable to meet the standard, the client is linked to an Optum care advocate who help them obtain needed services in a timely manner. If necessary, a single case agreement may be offered to an out-of-network clinician or agency to treat clients with unique circumstances.

Providing services in Park City, Kamas and Coalville: OSC appreciates the Department providing space at various locations within the County and we will seek to use those made available in Kamas, Coalville, and Park City. It is our intention to have these offices used both by our contract providers and Optum staff. The office locations are especially convenient because they are located in the health departments where clients already seek care. We will work with our contracted providers to establish pre-defined office hours located at these three locations and to maintain current provider levels in Kamas and Coalville, and will make sure health departments and local medical providers are aware of their schedules so they may refer clients in need of behavioral health services, coordinate care for clients with comorbid medical/behavioral health conditions, and promote health care integration across the provider community. The OSC team will use the space, when

available, to meet with clients and providers and other stakeholders.

Identify process activities focused on Implementation of this document for Summit County.

In anticipation of the contract award, we have developed a draft implementation plan based on RFP requirements and information we have gained through our meetings with stakeholders in Summit County. Please see our response to question 7, Implementation and Transition Plan in Form A, for more detail.

Implementation: This is the primary phase of the contract initiation process and begins immediately following contract award and continues until Go Live. All aspects of the initial implementation will be completed under the guidance of the Implementation Project Manager (IPM). Working with Summit County and the implementation team, the IPM will accurately define processes, identify accountabilities, resolve issues, and pinpoint Summit County's service priorities. The IPM will:

- Develop or adjust, and manage a detailed IPP
- Serve as the liaison with Summit County for all implementation activities
- Cultivate positive relationships between Summit County representatives and our operations personnel
- Oversee the research and resolution of all issues that arise
- Monitor and report on progress
- Disseminate critical information from Summit County to internal teams

Communication with Summit County: Regular status meetings will be the primary means to communicate progress. We will schedule an initial formal kick off meeting with Summit County on contract award. Thereafter, our IPM and key team members will meet regularly with Summit County to review implementation activities, discuss any outstanding issues, and provide progress reports. Reviewing the status of key action items is a regular agenda item in ongoing implementation meetings.

Identify process activities focused on Training of Evidence Based Practices in accordance with DSAMH guidelines and directives.

Provider contracts with OSC will include use of the DSAMH Evidenced Based Practices (EBPs). The Network Team will notify providers via eblast of trainings offered in the community related to the identified EBPs. All claims are required to include the EBP used to provide the service. This data is then submitted with the encounters to the State. Provider orientation will include these expectations, and we will provide a link the DSAMH Evidence Based Practices on our provider portal.

Supervisory protocol agreement language between Optum and network providers explicitly states that treatment provided be consistent with the Level of Care and Best Practice Guidelines, which align with evidence-based treatment as per the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry Practice Guidelines. During audits, Optum will review the provider's adherence to the use of best practice guidelines as per supervisory standards. We will assess providers' adherence to level of care guidelines through our utilization management reviews on an ongoing basis.

Identify marketing and public relations activities focused on educating and developing a community based behavioral health service organization.

We will make sure that clients, the community, and key stakeholders receive detailed information regarding behavioral health care and services that will be available through the OSC team. Our marketing and public relations activities include education and outreach to clients, providers, community organizations, and other stakeholders as described below. We will collaborate closely with the Summit County Mental Wellness Alliance's Public Relations and Marketing Committee, CONNECT and Summit County to develop communication and other public relations initiatives and make certain our initiatives align with and supplement those of existing organizations and stakeholder..

Educating Clients: We will educate and inform clients about the overall program, our plan, and what we offer through a variety of methods including content on our Client Portal, which provides information 24/7/365 (see example at <https://optumhealthslco.com/content/ops-optslcty/salt-lake-county/en/consumers---family.html>);

Welcome Packet, including the Member Handbook; customer service toll-free number; support staff such as our Care Advocates, Peer Support Specialists, and FRFs; and Community meetings/support groups.

Educating Providers: Providers will have easy access to a wide variety of information through provider orientation, ongoing one-on-one office visits, group provider presentations/forums, the Provider Manual, provider newsletter and fax blasts, and content on our Provider Portal.

Other Initiatives: Before September, we will work with the Department to create a news release (or a series of releases) that they can share with all media that cover Summit County to provide key information about available behavioral health services, impending changes, and contacts within the Department and OSC for additional information. Across the contract period, we will coordinate with Optum Corporate Communications to outreach to local media organizations to provide them information and seek coverage for events/activities related to such as Mental Health Awareness Month, Recovery Day, Recovery Rally, NAMI Walk, and others. We will promote activities related to Summit Clubhouse, Drug Court and Crisis Redesign programs to better educate the community and increase awareness of activities and services to promote education, and better access to services.

Identify activities focused on increased service capacity.

Our ongoing network management activities to increase service capacity include assessing the demand for services and verifying that the current network is able to address it through rendering timely, quality care to our clients. If our analytics indicate that more service providers are needed in a given area or for a specific service, we outreach to existing providers to inquire if they will expand their current offerings, engage similar type service providers to see if they want to expand their treatment offerings, and look to adjacent geographic areas to see if providers are willing to expand geographically.

We will offer virtual visits, as described, and continually seek opportunities to partner with providers to expand access by offering extended office hours or opening closed panels. Additionally, we will develop a unique sub-network of Express Access providers that contractually agree to see clients up to five days sooner than the Medicaid standard of 10 days. We typically offer incentives to providers to encourage participation in this network.

Please also see Form B, Question 26 and Form C, Question 11 for how we will expand access to mental health and SUD programs and services.

Identify process improvement activities focused on Increased Access for Medicaid & Non-Medicaid Funded Individuals.

Access to services to improve health and wellbeing is impacted by a variety of factors including: covered benefits, funding levels, client education about covered benefits and how to access them, a convenient and qualified network of providers, transportation barriers, care advocates and navigators that help clients connect with services, administrative infrastructure including experienced staff, IT platform and policies and procedures to support day to day operations and provide payers, providers, regulators and health plan staff required reporting and analytics.

Throughout our response we have described how we and our providers identify client needs-which is much easier for Medicaid than for non-Medicaid clients- how we build and monitor our network to identify gaps and bring on new providers, how we work with clients and their families to educate them about benefits and providers and connect them to services, how we engage with community stakeholders to collaboratively build solutions that improve access to services and how we recruit, hire and train administrative staff to engage clients to connect them to needed service.

We look forward to working with the County and all other stakeholders to design and deploy initiatives and programs that improve access for County residents in the short term and strategic initiatives that improve access but may require more funding and/or time available in the current system.

Identify process improvement activities focused on efforts to respond to community input/need

Throughout our response, we have described how we and our providers identify client needs, which is much easier for Medicaid than for non-Medicaid clients. We describe how we build and monitor our network to identify gaps and bring on new providers, how we work with clients and their families to educate them about benefits and providers and connect them to services, how we engage with community stakeholders to collaboratively build solutions that improve access to services and how we recruit, hire and train administrative staff to engage clients to connect them to needed service.

Identify process improvement activities focused on Coalition Development

To support the Summit County Wellness Strategic Plan goals, OSC will participate in existing community coalitions such as the Summit County Mental Wellness Alliance, Summit County Communities that Care (CTC), the Children’s Justice Center, mental health advocacy groups such as the Latino Mental Health Group, or others as applicable, appropriate, or allowed. We will also collaborate with the County to develop new coalitions as needed and participate with key community partners such as CONNECT Summit County, Summit County Clubhouse, school districts, local governmental agencies and local non-profits.

Describe how mental health needs for people in Nursing Facilities will be met. (Summit County has one Nursing Facility located in Oakley.)

As part of our network development in Summit County, we will meet with the nursing facility in Oakley to determine what current arrangements are in place to assess and address behavioral health needs of their residents. Our network and clinical leadership will work with the nursing facility to address the identified opportunities.

We will offer to provide Mental Health First Aid and QPR training in the facility, as well as educate staff about the resources available on our portal such as the Behavioral Health Toolkit for Medical Providers. We also will make certain they are aware of the training available through OptumHealth Education focused on caring for older adults such as Management of Comorbid Behavioral and Physical Illness Near the End of Life and Nonpharmaceutical Management of Behavioral Issues in Older Adults.

Has the LCP met the services and metrics of this required service?

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27) Integrated Care

Describe how you will develop partnerships with the Department, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.

Establishing Partnerships to Integrate Care

We will establish an ongoing action plan for initiatives to collaborate with the Department and other physical health providers for overall integrated care and improved health outcomes. Initial topics for exploration and next steps would include education of behavioral health assessments and referrals in medical settings; possible use of whole health peer coaching services, and care teams’ structure and preferred mechanisms for communication. We will establish contact information and set up ongoing meetings with the ACOs to discuss individual cases to integrate care. Our clinical team will notify the ACO of an inpatient psychiatric admission for its clients, as well as notify them of the discharge and the discharge medications prescribed for the client. The ACOs can use this information to follow up with discharge services and support as needed.

FQHC Partnerships

While there are no FQHCs currently in Summit County, we will seek to contract with its Rural Health Clinics, Kamas Health Center and Coalville Health Center, for any behavioral health services they provide for clients in

its service area. Although People's Health Clinic is not an FQHC and only sees the uninsured, they are an important provider of medical care to the uninsured and Optum will work collaboratively with the People's Clinic to facilitate integrated and coordinate care with our contracted behavioral health providers. We will seek to contract with any new FQHCs that move to Summit County once they become available.

Other Physical Health Providers

Following implementation, our providers' case managers and peers will collaborate with physical health providers on clients with comorbid medical/behavioral health conditions and solicit their inputs for any unmet needs that the physical health providers experience for clients with behavioral health resource needs so they can be incorporated into the clients' plans of care and addressed.

Describe plans to integrate care and ensure that clients have their physical, mental and substance use disorder needs met, including screening and treatment and recovery support.

Plans to Integrate Care to Meet Clients' Physical, Mental, and SUD Needs

We are committed to addressing co-occurring disorders and working with medical practitioners to holistically address co-morbid physical and behavioral health issues. We will offer behavioral health tools, resources, and trainings to medical providers on behavioral health and outreach to them for inclusion in the clients' care team with the client's permission. Our network BH providers are required to keep clients' PCPs informed when there are changes in care (with release of information). We expect our network providers to share information and coordinate care with PCPs and other treating behavioral health practitioners throughout the care process.

Screening, Treatment, and Recovery Support

We require our behavioral health network providers to complete biopsychosocial assessments on clients at intake and assess and address their holistic care needs during the course of treatment, inclusive of referrals to medical practitioners and specialists when warranted. Holistic care includes assessing for social needs with referrals to recovery supports, such that unmet needs do not adversely impact the client's overall health outcomes. SUD providers within our network meet the definition of co-occurring diagnoses capable by American Society of Addiction Medicine (ASAM) standards. In addition, we contract with SUD providers such as VOA and Odyssey House to provide ASAM co-occurring disorders enhanced services. Additionally, AAU expanded its services to become a co-occurring disorders enhanced program.

Please see our response to Form C, Question 8 for our approach to Recovery Support Services.

Describe plans to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

Incorporating Wellness into Treatment Plans

At the outset of services, our providers are required to conduct a holistic assessment that includes medical, behavioral health, and social needs, with treatment plans developed to address clients' comprehensive needs. Provider medical records will be subject to periodic audits to make certain that wellness information is being shared with clients. Providers and our Care Advocates educate clients on the wellness resources available to them.

Education and Referrals Regarding Physical Health Concerns

We will use a multi-modal approach to provide education and referrals to clients regarding their physical health concerns. Clients receive information in their handbook about our Client Portal and our case management and peer support staff educate clients on resources specific to addressing their needs on our portal, including resources for arthritis, asthma, cancer, chronic pain, diabetes, HIV, TB, heart health, infertility, men's health, obesity, traumatic brain injury, and women's health, including pregnancy. We will host network trainings that include a focus on the importance of the physical health assessment components as well as coordinating with PCPs as needed for their services.

Optum Care Advocates will collaborate with Medicaid ACOs and clinicians to address physical health needs and to coordinate care.

Recovery Plus: Describe your plan to reduce tobacco and nicotine use and how the LCP will maintain a tobacco free environment. SUD Target= reduce tobacco and nicotine use by 5%.

Optum has 30 years of experience providing tobacco cessation services and research and nearly 20 years of experience operating state Quit Lines. Since 2014, we have provided tobacco cessation services to over 18,900 Utah residents. In Fiscal Year 2018 alone, we mailed 2,821 quit materials, 2,592 participant shipments of NRT patches, and 1,405 participant shipments of nicotine gum. We enrolled 1,869 into the Web Coach® program. We also provided services for 54 pregnant women and have supported the needs of the diverse health disparity populations in Utah. Overall, our partnership with Utah Department of Health has achieved a return on investment of \$5,155 per quitter.

Plan to Reduce Tobacco and Nicotine Use

The OSC team will implement Recovery Plus to help reduce tobacco and nicotine use to meet the County's goal of five percent. We will use a Holistic Approach to Wellness by identifying tobacco use in the client's assessment and providing smoking cessation services, resources, and medication if needed. We will educate providers on the Recovery Plus program and the mandate to diagnose and provide treatment for nicotine addiction as a healthcare issue. We will present Recovery Plus at provider meetings and trainings. We will regularly remind clinicians about the health implications of smoking for our clients, the need to ask clients if they are interested in cessation services, and the need for proper documentation of these efforts. Due to the popularity of previously non-traditional ways to use nicotine, we will also educate providers to address any type of nicotine delivery system with clients. We will regularly review Recovery Plus initiatives during audits, providing a forum for conversation about the importance of offering cessation services to clients.

We will also provide information to clients in the Member Handbook, and other outreach efforts. Our Member Portal is a wealth of information and resources to help clients quit smoking and has a center dedicated to tobacco addiction. Under our Member Portal's Recovery & Resiliency page, we will list both a link and phone number to Utah's smoking cessation resources: UtahQuitNet.com and 1-800-QUIT-NOW. For example, see <https://optumhealthslco.com/content/ops-optslcty/salt-lake-county/en/consumers---family/recovery---resiliency.html>. Each provider is mandated by contract to provide nicotine cessation for those clients who are willing to receive these services. While these services include UtahQuitNet.com and 1-800-QUIT-NOW, we also encourage providers to use recommended MAT, as appropriate. Within our Tobacco Addiction Center, they can access addiction recovery tools and articles, find a local Nicotine Anonymous support group, take a self-assessment on their readiness to change followed by targeted feedback, and watch videos from peers to help them in their recovery journey. Should the County wish to explore additional options, we have a program called Quit for Life Tobacco Cessation Behavioral Health Program. The program provides seven coaching calls, 12 weeks of combination nicotine replacement therapy, and care coordination between Quit Coaches and the member's broader care team. The interventions are delivered by a team of dedicated Quit Coaches trained to provide tailored treatment to these participants. To date, the 30-day quit rate was 30 percent at seven months post registration, compared to 22 percent of standard program participants with behavioral health conditions.

How we will maintain a tobacco free environment

Our offices and the locations where services are provided will be mandated smoke/nicotine free environments. We will also offer smoking cessation program and supports to our employees.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

28) Children/Youth Mental Health Early Intervention

Describe the *Family Resource Facilitation with Wraparound* activities you propose to undertake and identify where services are provided. Describe how you intend to partner with other Department of Human Services child serving agencies. For each service, identify whether you will provide services directly or through a contracted provider.

Family Resource Facilitation with Wraparound Activities that Optum Will Undertake

Optum will partner with the Utah Family Coalition to provide FRFs who are specially trained family members that work to develop a formalized, family-driven and child-centered public mental health system in Utah. The Utah Family Coalition has partnered with DSAMH to make sure each FRF receives standardized trainings, coaching,

and supervision. Additionally, the coalition determines the anchoring sites within a community. At no charge to families, FRFs provide referrals to local resources, advocacy for culturally appropriate services, links to information and support groups, and family wraparound facilitation. These services encourage increased family involvement at the service delivery, which help lead to improved outcomes for families and the communities. We will identify organizations within Summit County who provide children, youth, and family services and ask them to partner and anchor an FRF within their treatment team. Through previous experience with FRFs, Optum has learned that this approach yields optimal outcomes by supporting families while they are trying to navigate complex procedures and systems.

Where Services Will be Provided

Once an organization is identified, the FRF will provide the majority of services in the community and in the client's/family's home. Optum will maintain ongoing communication with the partnering agency and the FRF to identify and resolve barriers to success.

How We Will Partner with Other DHS Child Serving Agencies

Optum places a high priority on collaboration with other systems to facilitate effective coordination of care. Optum has developed collaborative relationships with the Division of Child and Family Services and the Juvenile Justice System to develop individualized care plans designed to provide optimal support to a child or youth and their family. Optum will use the existing relationships with the abovementioned systems to provide the same level of collaboration within Summit County. The priority will be to emphasize a least restrictive setting to meet the needs of the youth and their family and offer services within the home/community when possible.

Do you agree to abide by the Mental Health Early Intervention Family Resource Facilitation and Wraparound Agreement? YES/NO

Yes, Optum Summit County agrees to abide by the Mental Health Early Intervention Family Resource Facilitation and Wraparound Agreement.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

29) Children/Youth Mental Health Early Intervention

Describe the Early Intervention activities you propose to undertake and how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider.

Proposed Activities

Upon contract award Optum will work with the Department to review existing Summit County policies and programs for Early Intervention activities. We will work with the Department, Connect, the Mental Wellness Alliance, providers and other stakeholders to ensure parents are aware of resources available on the "Utah Act Early" website which helps parents learn about healthy development for their newborns and young children by offering a variety of tools and checklists. Optum will work with these same entities and stakeholders to ensure Early Head Start teachers, child care providers and other professional who work with young children, including our contracted behavioral health providers, are aware of what they can do to help parents learn about developmental milestones. We will work with Medicaid ACOs offered in Summit County to ensure their primary care clinicians are aware of information available on the Utah Act Early website about developmental screening tools, referring to community resources, behavioral health providers and coordinating care. We will contract with providers with expertise in working with newborns and young children to render needed services and supports to both the child and their family. Provider expectations are detailed in our Provider Manual and we offer resources to aid providers in early intervention with a section in our Behavioral Health Toolkit for Medical Providers specifically for early intervention with assessments, best practices, and tools for their practices. Early identification and interventions for behavioral health symptoms in young children leads to improved outcomes.

Optum is committed to partner with key stakeholders to help connect children with developmental delay and their family with needed services and supports.

Supporting Family Involvement

Family members are an integral part of the treatment process and their engagement should go beyond input into the assessment and include development of the treatment plan and care preferences, being active participants in the treatment process, ensuring they have been informed of their rights and responsibilities, and offered information about support groups and resources (e.g. NAMI Family to Family, Family Resource Toolkit on our Member Portal).

Describe outcomes that you will gather and report on.

Optum will track and report on the following outcomes:

- For clients 12 and older, provider conducts a substance use screening
- If the screening indicates an alcohol or substance use problem, there is documentation that an intervention for substance use/dependence occurred
- County child/youth suicide attempts/completed suicides
- Total number of youth contacts and outreaches
- Number of contacts/outreaches that avoided out-of-home placement
- Number of contacts/outreaches avoided legal involvement
- Number of clients who received assistance when they were in danger of harming themselves or others

We will explore additional outcomes with the County.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

30) Suicide Prevention, Intervention & Postvention

Describe the proposed role the LCP will play in working with the community for suicide prevention. (Summit County utilizes the ChooseLife program developed by the National Health Service – Scotland.)

Optum Summit County will work with established community resources and programs to support suicide prevention, including the ChooseLife program used as the basis for the County’s program of Hope Elevated. Optum has considerable experience with suicide prevention programs and initiatives and we look forward to being part of the Summit County Mental Wellness Alliance, working with other member organizations, sharing or experience and resources to consistently reduce suicides.

Describe the proposed role the LCP will play in working with the community for suicide intervention and postvention. (Summit County utilizes the ChooseLife program developed by the National Health Service – Scotland.)

Our network providers will work with those who are at risk or have a history of suicidal thoughts or gestures to develop crisis plans specifically for them. This may include completion of a Wellness Recovery Action Plan or Whole Health Tracker as well. We will offer transitional care management and peer bridger for services for clients transitioning back to the community following ER, inpatient or residential care. We will also offer 24/7 crisis call center support with engagement of local crisis services for mobile interventions, crisis respite, and other services needed to keep the client safe during a crisis episode. Please see our responses to Form B - Question 7, Adult 24-Hour Crisis Care, and Form B – Question 8 – Children/Youth 24-Hour Crisis Care for additional information.

Describe how you will collaborate with emergency services (Park City Hospital, UNI, MCOT, Stabilization Team, etc.) to coordinate follow-up care after ER visits for suicide related events; both general collaboration efforts as well as specific efforts for your clients.

Our Clinical Team will coordinate care with our crisis programs and community providers to help our clients access the care they need. For a client experiencing acute emotional or psychiatric distress, we will provide a comprehensive array of services and supports 24/7. These services are structured to address acute needs and also provide for personal and public safety and support clients in a manner that encourages their recovery and equips them with resources to manage future acute circumstances. This array of services will include telephone crisis-line services, warm-line services, close coordination with Summit County police department, Park City Hospital, a receiving center, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

31) Justice Reinvestment Initiative.

Identify key staff members who will be part of the JRI Implementation Team and their qualifications.

Optum Summit County staff supporting the JRI Implementation Team will include our OSC Director, Medical Director, Clinical Director, Network Director and Recovery and Resiliency Manager. The Recovery and Resiliency Manager will handle the training and a representative of the Clinical staff will provide some portions related to clinical oversight.

Key Staff Qualifications

Most of the Optum team members have many years of behavioral health industry experience including working as licensed mental health professionals, managing behavioral health programs, working with law enforcement, providers, and drug courts developing successful programs for justice involved clients from initial contact with law enforcement to release from a jail or prison.

Describe the evidence-based mental health screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.

Mental health screening and assessment includes a clinical interview with evidence-based screening tools for prevalent behavioral health conditions. We propose to use the PHQ-9, GAD-7, DAST-10, and AUDIT-C. For the criminogenic risk assessment, we will examine the current tools used by providers in Summit County and other parts of the State to determine what works best. Based on research to date, we are aware that there are a variety of tools in use such as the LSI-R, the LSI-R (SV), the LSI (SV), Historical Clinical Risk Management 20 Tool, Drug Use Screening Tool (DUSI), and the Risk and Needs Triage (RANT). Screening and assessment will be conducted by contracted providers serving Summit County. Prevention efforts for the justice system include working with local law enforcement and the justice system to identify at and high risk individuals due to behavioral health needs, providing case management, peer support, and treatment interventions with these individuals while addressing their social determinants of health that may impede their success in maintaining community tenure.

We will offer treatment through network providers with expertise to address the individuals' specific behavioral health conditions and needs, as well as those with background in working with justice-involved individuals. Areas of expertise in our network that will be leveraged to support individuals include abuse, anger management, domestic violence, forensic, rape issues, and more. Recovery support services will be provided to address individuals' specific circumstances including the Drug Court Access to Recovery (ATR) and the Parole Access to Recover (PATR) programs to provide clients with culturally and linguistically appropriate services that support their recovery. Most contracted providers offer aftercare services to clients wanting to stay connected with their treatment provider. Optum and contracted providers will actively support Utah Support Advocates for Recovery Awareness (USARA's) and Summit County's efforts to advocate for recovery awareness. We support the Recovery Oriented Systems of Care initiative.

Leveraging our Salt Lake County affiliate's best practice, and if funding is available, we will initiate a Sober Living voucher program. Residential providers will be able to refer to a state licensed sober living facility, offered through a voucher/authorization process similar to RSS. Individuals will be able to use a sober living facility for six months.

Identify your outcome measures.

As part of our continuous QI process, we monitor key metrics at regular intervals through our Quality Work Plan. Our JRI outcome measures will include:

- Number of clients referred for services
- Number of clients engaged in treatment services
- Percentage of clients remaining in the community/total engaged in treatment services
- Providers certified as meeting the JRI treatment standards (capacity and quality of treatment) established by DSAMH available to Summit County

Based on sample of provider records, we will assess additional outcome measures as follows:

- Number of participants evaluated for criminogenic risk factors
- Number of participants evaluated for co-occurring disorders
- Number of treatment plans containing a criminogenic risk tool
- Number of individuals receiving recovery supports during treatment and offered after completion

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

- END OF FORM B -

Form C

Substance Use Disorder

Treatment Narrative

RFP # SUCO2019755

RFP # SUCO20197552 FORM C - SUBSTANCE USE DISORDER TREATMENT BUDGET NARRATIVE

Submitting Agency (LCP): United Behavioral Health, Inc. (Optum or Optum Summit County)

Instructions:

The following form is modeled off of the annual **Substance Use Disorder (SUD) Area Plan** the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

If you are unable to provide a service, please indicate the reasons why. If you feel you need to amend your ability to meet the service, provide detailed rationale along with the proposed amended delivery.

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form A is limited to a maximum of 40 pages.** Refer to Section 1-VII of the RFP to ensure **all required services and metrics are provided in your provided responses.** FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for FY20. Funding contracts are for July 1st to June 30th.

The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. Final numbers will be known by July, 2019.

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

Projected FY19 Mental Health Funding from Contracted Sources: \$700,000

1) SUD Screening and Assessment Services (S2BI, BSTAD, NMASSIST, AUDIT Test-C, TAPS, NIAA, SKINNER, etc.)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$3,000	Form B - Projected Clients Served in FY19 Area Plan	15
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$30,000	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	175

Describe activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Proposed SUD Screening and Assessment Services Activities

Optum supports a “Strategic Prevention Framework” as outlined by SAMHSA, with the assessment being the first step towards recognizing the need for treatment. The assessments listed in the question are primarily “self-report” assessments. These can be administered in a variety of settings within a community setting. DSAMH recognizes the AUDIT tool as a best practice when assessing for alcohol abuse disorder.

Where and How Services Will be Provided

Optum’s network of qualified SUD providers offers a full continuum of SUD and co-occurring treatment services, including assessments. Our network recruitment efforts to expand services, our telehealth capabilities including our virtual visits program, and our credentialing/recredentialing processes will provide Summit County clients access to all the levels of SUD services required to meet their needs.

When we contract with providers, we identify their areas of expertise so we are prepared to provide the most effective referrals for special populations (e.g. veterans, youth) experiencing SUDs. Our ongoing quality management and oversight efforts verify that network providers retain their qualifications and are performing at the highest levels for better outcomes.

To support client choice, a full continuum of services and supports will be developed, and to ensure that the network incorporates providers with an array of sub-specialty skills, Optum will deliver services through a network of qualified SUD providers. All will use the American Society of Addictive Medicine (ASAM) as an assessment tool that points to the most appropriate level of care. ASAM criteria use a six-dimensional view to create a holistic, bio-social assessment of an individual that can be used for assessment through individual service planning and treatment across all services and levels of care. The ASAM criteria ensure that clients with SUDs receive care in the least restrictive setting resulting in better outcomes and cost efficiency. Optum’s current practice has been to cover the cost of any SUD ASAM assessment, whether or not the client agrees to findings, treatment and/or services recommended.

Provider Qualifications

Through our NCQA certified credentialing, recredentialing and contracting standards and guidelines, Optum Summit County (OSC) will validate that network providers have the proper education, qualifications, licensure, and experience to render care and services appropriate to their provider type and specialty. Our credentialing processes require that any provider that does not hold national accreditation (e.g., from the Joint Commission, Utilization Review Accreditation Commission (URAC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other governing body) must pass a site visit before joining our network and then every three years during routine recredentialing. We also incorporate Utah’s certification requirements for SUD counselors and case managers into our credentialing processes. We promptly investigate quality of care complaints as well as suspected quality concerns; these investigations may result in additional onsite visits. OSC will also partner with the County to conduct any additional audit or outreach as required. See Form A, Question 3 – Staffing and Administration for more detail on our credentialing process.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

2) SUD Detoxification Services (ASAM IV-D, III.7-D, III.2-D, I-D or II-D)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$7,841	Form B - Projected Clients Served in FY19 Area Plan	3
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$7,841	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	2

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide detox services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Proposed Activities for SUD Detoxification Services

Through our network of providers, Optum will provide all required SUD detoxification services for youth and adults, including women and mothers with dependent children.

Where and How Services Will be Provided

Optum’s network of qualified providers includes the detoxification services available currently in Salt Lake County. One of the initial responsibilities of the Summit County Director will be to assess the extent of the need for detoxification services in Summit County, and determine what options are available to work with through the Community’s Strategic plan and Coalition members. Additional services can be identified and developed as part of the Optum ongoing collaboration. We also are aware of the restrictions on where detoxification can be provided if Medicaid reimbursement is utilized, and we will work with Summit County to ensure compliance with regulations of all funding streams.

We will provide services through our contracted provider network. We offer a selection of SUD detox providers within 25 miles of Summit County, including University Neuropsychiatric Institute, Salt Lake Behavioral Health, Highland Ridge Hospital, Recovery Ways Denali, and Provo Canyon Behavioral Hospital. University and Provo are already in our SUD detoxification network and we will recruit the others for inclusion in our Medicaid network.

Provider Qualifications

Please see our response to Question 1 above for information on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

If this service is not provided by the LCP in Summit County, where are individuals accessing detox services?

Please see our response to the question above under “Where Services Will be Provided.” Services not available in Summit County will be available in Salt Lake County.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

3) Residential SUD Treatment Services (ASAM III.7, III.5, III.3, III.1)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	19,842	Form B - Projected Clients Served in FY19 Area Plan	2
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$39,683	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4

Describe the activities you propose and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Proposed Activities

Our network of qualified residential providers will offer these services. They provide medically necessary, post-stabilization services according to Optum’s Level of Care Guidelines, which are based on ASAM criteria.

The OSC Utilization Management (UM) team will provide utilization management (UM) services to ensure quality of care and patient engagement. The UM team also monitors and manages treatment to ensure that the client is receiving the appropriate level of care. In addition, the UM team provides a bridge between clients and their outpatient treatment providers through individualized care coordination to ensure the client is linked to appropriate step down services and supports upon discharge. The OSC UM team is made up of experienced, licensed clinicians who work in tandem with our Psychiatrist.

Where and How Services Will be Performed

Optum currently contracts with SUD residential providers that offer treatment to individual adults and adolescents and also to adults with their children. Services are provided at locations within 25 miles of Summit County. Network providers include Odyssey House and House of Hope. We are actively engaged with these providers and others in the area to ensure they are willing to provide these services to Summit County residents. Please see Attachment E for a list of providers we are planning on subcontracting with to provide services under this contract.

Provider Qualifications

Please see our response in Form B, Question 1 for detail on how we verify—and regularly validate—that our

network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) Outpatient (Non-methadone – ASAM I)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$440,957	Form B - Projected Clients Served in FY19 Area Plan	314
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$431,003	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	279

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Proposed Activities

We will provide these services through our network of qualified providers. Providers will conduct an individualized ASAM assessment. When indicated, the client will be referred for outpatient non-methadone treatment. Providers will offer a variety of treatment modalities, including client assessments; medication prescribing and management; group, individual, couples, and family therapy; and group programs that address issues such as substance use, domestic violence, peer services, trauma-informed care, and other critical issues. In collaboration with each client, providers will develop and implement individualized treatment plans designed to prevent relapse.

Where and How Services Will be Provided

We have multiple non-methadone SUD outpatient providers that can provide required outpatient services. Services will be available in both Salt Lake County and Summit County through our network of providers, which includes Clinical Consultants, Odyssey House, Ascendant Behavioral Health, VOA, and Psychiatric Behavioral Solutions.

Provider Qualifications

Please see our response to Question 1 above for information on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

5) Outpatient (Methadone - ASAM I)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$2,000	Form B - Projected Clients Served in FY19 Area Plan	1
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$2,000	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	1

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. If you will not be providing or subcontracting for this service, describe future plans.

Proposed Activities

Through our provider network, we will make Outpatient ASAM 1.0 services with methadone maintenance available, as required by contract.

Where and How Services Will be Provided

Because of the extensive requirements to open and maintain a methadone clinic, we will work towards contracting with an existing methadone clinic in the Summit County area. We also have the ability to develop a single-case agreement with any existing provider to serve an individual client. Project Reality has expressed interest in working with Optum to provide services to Summit County clients in their Salt Lake County offices.

Provider Qualifications

Please see Question 1 for detail on how we make sure, and regularly validate, that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Office-based Opioid Treatment - (Vivitrol, Naltrexone, Buprenorphine)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$33,917	Form B - Projected Clients Served in FY19 Area Plan	49
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$0	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	0

Describe activities you propose to ensure access to Buprenorphine, Vivitrol and Naltrexone and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. If you will not be providing or subcontracting for this service, describe future plans.

We share Summit County’s concern regarding the opioid use epidemic. Optum issued a publically available White Paper in 2018 to highlight the most effective tools we have as a nation to end the opioid epidemic. We believe a multifaceted, evidence-based approach offers the greatest hope to treat opioid use disorder and help people regain their human potential by overcoming their struggle with addiction. This includes three key intervention areas:

- Prevent opioid misuse and addiction from developing in the first place.
- Guide people to evidence-based treatment.
- Support people throughout treatment and recovery, including care for co-occurring disorders

Optum looks forward to discussing these interventions further with Summit County.

Access to Buprenorphine, Vivitrol and Naltrexone

Through our network of qualified providers, we will provide office-based access to Buprenorphine, Vivitrol and Naltrexone for clients actively engaged in SUD treatment. The OSC team will work with the Health Department and other county staff as well as key stakeholders (e.g. local law enforcement and health care facilities) for medication and treatment and to identify a qualified prescriber who is appropriately certified to prescribe the medications.

Where and How Services Will be Provided

Our contracted network providers will provide services in their offices, as described above.

Other Resources to Support Office-Based Opioid Treatment

The dedicated OSC website will have MAT provider education and training materials available through a link on our provider portal (<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/mat.html>)

This site offers resources and trainings to assist practitioners with providing MAT-related services and office-based opioid treatment. The site also includes information on a SUD helpline for clients and families; MAT fliers, white papers, and quick reference guides; information on how to find MAT providers; and office-based opioid treatment protocols.

Our provider training portal also offers free Continuing Medical Education/Continuing Education Units to practitioners for taking MAT courses such as *The Fight Against the Opioid Epidemic*, *US Opioid Epidemic: Mitigation and Treatment Opportunities*, and *The Role of the Health Care Team in Solving the Opioid Epidemic*.

Provider Qualifications

Please see Question 1 for detail on how we make sure, and regularly validate, that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

7) Intensive Outpatient (ASAM II.5 or II.1)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$175,797	Form B - Projected Clients Served in FY19 Area Plan	118
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$140,064	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	95

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider.

Proposed Activities

We will provide 2.1 and 2.5 ASAM level of care services through our SUD provider network. This includes evaluation services; individual or family sessions; random drug testing; Seeking Safety groups; and other group services and education (e.g. coping skills, relapse prevention, cognitive behavioral therapy) as appropriate based on the treatment plans developed by individual clients.

Where and How Services Will be Provided

Optum will contract with an array of agencies to provide ASAM 2.1 and/or 2.5 for youth, women, mothers with dependent children, and general adult clients in multiple sites across Summit County and in Salt Lake County. We will provide psychiatric medication evaluation services through our contracted providers Odyssey House, House of Hope, and VOA for all levels of care, which are accessible by any client currently served.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

8) Recovery Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$5,543	Form B - Projected Clients Served in FY19 Area Plan	6
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$3,342	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Proposed Activities

Optum will comply with the requirements set forth in RFP Section VIII.I – Recovery Support Services (RSS). Our approach includes a full array of social, legal, and other evidence-based services that facilitate recovery, wellness, and linkage to/coordination among service providers. Our RSS augment the treatment services that clients receive, addressing social determinants of health that present barriers to optimal health outcomes. We will document and report all RSS services in the Substance Abuse Mental Health Information System (SAMHIS).

Most contracted providers in our network offer aftercare services to clients who choose to stay connected with their treatment provider. Optum and contracted providers will actively support Utah Support Advocates for Recovery Awareness (USARA's) and Summit County's efforts to advocate for recovery awareness. We support the Recovery Oriented Systems of Care initiative.

Where and How Services Will be Offered

Optum and our network of SUD providers will work with the Mental Wellness Alliance and other key stakeholders to identify available resources and then Optum will educate our providers and key stakeholders. We will monitor to assure our providers are accessing these client supports.

Provider Qualifications

Please see Question 1 for detail on how we make sure, and regularly validate, that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

9) Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$12,799	Form B - Projected Clients Served in FY19 Area Plan	35
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$8,775	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	20

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities and Means to Provide Peer Support Services

Peer Support Specialists are critical to supporting the strategic goals of Summit County, including increasing access, education, success and sustainability, and recovery and integration. Our providers employ Certified Peer Support Specialists (CPSS) who provide a bridge for support, advocacy, and skill building through individual client contact, providing linkages to substance use disorder services, physical health, and social services such as social clubs, peer-support groups, and other peer-organized activities.

Optum employs a Certified Peer Support Specialist, whose role includes supporting Peer Navigation programs, working with providers to develop and expand peer support resources within agencies, and encouraging clients to participate in DSAMH’s peer support certification training program. The CPSS on the Optum Summit County team will also collaborate and coordinate with external stakeholders to offer training in Summit County, including the evidence-based models called Seeking Safety and Double Trouble. Seeking Safety is designed to support those who have experienced trauma. It is a present-focused, coping skills therapy to help adults, children, and youth attain safety from trauma and/or SUDs and may be conducted in group or individual format. Double Trouble is a peer-facilitated support group for individuals who live with co-occurring disorders such as a substance use disorder and a serious mental illness..

Where and How Services Will be Provided

We will offer peer support services through our contracted network. Peer support services will be provided in the community, at a facility or other location where the client is receiving treatment/services. The CPSS employed by Optum will provide training and encourage the expansion of peer support services by our network providers serving Summit County clients.

Provider Qualifications

Please see Form B, Question 1 for detail on how we verify—and regularly validate—that our network is comprised of well-qualified providers.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured, equitable to both the County and Optum.

How is peer support supervision provided? Who provides the supervision? What training do supervisors receive?

Providing Peer Support Supervision

Our provider network will provide supervision to CPSSs as identified in paragraph A.1, A.2 or A.3 (b) of Chapter 1-5. Optum will provide oversight to ensure that all CPSS supervisors are in compliance with supervision

requirements and show evidence of participation in DSAMH sponsored supervision trainings.

Optum's Recovery and Resiliency Manager will provide supervision to Optum's CPSS. Additionally, Optum's CPSS will be fully integrated into the Optum Care Coordination team which will be available for consultation on complex individuals.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

10) Opioid Treatment Funds (STR & SOR)

The allowable uses for this funding are described in the SFY 18 Division Directives:

1. Contract with Opioid Treatment Programs (OTP);
2. Contracts for Office Based Treatment (OBT) providers to treat Opioid Use Disorder (OUD) using Medication Assisted Treatment (MAT);
3. Provision of evidence based-behavioral therapies for individuals with OUD;
4. Support innovative telehealth in rural and underserved areas;
5. Implement or expand access to clinically appropriate evidence-based practices (EBPs) for OUD;
6. Provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings;
7. Enhance or support the provision of peer and other recovery supports.

Describe the activities you propose and identify where services will be provided.

OSC will leverage our Salt Lake affiliate's successful approach to using Opioid Treatment Funds to help clients receive the treatment services they need (e.g. MAT, therapies for individuals with OUD, treatment for clients re-entering communities from criminal justice or other rehabilitation settings, and peer and other recovery supports) covered under this contract. Our evidence-based approach includes:

STR Grant—Formula Funds: Optum will partner with Project Reality to offer clinically appropriate evidence-based MAT for clients. For example, the Murray Clinic offers the full spectrum of MAT (methadone, Suboxone, and Vivitrol) and general outpatient therapy in Salt Lake County. This expansion offers client-specific MAT for up to 300 unique clients annually between the Murray and Salt Lake City locations. Project Reality will provide these same services in Summit County to the extent funds are available.

STR Grant—Application Funds: We partner with Clinical Consultants to offer clinically appropriate evidence-based MAT for clients residing in the southwest region of Salt Lake County. They offer clients Suboxone and Vivitrol coupled with all outpatient treatment services. This new clinic offers client-specific MAT for up to 133 unique clients. Clinical Consultants will provide these same services in Summit County to the extent funds are available.

Additionally, as stated, Optum offers telehealth virtual visits and uses Opioid Treatment funds to support our ongoing efforts to expand this solution if monies are available.

How will you identify, engage and retain individuals in your area with opioid use disorders?

Identifying Individuals with OUD

We will identify individuals with opioid use disorders through assessments conducted by providers, our utilization management efforts for clients seeking treatment, referrals from Drug Court, case managers, and others as appropriate. We conduct client/family outreach to encourage assessment and treatment engagement.

Engaging Individuals with OUD

To engage and keep clients with OUD engaged in treatment, we will use SUD recovery coaching by peer support staff, ongoing contact with case management, treatment through providers trained to address OUD (e.g. MAT providers), engagement in Seeking Safety groups, and the SUD Helpline.

SUD recovery coaches support clients with OUD, including pregnant women, and their families, to promote addiction recovery. Through this service, participating clients and the client’s family can embark on the road to recovery from OUD symptoms. This benefit can help a client improve his/her overall physical and behavioral health and it can help to reduce hospitalizations and ER visits related to OUD complications. The coaches offer telephonic and face-to-face support, as appropriate. These individuals are certified paraprofessionals who have been educated to help clients improve their OUD outcomes. SUD recovery coaches communicate with each participating client, as well as his or her family or caregiver (with consent), to support engagement in community-based services and supports. We will have a SUD recovery coach specifically focused on working with pregnant women to reach out and connect with those identified with OUD.

Retaining Individuals with OUD

Our network providers will apply evidence-based practices to retain clients in treatment through motivational interviewing, creation of a Wellness Recovery Action Plan with the client, relationships developed with their SUD recovery coach and case manager, and by linking them to providers with expertise in OUD treatments. We will also retain clients by using experienced, caring providers that clients know and trust and that are accessible to Summit County residents. For example, Project Reality and Clinical Consultants promote the expansion of services and the new locations to the target community through other community providers and in areas that experience limited access to this information. They coordinate recruitment efforts with local law enforcement, social services organizations, the Salt Lake County Coordinating Council, and contracted medical providers. The programs assist in reducing stigma and addresses bias, beliefs, values and norms by educating clients with OUDs, family members, and others engaged with these clients [e.g. police, Division of Child and Family Services (DCFS), medical providers] on the benefits and outcomes of MAT. Both programs actively work with the Salt Lake County Vivitrol program to identify referral pathways for current County clients and for opportunities to work with the Department of Corrections.

Describe how your plan will improve access and outcomes for individuals with OUD in your community.

Improving Access for Individuals with OUD

We will leverage our current commercial network in Summit County in addition to taking advantage of our current Medicaid network in Salt Lake County to increase access to treatment in Summit County.

Improving Outcomes for Individuals with OUD

We will use a multi-pronged approach to improve outcomes for our clients with OUD. For example, we have developed a broad network of behavioral health providers and have set the expectation for referral to MAT as the standard evidence-based treatment. We have developed a MAT recovery and support program and will enhance our strategy through collaboration with primary care providers, telehealth (virtual visits), and clinical pathways.

For each service, identify whether you will provide services directly or through a contracted provider. List all contracted providers that will provide these services.

We will provide all services directly through Project Reality or Clinical Consultants, both are contracted network providers that have agreed to treat our Summit County clients.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

11) Quality & Access Improvements

Describe how you will increase access to treatment?

Optum will increase access to treatment through network development and maintenance, holding providers to timely access standards, offering virtual visits (our telehealth service), and encouraging providers to participate in our Express Access program. Express Access providers agree to see our clients more quickly than the standards to which we hold other network providers.

Increasing Access to Treatment through Network Development and Maintenance

Optum has participated in the transformation of the Salt Lake County behavioral health system since 2011. This new model increased the provider network from a single provider agency to 55 providers (MH and SUD), expanded specialty provider expertise, increased client choice, addressed service gaps, and increased the focus on recovery and resiliency for clients and families. The transformation has resulted in an increase in the number of people served; a significant reduction in the reliance on inpatient services through expanded crisis response resources; a redirection of savings to greater community-based resources; and significant increases in the role and participation of peers and clients in direct service delivery and system planning.

We will leverage our current commercial network in Summit County (providers with whom we currently contract to serve members with UnitedHealthcare insurance) as well as our current Medicaid network in Salt Lake County to increase access to treatment in Summit County. To ensure that our current network providers will be available to serve the clients for whom OSC would be responsible, we are working to amend their existing contracts and add those clients. We have successfully employed this approach in other markets such as Nebraska and Missouri. Our Network team will use GeoAccess reports to monitor and review access and compliance to standards on a quarterly basis. We will immediately initiate actions to remediate any gaps identified. To fill identified gaps, we would recruit new providers, ask current providers to see additional clients, or implement single case agreements (a contract with an out-of-network provider to serve a particular client). We will also continually recruit service providers that specialize in serving the Latino population, a key component of Summit County's health equity goals.

Moving from Fee-for-Service to Value Based Contracting (VBC)

Over the contract period, OSC will help interested and qualified providers prepare to move away from traditional fee-for-service models to more sophisticated and accountable reimbursement strategies. While there are some limitations with behavioral health, Optum has been a leader both in offering providers training on these strategies and also as a key participant in national conferences such as Open Minds, National Association of Addiction Professionals, and Mental Health Council of America.

Value-based contracts (VBCs) are a key initiative for Optum in 2019. VBCs are part of structured programs that offer shared savings. For example, in our Community Mental Health Center (CMHC) shared savings program, a bonus is awarded to participating providers that implement best practices which result in reduced inpatient admissions. We also have a 7- and 30-day follow up appointment metric in which providers can receive a tiered payment incentive based on kept appointments. The available payment increases as the provider achieves target metrics.

Finally, we can work with Summit County to design VBCs that meet county-specific needs we will identify through analysis of claims data. We look forward to working with Summit County on implementing a program that benefits its budget and drives improvement in meeting its goals and objectives.

Holding Providers to Timely Access Standards

To verify that all clients have access to appropriate treatment as needed, not only do we develop and maintain a network with adequate numbers and types of clinicians, we also require that the network adhere to specific access standards. Our Medicaid Timely Access Standards are:

- Routine Appointment –An appointment must be available within 14 business days of the date of the request for services, unless the client requests a later time
- Urgent Care Appointment – Appointment available within five business days
- Emergent – Appointment available within 30 minutes by phone; one hour face-to-face

In all cases, we expect providers to reply to a client within 24 hours of the time the client first asks for an appointment for routine outpatient MH/SA care.

virtual visits/Telehealth

OSC will introduce our virtual visits telehealth platform. Virtual visits allows clients to receive behavioral health outpatient services via a secure internet connection on a tablet, cell phone or computer. Clients and their providers can connect wherever they are—office, home, or other location—as long as Medicaid and other state requirements are met. To set up a virtual visit, clients download an app that enables them to make an appointment with licensed behavioral health provider who is enrolled with Utah Medicaid as well as Optum’s virtual visits program. Using virtual visits, clinicians can provide counseling and prescribe medications if they are appropriately licensed and tele-prescribing is allowed under the Medicaid state plan.

Express Access

For many contracts, we develop a unique sub-network of providers that contractually agree to see clients in eight days or less, rather than the 14 days required by our timeliness standard for Medicaid clients. We typically offer incentives to providers to encourage participation in this sub- network. Across the country, Express Access providers deliver approximately seven percent of Optum’s outpatient visits for behavioral health services. Over the contract period, Optum’s Provider Relations Team will develop an Express Access sub-network to serve OSC clients.

Describe your plan to improve the quality of care.

At Optum, quality improvement (QI) is much more than data collection, it is a fundamental part of the day-to-day activities of every department. We continually monitor multiple areas of our performance; our impact on clients, families, and providers; and constantly look for areas of improvement. To evaluate the impact and effectiveness of our QI program, we will establish clearly defined goals related to both clinical and administrative effectiveness. This will include measurable objectives, data feeds, responsible parties, frequencies of activities, and target completion dates. They will be part of our Quality Improvement Program Description and Quality Improvement Work Plan. We also will fully participate with the County’s fiscal, administrative, and program monitoring, including quality assurance and utilization review visits. We will document findings as a result of our monitoring activities.

Continuous Quality Improvement Process

To achieve our improvement goals, Optum has structured a comprehensive QI program that provides the framework for continuous monitoring and evaluation of all aspects of behavioral healthcare delivery and service. We ask staff to always look for any areas of weaknesses in the performance of the organization and also for innovative ways to improve our service to clients and providers and support the recovery and resiliency of clients and families.

Optum’s QI Program employs a Continuous Quality Improvement (CQI) process consisting of ongoing analysis of clinical data and program results, identifying and prioritizing opportunities for improvement, implementing interventions, and evaluating the effectiveness of those interventions on the quality of care and services. Elements vital to our use of the CQI process include:

Data Collection and Analysis: We continuously identify opportunities for improvement that will be addressed through a systematic process. We routinely monitor recognized important aspects of care and service, and our performance is evaluated against appropriate benchmarks, practice norms, or performance goals. Data are collected through several sources, including the claims database, the clinical management information system, client and provider satisfaction surveys, Geo-Access® analysis of provider availability, client grievances and appeals, treatment records, credentialing information, and office site visits. In addition, we establish valid methodologies with guidance from internal data analysts and statisticians.

Barrier Analysis: When quality of care or services does not meet the expected standards, we conduct a barrier analysis to assess the reasons for the identified deficiencies. Techniques used to determine the barriers or root causes for the results may include the collection of additional data, stratification of the data, or analysis of subgroup data to drill down sufficiently to understand the reasons for the results. We employ common techniques of CQI such as brainstorming, cause-and-effect diagramming, identification of key factors, and others to identify barriers to improvement. We may also apply already identified citations from literature that contain information

about barriers to performance.

Interventions

In accordance with the barrier analysis, we identify and prioritize opportunities by focusing on variables that can result in improved performance. We deliberate, select, and implement appropriate interventions to overcome the barriers. Various subcommittees, work groups, or the QMC then recommend applicable interventions.

Evaluation of Effectiveness: All interventions and corrective actions are followed by re-assessment or re-measurement to evaluate the effectiveness of the intervention. We identify and analyze trends to determine their significance. We then examine casual links between the interventions and the results. We then identify interventions that influenced the outcome, which are differentiated by those that were most influential, including any intervening or confounding factors that may have contributed to any changes that occurred.

Communication of Results: We communicate results of QI Program activities to the County, clients, providers, and other stakeholders as appropriate.

Client, Family & Provider Involvement: Client, family, and provider involvement are vital to our QI programs. Optum will obtain and incorporate input and representation from representatives of these stakeholder groups in various ways at different levels of our QI structure, including through participation on Advisory Committees and work groups. Representative stakeholders named to QM Committees will support the QI program by providing input and expertise relative to clinical QI projects, best practice guidelines, preventive health programs, and coordination and continuity of care across the healthcare continuum.

Quality Monitoring: We help foster the quality of care that clients receive by validating that care is clinically sound and based on the most current and prevalent clinical knowledge, practices, and technology. Quality personnel, under the direction of the Quality Committee, will monitor key metrics on a monthly, quarterly, and annual basis through the Quality Improvement Program Description and Quality Improvement Work Plan. In addition, we will conduct a formal written evaluation of our Quality Improvement program. This annual evaluation includes the following information:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care
- Analysis of the results of QI initiatives, including barrier analysis
- Evaluation of the overall effectiveness of the QI programs, including progress toward influencing network-wide safe clinical practices.

Provider Audits: Clinical monitoring audits are essential to overseeing and improving the quality of care we providers deliver to our clients. As part of our focus on provider quality performance, we conduct routine clinical monitoring audits of treatment records. For our audits, we select providers at random, with sampling at a 90 percent confidence level.

We also conduct audits to address specific quality of care issues or in response to client complaints about the quality of the office or facility environment. These audits, conducted by independently licensed behavioral health clinicians, evaluate whether providers meet Optum and community standards for assessment, diagnosis, treatment planning, coordination of care, and ongoing documentation of services. When necessary, providers submit a corrective action plan (CAP) that we monitor to verify that changes have been implemented and the identified issues are resolved. We address audit results on an individual basis and trend them across the system to identify systemic opportunities for training, policy adjustment, or other actions.

Describe Implementation and Training of Evidence Based Practices to Ensure Fidelity.

Provider contracts with OSC will require use of the DSAMH Evidence Based Practices (EBPs). The Network Team will notify providers via eblast about trainings offered in the community related to the identified EBPs. All claims are required to identify the EBP used in providing the service. This data is then submitted with the encounters to the State. Provider orientation will include these expectations, and we will provide a link to the DSAMH Evidence Based Practices on our provider portal.

In addition, language in the supervisory protocol which is part of the provider contract between Optum and network providers explicitly states that treatment provided must be consistent with Optum's Level of Care and Best Practice Guidelines. The Guidelines align with evidence-based treatment set forth in ASAM and by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry Practice Guidelines. During audits, Optum will review the provider's adherence to the use of best practice guidelines as per supervisory standards. We will assess providers' adherence to level of care guidelines through our utilization management reviews on an ongoing basis.

Describe Clinical Supervision Protocol or Plan.

DBHS and Optum continue to support providers in their use of evidenced-based practices. However, individual providers are responsible for getting training in evidence-based practices. By contract, all current providers have to provide evidenced-based practices, including the supervision required by the EBP. DBHS and Optum have seen increased use of EBPs by providers including increased use of Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Solution-focused Therapy, Trauma Awareness Focused Therapy, Strengthening Families, and gender specific treatments.

How do you evaluate client outcomes?

The Outcomes Questionnaire (OQ) and Youth Outcomes Questionnaire (YOQ) are mandated by the State of Utah to be used by every provider. In turn, Optum requires that all providers utilize these questions in the development of treatment plans.

Correctional Program Checklist (CPC) - The CPC is a tool developed to assess correctional intervention programs and is used to ascertain how closely those programs meet known principles of effective intervention. Several studies conducted by the University of Cincinnati—of both adult and juvenile programs—were used to develop and validate the indicators on the CPC. These studies found strong correlations with outcome between overall scores, domain areas, and individual items.

The CPC is divided into two basic areas: CAPACITY and CONTENT. The CAPACITY area is designed to measure whether a correctional program has the capability to deliver evidence-based interventions and services for offenders. There are three domains in the capacity area are: (1) Leadership and Development; (2) Staff; and (3) Quality Assurance. The CONTENT area focuses on the substantive domains of: (1) Offender Assessment; and (2) Treatment Characteristics. This area evaluates the extent to which the program meets the principles of risk, need, responsivity, and treatment. There are a total of 77 indicators, worth up to 83 total points. Each area and all domains are scored and rated as either "HIGHLY EFFECTIVE"; "EFFECTIVE"; "NEEDS IMPROVEMENT"; or "INEFFECTIVE".

Optum will work in partnership with Summit County to develop additional outcomes measures in alignment with the Goals of the Strategic Plan.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

12) Services to Persons Incarcerated in the Summit County Jail

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Activities Proposed to Address Services to Incarcerated Persons

Optum will work with its network providers to implement a nationally recognized sequential intercept model that

provides a conceptual framework for communities to organize targeted strategies for justice-involved clients with behavioral health disorders. There are numerous intercept points that are opportunities to connect justice-involved clients with behavioral health services and prevent the client from moving further into the criminal justice system. Our approach will be based on our eight years of experience in Salt Lake County.

The OSC team will identify and contract with a network provider to deliver crisis services for jail-based behavioral health services. We will work with Summit County and the jail system to determine how to best meet the request for non-emergent behavioral health services.

Where and How Services Will be Provided

We will work closely with Summit County and the jail system to consider options, including the feasibility of telehealth. To implement a telehealth solution, OSC would establish the processes and procedures; secure appropriate space within the facility that would ensure client confidentiality for the visit; verify that we can access clinical records for services rendered to incarcerated clients; and install equipment to deliver telehealth visits in the selected space.

In cooperation with the Summit County Jail, Optum will collaborate with both the Jail and an identified provider to develop an individualized release plan to behavioral health services which includes an assessment of transportation needs. It is our intent that this collaboration occur prior to individual's release from jail. When it is determined that transportation is necessary to provide linkage to treatment, Optum will make transportation arrangements that can occur directly between jail and the agency.

Provider Qualifications

Please see our response to Form b, Question 1 for information on how we verify—and regularly validate—that our network is comprised of well-qualified providers. For Services to Incarcerated Persons, we will use contracted providers with experience serving these clients including a psychiatrist or psychiatric APRN to consult on treatment, medications, and diagnosis within the Summit County Jail along with general mental health services.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of clients the LCP proposes to serve either directly or through contract. (10% or greater change).

As a non-incumbent bidder, OSC has based our response (FY20) on the LCP amount budgeted and projected clients served for FY18 and FY19 provided by the Summit County Council in the RFP. We have not made any changes for this proposal.

Describe your proposed crisis coverage plan for 24/7, 365-day coverage within the Summit County Jail. If you plan to subcontract, please describe your oversight plan to ensure full coverage in the Summit County Jail.

Proposed Plan for Crisis Coverage

The OSC team will identify a local contracted partner to deliver crisis services for jail-based behavioral health services. We are in discussions with UNI, which is part of our current provider network, to determine what back-up role it can plan to support our local provider. The intent is to have the Summit County provider available for crisis coverage 24/7/365 as well as providing assessment, care planning, medication management, therapy, and care coordination with the jail health services personnel. Should this prove to be more than one provider can do, we will work with the providers and the jail on a 24/7/365 coverage plan.

Oversight Plan to Verify Full Coverage in Summit County Jail

The OSC Director will oversee our contracted providers for the jail to verify that we are providing full coverage to incarcerated clients. The Director will meet at least monthly with Jail personnel and with contracted providers responsible for jail services. The intent of these contacts is to ensure services are being provided timely and as needed for those incarcerated in the county jail and to identify any areas that are opportunities for improvements. Jail provider records will be subject to clinical audits through our quality and network oversight process.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

13) Integrated Care

Describe how you plan to partner with the Department, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers to integrate client care between behavioral health and physical health.

Establishing Partnerships to Integrate Care

We will establish an ongoing action plan for initiatives to collaborate with the Summit County Health Department and other physical health providers for integration of client care and health outcomes. Initial topics for exploration and next steps would include mechanisms for communication. We will establish contact information and set up ongoing meetings with the ACOs to discuss individual cases where integration and coordination is critical.

FQHC Partnerships

While there currently are no FQHCs in Summit County, we will seek to contract with its Rural Health Clinics, Kamas Health Center and Coalville Health Center, for any behavioral health services they provide to clients in their respective service areas. Although People's Health Clinic is not an FQHC and only sees the uninsured, they are an important provider of medical care, and Optum will work collaboratively with the People's Clinic to facilitate integrated and coordinated care with our contracted behavioral health providers. We will seek to contract with any new FQHCs that move to Summit County once they are established.

Describe your efforts to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy, Nicotine).

Incorporating Wellness into Treatment Plans

At the outset of services, our providers are required to conduct a holistic assessment that includes medical, behavioral health, and social needs. They then work with the clients to develop treatment plans that address those comprehensive needs. Optum Summit County will work closely with our providers and clients (or their caregivers) so that we identify and incorporate wellness activities into treatment plans. Provider medical records will be subject to periodic audits to make certain that expectations are met. Providers will educate clients on the wellness resources available to them, such as smoking cessation resources, mindfulness exercises, and online personal empowerment programs (i.e. cognitive behavioral therapy) for addressing substance misuse and other areas for overall wellbeing.

Education and Referrals Regarding Physical Health Concerns

We will use a multi-modal approach to provide education and referrals to clients regarding their physical health concerns. Clients receive information in their handbook about our Member Portal. Our care management and peer support staff educate clients on resources specific to addressing their needs on our portal, such as information about arthritis, asthma, cancer, chronic pain, diabetes, HIV, TB, heart health, infertility, men's health, obesity, traumatic brain injury, and women's health, including pregnancy.

For providers, we will host network trainings that include a focus on the importance of the physical health assessment components as well as coordinating with PCPs as needed for their services. When and what information our BH providers are expected to coordinate with medical practitioners is outlined on our Provider Manual and providers are oriented to those expectations.

Additionally, our clinicians will educate ACOs and providers on the metabolic effects of second-generation antipsychotics on clients. They also will collaborate with the respective ACOs on a case-by-case basis when a client's medical needs are adversely impacting their behavioral health and/or a part of their recovery. Some of the conditions that typically have a negative impact on a client's mental health are the human immunodeficiency virus

(HIV), acquired immune deficiency syndrome (AIDS), diabetes and pregnancy. We will identify a point of contact for each ACO.

Recovery Plus: Describe your plan to reduce tobacco and nicotine use and how you will maintain a tobacco free environment. SUD Target= reduce tobacco and nicotine use by 5% as set by DSAMH.

Optum will implement Recovery Plus to full fidelity. Optum will educate providers on the Recovery Plus Program and the mandate to diagnose and provide treatment for nicotine addiction as a healthcare issue. Recovery Plus will be addressed at provider meetings and trainings. Clinicians will be reminded in provider trainings of the health implications of smoking for our clients, the need to ask clients if they are interested in cessation services, and the need for proper documentation of these efforts. Due to the popularity of previously non-traditional ways to use nicotine, the providers are also being educated to ensure that any type of nicotine delivery system is addressed with clients. Optum will incorporate a review of Recovery Plus initiatives during audits providing a forum for another conversation about the importance of offering cessation services to clients. Optum will make available both a link and phone number to Utah’s smoking cessation resources: UtahQuitNet.com and 1-800-QUIT-NOW. Optum providers are required to screen for nicotine use as part of the assessment process, to diagnose accordingly, and to refer consumers to cessation services when indicated. In addition, Recovery Plus program and contact information is made available through all providers. Each provider is strongly encouraged, and mandated by contract, to provide nicotine cessation for those clients who are willing to receive these services. While these services do include UtahQuitNet.com and 1-800-QUIT-NOW, providers are also encouraged to use recommended medication assisted treatment, where appropriate.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

14) Women's Treatment

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$198,995	Form A1 - Projected Clients Served in FY19 Area Plan	113
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$212,761	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	113

Describe the evidence-based services provided for women including gender-specific substance use disorder treatment and other therapeutic interventions that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting.

Evidence-based Services for Women Including Gender-specific SUD Treatment

Women’s substance use disorder treatment should attend to not only to the biological issues facing women but also the social and environmental factors. The unique factors women experience can influence the motivations for drug use, the reasons for seeking treatment, the types of environments where treatment is obtained, the treatments that are most effective, and the consequences of not receiving treatment. For example, research has shown that physical and sexual trauma followed by post-traumatic stress disorder (PTSD) is more common in drug-abusing women than in men seeking treatment. Other factors unique to women that can influence the treatment process include issues around how they come into treatment (as women are more likely than men to seek the assistance of a general or mental health practitioner), financial independence, and pregnancy and child care.

Optum will establish a network of providers offering range evidence-based practices for gender-specific treatment of substance use disorders in women. From standard outpatient to residential services, all providers will be expected to support the use of MAT services during treatment.

We will provide referrals to women's specific programs such as House of Hope, Odyssey House women's and children program and we will support agencies that offer parenting classes for families with children. We will encourage our providers to offer options for childcare during therapy sessions, such as allowing children to accompany their mothers during treatment or offering temporary childcare if needed during the session. We have providers in our network that offers all levels of treatment for mothers and their children concurrently.

Describe the therapeutic interventions for children of clients in treatment that addresses their developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect.

Children of families that receive SUD treatment are provided therapeutic/developmental services during the day while their parents attend group/individual client therapy sessions. These services include assessment, client and family therapy, and practicing pro-social and health behaviors. Specific interventions include:

- Addressing potential for SUD with referrals to support groups for those with family members that have SUD such as AlaTeen (offered through two local churches in Park City), use of Narconon's Truth About Drugs Video program offered to the Summit County schools for middle and high school students, engagement in Seeking Safety groups for youth
- Addressing issues related to sexual and physical abuse and neglect addressed through referral, and therapy services by a trauma informed practitioner with expertise in the area(s) of abuse/neglect experienced by the youth.
- Children in the transition program are eligible to continue receiving services while their parents work and move into permanent or transitional housing

Describe case management, childcare, and transportation services for women the LCP is able to provide to ensure they have access to the services you provide.

Case Management Services

Parent and children programs provide case management assistance with obtaining children's records such as birth certificates and social security cards, obtaining Medicaid or other financial supports, and monitoring court dates. Services are provided through providers contracted with Optum. Optum helps set up educational, mental health, and/or developmental referrals for current and future assistance. Optum also works with families to manage financial assistance already in place.

Transportation Services

Optum will offer transportation services, as per Medicaid regulations, through a contracted entity for those clients that are Medicaid eligible. Clients can contact their provider to work through Optum to arrange for transportation. We will also refer clients to free transportation services offered by community organizations such as churches or other entities such as Kimball Circulator, which provides free rides around the Kimball Junction area.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

15) Adolescent (Youth) Treatment

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$65,207	Form A1 - FY19 Projected clients Served:	23

Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$66,610	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	31
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Describe the evidence-based services provided for adolescents and families. Identify your plan for incorporating the 10 Key Elements of Quality Adolescent SUD Treatment: (1)

- 1. Screening / Assessment,**
- 2. Attention to Mental Health,**
- 3. Comprehensive Treatment,**
- 4. Developmentally Informed Programming,**
- 5. Family Involvement,**
- 6. Engage and Retain Clients,**
- 7. Staff Qualifications / Training,**
- 8. Continuing Care / Recovery Support,**
- 9. Person-First Treatment,**
- 10. Program Evaluation.**

Optum’s network of qualified providers will provide evidence-based services according to the adolescent ‘s ASAM assessment findings and what each client’s treatment plan incorporates to facilitate quality adolescent SUD outcomes. The approach will include:

- 1. Screening / Assessment** – The contracted provider will conduct an ASAM assessment.
- 2. Attention to Mental Health** – Providers will complete comprehensive assessments on all clients as required of providers and detailed in our provider manual.
- 3. Comprehensive Treatment** – Optum will refer clients to providers with expertise in meeting individual client’s needs. Our expectation is that providers complete holistic assessments and treatment plans with referral and coordination for external services (e.g. PCP or specialist) when needed
- 4. Developmentally Informed Programming** – We will contract with providers that have experience by age group (infants, preschool, children, adolescents in our provider directory) and specific conditions
- 5. Family Involvement** – Our providers’ multidisciplinary care teams will include representatives from the client’s family and support system
- 6. Engage and Retain Clients** –Our providers will offer case management outreach/engagement; and offer peer support services.
- 7. Staff Qualifications / Training** – We will identify provider qualifications and training through our credentialing/recredentialing process and we will document provider specialties and credentials in provider directory
- 8. Continuing Care / Recovery Support** – Our providers will facilitate continuity of care through case management and peer support services. As documented in network contracts and our provider manual, we will require providers to foster continuity of care through client transitions and coordination. We will also conduct regular treatment plan reviews/modifications to validate appropriate, comprehensive care.
- 9. Person-First Treatment** - Our philosophy is to have person-first, recovery-oriented treatment services, and those expectations are included in our provider manual. UM and Quality provide oversight of the treatment plans developed and signed/agreed upon by clients or their caregivers.
- 10. Program Evaluation** – We will produce claims reports and UM reports on an ongoing basis to monitor performance and issues and produce provider scorecards on indicators such as hospital admits/readmits, episodes/cost of care. We will also perform clinical quality audits of provider records to validate quality performance.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Due to the lack of detailed information, we have made no changes to the budgeted amounts or projected clients. We look forward to collaboratively addressing funding levels, during negotiations and thereafter as needed, when utilization data becomes available to ensure sustainable funding for Medicaid covered clients and the uninsured,

equitable to both the County and Optum.

Describe collaborative efforts with other state child serving agencies (DCFS, DJJS, SOC, DSPD, Juvenile Court) and any significant programmatic changes from the previous year.

Experience with Collaborating with Other State Child Serving Agencies

Optum has been collaborating with other Utah child-serving agencies since 2011 when our contract with Salt Lake County was implemented. Over the last eight years, the Salt Lake team has worked closely with multiple agencies including the Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), SOC, Division of Services for People with Disabilities (DSPD), Juvenile Court, and others. In Salt Lake County, we collaborate closely with other State agencies serving children and youth to verify that needs are continually met. Optum SLCo monitors these efforts, and we request that providers document their efforts at collaboration as part of each client's plan. The Salt Lake County team also participates in the weekly Multi Agency Staffing (MAS), which includes representatives from Juvenile Court, Granite School District, and other treatment providers.

In addition to the agencies described above, OSC will participate in existing community coalitions such as the Summit County Mental Wellness Alliance, Summit County Communities that Care (CTC), the Children's Justice Center, mental health advocacy groups such as the Latino Mental Health Group, or others as applicable, appropriate, or allowed to support the Summit County Wellness Strategic Plan goals. We will also collaborate with the County to develop new coalitions as needed and participate with key community partners such as CONNECT Summit County, Summit County Clubhouse, school districts, local governmental agencies, and local non-profits.

Significant Programmatic Changes from the Previous Year

Optum is not currently contracted as an LCP in Summit County. As a non-incumbent, Optum does not have any significant programmatic changes from any previous years to report.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

16) Drug Court

Form B - FY19 Amount Budgeted: Felony	\$61,791	LCP Amount Budgeted: Felony	
Form B - FY19 Amount Budgeted: Family Dep.	0	LCP Amount Budgeted: Family Dep.	
Form B - FY19 Amount Budgeted: Juvenile	0	LCP Amount Budgeted: Juvenile	
Form B - FY19 Recovery Support Budgeted	\$5,543	LCP Amount Budgeted: Recovery Support	

Describe your experience with Drug Court programs.

On a national level, Optum has experience in several states working with drug courts to divert clients from incarceration and engage them in behavioral health treatment services. A recent example is our Medicaid program in Missouri program that started in May 2017. For this statewide program, we have a liaison assigned to work with the court system, including the mental health and drug courts throughout the state. The liaison coordinates communications and the exchange of clinical information between our staff and courts, law enforcement, juvenile justice centers, and others who are part of Missouri's legal system. We work with drug courts as part of some of our other statewide Medicaid contracts, including Kansas, Arizona, Louisiana, Ohio,

Washington, and Iowa.

We have providers in our network that have experience with the drug court program in Salt Lake County.

Identify the service you will provide directly or through a contracted provider for the Drug Court Program.

Services We Will Provide

We will provide through our qualified network of providers all the required counseling and Drug Court related services per VIII.M – Drug Court Program. Services will be provided or authorized based on the Drug Court participant/client’s level of care, including participants identified as High Risk/High Need by using a validated criminogenic risk tool. Our providers will offer MAT, case management, RSS, group and individual counseling, and drug testing. We will assess clients for the least restrictive environment as well as private funding sources available to them to refer them to the best treatment option for them. Our goal is to maximize treatment while minimizing costs to the County.

Who Will Provide the Services

Optum’s qualified network of providers will serve Summit County residents including Psychiatric and Behavioral Solutions, and others as described in the following subsections. Urinalysis and drug testing will be done through either LabCorp or QUEST Diagnostics, entities with which we already have contracts in place. After being selected as Summit County’s next LCP, we will also explore the option of offering Drug Court services using our virtual visits telehealth technology.

Describe MAT services to be provided as part of the Drug Court Program. Will services be provided directly or by a contracted provider (list contracted providers).

MAT Services to Be Provided

MAT is the evidence-based practice of choice to treat opioid use disorder (OUD) and help more clients focus on their recovery. A significant body of research suggests that a holistic medication assisted model saves lives and has a substantial impact on total cost of care. We anticipate reducing the incidence of opioid use disorder and a resultant reduction in the total cost of care using this holistic, person-centered approach.

All adult Drug Court clients are eligible to participate in the County’s MAT services, including methadone or suboxone through Project Reality and the Vivitrol Program. Taking advantage of the county program(s) will help reduce their cravings. MAT plays a critical role in sustained recovery as it pairs therapies such as counseling or cognitive behavioral therapy with an FDA-approved medication to treat SUDs and prevent opioid overdose.

Where Services Will Be Provided

All MAT services will be provided by contracted providers. SUD treatment will be available through First Step House, Odyssey House, Clinical Consultants and Project Reality for Summit County

Describe drug testing services you propose to undertake. For each service, identify whether you will provide services directly or through a contracted provider. (The Department provides additional funding for Drug Court UAs.)

Proposed Drug Testing Services and Who Will Provide Them

Optum Summit County’s drug testing services will comply with the requirements outlined in Administrative Rule R523-15. OSC will rely on its contracted network partners of LabCorp and QUEST Diagnostics for drug testing services. All regular urinalyses will be completed within 72 hours as required. Our partners will use current research and comply with the national standards for drug testing techniques. They will give clients a five- or eight-panel drug test and a random specialty test to determine if cross-addiction is occurring. They will provide observed sample collection, temperature readings, and checks for creatinine and specific gravity to detect adulterated samples.

Where We Will Provide Services

Individuals who receive ASAM 3.1 and above are usually drug tested at the facility where treatment is being

provided. In some cases, if the provider does not have the resources for drug testing or is not able to provide the frequency of 2-3 times per week, including weekends and holidays, the client will be sent to our contracted provider for testing. Family Dependency Drug Court and Juvenile Drug Court clients are tested randomly twice a week by the treatment provider by which they are served.

Are you able to meet a 72-hour testing period from collection to results being delivered to appropriate staff?

OSC will meet the 72-hour testing period from collection to results being delivered to appropriate staff. We also will implement a process to verify that we transmit all Drug Court-related urinalysis test results to appropriate Drug Court or Probation staff members.

Outline drug court fees assessed to the client in addition to treatment fees.

OSC will follow the current policy, which we understand requires participants to cover the cost of challenges to a positive drug test if the results of the challenge drug test are also positive. Optum will cover the cost of the challenge drug test if the results of that test are negative.

Describe any significant programmatic changes from the previous year.

Optum is currently not contracted as an LCP in Summit County. As a non-incumbent, we have no significant programmatic changes to report from prior years.

Describe the Recovery Support Services you will provide with Drug Court RSS funding. (These services must be services that are approved on the DC RSS service list)

Optum will offer clients who are in Adult Drug Court (ADC) and receive RSS funding the opportunity to select how to spend their money on services approved on the DC RSS service list. They can use the funds for more stable housing, to improve their physical health, to expand their social relationships, or to improve their sense of self-worth. Clients can use this money as they feel it best helps them support a drug-free lifestyle and enhance all areas of their recovery.

Leveraging our approach, experience, and expertise in Salt Lake County, our Recovery and Resiliency Manager, our Peer Support Specialist, and Family Resource Facilitator (FRF) will support RSS. This staff will provide training and education, facilitate mutual support groups, help coordinate transition from inpatient services back into the community, offer direct services, and make referrals to external peer specialists and FRFs or other services as needed. For example, OSC staff will work with clients to determine which services would be most beneficial to them in their recovery such as drug testing, transportation (bus passes and gas cards), housing (transitional and emergency), dental services, and other special needs such as checks for identification cards/documentation and birth certificates.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

17) Justice Reinvestment Initiative (JRI)

Form B - FY19 Amount Budgeted:	\$18,000	LCP Amount Budgeted:	
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Describe your experience with JRI.

Although Optum works with a number of programs for justice involved populations around the country, our current

scope of responsibilities in Salt Lake County do not include the management and oversight of the Salt Lake JRI program.

While each community will have unique challenges addressing the needs of justice involved clients there are many similarities among the goals, priorities and challenges of such programs.

Utah's JRI priorities are:

- Focus prison beds on serious and violent offenders
- Identify offenders' risk level and target their criminogenic needs
- Strengthen probation and parole supervision
- Incorporate rewards and incentives in offender supervision and use swift, certain, and proportionate sanctions for violations
- Improve and expand re-entry and treatment services
- Frontload treatment and supervision resources for better outcomes
- Support local corrections systems by establishing evidence-based jail treatment standards
- Incorporate validated risk and needs assessment tools that inform treatment and supervision practices
- Ensure oversight and accountability on system reforms

Understanding the current system of care for justice involved clients in Summit County, identifying what is working and any deficiencies will be an important priority for Optum leadership, our providers and Optum staff.

We will work with the Department to: ensure compliance with all State and Local justice reform efforts, build and train a network of community based providers capable of identifying clients behavioral health needs and delivering evidence based treatment and provide ongoing training to Drug Court staff on criminogenic risk, need and responsivity.

We look forward to working with the Department, law enforcement, the jail, Drug Court staff and other stakeholders to evaluate how well the system of care in Summit County is meeting the needs of justice involved clients and developing an engaged and capable community based behavioral health system.

Optum also participates in justice reinvestment initiatives in our Kansas and San Diego County affiliates. For example, Optum has worked collaboratively with the County of San Diego Health and Human Services Agency and Probation Department to assess the behavioral health needs of individuals returning to the community from the California State prison system since July 2012. Their goal is to screen for behavioral health needs, identify treatment priorities, refer clients to community agencies, and prevent recidivism. For additional experience with JRI, please see Form A, Question 2 – Experience and Capability.

Describe the evidence-based substance abuse screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.

The approach to substance abuse screening, assessment, prevention, treatment, and recovery support services that the OSC team intends to implement, including addressing criminal risk factors, includes the following:

- **Screening**—We will use Drug Abuse Screening Test (DAST-10) and AUDIT-C
 - The DAST-10 is a 10-item, yes/no self-report instrument designed to provide a brief clinical screening and treatment evaluation used for adults and older youth
 - AUDIT-C is a three-question screen for hazardous or harmful drinking that can be stand-alone or incorporated into a general health history questionnaire.
 - Additional evidence-based tools for provider use are available through the Behavioral Health Toolkit for Medical Providers on our provider portal.
- **Assessment**—We will perform comprehensive assessment to address biopsychosocial aspects of clients' care needs. We will use assessment results to develop clients' care plans.
- **Prevention**—We offer case management and peer support as previously described in this section. We will also provide the school systems Narconon's Truth about Drugs video programs for middle and high school students.
- **Treatment**—We offer a full continuum of services through our network providers to address client's mental health and SUD needs; offering expertise in EBPs, special populations, and conditions

- **Recovery Support Services**—See our response in the above Question 16.
- **Addressing Criminal Risk Factors**—We will assess and work collaboratively with local law enforcement and the justice system to identify and engage high risk clients due to mental health conditions; offering Crisis Intervention Team (CIT) training for law enforcement; and providing ongoing engagement with local crisis provider(s) to identify at risk clients.

For the criminogenic risk assessment, we will examine the current tools used by providers in Summit County and other parts of the State to determine what currently works best. Based on research to date, we are aware that there are a variety of tools in use within Utah already such as the LSI-R, the LSI-R (SV), the LSI (SV), Historical Clinical Risk Management 20 Tool, Drug Use Screening Tool (DUSI), and the Risk and Needs Triage (RANT).

Identify training and/or technical assistance needs.

We will collaborate and partner with Summit County first responders to arrange training such as Effective Practices in Community Supervision (EPICS), trauma-informed training, and effective practices in working with the seriously and persistently mentally ill population such as Crisis Intervention Team (CIT) training and Mental Health First Aid (MHFA). CIT programs include 40-hour Advanced Officer Training. MHFA is an eight-hour program, which teaches law enforcement or others how to provide help to clients who may be developing a mental health problem, experiencing a worsening of an existing problem, or are in a mental health crisis. The MHFA is offered until appropriate professional help is received or the crisis is resolved.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

- END OF FORM C -

Attachment D

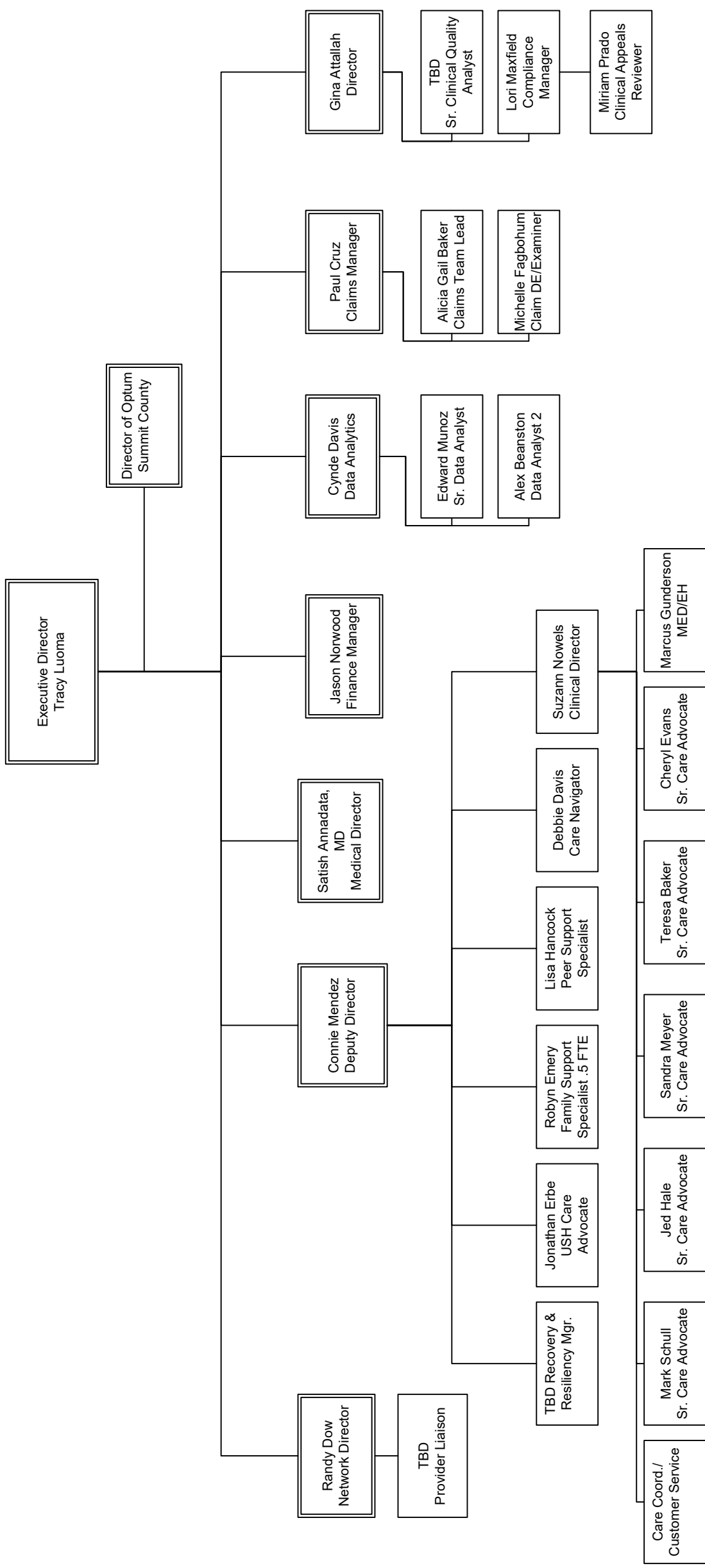
Proposed Organization

Chart



Attachment D: Optum Organizational Chart

March 2019



Attachment E

List of Network Providers

Attachment E

Complete the following worksheet for each entity you currently or are planning on subcontracting with to provide services under this contract. If you currently are not in a relationship with an entity, but are anticipating you will for this Contract, include a letter of intent with this form stating so.

Entity Contracted	Service(s) Provided	Type of Organization	Location of Services Being Provided Under this Contract
EXAMPLE	EXAMPLE	EXAMPLE	EXAMPLE
Blessing Mental Health	Outpatient	Non-Profit 501c3	1100 Old Town, Park City, UT 84098
Dr. Nate Tate, Psychiatrist	Medication Management	Individual Contractor	1200 Twain Rd., Coalville UT, 84017
Rutan Behavioral Health Center	Inpatient	Non-Profit 501c3	6 Moline Dr., Salt Lake City UT,
Kim Bester, LCSW	School Based Services	Individual Contractor	12 Quincy Dr., Kamas UT,
Entity Contracted	Service(s) Provided	Type of Organization	Location of Services Being Provided Under this Contract
Alliance House	Outpatient (Clubhouse Model)	Group Contract	1724 Main Street Salt Lake City, UT 84115
Ascendant Behavioral Health	Outpatient MH and SUD Treatment, Psychological Testing and Medication Management	In Process for Medicaid Group Contract (already INN for commercial I believe)	5383 South 900 East Unit 103 Salt Lake City, UT 84117 (Summit County location post award)
Asian Association of Utah (Refugee and Immigrant Center)	Outpatient	Group Contract	155 South 300 West Suite 101 Salt Lake City, UT 84101
Clinical Consultants	Outpatient Substance Abuse and Mental Health Services, MAT, Domestic Violence Treatment Services	Group Contract	7601 So. Redwood Rd. West Jordan, UT 84084
First Step House	Outpatient and Residential Substance Use Treatment for Adults	Facility Agreement	411 No. Grant Street Salt Lake City, UT 84116 440 So. 500 East Salt Lake City, UT 84102 2200 So State St. Salt Lake City, UT 84115
Hopeful Beginnings	Outpatient Services, Medication Management, School Based Services, Crisis Management, In-Home treatment, Unskilled Respite	Facility Agreement	3280 West 3500 South Ste E West Valley City, UT 84119 (Park City location post award)
House of Hope	Outpatient, and Residential SUD Treatment for Women and Children	Facility Agreement	857 East 200 South Salt Lake City, UT 84102 and 1726 Buckley Ln Provo, UT 84606

Entity Contracted	Service(s) Provided	Type of Organization	Location of Services Being Provided Under this Contract
Lotus Center for Healing and Wellness	Outpatient	Group Contract	348 East 4500 South Ste. 360 Salt Lake City, UT 84107
Multicultural Counseling Center	Outpatient Mental Health Services with Spanish speaking capability	Group Contract	7625 South 3200 West, #2 Salt Lake City, UT 84084
New Beginnings Behavioral Treatment	Mental Health Residential Treatment for Youth ages 9 to 17	Facility Agreement	1875 West 9000 South West Jordan, UT 84088
Odyssey House	Outpatient, IOP, and Residential Programming for SUD and Dual Diagnoses Treatment. They also have an onsite medical clinic for integration. Also provide school based services in Salt Lake City School District	Facility Agreement	(Various sites in Salt Lake County) 344 East 100 South Salt Lake City, UT 84111
Park City Therapy	Outpatient (Also Jail and Drug Court consideration)	Letter of Intent	700 Bitner Road Park City, UT 84098
Project Reality	Outpatient Substance Abuse Services, MAT	Group Contract	5280 South Commerce Dr. Murray, UT 84107 150 East 700 South SLC, UT 84111 151 South University Avenue Suite 1400 Provo, UT 84601
Psychiatric and Behavioral Solutions	Outpatient MH and SUD treatment, Relprev and Clozaril Clinics, Medication Assisted Treatment, Case Management, Peer Support	Group Contract	1522 So. 1100 East Salt Lake City, UT 84105 (Park City location post award)
Salt Lake County Youth Services	Juvenile Receiving Center, FAST Program (Crisis Respite and Treatment to keep clients in home)	Group Contract and Facility Agreement	177 West Price Ave Salt Lake City, UT 84115
Sarah Rothstein	Outpatient Adult and Youth	Letter of Intent	2760 Rasmussen Rd. Building D, Suite 202 Park City, UT 84098
Silverado Counseling	Outpatient	Group Contract	2900 So. State St. #101 Salt Lake City, UT 84115
Summit Community Counseling	Outpatient Services, Psychological Testing, In-Home Treatment,	Group Contract	5689 So. Redwood Rd #27 Taylorsville, UT 84123 359 E. 1200 So. Orem, UT 84058

Entity Contracted	Service(s) Provided	Type of Organization	Location of Services Being Provided Under this Contract
	Unskilled Respite		(Park City location post award) 150 N. Main Street Heber, UT 84032
SunDance Behavioral	Outpatient Mental Health treatment, Medication Management	Group Contract	845 East 4800 So #200 Murray, UT 84107 (Summit County location post award)
Volunteers of America	Outpatient MH and SUD treatment, Intensive Case Management	Group Contract	435 Bearcat Dr. South Salt Lake, UT 84115

Attachment E

Letters of Intent



Rebuilding Confidence, Purpose and Community

March 4, 2019

Board of Directors

Jon Paulding, President
Don Mueller, Treasurer
Jordana Flavin, Secretary
John Poelman
Byron Kirton
Eric Roux
Kristin Schut
John Wunderli
Spencer Whiting
Richard Lovato
Siamak Khadjenoury

Emeritus Members

Jake Banyai
Jeanne Christensen
Margaret Currin
Norman Nelson
Janet Nelson
Jon Paulding
Bernadette Velick

Ex-Officio Members

Amber Mackay, Associate Director
Rebecca Cross, Program Director

Executive Director

Paige Huff

To whom it may concern,

I am writing this letter regarding Alliance House and their partnership with Optum. Alliance House became a standalone agency in January 2018. At that time, we began a contracted partnership with Optum for our Medicaid billing. We have had a successful partnership with Optum and would be willing to work with them on Summit County Client. Please let me know if you have any additional questions.

Thank you for your time,

Paige Huff

Executive Director

1724 South Main Street
Salt Lake City, Utah 84115
Telephone (801) 486-5012
TTY 7-1-1
Fax (801) 466-5077
www.alliancehouse.org
Tax ID: 74-2440617



5383 South 900 East #103
Murray, Utah 84117

February 15, 2019

Mr. Randy Dow
Optum Health
via email

Dear Mr. Dow:

Thank you for the opportunity for Ascendant Behavioral Health, LLC to potentially partner with Optum, Inc. and UnitedHealth Group to serve patients in Summit County, Utah. On behalf of Ascendant Behavioral Health, it is my pleasure to express our interest in becoming a provider for Optum in Summit County, Utah. Our capabilities include, but are not limited to: mental health and chemical dependency counselling, ambulatory detox, medication assisted treatment for addictions, partial hospitalization and intensive outpatient programs, toxicology lab and tele-health services.

If you have any questions, please do not hesitate to call me at (650) 226-3764, or to call Siamak Khadjenoury at (520) 907-6890.

We look forward to partnering with Optum to serve the needs of Optum's clients.

With best regards,

Jason B. Wacha
Managing Member
Ascendant Behavioral Health, LLC



Refugee & Immigrant Center
ASIAN ASSOCIATION OF UTAH

P: 801-467-6060 • F: 801-486-3006 • ric-aaau.org
155 South 300 West • Suite 101 • Salt Lake City, Utah 84101

February 21, 2019

To Whom it May Concern,

It is my pleasure to write a letter in support of Optum.

Asian Association of Utah dba Refugee & Immigrant Center (RIC-AAU) has been providing direct services to refugees and immigrants in Utah since 1977. The agency has grown to include ESL classes, adult case management, youth case management, mental health treatment, substance use treatment, domestic violence treatment, and a Trafficking in Persons (TIP) department. All services are provided in a culturally responsive manner by including interpreters when necessary and by considering all aspects of a client's history and culture in creating a plan for his or her success.

RIC-AAU has been collaborating with Optum since they were awarded the Salt Lake County contract in 2012. During this partnership, Optum has supported RIC-AAU in our mission to improve the quality of life for refugees and immigrants in Utah. Optum has always been responsive to all questions and concerns. Optum has also provided in-house training as requested, and we participate in Optum's Culturally Responsive Committee, which showcases Optum's commitment to serving culturally diverse populations.

Currently, RIC-AAU's TIP department works with victims of human trafficking (both sex and labor trafficking) who reside in Summit County in addition to Salt Lake County. If Optum is awarded the Summit County Behavioral Health contract, RIC-AAU will be able to continue providing the much needed services at our Salt Lake City location to these clients.

RIC-AAU looks forward to working with Optum and Summit County in providing trauma informed, culturally responsive services to those in need.

Thank You,

Andy Tran, LCSW, MPH
Chief Program Officer
andy.tran@aaau-slc.org
801-990-9485



February 20, 2019

Re: Optum Behavioral Health
Salt Lake County

To whom it may concern;

We are writing in support of Optum proposal to you.

Clinical Consultants of West Jordan has been a contract provider of Optum since July 2012. We offer outpatient mental health and substance abuse treatment services, including medication assisted treatment via vivitrol and suboxone. We employ 3 Psychiatrists, one DO in Addiction Medicine,(all are Buprenorphine waivered) 18 Masters Level therapists, Substance Abuse Counselors and Case Managers.

It has been my experience over the past 9 years that Optum has been a very beneficial and important link in the delivery of services to these populations. Optum is responsive, very well managed and provides excellent community support to the human services field and ultimately, the consumers.

Optum has been a very active supporter in the local community and involved in professional training support of the workforce, public informational events for consumers and families, and has always strived to support recovery efforts.

On a note of administrative functions Optum has been fair, professional and very accommodating group to work with and has always maintained a high clinical and consumer protection role. As an Agency, we would support any expansion Optum is involved in.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael R. Odom", written over a horizontal line.

Michael R. Odom, A.S.U.D.C.
Agency Administrator

2661 Washington Blvd.
Suite #100
Ogden, Utah 84401
OFFICE: (801) 621-8670
FAX: (801) 621-4512

7601 SOUTH REDWOOD ROAD
BUILDING E
WEST JORDAN, UTAH 84084
OFFICE: (801) 233-8670
FAX: (801) 233-8682



Meaning • Purpose • Recovery

426 South 500 East Salt Lake City, Utah 84102

P 801.359.8862

F 801.359.8510

firststephouse.org

February 21, 2019

Randy Dow
Network and Contracts Director
Optum Salt Lake County
2525 Lake Park Blvd
West Valley City, Utah 84120

Dear Randy Dow:

On behalf of First Step House, I am pleased to provide this letter of intent to join with Optum Salt Lake County Medicaid to expand treatment access and healthcare services to the economically disadvantaged and medically under-served citizens of Summit County. We, unfortunately, know all too well the struggle that some Summit County Citizens presently face when they seek care for a serious substance use disorder. Because of our extensive history as collaborative partners we are confident that the distress that individuals and families in Summit County experience when seeking access to services will be significantly relieved, were Optum Salt Lake County Medicaid selected to manage the Summit County Managed Medicaid Plan.

Founded in 1958, First Step House has evolved into a dual diagnosis capable, behavioral health treatment and housing provider for no and low-income individuals and families. As you know we have served as a member of the Optum Salt Lake County Medicaid Network since its inception. You also know that our organizations have in common a commitment to deliver quality, evidence-based interventions, known to be effective for people who struggle with serious and chronic behavioral health conditions, histories of homelessness, criminal justice involvement, and primary health concerns.

We serve over 730 people annually with patient-centered services, including integrated substance use disorder and mental health assessments, residential and outpatient substance use disorder treatment, recovery residence housing, case management services with an emphasis on housing and employment, primary health care and dental services, and, importantly, long-term recovery management.

As a service provider partner for Summit County Managed Medicaid Plan Members, First Step House will:

- Provide evidence-based treatment services to Summit County Managed Medicaid Plan members.
- Utilize resources available through the Optum Salt Lake County Medicaid Network to increase efficiency and effectiveness and improve patient care in Summit County.
- Collaborate with Optum Salt Lake County Medicaid Network to continue to capitalize on opportunities for innovation and increase our collective capacity to deliver effective, affordable, patient-centered healthcare.

We are honored to submit this letter of intent to Optum Salt Lake County Medicaid to articulate our desire to partner, as a member of the team of experienced providers, to expand services to members of the Summit County Medicaid Plan. Please contact me with any questions you may have about this letter or our intent to provide services.

Best regards,

Shawn M. McMillen, MPA ASUDC
Executive Director

Board of Directors

Charin M. Christensen, Esq. Chair
Joe Culbertson, MD, Vice-Chair
Brandy Farmer, Secretary
Pamela Gold

Ken Jackson, MBA
Jacob C. Smith, CPA
Annette Pöckelstein, MS, PhD
Kerry Bate
Charles Talcott

Supported by

SALT LAKE COUNTY



To Whom It May Concern,

February 13, 2019

Thank you for your consideration in being a provider in your attempt to secure the Summit County RFP. Hopeful Beginnings is excited for this opportunity and if the RFP is secured we will make the necessary arrangements to have staff available to provide our services within Summit County.

Hopeful Beginnings Mission is to promote hope and healing, while empowering you to reach your full potential. We are dedicated to helping you achieve your life goals and help pave the road to recovery. Our goals are three fold: Self-Awareness, Self-Dignity and Self-Accountability, so you can help yourself.

Hopeful Beginnings has been an active provider in outpatient mental health services since 2011 and is shaping how services are delivered. With a unique client centered approach to providing outpatient mental health services, we allow the client to determine a setting that best fits their needs for treatment. This could be in the client's home, in an office setting, or in some cases services can be provided in the school the client attends. Hopeful Beginnings contributes across many community settings attending and providing input with the Multi Agency Staffing (Granite School District, JJS, Probation, DCFS, and community partners), The FAST program with Salt Lake County Youth Services, Systems of Care, Salt Lake County Permanency Planning Meeting (PPM), Coordination of Care Court in the 3rd district Juvenile Court (C3 Court) and the Utah Quality Assurance and Performance Improvement (QAPI).

Hopeful Beginnings provides the following services: medication management, skills development services, case management services, respite for children 7-17, DBT skill based day treatment for children 12-17, Crisis services 6am to 11pm 7 days a week, Timely Access step down from UNI, Primary Children's and transitions from The Children's Center, group therapy developed by demand within the community (currently offering a parenting group complete with certificate and a role playing group for teens) and outpatient therapy (MHA, individual, family, family without client, couples) Hopeful Beginnings also provides diversion for individuals in the community and/or incarcerated who are requesting diversion services in order to remain at community-based and/or current level of services to prevent an inpatient / higher level of care placement.

Hopeful Beginnings specializes in trauma informed care, person centered approach, providing the option of in-home services with wrap around supports to stabilize families, teaming with DCFS to maintain children in their homes and have the ability to utilize Foster Care Medicaid if a child is in custody. We also have Spanish speaking providers, LGBTQIA friendly, clinicians with a wide array of experience and certifications including: Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Play Therapy, Emotional Intelligence, Motivational Interviewing, Stages of Change and Grief and

Hopeful Beginnings, LLC 3280 W. 3500 So. Ste E West Valley City, UT 84119 801-979-1351
www.hopefulbeginnings.net



Loss. Hopeful Beginnings also has experience with children whose parents are incarcerated and providing family therapy while in a jail/prison setting.

We look forward to partnering on this proposal if there are other items necessary we can send items over as needed.

Sincerely,

Nicole Nickles

Owner/CFO

Amy Firth

Owner/Executive Clinical Director



House of Hope

Serving Utah Families Since 1946

February 15, 2019

Optum Salt Lake County Medicaid
Attn: Randy Dow
2525 Lake Park Blvd
West Valley City, UT 84120

To Whom It May Concern:

As Executive Director of House of Hope, I would like to inform you of my interest in providing services to the clients in Summit County through Optum Health. For the past twenty years, we have provided residential substance abuse disorder treatment to women and young children from Summit County at our seven facilities located in Salt Lake and Utah Counties. Many of the clients we serve have Division of Child and Family Services (DCFS) involvement and are seeking to reunify as a family or to maintain the bond with a newborn infant concurrently. We also serve women with or without children, who come from counties, like Summit, who do not have residential treatment locally and then work with providers to transition them into outpatient treatment when they return home so that they have a seamless continuum of care.

I appreciate our partnership with Optum Health and look forward to future opportunities to collaborate on behalf of women and children in Summit County. Please feel free to contact me for further discussion of possible options in the future as needed.

Sincerely,

Lisa Heaton, LCSW
Executive Director
House of Hope
lheaton@houseofhopeut.org
(801)487-3276, ext. 1218

House of Hope Corporate Office and Treatment Center, 857 East 200 South, Salt Lake City, UT 84102-2317
Phone 801-487-3276 TTY: 711 Fax 801-467-3725 Email info@houseofhopeut.org Website www.houseofhopeut.org

Funding is received from: U.S. Dept. of Housing & Urban Development; Utah Dept. of Workforce Services; Utah Dept. of Community and Economic Development; Salt Lake County Behavioral Health Services; Utah County Dept. of Drug and Alcohol Prevention and Treatment; Weber Human Services; Salt Lake County Community Resources and Development; Salt Lake City Corporation Housing and Neighborhood Development; Provo City Corporation Redevelopment Agency; City of Orem Office of Community and Neighborhood Services; Mountainland Association of Governments; Sandy City Community Development; West Valley City Community Development; United Way of Salt Lake; Intermountain CFC; Access to Recovery.



February 21, 2019

This letter is regarding the RFP bid for Optum Summit County mental health services. The Lotus Center for Healing and Wellness is interested in being a provider for these Optum consumers. The Lotus Center is located in Salt Lake City, where we can provide mental health services. In addition, we also provide telehealth option to those who are unable to travel to Salt Lake City for in- person visits.

The Lotus Center utilizes a trauma informed environment and philosophy of care approach. We provide outpatient group and individual therapy to individuals across the lifespan. In addition to individual, family and couples therapy, our team of 8 therapists offer group therapy including bereavement support, domestic violence survivor support including children survivors impacted by domestic and sexual violence, trauma therapy, DBT skills training, whole health and wellness, nicotine cessation, adolescent groups for wellness, parenting support, and play therapy for children. Therapists utilize many therapeutic interventions including CBT, DBT, EMDR, Solution Focused Therapy, and Rational Emotive Behavior. Our medical team includes 2 APRNs who can assist individuals across the lifespan with medication management, including prescribing and coordinating overall medical care to promote healing and wellness. Integrative treatments are also offered at The Lotus Center including Transcranial Magnetic Stimulation, nutritional counseling, hormone management, yoga and meditation classes.

Dr. Cindy Wasek, APRN, DNP



February 8th, 2019

To Whom It May Concern:

This letter is to formally express our support and extend our continuing partnership with Optum as they seek to manage Medicaid services in Summit County.

Multicultural Counseling Center provides short-term mental health counseling from an evidence/systems-based perspective, which involves providing the services of case management and peer support services along with mental health counseling. Mental health counseling has been proven to be effective, and when combined with case management and peer support services to underserved communities; it has been shown to aid consumers in promoting resiliency, increasing their ability to adaptation when managing the diverse social and criminal justice systems they may be interacting with and maintaining their mental health.

Multicultural Counseling Center, offers a unique advantage to increase the ability to access services for the Spanish speaking and Latinx population, as all the staff employed in this agency are bilingual/bicultural in Spanish and 90% of its staff identifies as Latinx. Further, the Multicultural Counseling Center operational procedures have been modified to minimize the barriers the Latinx community may face when accessing services such as telehealth, ability to communicate by text, 3-way communication with insurances and other social service providers, etc.

The Summit county, specially the Latinx community would greatly benefit from the established partnership between Optum and the Multicultural Counseling Center for several reasons: 1) provide Summit County Medicaid consumers the ability to access Spanish speakers/Latinx mental health counselors and supportive services; 2) ensure Summit County Medicaid consumers are being provided quality services as



Optum standards and support to providers is well established within their existing network; 3) lower the margin of implementation errors when consumers access mental health services that may result in mental health practices denying much needed services.

In conclusion, the Multicultural Counseling Center leadership and team members wholeheartedly support Optum in pursuing the management of Medicaid in Summit County. Furthermore, Multicultural Counseling Center is committed to opening an office in Summit county to support the community and to assure our continuation with this partnership. Please feel free to contact me with any further questions or information that may be needed for this partnership, by email at karlaa@mccounseling.com or by phone at 801-915-0359 Ext 701.

A handwritten signature in black ink, appearing to read "Karla Arroyo", with a long, sweeping underline that extends to the right.

Sincerely,
Karla Arroyo, LCSW
Director/Bilingual Therapist
801-915-0359 Ext 701



NEW BEGINNINGS

Setting today's path for tomorrow's journey.

A Behavioral Treatment Agency

1875 West 9000 South

West Jordan, Utah

Phone 801-282-6953

Fax 801-282-4912

www.newbeginningsutah.com

February 19, 2019

To Whom It May Concern:

New Beginnings Behavioral Treatment Agency has been a Salt Lake County Optum Medicaid provider for the last five years. New Beginnings provides structured therapeutic programs for boys and girls 9-17 years old suffering from severe emotional disturbance(s). Within our treatment programs we strive to provide our clients with tools to cope more effectively with living in society; to provide an opportunity to recover from the effects of trauma; and to increase functioning mentally, emotionally, socially, spiritually, and physically, with the ultimate goal of family re-unification and emotional stability.

New Beginnings is an extremely unique organization. We offer the full continuum of mental health care services allowing for continuity of care. Families have the ability to choose from the three levels of care that we offer:

- Residential Treatment-Mental Health
- Partial Hospitalization Program (PHP)/Day Treatment-Mental Health
- Intensive Out-patient Program (IOP)-Mental Health

As a current Salt Lake County Optum Medicaid provider we are able and willing to support the mental health needs of Summit County, Utah consumers through our ongoing relationship with Optum.

Should you have any questions please do not hesitate to contact me.

Kind Regards,

Femia D. Pittman, MPA, PhD(ABD)

Owner, Chief Administrative Officer

Office (801) 282-6953 Ext. 1

Fax (801) 282-4912

Femia@newbeginningstv.org

www.newbeginningstreatment.com



ODYSSEY HOUSE

A NON-PROFIT

Executive & Accounting Offices

344 East 100 South, Suite 301
Salt Lake City, Utah 84111
(801) 322-4257

Admissions

344 East 100 South, Suite 201
Salt Lake City, Utah 84111
(801) 322-3222

Adult Residential Program

68 South 600 East
Salt Lake City, Utah 84102
(801) 322-1001

Adolescent Program & Odyssey Academy

607 East 200 South
Salt Lake City, Utah 84102
(801) 363-0203

Youth in State Custody Program

880 East 3375 South
Salt Lake City, Utah 84106
(801) 708-7004

Mothers with Children Program

42 South 500 East
Salt Lake City, Utah 84102
(801) 596-1990

Fathers with Children Program

623 South 200 East
Salt Lake City, Utah 84111
(801) 428-3476

Outpatient Services

350 East 2100 South
Salt Lake City, Utah 84115
(801) 322-1185

Transitional Services

344 East 100 South
Salt Lake City, Utah 84111
(801) 428-3463

Vocational Training Services

68 South 600 East
Salt Lake City, Utah 84102
(801) 428-3464

Children's Services Center

340 East 100 South
Salt Lake City, Utah 84111
(801) 532-4184

Martindale Integrated Health Clinic

340 East 100 South
Salt Lake City, Utah 84111
(801) 428-3500

Generously Supported by

United Way
Salt Lake County Division of
Behavioral Health Services

www.odysseyhouse.org



February 12, 2019

Randal Dow, LCSW
Network and Contracts Director
Optum Salt Lake County Medicaid
2525 Lake Park Boulevard
West Valley City, UT 84120

Dear Randy,

On behalf of Odyssey House, Inc. – Utah, I would like to confirm our willingness and interest in partnering with Optum to provide treatment services to Summit County.

For over 48 years, Odyssey House has provided extensive behavioral health services including Dual Diagnosis Enhanced Substance Use Disorder (SUD) Treatment and Mental Health services. During that time, Odyssey House has expanded to meet Utah's behavioral health care needs though a full continuum of treatment and wellness services. Within Salt Lake County, Odyssey House provides ASAM Level 0.5 through 3.5 level services to single adults, parents with children (both mothers and fathers), and adolescents for substance use and mental health conditions. Additionally, Odyssey House operates an integrated medical clinic that specializes in Medication Assisted Treatment (MAT), psychiatry, and is a recovery-friendly family practice. Our other unique services include SUD treatment services within the Salt Lake County jails, early intervention and prevention services, and school-based mental health services through a partnership with Salt Lake City School District.

Odyssey House is willing and able to expand our clinical services into Summit County, including a full range of mental health and SUD services to both youth and adults, as well as school-based early intervention and prevention. Access to Residential and Recovery Residence services will be ensured through our existing system within Salt Lake County. We are also willing to assess viability of an integrated clinic to provide access to MAT and other health care services for your consumers.

Thank you for your partnership and interest in future engagement,

Adam Cohen, MBA
Chief Executive Officer

Park City Therapy

700 Bitner Road
Park City, UT 84098
435-640-6574
dodi@parkcitytherapy.net

FEBRUARY 22, 2019

TO WHOM IT MAY CONCERN,

Let this letter serve as a letter of intent to provide services for Optum, in the event that they are elected as the contracted entity for the Summit County RFP, at the rates agreed upon by both parties.

Sincerely,

Dodi Wilson, MS CMHC

Park City Therapy
parkcitytherapy.net
435-640-6574
dodi@parkcitytherapy.net

Project Substance Abuse Services Reality Prevention and Treatment

Main Office

150 East 700 South
Salt Lake City, UT 84111
Phone (801) 364-8080
Fax (801) 364-8098

March 7, 2019

Murray Office

5280 Commerce Dr.
Suite D110
Murray, UT 84107
Phone (385) 881-0170
Fax (385)-212-3234

Re: Optum proposal to provide services in Summit County

To Whom It May Concern,

Utah County Office

151 South University Ave.
Suite 1400
Provo, UT 84606
Phone (801) 851-7118
Fax (801) 851-7137

Project Reality has provided comprehensive Opioid Treatment Program (OTP) Medication Assisted Treatment (MAT) services to individuals with opioid use disorders (OUD) in collaboration with Optum Salt Lake County for many years. Our services involve outpatient MAT options including buprenorphine, methadone, and extended release naltrexone as well providing MAT options in various IOP and residential settings with our community partners. Project Reality treatment programs integrate MAT medications with behavioral, psychosocial, and primary care services to address the complex needs of individuals with OUD to support long term recovery and wellness.

Price Office

Operation Recovery

77 South 600 East
Suite C
Price, UT 84501
Phone: (435) 613-7289
Fax: (435) 613-1420

Project Reality is committed to helping address opioid use disorders throughout Utah. We are willing to partner with Optum in helping provide services to individuals in the Summit County area struggling with opioid use disorders.

Executive Staff

Executive Director:
Linda Moore, LCSW
Medical Director:
Katherine Carlson, MD

Sincerely,

Board of Governors

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Secretary/Treasurer:
Patricia Graff, LCSW
Past President:
Jerome H. Mooney, JD

Linda Moore, LCSW
Executive Director

David Christensen, DDS
Gerald Maughan, MPA
Peter Weir, MD
Sean Mosman





February 14, 2019

Dear Randal,

Psychiatric & Behavioral Solutions would be honored to provide services to Summit County Medicaid clients. At PB-Solutions we are a clinic whom believes in offering quality services for underserved populations. Our clinicians look forward to the opportunity.

Thank you,

A handwritten signature in black ink that reads "Tammy Steans".

Tammy Steans, LCMHC

Managing Partner

February 13, 2019

To Whom It May Concern:

Salt Lake County Division of Youth Services has partnered with OPTUM since 2013 to provide step-down and hospital diversion services for youth and families within Salt Lake County. This is a unique program and not offered in other counties. Services include up to 30 days of supportive community placement, individual and family therapy, targeted case management and after care services of in-home therapy and Family Resource Facilitator referrals. Youth Services is open to serving youth outside of Salt Lake County if funding were provided for out of county youth. We often serve youth from other counties through our Juvenile Receiving Center as this is service only offered in limited counties.

Respectfully,



Carolyn Hansen, LCSW
Division Director, Youth Services

Sarah Rothstein, LLC

2760 Rasmussen Rd

Building D, Suite 202

Park City, UT 84098



February 26, 2019

To Optum Salt Lake County Medicaid:

I am interested in becoming a partner to provide Medicaid in Summit County. I share a commitment to serving economically disadvantaged individuals, as demonstrated through my independent contractor work through Valley Behavioral Health in North Summit High School, which is in addition to a successful full time private practice.

I relevant training and experience with underserved and disadvantaged populations, with a strong background in case management, family systems therapy, and DBT. I have worked extensively with those diagnosed with severe and persistent mental illnesses in both inpatient and outpatient settings. A full resume is available upon request.

Sincerely,

Sarah Rothstein, LCSW



SILVERADO

C O U N S E L I N G

Office Address

2900 South State Street #101
Salt Lake City, UT 84115
Ph.# (801) 983-5540

Billing Address

P.O. Box 521207
Salt Lake City, UT 84152
Fax# (801) 983-5542

February 21, 2019

Re: Letter of Intent for OptumHealth Summit County RFP

To Whom It May Concern:

OptumHealth has requested that we provide a letter indicating our interest in being a contracted provider if they are awarded the Summit County Medicaid RFP.

While Silverado Counseling does not maintain an office in Summit County, we have occasionally provided services there through our other State contracts. Our South Salt Lake office is easily accessible to anyone with transportation coming down Parley's Canyon. Silverado Counseling also has the ability to provide HIPAA compliant Telehealth services, which would also allow us to serve Summit County Medicaid consumers who are in more remote locations than say Park City.

Thank You,

Taylor Weisbender
Office Manager
Silverado Counseling Services, LLC



February 11, 2019

To Whom It May Concern:

Summit Community Counseling has been partnering with Optum to provide mental health services in Salt Lake County since they took over the mental health contract years ago. We have been providing services in Summit County through Valley Behavioral Health since 2012 and continue to be a resource to the Medicaid Community in Summit County. Summit Community Counseling has always been dedicated to serving the Medicaid population and look forward to continuing to be a resource to Summit County.

A handwritten signature in blue ink, appearing to read "Karen W. Malm, PhD".

Karen W. Malm, PhD
Licensed Psychologist

SUNDANCE


BEHAVIORAL RESOURCES, LLC

March 5, 2019

To Whom It May Concern:

We wanted to confirm that SunDance Behavioral Resources is interested in working with Salt Lake County Optum to provide Mental Health services in Summit County if they are awarded the contract. We currently are providing Medication Management and Mental Health therapy in Salt Lake County. If you have any questions, please contact me at 801-264-9522.

Thanks,



Loren Mitchell, LCMHC

Operations Manager,

SunDance Behavioral Resources

February 15, 2019

To Whom It May Concern;

Volunteers of America, Utah is writing to express interest in collaborating with Optum Healthcare to provide behavioral health services to Summit County residents. This potential expansion of services is an opportunity for both organizations to extend quality care to another community in Utah.

Volunteers of America, Utah is a nonprofit social service organization with 30 years of experience operating programs in Salt Lake County. Our organization currently provides outpatient behavioral healthcare, social model detoxification, and Assertive Community Treatment Services in Salt Lake County. Many of these services are supported through our current partnership with Optum Healthcare. Volunteers of America, Utah has successfully partnered with Optum Healthcare for many years to provide a bridge to self-reliance and health for vulnerable individuals and populations in need.

We look forward to this new project and are committed to working with you to create the best possible service delivery system for Summit County.

Sincerely,



Kathy Bray
President and CEO



UTAH

Volunteers of America, Utah
435 West Bearcat Drive, Salt Lake City, UT 84115 • 801.363.9414 • voaut.org

Helping America's most vulnerable®



United Way of Salt Lake

Attachment F

Copy of FY18 Annual Report



2017

Annual Review

Helping people live healthier lives and
helping make the health system work
better for everyone



Contents

- 02 UnitedHealth Group
- 04 UnitedHealthcare
- 08 Optum
- 12 Commitment to Excellence

Our Mission

Our mission is to help people live healthier lives and to help make the health system work better for everyone.

Our Values

Integrity: We will honor commitments. We will never compromise ethics. We will speak the truth and deliver on our promises.

Compassion: We will walk in the shoes of people we serve and those with whom we work. We celebrate our role serving society in an area so vitally human as health care.

Relationships: We will approach all people with respect, humility, confidence and a spirit of collaboration to build trust and deeper relationships.

Innovation: We will learn from experiences of the past and use those insights to invent a better health care future, encouraging and investing in new ideas.

Performance: We are committed to excellence in everything we do, consistently delivering high-quality and superior results that make a positive difference.

On the cover: Our HouseCalls program enables many seniors to receive an annual health check-up in the comfort of their own home at no cost. These visits often identify care opportunities, such as overdue immunizations or needed cancer screenings. We seek to close these gaps in care so seniors can live their lives to the fullest.

Welcome to Our Annual Review

At UnitedHealth Group, we work every day to achieve our full potential to help improve the health of those we serve and health systems serving society. The business result is consistent, sustainable growth.

UnitedHealth Group, Optum and UnitedHealthcare have remarkable potential to help improve health care and the lives of people around the globe — a humbling responsibility and social pursuit. The 285,000 people of this enterprise are dedicated to this task. We are intently focused on serving individuals, *one person at a time*, working closely with clients, customers and health systems to increase the quality of health care and improve the affordability and experience of care. This approach is building trust and loyalty among the consumers and customers we serve which, in turn, drives consistent, sustainable, market-leading growth.

This review summarizes our solid performance in 2017 and our plans for 2018 and beyond. We fully appreciate that our shareholders' investments enable us to serve more people in more and better ways each year. UnitedHealth Group remains committed to long-term earnings growth and distinctive total shareholder returns.

Our future success will be powered by the hard, intelligent and caring work of our people to achieve our mission and the opportunity to serve offered by the growing and challenging global health care markets. Thank you for your interest in our company.

We are intently focused on improving the quality of health care and making it more accessible and affordable for more people.

Advancing Health Care Quality

We are a mission-driven enterprise motivated to serve the emerging health care needs of more people in more ways. In 2017 we delivered distinguished growth performance.

UnitedHealth Group is a highly diversified, innovative and adaptable health care enterprise, dedicated to helping create a more modern, high-performing, simpler health care system. We are privileged to serve approximately 140 million individuals, providing medical benefits to people residing in all 50 states in the United States and more than 130 other countries. Our 285,000 employees, including tens of thousands of

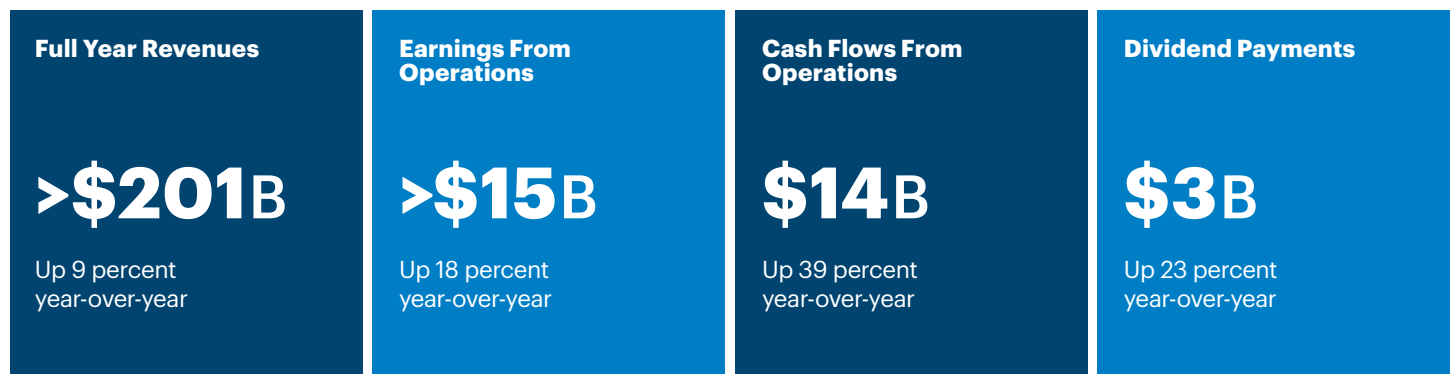
physicians, advance practice clinicians, nurses and other health care workers on staff globally, work continuously to improve quality and outcomes with compassionate service.

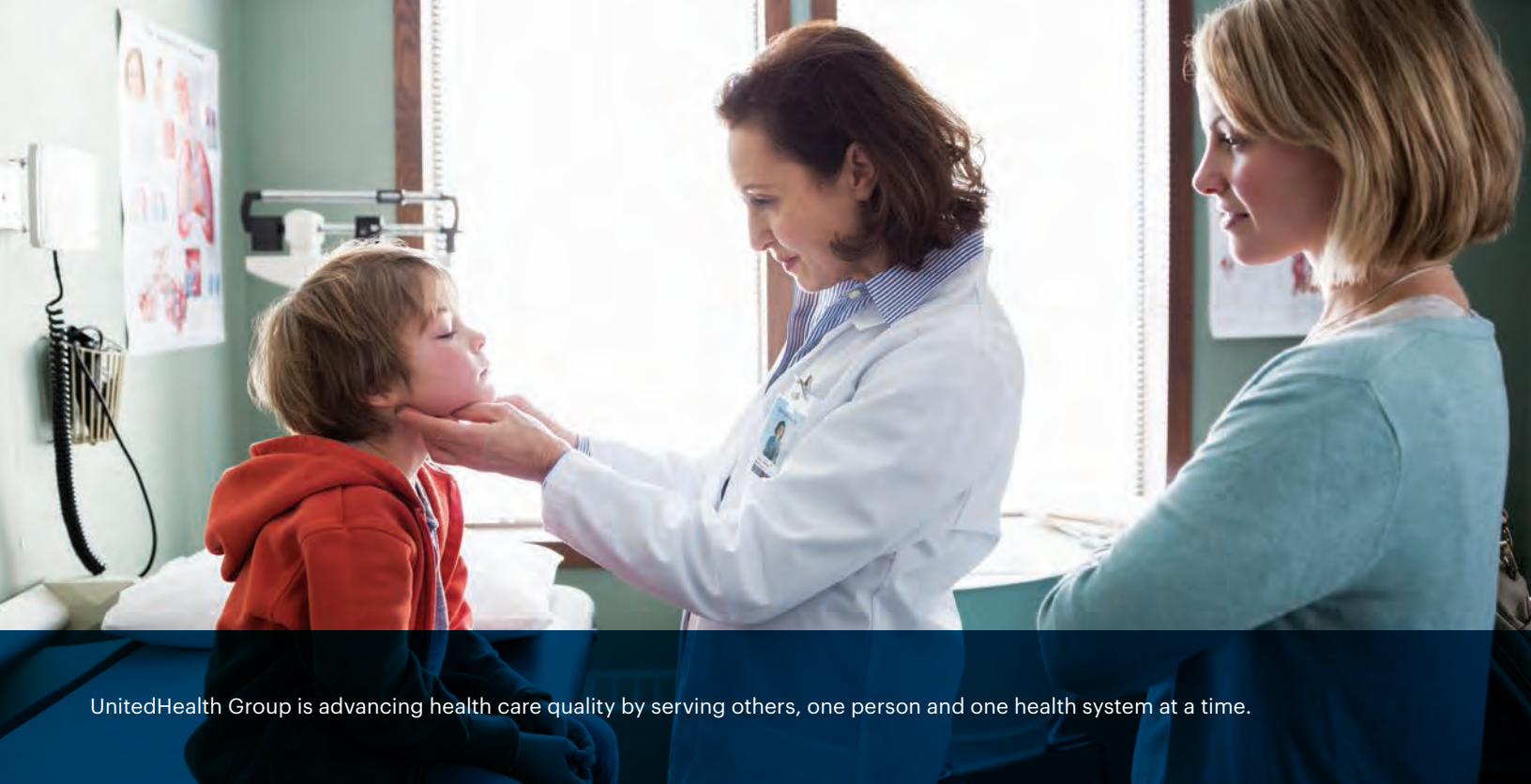
Delivering higher quality in health care and a better consumer experience is helping advance greater value and trust among our customers and the people we serve. The result is distinctive growth.

At its core, UnitedHealth Group is shaped by its people and their commitment to a culture, based on integrity, compassion, innovation, relationships and performance. Motivated by a dedication to creating greater value in health care, they deploy and repurpose the core competencies shared across our business platforms, UnitedHealthcare and Optum:

- **Data and health information** – to inform and guide;
- **Advanced technology** – to enable; and
- **Clinical expertise** – to deliver care at higher quality, with greater consistency, at lower costs.

2017 Performance Highlights





UnitedHealth Group is advancing health care quality by serving others, one person and one health system at a time.

UnitedHealthcare is a leader in health coverage and benefits, and Optum is the leader for health services, broadly. These two businesses are purposefully complementary and positioned to work together as an integrated and strategically aligned operating portfolio, as well as to be fully free-standing, market-facing businesses. Together, they leverage our core competencies to apply actionable insights to some of the most complex challenges facing health care.

We use Net Promoter Score (NPS) to measure the quality of our products and services. NPS is based on the answer to a single question, “How likely are you to recommend our company to a friend or family member?” Our NPS rose sharply in 2017 and we expect this momentum to continue through 2018 and beyond. Our commitment to NPS is about more than just numbers. We are changing our culture to be much more consumer-centric, listening more intently than ever to our customers, taking actions based on what we learn and monitoring our improvements over time.

As we continue to improve quality and service, we build increasing trust and loyalty among the people and customers we serve. In turn, we continue to grow.

Our enterprise is focused on five growth areas where we believe we have the opportunity to improve health care and better serve the needs of individuals and the system overall. These are:

Health Care Delivery: We have a growing presence in the direct delivery of care, where our goals are better quality, lower cost and higher consumer value and satisfaction, informed by appropriate site of service for care.

Pharmacy Care Services: Pharmacy transactions are the most common point of contact between health care consumers and the system. We use the pharmacy interaction to engage consumers with our whole-person care model, to encourage smart decisions and healthy behaviors.

Consumer-Centric Benefits:

Consumers expect a simple, personalized, dependable care experience. Our affordable product designs use incentives to reward healthy behaviors and lifestyles, guiding people along a more engaged and healthier path.

Digital Health Care: Innovation, new product development and fresh approaches are critical to improving simplicity, connectivity, service and accuracy, so we continue to grow our digital offerings and technology solutions for consumers and care providers.

Global Opportunity: Our global businesses had strong, positive 2017 performance and are carrying that momentum into 2018. The closing of the Banmédica acquisition in the first quarter 2018 adds a major provider of health care services and health benefits in Chile, Colombia and Peru.

These five areas of strategic focus underpin our strategy as we look to evolve forward with our customers and markets toward fulfilling existing and emergent needs in 2025.



At UnitedHealthcare, we serve people with health benefits through every stage of their lives, from childhood and youth through working life and into retirement. We are a company with a vital social role. Effective, sustainable health insurance underpins our nation's ability to deliver effective, sustainable health care.

UnitedHealthcare is dedicated to supporting better health and creating a better consumer experience, all while making health care more affordable. This involves putting the individual at the center of how we operate and equipping the people we serve to be actively engaged health care consumers. We also work with care providers, collaborating to establish new ground rules based on improving patient care through value-based payment initiatives and incentives.

Creating a Better Health Care Experience

We are dedicated to supporting better health and more affordable care.

Since 2010, UnitedHealthcare has produced one of the strongest periods of growth for any company in health care, growing organically in the U.S. by more than 11 million people. Today, we serve nearly 50 million medical members, primarily in the U.S. and Brazil. UnitedHealthcare is comprised of four operating segments:

UnitedHealthcare Employer & Individual provides health benefits for over 27 million Americans through fully insured and self-funded medical plans. We offer consumer-oriented benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses and individuals.

UnitedHealthcare Medicare & Retirement is dedicated to serving the growing health and well-being needs of individuals over the age of 50. We help more than 12 million seniors manage their health through a comprehensive and diversified array of products and services.

UnitedHealthcare Community & State is dedicated to providing health care products and services to state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health

care coverage in 28 states and the District of Columbia.

UnitedHealthcare Global operates in two distinct segments: Global Solutions and Global Markets. Global Solutions serves employers and individuals in more than 130 countries who live and/or work outside their home nations. The Global Markets business serves the in-country health care needs of specific populations with health benefits and medical care delivery, primarily in Brazil and Portugal. Through our 2018 merger with Empresas Banmédica, a leading private health benefits and care delivery provider, we further expanded our services to Chile, Colombia and Peru.

Following are stories that highlight how UnitedHealthcare is improving the delivery of value-based care, addressing the social determinants of health and helping make health care more accessible and affordable for more people, while continuing to drive growth.

- **NexusACO**
- **myConnections**
- **Serving Seniors**

NexusACO primary care physicians help people navigate the health care system, making sure they and their families receive the right care with the right doctors.

NexusACO: Expanding Access to Quality Care at Lower Costs



Accountable care organizations (ACOs) help reduce costs and improve the quality of the health care system and health outcomes. This health care model can:

- improve prescribing and patient referrals;
- minimize unnecessary emergency room use and reduce hospital admissions and readmissions;
- better coordinate care transitions from post-acute to rehab to home; and
- identify gaps in care so they can be appropriately closed.

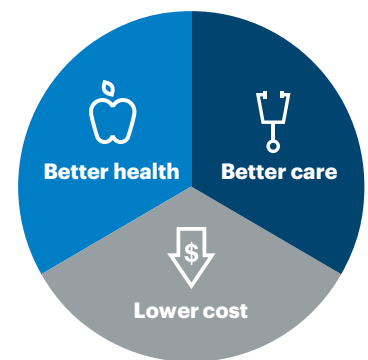
UnitedHealthcare's NexusACO is the first national health benefits plan to integrate value-based ACO contracts with incentive-based consumer benefits. Many of our employer customers have employees living across the country, yet most ACOs today only serve a single market. NexusACO represents the next generation of value-based health plans, organizing our high-performing ACOs and our premium care physicians into a national-tiered network, all supported by comprehensive digital resources.

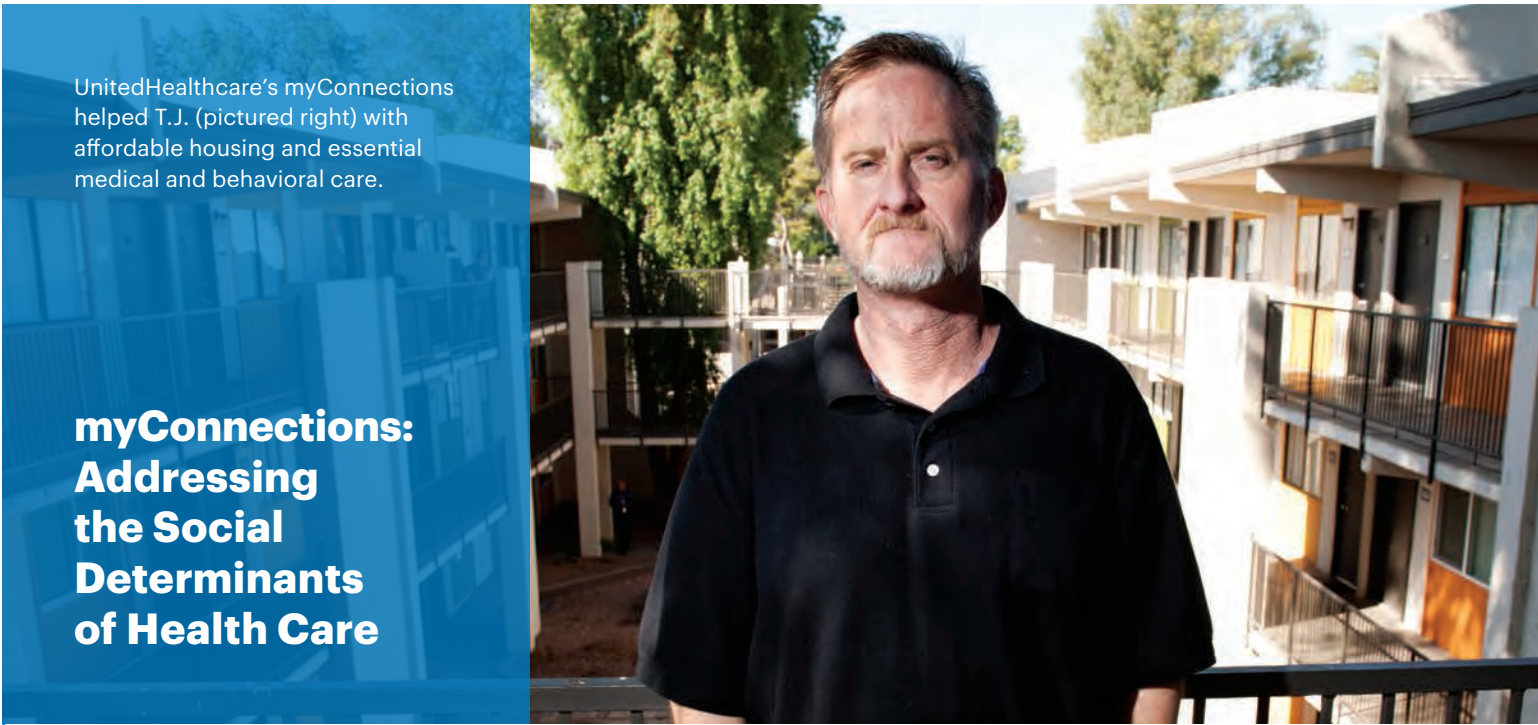
Employees in the NexusACO program receive better care coordination. Primary care physicians help people navigate the health care system, making sure they and their families receive the right care with the right doctors at the most appropriate site of care. By using our real-time data analytics, NexusACO physicians are proactively engaging with their patients, helping lower costs and improve health outcomes. And this higher level of quality care is delivered at lower costs by UnitedHealthcare, helping our members save 8 percent to 12 percent on their health plans.

NexusACO launched in 2017 and is already delivering strong results. We expect to grow to 250,000 people in NexusACO by the end of 2019.

Value-Based Agreements

NexusACO is the first national health benefits plan to integrate value-based ACO contracts with incentive-based consumer benefits.





UnitedHealthcare's myConnections helped T.J. (pictured right) with affordable housing and essential medical and behavioral care.

myConnections: Addressing the Social Determinants of Health Care

Individuals who are homeless average nine times the number of ER visits, six times the number of hospitalizations and three times the overall health care costs of individuals who are not homeless. UnitedHealthcare's myConnections is helping these vulnerable people, including individuals eligible for state programs for the economically disadvantaged and medically underserved, receive essential social, medical and behavioral services. Through the program, UnitedHealthcare is arranging for consistent and affordable housing, facilitating transportation and job training, and connecting people with community health workers who can help provide additional support.

T.J.'s story is a great example of how UnitedHealthcare can help. T.J. was homeless and unemployed, on the streets for some time, suffering from depression, diabetes, asthma and chest pain. Since 2015, he made 254 trips to the emergency room and had 32 admissions to the hospital.

UnitedHealthcare's myConnections helped T.J. move into a supportive housing community and buy furniture to set up his apartment. The next step was to initiate a wraparound health plan, including counseling for his depression, treatment for his diabetic foot ulcer, help applying for Social Security Disability and education on rental housing.

T.J.'s health is improving, he is staying out of the emergency room and beginning to establish goals and imagine a future for himself, working toward achieving self-sufficiency.

myConnections is helping people receive essential social, medical and behavioral services.

In five years, UnitedHealthcare has grown to serve 1.3 million more people in Medicare Supplement, 850,000 more in group Medicare Advantage and 1 million more in individual Medicare Advantage.

Medicare: Serving Seniors With Stable Benefits, Personalized Care and Quality Customer Service



At UnitedHealthcare, we've learned seniors value stability in their health care benefits and experiences. As simple as it sounds, it makes a huge difference for the people we serve.

UnitedHealthcare Medicare & Retirement has a well-diversified portfolio of stable products that will carry the AARP brand exclusively through at least 2025. In 2017, our new low premium Part D plan grew more than any other competitor nationally, and we introduced a low premium Medicare Supplement product in 43 states. Across Medicare Supplement, we've grown to serve 1.3 million more people in just the past five years.

In group Medicare Advantage, leading employers continue to choose our products to serve their retirees, adding more than 850,000 people to UnitedHealthcare over the last five years. And stability in our individual Medicare Advantage products has contributed to our record retention level and growth of approximately 1 million people over the past five years.

But our service and growth story is about much more than product design and stability. It's also about the ever-advancing positive, simpler and personalized experience we create.

For example:

- **Navigate4Me** provides seniors personalized one-stop service for financial, social, medical, behavioral and product needs.
- **HouseCalls**, offered in collaboration with Optum, delivers a personal health assessment in the comfort of seniors' homes at absolutely no charge to them and provides seniors information on current and potential health issues. We completed 1.3 million HouseCalls and closed more than 2 million gaps in care in 2017.

Our diversified portfolio of stable products and services combined with customer service advocates who view their role as helping to save lives — not just answering the phone — will continue to drive our growth in the expanding senior market.

We completed

1.3 million HouseCalls

and closed more than 2 million gaps in care in 2017. These meaningfully improved stability of health care benefits and premiums for seniors.





A leader in health services, Optum serves virtually all types of participants in the health care system, helping to create better consumer experiences, achieve higher-quality outcomes, reduce costs and improve physician satisfaction. We serve our diverse clients and consumers through five capabilities that drive meaningful change and measurably move health care forward:

- Data and analytics
- Pharmacy care services
- Population health management
- Health care delivery
- Health care operations

Powering Modern Health Care Across the Health System

We are helping our clients and the people we serve solve their biggest problems, navigate change, capture opportunities and achieve their health care goals.

Optum's capabilities are infused with OptumIQ — our longstanding expertise in data and analytics — and delivered across three businesses:

OptumHealth serves broad market needs through OptumCare and Optum Consumer Solutions. OptumCare is a provider-led, patient-centric, ambulatory care system that is advancing value-based care at the local level, delivering the right care at the right time in the right setting to more than 14 million patients. Optum Consumer Solutions helps people achieve better health and helps employers, health plans, government agencies and care providers effectively manage health care trends. Services include digital tools, wellness coaching and incentives, behavioral health, care management, clinical specialty services and financial services to help people save and pay for their health care needs.

OptumInsight provides health care analytics, software, technology, consulting and process management, serving hospitals, physicians, health plans, government agencies, life sciences companies and other organizations.

OptumInsight helps clients reduce costs, meet compliance mandates, improve clinical performance and adapt to change.

OptumRx delivers a full spectrum of pharmacy care services that improve health outcomes and reduce total health care costs. OptumRx continuously engages with stakeholders across the health system to help synchronize individuals' clinical care, provide a whole-person approach to specialty pharmacy and home infusion services, simplify the consumer experience, empower physicians to make better decisions at the point of care and drive meaningful savings in health care expenditures.

The following stories share a few examples of how Optum is making the health system work better for everyone by helping people find the right care at the right time in the right setting, managing pharmacy care services — the point of care consumers use most — and helping improve the quality, effectiveness and efficiency of health care.

- **Surgical Care Affiliates**
- **PreCheck MyScript**
- **Performance Analytics**

Surgical Care Affiliates, which joined Optum in 2017, provides high-value surgical services through a network of more than 200 independent ambulatory surgical centers and surgical hospitals in the U.S.

Surgical Care Affiliates: Outstanding Clinical Outcomes and Patient Satisfaction at Lower Cost



Surgical Care Affiliates' (SCA) leading ambulatory surgical care centers add to our comprehensive care platform of primary and specialty care, urgent care and surgical care services.

A significant portion of the care currently delivered in hospitals or hospital licensed facilities can be performed at one of more than 200 facilities in our growing SCA network. Our clinicians and physician partners provide a broad range of high-quality surgical and procedural care at 50 percent to 75 percent lower costs than if the same care was provided in a hospital setting.

In 2017, approximately 1 million surgeries and procedures were performed in SCA facilities. Total joint replacement surgeries exemplify the quality and affordability provided by SCA. These procedures, which often cost \$50,000 or more in a hospital setting, can now be performed at half that cost in an ambulatory surgery center with outstanding clinical outcomes and patient satisfaction.

In many markets, we have the opportunity to shift appropriate care to the ambulatory surgery center setting, while driving outstanding clinical outcomes and receiving a Net Promoter Score above 90.

Optum improves clinical outcomes by developing data driven, risk bearing, high-value ambulatory care systems in local communities.

SCA provides care at

50% to 75%

lower cost compared to care provided in a hospital setting.



With PreCheck MyScript, physicians and patients can determine the out-of-pocket costs for medications and identify lower-cost alternatives while in the doctor's office.

PreCheck MyScript: Prescribing the Right Drug at the Best Price With Less Hassle



PreCheck MyScript is a breakthrough capability that provides real-time visibility into patients' drug benefits. Here's how it works. Imagine you're a patient in the exam room with your physician. Your doctor wants to prescribe a medication. Because PreCheck MyScript is seamlessly integrated into your medical record, your physician can immediately look up the desired medication. The two of you can then talk about whether or not the drug is covered by your health benefits plan, how much it costs you in out-of-pocket expenses, and whether or not there's an alternative medication that might save you money. For your physician, it's simple and easy to use.

PreCheck MyScript also alerts physicians if a prior authorization is required. It enables them to take action, saving patients from potential disruption at the pharmacy counter. Physicians have the option to either prescribe an alternative drug or file electronically for authorization. They receive instant notification regarding approval.

With PreCheck MyScript, patients receive the right drug at the best price with less hassle. That's important because if they encounter problems when filling their prescriptions, they might not fill the prescriptions at all.

UnitedHealthcare has already adopted PreCheck MyScript. In the brief time it's been in action, tens of thousands of prescribers have used it, accessing it over a million times. In 20 percent of the cases where an alternative, lower cost drug is offered, physicians prescribe it. The results are savings for consumers and our clients, and less frustration for everyone.

Real-time visibility into patients' drug benefits with PreCheck MyScript simplifies the drug prescribing experience for care providers and patients.

OptumIQ converts data into insights that care providers, health plans, employers and government agencies rely on to improve care quality, better manage cost and utilization and enhance consumer satisfaction.

OptumIQ: Transforming Data Into Insights and Actionable Information



Data and analytics form the foundation of Optum's health services business. In 2017, we introduced OptumIQ, an integrated, modern architecture for our data and analytics capability.

Our data is deep and dynamic with nearly 190 million lives of claims data and over 100 million lives of clinical data, including more than 6.5 billion medical procedures, over 18 billion lab results, and nearly 6 billion diagnoses. Although the size of our data assets is impressive, it's the enrichment and curation that makes them unparalleled in the industry.

Through OptumIQ we are actively investing in the future, leveraging artificial intelligence — neural networks, machine learning, deep learning and linguistic analysis — in preparation for the next decade and beyond. By applying artificial intelligence capable of addressing massive data sets, OptumIQ is uncovering patterns in quality and outcomes, consumer behavior, cost, risk and utilization, and operational performance. OptumIQ gets smarter every day, transforming that data into insight for our clients and helping them more easily keep up with the pace of change in health care.

Positioned at the epicenter of health care, OptumIQ is building a common language across the health care system by aggregating, cleaning, normalizing and integrating countless types of data from different sources.

Using our data and the latest technologies made by experts, for experts, our people are continually innovating with a purpose to solve real world challenges — transforming data into insight with industry-leading, dynamic metrics and measures.

OptumIQ claims and clinical data provide an unparalleled database of:

190 million

lives of claims data, over

100 million

lives of clinical data, including

6.5 billion

medical procedures,

18 billion

lab results and

6 billion

diagnoses.



Commitment to Excellence

UnitedHealth Group, Optum and UnitedHealthcare are committed to strong fundamental execution on behalf of the people and customers we serve, innovation, community involvement and value creation for both the health care system and our shareholders. We are honored to be acknowledged for our performance by the following awards and recognition.

UnitedHealth Group is the top ranking company in the insurance and managed care sector on **Fortune's 2018 "World's Most Admired Companies"** list. This is the eighth straight year UnitedHealth Group ranked No. 1 overall in its sector.

UnitedHealth Group was included among the 2017 **Best Employers for Diversity** by *Forbes*.

UnitedHealth Group is a member of the **Dow Jones Industrial Average**, a blue chip group of 30 companies deemed industry leaders.

In 2017, **The Civic 50**, a Points of Light initiative that highlights companies that improve the quality of life in the communities where they do business, ranked UnitedHealth Group one of America's 50 most community-minded companies.

Project HOPE, a global health and

disaster response organization, honored UnitedHealth Group with a 2017 **Project HOPE Global Health Award**, which recognizes outstanding contributions to advance health outcomes in the developing world.

UnitedHealth Group has been listed in the **Dow Jones Sustainability World Index** and **Dow Jones North America Index** annually since 1999.

In 2017, for the seventh consecutive year, the National Business Group on Health honored UnitedHealth Group with a **"Best Employers for Healthy Lifestyles"** top-tier Platinum award.

UnitedHealth Group was named a 2017 **Military Friendly Employer** by Victory Media, the publisher of *G.I. Jobs* and *Military Spouse* magazines.

In 2017, for the third consecutive year, Optum ranked **No. 1 on the Healthcare**

Informatics (HCI) 100, a listing of the top health care IT companies based on U.S. revenues.

Optum360, a leading provider of health care revenue management services, received the following recognition:

- **No. 1 in the 2017 Black Book Rankings** for revenue cycle management software, outsourcing and computer-assisted coding services.
- The **2017 United States Market Leadership Award** for revenue cycle management coding and clinical documentation from **Frost & Sullivan**.

Valor Econômico, a leading business newspaper in Brazil, ranked Amil first in the insurance sector in the **2017 Innovation Valor Brazil rankings**. The rankings are compiled in partnership with Strategy&, a PwC group.

UNITEDHEALTH GROUP®

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Attachment G

Copy of FY18 DSAMH Audit (Area Plan Audit)



Site Monitoring Report of

Salt Lake County
Division of Behavioral Health Services and
Health Department

Local Authority Contracts #160237 and #160424

Review Date: February 27th, 2018

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Salt Lake County Division of Behavioral Health Services (also referred to in this report as SLCo or the County) on February 27th, 2018. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 3 None	7-9
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	11-12
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None 2 2 2	15-16 16-17 18-19
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	20
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 1	23-24 24

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Salt Lake County Division of Behavioral Health Services (SLCo) and Salt Lake County Health Department (SLCHD) for prevention. The Governance and Fiscal Oversight section of the review was conducted on February 27th, 2018 by Chad Carter, Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained.

As part of the site visit, the most recent version of the Medicaid Cost Report was reviewed. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter.

Mental health and substance use disorder services are contracted to outside providers. SLCo must ensure that subcontractors comply with all provisions identified in the DHS Contract with Local Mental Health Authority. The Governance and Oversight section of the review was extended to include some contracted providers to test for compliance. Site visits were done on First Step House and Fourth Street Clinic. The visits included a review of insurance, code of conduct, conflict of interest and licensing.

There is a current and valid contract in place between the Division and the Local Authority. Salt Lake County met its obligation of matching a required percentage of State funding.

As required by the Local Authority, Salt Lake County received a single audit for the year ending December 31st, 2016 and submitted it to the Federal Audit Clearinghouse. The firm Squire completed the audit and issued a report dated June 29th, 2017. The auditors' opinion was unqualified stating that the financial statements present fairly, in all material aspects, the financial position of Salt Lake County. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. Substance Abuse and Mental Health were both identified as major programs and were selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2017 Audit:

No findings were issued in FY17.

Findings for Fiscal Year 2018 Audit:

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

1) *Subcontractor Monitoring*: The following issues were found:

- SLCo contracts with Optum as a Managed Care Organization (MCO). The DHS Contract sets up a monitoring structure where DSAMH is responsible for monitoring SLCo, as a subrecipient of State and Federal funds. SLCo is then responsible to monitor Optum to ensure that Federal, DHS contract, Utah Code and Division Directive requirements are followed. The Division relies on SLCo's audit and reviews it each year as part of annual monitoring. This year, SLCo had not yet finalized their FY16 financial review of Optum and their FY17 review was still in progress. Provider monitoring should be completed at the time of the Division's scheduled site visit. It is essential that these reviews are completed timely so that any issues that have been identified can be addressed within a reasonable time frame. SLCo contracts for all services, so monitoring is now one of its primary functions and should be given a high priority. DSAMH will work with SLCo to schedule the annual site visit later in the year if needed.
- During the review of SLCo subcontractor files, the DSAMH Substance Abuse Disorder team found two subcontractors (Project Reality and First Step House) that were not monitored in the previous year by SLCo as required by the DHS Contract and SAPT Block Grant.
- Subcontractor files were reviewed at the Salt Lake County Health Department. All contracts were monitored, but one file was found to have an expired insurance certificate that was not addressed in the monitoring review.

Center's Response and Corrective Action Plan:

- Regarding the first bullet, Salt Lake County Division of Behavioral Health Services (DBHS) recognizes that to not have the FY16 monitoring completely finalized by the FY18 DSAMH monitoring visit is unacceptable. Internal re-structuring has occurred and additional employees hired in order to assure that this does not reoccur.

Regarding the issue of the FY17 monitoring still being in progress, this is not completely accurate. The monitoring was completed by June 30, 2017 but the report had not yet been finalized due to various personnel issues. We realize taking so long to complete the report is not acceptable, and is certainly not the standard to which we hold ourselves. Due to the issues which caused such a lengthy completion of the report, the entire process was

re-examined. The Quality Assurance team was re-structured and the report has been re-formatted to ensure this does not occur again. However, it is not possible to have the entire monitoring visit with the accompanying report for the present fiscal year completed before DSAMH performs their monitoring visit. DSAMH needs to recognize the scope and magnitude of this audit. It would be akin to DSAMH completing all of their monitoring visits for all the LMHAs, and completing the reports, within four months, with less than half the staff DSAMH currently uses to complete these visits. All this while continuing to perform all the other many job responsibilities the QA team has. To begin earlier is not practical due to changes within the DSAMH and Medicaid contracts. Time is needed for the providers to put into practice the changes the contracts may necessitate. Additionally, the administrative part of the monitoring visit which requires significant preparation by Optum is most easily completed simultaneously when Utah Medicaid's externally quality review organization completes their monitoring visit, which is usually in the July after the fiscal year has closed. Therefore, if DSAMH would like to re-schedule DBHS' monitoring visit for the second half of June, we would have all of the clinical monitoring completed. However, we could only provide verbal feedback as the written report will not be completed until September 15 of any given year (this is the new standard).

- Regarding the second bullet of the two subcontractors not being monitored, measures have already been taken to assure that this will not occur again. All subcontractors either have been monitored with the reports issued or are scheduled to be monitored for FY18.
- Salt Lake County Health Department will contact this provider to obtain an updated insurance certificate, and add it to their contract file no later than July 16, 2018.

2) *Code of Conduct:* The DHS contract requires that the Local Authority and its contracted providers develop, maintain and enforce a Code of Conduct for the provision of services to its clients which includes the elements, and is at least as stringent as the DHS Provider Code of Conduct. Salt Lake County Health Department only has their employees sign the Salt Lake County Code of Conduct, but it is missing many elements from the DHS Provider Code of Conduct, only addressing employee conduct at work and not conduct between employees and their clients. SLCo has all of their employees sign both of these codes, SLCHD should ensure that any employees providing services under this contract do this also.

Center's Response and Corrective Action Plan:

Salt Lake County Health Department employees providing services under this contract will sign both the Salt Lake County Health Department Code of Conduct and the Division of Human Services Code of Conduct, and those documents will be added to the employees' files no later than July 16, 2018.

3) *Contractor Compliance:* SLCo is required to ensure that all contracted service providers are complying with the provisions in the DHS contract. Some contracted providers are selected for sampling to test for contract compliance. During the review of Fourth Street Clinic, it was found that one employee did not have a current conflict of interest form completed. The

previous form was completed in 2016 and stated that a potential conflict did exist. The DHS contract requires that all potential conflicts of interest are declared in writing and reviewed annually.

Center’s Response and Corrective Action Plan:

As part of our annual contract renewal process, we ask agencies to fill out and submit conflict of interest forms. We then remind them of this contract requirement throughout the fiscal year during provider meetings and at the time of the annual site visit. For FY18, we were negotiating a contract modification for Fourth Street Clinic and it was not noticed that the form did not get submitted. The contract was modified from providing assessment services to providing case management services. At the time of the contract signing Fourth Street Clinic was in the process of hiring someone to fill the case manager role. For FY17, the form that we have on file indicates that no conflict existed. This is available for review upon request. We have a new form that was filled out in May of 2018 for FY19 that indicates that no conflicts exist.

FY18 Deficiencies:

None

FY18 Recommendations:

None

FY18 Division Comments:

- 1) Each year, SLCo provides a match amount that is well over the required minimum. DSAMH appreciates SLCo’s commitment to the health of its population through funding mental health and substance use services.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

Child, Youth, & Families team conducted its annual monitoring review at Salt Lake County on February 27th and 28th of 2018. The monitoring team consisted of Eric Tadehara, Program Administrator; Codie Thurgood, Program Manager; Mindy Leonard, Program Manager; and Wendy Mair, Family Mentor with the Utah Family Coalition (NAMI Utah). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, and feedback from families through questionnaires and a focus group. During the visit, the monitoring team reviewed Fiscal Year 2017 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; juvenile civil commitment; compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2017 Audit

No findings were issued in FY17.

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

None

FY18 Deficiencies:

- 1) *Youth Outcome Questionnaire (YOQ)*: The frequency the YOQ is being administered is below the required guidelines of "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives. In seventeen charts reviewed, only six charts showed evidence of the YOQ being administered within the required guidelines. It is recommended SLCo continue to hold trainings for their providers on the administration and clinical use of the YOQ to increase the administration rate to fall within the required guideline of "every thirty days or every visit (whichever is less frequent)."

Center's Response and Corrective Action Plan:

In July 2018, all Optum SLCo providers will receive step-by-step instructions to create client profiles in the OQ Analyst. Subsequent use of the OQ Analyst will be monitored and providers not using the system will be required to attend and in-person training in the Fall of 2018. Optum

SLCo will continue to provide, at a minimum, annual OQ/YOQ Measures Trainings for providers. In addition, the training for FY19 will focus more on how to interpret the Clinician Report for inclusion in treatment planning, per provider feedback. OQ and YOQ administration with incorporation into treatment planning continues to be monitored through provider audits. Any training regarding the YOQ will emphasize the need and importance of completing the YOQ “every thirty days or every visit (whichever is less frequent)”.

FY18 Recommendations:

- 1) *Emergency data:* SLCo has made improvements in the way it captures emergency data, with FY17 emergency data reported as 150 children and youth receiving these services. DSAMH recognizes that data for emergency services through the Mobile Crisis Outreach Team is not accessible at this time and efforts are being made to be able to capture the data. It is recommended that SLCo continue to work with their other providers who provide emergency services to continue to effectively capture this data.
- 2) *School-based Behavioral Health:* SLCo continues to provide school-based behavioral health (SBBH) services through Valley Behavioral Health. Over the past six months, community partners have reported concerns regarding providers not being available in the capacity they have been in the past. It is noted that there are state wide problems in maintaining a full therapeutic workforce and that Valley Behavioral Health is working on filling the open positions. It is recommended that SLCo and Valley Behavioral Health continue to monitor and fill these positions to ensure children and youth are able to maintain access to SBBH services throughout the schools in Salt Lake County. It is also recommended that SLCo work with Valley Behavioral Health if there are other needs regarding SBBH and the partnerships with the local schools throughout the county.

FY18 Division Comments:

- 1) *Community Partnerships:* SLCo partners with the Carmen B. Pingree Autism Center of Learning and with New Beginnings Behavioral Treatment Agency. Carmen B. Pingree Autism Center of Learning has continued to evolve and adapt their services to provide a learning environment that can be tailored to fit the needs of each child attending. Additionally, New Beginnings Behavioral Treatment is able to tailor interventions for each youth and is willing to think outside the box to meet the needs of their clients. These community partners reported positive feedback in their relationship with SLCo and the collaboration to provide quality services for the clients.
- 2) *Family Feedback:* The Utah Family Coalition (UFC) collected feedback from four families via survey and two families who participated in a focus group. Feedback included a young transition aged adult who reported positive experiences in regards to their mental health treatment and supportive services.

It is recommended that SLCo and Optum continue to collaborate with the Utah Family Coalition (UFC) to strengthen the family feedback process.

- 3) *Wraparound and Family Resource Facilitators:* SLCo is using High Fidelity Wraparound principles with many of their families. Some of the charts reviewed demonstrated to all

fidelity measures and are considered High Fidelity Wraparound as defined by the UFC. SLCo Family Resource Facilitators (FRF) are an integral part of the service delivery system. FRFs play a key role in helping families engage with the services offered through SLCo. Families report that they appreciate the ability the FRFs have to “just listen” and be a support for them.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Monitoring Team conducted its annual monitoring review at Salt Lake County on February 27th and 28th, 2018. The team consisted of Pam Bennett, Program Administrator, Robert H. Snarr, Program Administrator, LeAnne Huff, Program Manager and Cami Roundy, Peer Support and Resiliency Program Manager. The review included: record reviews, and discussions with clinical supervisors and management teams, including Salt Lake County Division of Behavioral Health (SLCo), OptumHealth, and multiple providers and community partnerships throughout the County. Site visits were conducted at Volunteers of America Assertive Community Treatment (VOA/ACT) team, University Neuropsychiatric Institute (UNI) receiving center and UNI weekly discharge planning meeting. During the site visit, the team discussed and reviewed the FY17 audit findings; the mental health scorecard; area plan; Outcome Questionnaires; and SLCo's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2017 Audit

FY17 Minor Non-compliance Issues:

- 1) *Documentation of Mandated Outpatient Services:* This finding is continued from FY13 as documentation issues continue to be found in the assessment, treatment plans and progress notes, which could result in inadequate treatment. Thorough documentation in all these areas helps clinicians evaluate treatment progress and work with clients to create new goals and objectives as life adjustments occur. Issues were found related to ongoing assessments, inconsistencies within the progress notes, and missing objectives.

This Finding has not been resolved and will continue in FY18; see Significant Non-compliance Issue # 1

- 2) *Data collection of Incarcerated Individuals:* Accurate data of incarcerated individuals with severe mental illness served in Salt Lake County has not been collected since FY12. DSAMH recognizes that this data is not collected by SL County Behavioral Health directly, but it is required for SLCo to collect and report the data annually. This finding is a Minor Non-compliance Issue due to the length of time that SL County has been out of compliance with this data finding.

This Finding has not been resolved and will continue in FY18; see Significant Non-compliance Issue # 2

FY17 Deficiencies:

- 1) *DSAMH Directive on Outcome Questionnaire (OQ) Administration:* SLCo's rate of OQ administration has dropped from 78.5% in FY15 to 35.7% in FY16. Division Directives require at least 50% OQ collection rate to be in compliance. DSAMH recognizes the complexity of providing OQ training to over 200 providers and appreciates SLCo and OptumHealth's efforts in continuing to provide training and guidance to their providers. DSAMH recommends SLCo and OptumHealth continue to provide training and direction on

OQ administration to reach the Division Directives requirement of 50%. This reflects the finding in the SLCo FY15 Monitoring Report of OptumHealth.

FY18 scorecard shows OQ administration for SLCo at 59.7% which exceeds the 50% required administration rate; this deficiency has been resolved

- 2) *Use of OQ as an Intervention:* Division Directives require that data from the OQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. Only eight of 20 (40%) charts had evidence of integration of OQ as a tool in therapy sessions. The OQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. It is recommended that SLCo and OptumHealth work with providers to increase understanding of the clinical use of the OQ. This reflects the finding in the SLCo FY15 Monitoring Report of OptumHealth and a recommendation by DSAMH in FY16.

During the chart review, eleven of sixteen charts did not have the OQ used as an intervention. This finding has not been resolved and will be continued in FY18; see Minor Non-compliance Issue #1

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

- 1) *Safety-Related Documentation:* Sixteen charts were reviewed and four charts did not have a Columbia Suicide Severity Rating Scale (CSSR-S) when needed, reflective of the Salt Lake County Division of Behavioral Health Services (DBHS) Monitoring Report of Optum/Mental Health Services FY16 and FY17 findings. Three of those four charts did not contain safety plans. One chart that did include a CSSR-S (indicated due to a previous suicide attempt), but did not include an adequate safety plan. For example, the safety plan was: 1) “I feel overwhelmed when I am in a crisis”; and 2) “I need time to myself”.

Center’s Response and Corrective Action Plan:

In July 2018, information related to the C-SSRS mandate will again be distributed to all Optum SLCo providers. This will include step-by step instructions of how to submit the data. Reference to the screening tools, as well as the Stanley Brown Safety Plan will be offered. Provider use of the tool will be monitored by their data submissions, which will indicate if a safety plan was warranted as well. Providers not complying with the mandate will be required to attend an in-person training in the Fall of 2018.

We request the name for the providers who did not administer the C-SSRS and created an inadequate safety plan so we may follow-up and provided targeted support.

- 2) *Data collection of Incarcerated Individuals:* Accurate data of incarcerated individuals with severe mental illness served in Salt Lake County has not been collected since FY12. DSAMH recognizes that this data is not collected by SL County Behavioral Health directly, but it is required for SLCo to collect and report the data annually. This finding has been moved to a Significant Non-compliance Issue due to the length of time that SL County has been out of compliance with this data finding.

Center’s Response and Corrective Action Plan:

As is known by DSAMH, the SLCounty Jail provides mental health (MH) services to incarcerated individuals without any State or Federal funds and without oversight by DBHS. It was our intent to have the data extracted from the Jail’s electronic medical record (EMR) for these services and provide it via a data sharing agreement. It was determined this year, FY18, that the data extraction from the SLCo Jail EMR was not possible. We have been working with the Jail staff to format and extract data from the Jail data system (OMS) that would be representative of the individuals served in a Jail specific area as Residential MH. It is a cumbersome process and may not be accurate of all individuals or all service days. We have requested a Provider ID for the Jail under which to submit, but we have not yet received that from DSAMH. Once the ID is provided we will be submitting the data extracted for the last quarter of FY18 and submitting it as a pilot process. From there we will work with Jail staff to extract and report on a regular basis in FY19.

FY18 Minor Non-compliance Issues:

- 1) *Use of OQ as an Intervention:* Division Directives require that data from the OQ shall also be shared with the client and incorporated into the clinical process, as evidenced in the chart. The OQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. During chart reviews, eleven of sixteen, or 69% of the charts had no evidence of integration of OQ as a tool in treatment. The SLCo DBHS Monitoring Report of Optum/Mental Health Services FY16 and FY17 indicates that OptumHealth has provided training around treatment plan reviews and the OQ. This issue has been noted in DSAMH monitoring reports since FY14

Center’s Response and Corrective Action Plan:

While the use of OQ Measures has continued to be noted in the DSAMH Audit since FY14, the use of OQ has increased since Optum SLCo has been offering additional trainings. In July 2018, all Optum SLCo providers will receive step-by-step instructions to create client profiles in the OQ Analyst. Subsequent use of the OQ Analyst will be monitored and providers not using the system will be required to attend an in-person training in the Fall of 2018. Optum SLCo will continue to provide, at a minimum, annual OQ Measures Trainings for providers. In addition, the training for FY19 will focus more on how to interpret the Clinician Report for inclusion in treatment planning, per provider feedback. OQ and YOQ administration with incorporation into treatment planning continues to be monitored through provider audits.

- 2) *SLCo/OptumHealth's Provider Charting (Goals/Objectives) and Outpatient Documentation:* This finding has been addressed in previous years, as charts continue to have insufficient documentation, including issues with assessments, absence of goals and objectives, and inadequate treatment plans. Ten of sixteen charts (62%) reviewed did not have measurable goals. In accordance with Preferred Practice Guidelines and ongoing planning principles, short term goals/objectives are to be measurable, achievable and within a timeframe. One possible option for developing measurable goals is encouraging staff to utilize SMART goals; Specific, Measurable, Attainable, Relevant, and Time-based. One of the sixteen charts reviewed (Volunteers of America) had no presenting problem, no clinical information in the assessment, symptoms did not support diagnosis, goals were not measurable, and there was no evidence of coordination. Nine of sixteen charts reviewed were from Valley Behavioral Health (VBH). Six of nine VBH charts did not have measurable goals (see comment above). Only three of the nine charts included adequate documentation. One chart reviewed had a hand written assessment, minimal clinical information, no symptoms to support diagnosis and no progress notes. Three other charts also did not have symptoms to support the diagnosis. Three charts had no assessment updates, and one of these charts did not have an assessment in the electronic medical record. Three of the charts did not provide follow up when indicated by client not showing up for treatment or dropping out of treatment. A review of the VBH Internal Audit Report indicates that only 10 of 30 SLCo VBH units had completed the required percentage of peer chart reviews over the previous 12 months. This is concerning, as the number of issues within each chart could have an impact on client care. DBHS/Optum has a network of 174 providers and 56% of the files reviewed came from just one provider, so this finding is not necessarily representative of the DBHS/Optum network of providers. This was brought to the attention of the DSAMH monitoring team prior to the monitoring visit, and they concurred that this was the data available for this monitoring visit through random data pull and acknowledge the limitations of the representative sample. Similar findings were reflected in the audit report SLCo provided DSAMH that they had performed on Optum.

Center's Response and Corrective Action Plan:

Optum SLCo meets with Valley Behavioral Health leadership on a bi-weekly basis. During the month of July, Optum will address the findings with VBH and request plan of action to address the items listed above. In addition, Optum will audit these issues within the next 6 months.

Regarding the larger network, Optum SLCo will offer a provider training focused on the Golden Thread concept in treatment planning, delivery and documentation. We will emphasize having client centered goals and measurable objectives. Interventions/methods will also be addressed which describe the specific activity, service or treatment, the provider or other responsible person (including the individual or family), and the intended purpose or impact as it relates to the Objective. The intensity, frequency and duration must be specified. We will revisit key requirements from previous trainings related to assessments and treatment plans, including medical necessity, support for diagnoses and SMART objectives to better monitor treatment progress.

FY18 Deficiencies:

- 1) *Readiness, Evaluation and Discharge Implementation (REDI) Program:* The REDI program is a list of patients referred for discharge, and not yet discharged, from the Utah State Hospital (USH). At the time of the site visit, there were 14 patients from SLCo on the REDI list. SLCo is working to ensure patients ready for discharge are discharged from the USH within 30 days. In the past State fiscal year, the average annual number of days the patient has been on the REDI list is 102 days. 48% on the REDI list in the past State Fiscal Year exceeded 30 days on the list. Two of these clients were on the list for an extended period of time due to multiple complicated issues. If these outliers are removed, the average length of time on the REDI list for SLCo patients would be 43 days. DSAMH recognizes the barriers to discharge and the work being done by SLCo and OptumHealth on creative solutions, along with the development of additional affordable housing resources. DSAMH recommends SLCo continue to work with DSAMH and the USH to refine the discharge process, addressing barriers from intake and engaging high level processes to find sustainable solutions to difficult barriers.

Center’s Response and Corrective Action Plan:

The Optum SLCo Utah State Hospital Committee will continue to collaborate with USH and DSAMH personnel to discharge Salt Lake County consumers with complex circumstances, including those who were moved from Forensics to the Civil side. Some consumers’ histories include violent crimes which pose unique challenges to coordinate housing and services in a community based setting. Optum SLCo is committed to creating discharge plans to maximize each consumer’s potential for success while being mindful of the community’s safety. We will support further discussion regarding the purpose of the REDI list and criteria for consumers to be added. In FY18, two consumers (one included in the data cited) remained on the REDI list after comprehensive discharge plans were created, but rejected by the USH physicians. As the LMHA, Salt Lake County accepts responsibility and liability for consumers leaving the USH. We believe the Optum SLCo Team is most knowledgeable to create consumer specific plans based on the resources available in our community.

- 2) *Coordinated Transitions:* It was noted in the University Neuropsychiatric Institute FCA meeting that staff turnover in Valley Behavioral Health’s Assisted Outpatient Team had impacted the transition from inpatient to outpatient care. In addition, there are barriers to tracking unfunded individuals that are released on civil commitment. These issues impact the ability of the individuals to remain stable in the community.

Center’s Response and Corrective Action Plan:

Valley Behavioral Health hired a dedicated staff to collaborate with inpatient providers and to coordinate discharge from inpatient care. In July 2018, VBH will hire a clinician to offer supervision and back-up support to the inpatient discharge coordinator. Optum SLCo continues to meet with Utilization Reviewers (UR) at UNI on a weekly basis and reviews cases as appropriate with URs at Jordan West Valley and St. Mark’s Hospital. Optum SLCo also has providers other than Valley Behavioral Health who are able to accommodate consumers discharging from inpatient care with more complex needs. Optum Care Advocates, Recovery & Resiliency Staff and Case Management Coordinator are able to assist with coordination of care

with these providers as well.

FY18 Recommendations:

- 1) *Continuity of Care:* SLCo serves over 25% of the adult mental health clients in Utah (FY17 Mental Health Scorecard for Adults). With the closure of the Wellness Receiving Center, SLCo will lose 16 of 48 mental health residential beds, leaving only 32 beds (CORE and CORE II) and limiting the continuum of care available. DSAMH appreciates efforts to alleviate this gap by developing a partnership to provide subacute beds at Highland Ridge Hospital. DSAMH encourages SLCo to continue to address limitations in the residential services provided.
- 2) *Salt Lake County DBHS Monitoring Report:* DSAMH recognizes and appreciates the comprehensive monitoring the Salt Lake County provides over a complex mental health system. It was noted that review and assessment of safety plans are not included in the current report, and it is recommended that SLCo add this to the monitoring list.

FY18 Division Comments:

- 1) *Intensive Case Management Teams (OptumHealth):* OptumHealth is commended for the development of Intensive Case Management teams at four agencies. These community-based model of care has been demonstrated to improve functioning in individuals with severe mental illness.
- 2) *Peer Support Services and Volunteers of America (VOA):* DSAMH Peer Support Program Manager Cami Roundy visited with a Certified Peer Support Specialist who is part of the team at VOA. He is an asset and is treated as an integral part of the team. His documentation includes how he has been able to use his story and experience to help others. The VOA Peer Support supervision model is also outstanding.
- 3) *Utah Support Advocates for Recovery Awareness (USARA):* DSAMH Peer Support Program Manager Cami Roundy met with a Seeking Safety Group that is held at USARA. This group is facilitated by Peer Support Specialists. There were seven peers who attended the group. All in attendance reported that the group is helpful and that USARA is an excellent resource. All group members also indicated that they have created their own treatment goals, that USARA helps them to make progress toward those goals, and that Peer Support is critical to their recovery. Quotes from the group include: “Peer Support helps more than anything, I don’t know what I would do without it.” “I am completely self- sufficient now and own my own vehicle. I am doing a great job.”

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of Salt Lake County Health Department Prevention on February 27th, 2018. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2017 Audit

FY17 Deficiency:

- 1) SLCo saw a decrease in the number of Eliminating Alcohol Sales to Youth compliance checks that occurred in FY16.

This finding has not been resolved and will be continued in FY18; see Deficiency # 1.

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

None

FY18 Deficiencies:

- 1) SLCO saw a decrease in the number of Eliminating Alcohol Sales to Youth (EASY) compliance checks for a fourth year. In FY16, SLCo had 378 compliance checks completed compared to 310 in FY17.

Center's Response and Corrective Action Plan:

There was a 21.9 percent decrease in the number of Eliminating Alcohol Sales to Youth (EASY) compliance checks during the fiscal year 2017. The total number of agencies performing compliance checks decreased from seven agencies to five agencies. The overall compliance rate increased from 90 percent to 92.58 percent. Salt Lake County has developed the following action plan to help resolve the discrepancy for the fiscal year 2018.

- 1) Contact all precinct offices to determine who are performing EASY compliance checks
- 2) Provide an EASY training with the Utah Highway Safety Office for all precincts in the county
- 3) Recruit precincts currently not involved in EASY compliance checks

FY18 Recommendations:

- 1) It is recommended that SLCo develop a data entry plan in collaboration with Salt Lake Behavioral Health. This is specific to the indicated services provided and required to be entered into the SAMHIS system.
- 2) It is recommended that SLCo share the information identified regarding the strategies funded and how those line up with prevention principles with existing coalitions. Identifying the strategies currently implemented within the coalition boundaries would be best for communities to see how they are addressing prevention principles.
- 3) It is recommended that SLCo work with the Health Community Coalitions (HCC) to draft up priority issues for each HCC.

FY18 Division Comments:

- 1) SLCo has a Data Dashboard, this assessment tool highlights the needs of the County. The data identified priority issues including substance use prevention and mental health needs.
- 2) SLCo is working with eight coalitions at this time. They are looking to build additional coalitions and capacity within the northwest area of Salt Lake County and West Valley City.
- 3) The community of Murray had a higher participation rate on the 2017 Student Health and Risk Prevention survey. This will allow the community to have data specific to them for prevention planning.
- 4) SLCo Synar compliance rate is 93.7%, this is an increase from the previous fiscal year. Synar compliance checks monitor tobacco sales to youth from establishments within the County.
- 5) More than 90% of the strategies contracted or implemented through Salt Lake County Health Department (SLCHD) are evidence based.
- 6) With other grant funding, SLCHD has distributed over 300 Naloxone kits throughout the County this fiscal year.
- 7) The Director of SLCHD attended the Community Anti-Drug Coalitions of America (CADCA) Forum. Director Edwards supports utilizing the Strategic Prevention Framework and Community Centered Evidence Based Prevention.

Substance Abuse Treatment

Becky King and VaRonica Little, Program Administrators, conducted the annual review of Salt Lake County Behavioral Health Services on February 27th, 2018. The visit focused on Substance Abuse Prevention and Treatment (SAPT) block grant compliance, compliance with Division Directives and Contracts, SLCo's monitoring of contracted programs and their providers compliance with contract and clinical requirements. Block grant compliance was evaluated through a review of provider contracts, discussions with staff members and a review of SLCo's audit reports. Compliance with Division Directives was evaluated by reviewing SLCo's audit instruments and procedures, reviewing provider contracts, comparing program outcome measures against DSAMH standards and visits with SLCo's agencies' staff members. Monitoring of clinical practices was evaluated by reviewing SLCo's audit reports, audit instruments, procedures and discussions with staff responsible for the audits of contracted providers.

Follow-up from Fiscal Year 2017 Audit

FY17 Major Non-compliance issues:

- 1) SLCo Criminal Justices has not implemented a Sliding Fee Scale or Fee Reduction Policy, which is a repeat finding from FY14, FY15 and FY16. Upon review of the Drug Court Manuals, it was not evident that there was a sliding fee scale. In addition, the Drug Court Manual appears to reflect that clients are required to (1) pay a minimum of \$360.00 to move phases; (2) pay their fees in full prior to graduation; (3) and pay for contested drug test results. This is not in compliance with the National Associations of Drug Court Professionals (NADCP) Best Practice Standards or Division Directives. Clients can only be charged for a contested drug test if the test is confirmed as a positive result. It is recommended that SLCo Criminal Justice Services (1) implement a Sliding Fee Scale; (2) Fee Reduction Policy; (3) follow NADCP Best Practice Standards and Division Directives; (4) and update the Drug Court Policy Manual to reflect the requirements in the Division Directives and NADCP Best Practice Standards.

This issue is resolved. It should be noted in the FY18 audit that SLCo completed on Criminal Justice Services files, identified no documentation of sliding scale fee. There was no documentation in the SLCo files on this audit about the follow up and changes made by Criminal Justice Services, however SLCo staff stated that Criminal Justice Services has corrected this issue and they will include documentation of the correction in their records.

FY17 Minor Non-compliance Issues:

- 1) The FY16 Utah Substance Abuse Treatment Outcomes Measures showed:
 - a) From FY15 to FY16, the percent of abstinence from alcohol use decreased from 20.6% to 13.6% respectively, which does not meet Division Directives.

- b) From FY15 to FY16, the percent of clients completing a treatment episode successfully decreased from 42.5% to 40.0% respectively, which does not meet Division Directives.
- c) From FY15 to FY16, the percent of clients retained in treatment 60 days or more decreased from 73.0% to 65.4% respectively, which does not meet Division Directives.
- d) From FY15 to FY16, the percent of clients employed from admission to discharge decreased from 21.2% to 5.9% respectively, which does not meet Division Directives.

Issues b, c, and d were all resolved and will no longer be findings for the next fiscal year. The percent of clients completing a treatment episode (b) increased from 40% to 41.3% from FY16 to FY17. The percent of clients retained in treatment 60 days or more (c) remained at 65.4% from FY16 to FY17 which meets the standard in the Division Directives. Percent of clients employed from admission to discharge (d) increased from 5.9% to 21.9% from FY16 to FY17. Issue A has not been resolved and will be a continued finding in FY18; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2018 Audit:

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

1) The FY16 Utah Substance Abuse Treatment Outcomes Measures showed:

- a) From FY15 to FY16, the percent of abstinence from alcohol use decreased from 20.6% to 13.6% respectively, which does not meet Division Directives. In FY17 the percentage went to 17.7%, so this will continue to be a minor non-compliance finding.

Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of clients who are abstinent from alcohol from admission to discharge at a rate that is greater than or equal to 75% of the national average. Abstinence from alcohol is defined as no alcohol use for 30 days.

Center's Response and Corrective Action Plan:

DBHS would first like to note that improvement was seen in this area going from 13.6% to 17.7%. Additionally, we foresee this pattern continuing in the reporting of alcohol abstinence when only first admission data is compared to last reported discharge data of a client's episode. If the State were to take into consideration the incremental and concurrent data submitted during the client episode it would see more improvement as client's full data picture is collected across our network of providers. We would also estimate that more than half of clients' reported episode

end at a different provider than the provider under which they admitted. This is only an estimate as the State does not include this information in the SAOutcomes report.

FY18 Deficiencies:

- 1) *Treatment Data Episode Set (TEDS)*: DSAMH requires local authorities to report whether clients have been “compelled” to treatment by the justice system. This has been required since January 1, 2016. DSAMH recognizes the effort SLCo has made to train and educate providers on this requirement. However, 31.1% of all SLCo’s TEDS submissions for the first six months of FY17 did not include this information, which is required to track outcomes related to Utah’s Justice Reinvestment Initiative. Please continue to reinforce with contracted providers the importance of tracking this information.

Center’s Response and Corrective Action Plan:

DBHS requests that DSAMH share their methodology for calculating the figure of 31.1%. DBHS calculated the data and found of the admissions submitted that fall between 7/1/2016 and 12/31/2016, in the current data we see that 61% are compelled = YES, 19% are compelled = NO, and 21% are ‘not collected’ or ‘Unknown’. The majority of these last 21% are for Detox client admissions, 60%, where the client was no longer available to obtain updated information. Therefore, will continue to have a certain amount of “not collected” or “unknowns” because some clients will immediately leave the social detox program once sober and not be willing to engage in any further conversations. Keeping that in mind, DBHS has and will continue to emphasize to providers the importance of tracking this information during our monthly provider meetings. However, it needs to be noted that without the effort DBHS made, DSAMH would have had very little, if any, information to provide to their stakeholders. Additionally, during the first six months it had not been made clear by DSAMH exactly what comprised “compelled”. When we had further discussions with DSAMH leadership about this and obtained a clearer understanding, DBHS (including the providers) devoted a lot of time and effort to not only correctly identifying those who were compelled going forward, but also going in and correcting records that had previously been misidentified. We believe this finding does not accurately represent all the effort made to be able to identify all those who were correctly identified as compelled to treatment.

FY18 Recommendations:

- 1) *Treatment Data Episode Set (TEDS)*: Please continue to review the TEDS submissions to ensure that medication assisted treatment (MAT) is accurately reflected in this data set. This is important to show the use of this evidence based practice (EBP) and ensure accurate Federal grants reporting.
- 2) *Monitoring*: There were some contracts that were not monitored in the past fiscal year. There was concern that there was not enough staff to complete these audits. If there are concerns or if there is support that is needed to be in compliance with doing the annual audits please seek support from DSAMH to ensure that they are completed.

FY18 Division Comments:

- 1) *Monitoring*: SLCo has started to complete the audits of CJS and this will help with continued compliance and ensure that all data and programming is consistent with the other contracted entities.
- 2) *Medication Assisted Treatment*: SLCo continues to encourage the use of MAT, which has improved client and program outcomes. All Drug Court and justice related programs are also required to allow the use of MAT, which has resulted in long term recovery and reduced recidivism rates. This was evident in some of the audit reports, but should be reviewed annually to ensure that there is no limitations to accessing treatment.
- 3) *Vivitrol Project*: SLCo Behavioral Health continues to experience positive outcomes with the Vivitrol Project. By providing the Vivitrol injection in jail and up to six months of injections for individuals in Salt Lake County Treatment Programs, there has been increased rates of sobriety. This project has made a positive difference in the community.
- 4) *Peer Support Specialists*: OPTUM has been working on increasing the reimbursement rates for the Peer Support Specialists, which will result in increased recruitment and retention efforts. SLCo considers Peer Support Specialists to be an asset to their community and are dedicated to increasing incentives for programs to employ Peer Support Specialists in their programs.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

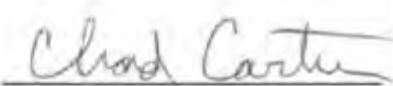

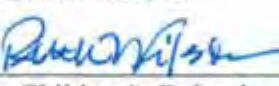

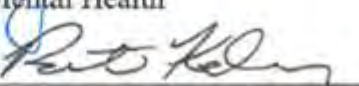
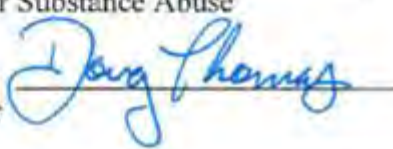
In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Salt Lake County and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

Prepared by:		
Chad Carter Auditor IV		Date <u>July 10, 2018</u>
Approved by:		
Kyle Larson Administrative Services Director		Date <u>July 10, 2018</u>
Ruth Wilson Assistant Director Children's Behavioral Health		Date <u>July 10, 2018</u>
Jeremy Christensen Assistant Director Mental Health		Date <u>July 10, 2018</u>
Brent Kelsey Assistant Director Substance Abuse		Date <u>July 10, 2018</u>
Doug Thomas Division Director		Date <u>July 10, 2018</u>

Attachment H.a
Audited Financial
Statements (United
HealthCare Services, Inc. &
Subsidiaries Consolidating
Supplemental Schedules)

United HealthCare Services, Inc. and Subsidiaries

Consolidated Financial Statements as of and for the
Years Ended December 31, 2017 and 2016,
United Behavioral Health
Consolidating Schedules as of and for the Year Ended
December 31, 2017, and Independent Auditors' Report

UNITED HEALTHCARE SERVICES, INC. AND SUBSIDIARIES

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
United HealthCare Services, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of United HealthCare Services, Inc. and Subsidiaries (the "Company"), a wholly owned subsidiary of UnitedHealth Group Incorporated (UHG), which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations, comprehensive income, changes in equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

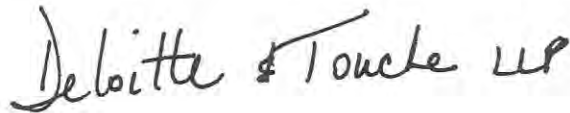
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of United HealthCare Services, Inc. and its Subsidiaries as of December 31, 2017 and 2016, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental consolidating schedules listed in the table of contents are presented for the purpose of additional analysis and are not a required part of the consolidated financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such schedules have been subjected to the auditing procedures applied in our audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the consolidating financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the consolidated financial statements as a whole.

A handwritten signature in cursive script that reads "Debitte & Touche LLP".

February 26, 2018

United HealthCare Services, Inc. and Subsidiaries

Consolidated Balance Sheets

(in millions, except share and per share data)	December 31,	
	2017	2016
Assets		
Current assets:		
Cash and cash equivalents	\$ 9,582	\$ 8,252
Short-term investments	3,011	2,420
Accounts receivable, net of allowances of \$565 and \$423	8,669	7,409
Other current receivables, net of allowances of \$401 and \$369	5,773	6,773
Assets under management	3,101	3,105
Related-party receivables, net	1,707	1,163
Prepaid expenses and other current assets	2,550	1,749
Total current assets	34,393	30,871
Long-term investments	23,747	19,086
Property, equipment and capitalized software, net of accumulated depreciation and amortization of \$3,085 and \$3,086	5,265	4,285
Goodwill	46,586	40,045
Other intangible assets, net of accumulated amortization of \$3,875 and \$3,300	7,580	7,769
Other assets	2,002	1,304
Total assets	\$ 119,573	\$ 103,360
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	\$ 15,359	\$ 13,570
Accounts payable and accrued liabilities	13,271	11,211
Unearned revenues	2,000	1,670
Current maturities of long-term notes payable to related party	-	766
Other current liabilities	11,874	9,953
Total current liabilities	42,504	37,170
Long-term notes payable to related party, less current maturities	4,430	4,248
Deferred income taxes	2,189	2,884
Other liabilities	3,776	3,048
Total liabilities	52,899	47,350
Commitments and contingencies (Note 13)		
Redeemable noncontrolling interests	1,301	1,269
Equity:		
Common stock, \$1.00 par value - 10,000 shares authorized; 1,000 shares issued and outstanding	-	-
Additional paid-in capital	49,065	45,811
Retained earnings	14,298	9,166
Accumulated other comprehensive loss	(47)	(139)
Nonredeemable noncontrolling interests	2,057	(97)
Total equity	65,373	54,741
Total liabilities, redeemable noncontrolling interests and equity	\$ 119,573	\$ 103,360

See Notes to the Consolidated Financial Statements

United HealthCare Services, Inc. and Subsidiaries
Consolidated Statements of Operations

(in millions)	For the Years Ended December 31,	
	2017	2016
Revenues:		
Premiums	\$ 135,664	\$ 121,132
Products	29,668	29,567
Services	15,911	13,867
Investment and other income	789	605
Total revenues	182,032	165,171
Operating costs:		
Medical costs	111,569	98,102
Selling, general and administrative expenses	28,857	25,987
Cost of products sold	27,184	27,127
Depreciation and amortization	1,994	1,832
Total operating costs	169,604	153,048
Earnings from operations	12,428	12,123
Interest expense - related-party	(202)	(189)
Earnings before income taxes	12,226	11,934
Provision for income taxes	(3,069)	(4,817)
Net earnings	9,157	7,117
Earnings attributable to noncontrolling interests	(269)	(82)
Net earnings attributable to shareholder	\$ 8,888	\$ 7,035

See Notes to the Consolidated Financial Statements

United HealthCare Services, Inc. and Subsidiaries
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31,	
	2017	2016
Net earnings	\$ 9,157	\$ 7,117
Other comprehensive income (loss):		
Gross unrealized gains (losses) on investment securities	187	(57)
Income tax effect	(71)	20
Total unrealized gains (losses), net of tax	116	(37)
Gross reclassification adjustment for net realized gains included in net earnings	(81)	(134)
Income tax effect	31	48
Total reclassification adjustment, net of tax	(50)	(86)
Total foreign currency translation gains (losses)	26	(13)
Other comprehensive income (loss)	92	(136)
Comprehensive income	9,249	6,981
Comprehensive income attributable to noncontrolling interests	(269)	(82)
Comprehensive income attributable to shareholder	\$ 8,980	\$ 6,899

See Notes to the Consolidated Financial Statements

United HealthCare Services, Inc. and Subsidiaries Consolidated Statements of Changes in Equity

(in millions, except share data)	Common Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)		Nonredeemable Noncontrolling Interests	Total Equity	
	Shares	Amount			Net Unrealized Gains (Losses) on Investments	Foreign Currency Translation			
						(Losses)			Gains
Balance at December 31, 2015	1,000	-	\$45,334	\$ 5,647	\$ 48	\$ (51)	\$ (105)	\$ 50,873	
Adjustment to adopt ASU 2016-09	-	-	-	19	-	-	-	19	
Net earnings	-	-	-	7,035	-	-	40	7,075	
Other comprehensive loss	-	-	-	-	(123)	(13)	-	(136)	
Share-based compensation	-	-	433	-	-	-	-	433	
Dividends and capital distributions	-	-	(2,134)	(3,535)	-	-	-	(5,669)	
Capital contributions	-	-	2,508	-	-	-	-	2,508	
Acquisition of redeemable noncontrolling interest shares	-	-	(143)	-	-	-	-	(143)	
Redeemable noncontrolling interest fair value and other adjustments	-	-	(187)	-	-	-	-	(187)	
Distributions to nonredeemable noncontrolling interest	-	-	-	-	-	-	(32)	(32)	
Balance at December 31, 2016	1,000	-	45,811	9,166	(75)	(64)	(97)	54,741	
Net earnings	-	-	-	8,888	-	-	194	9,082	
Other comprehensive income	-	-	-	-	66	26	-	92	
Share-based compensation	-	-	548	-	-	-	-	548	
Dividends and capital distributions	-	-	(2,750)	(3,756)	-	-	-	(6,506)	
Capital contributions	-	-	5,177	-	-	-	-	5,177	
Acquisition of redeemable noncontrolling interest shares	-	-	283	-	-	-	-	283	
Redeemable noncontrolling interests fair value and other adjustments	-	-	(4)	-	-	-	-	(4)	
Acquisition of nonredeemable noncontrolling interests shares	-	-	-	-	-	-	2,112	2,112	
Distributions to nonredeemable noncontrolling interests	-	-	-	-	-	-	(152)	(152)	
Balance at December 31, 2017	1,000	\$ -	\$49,065	\$ 14,298	\$ (9)	\$ (38)	\$ 2,057	\$ 65,373	

See Notes to the Consolidated Financial Statements

United HealthCare Services, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31,	
	2017	2016
Operating activities:		
Net earnings	\$ 9,157	\$ 7,117
Noncash items:		
Depreciation and amortization	1,994	1,832
Deferred income taxes	(989)	162
Share-based compensation	571	466
Other, net	394	36
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:		
Accounts receivable	(907)	(1,311)
Other assets	(918)	(1,619)
Medical costs payable	1,578	1,437
Accounts payable and other liabilities	1,676	1,717
Unearned revenues	183	(167)
Related-party receivables, net	(2,109)	(68)
Cash flows from operating activities	10,630	9,602
Investing activities:		
Purchases of investments	(12,509)	(13,849)
Sales of investments	3,252	5,873
Maturities of investments	4,753	3,417
Cash (paid for) assumed from acquisitions, net	(195)	1,178
Purchases of property, equipment and capitalized software	(1,833)	(1,509)
Receivable from shareholder	-	202
Other, net	(155)	(59)
Cash flows used for investing activities	(6,687)	(4,747)
Financing activities:		
Cash dividends paid	(3,671)	(3,520)
Capital distributions paid	(2,750)	(2,134)
Payable to shareholder	1,561	(931)
Repayments of long-term notes payable to related party, net	(766)	(67)
Customer funds administered	3,086	1,430
Other, net	(73)	(23)
Cash flows used for financing activities	(2,613)	(5,245)
Increase (decrease) in cash and cash equivalents	1,330	(390)
Cash and cash equivalents, beginning of period	8,252	8,642
Cash and cash equivalents, end of period	\$ 9,582	\$ 8,252
Supplemental cash flow disclosures:		
Cash paid for income taxes	\$ 4,141	\$ 4,906
Noncash contributions received for acquired entities	5,104	2,325

See Notes to the Consolidated Financial Statements

United HealthCare Services, Inc. and Subsidiaries
Notes to the Consolidated Financial Statements

1. Description of Business

United HealthCare Services, Inc. (individually and together with its subsidiaries, UHS or the Company), a wholly-owned subsidiary of UnitedHealth Group Incorporated (UHG or shareholder), is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information, advanced technology, and clinical expertise to help meet the demands of the health system. The Company offers a broad spectrum of products and services, including health care coverage, benefits and pharmacy care services, and information and technology-enabled health services.

2. Basis of Presentation, Use of Estimates, and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements in accordance with U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UHS and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets, and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period during which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulations, that fall below certain targets, are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums for these contracts. The Company also records premium revenues from capitation arrangements at its care delivery and management businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. CMS utilizes a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions, and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk-adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the diagnosis data submitted, and expected to be submitted, to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 13 for additional information regarding these audits.

Products and Services

For the Company's pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery and specialty pharmacy facilities. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee, and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network, or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers, regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings, and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, revenues are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives a monthly fixed fee per employee, which is recognized as revenue as the Company performs, or makes available the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation to fund the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, the Company charges fees and earns investment income on managed funds. The Company also provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. These revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2017, accounts receivables related to products and services were \$3.4 billion. In 2017, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheet as of December 31, 2017.

For the year ended December 31, 2017, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2017.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service, and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which include estimates for claims that have not been received or fully processed, using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers, either directly at its mail and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments having an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings, and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer, as well as specific events or circumstances that may influence the operations of the issuer, and the Company's intent to sell the security, or the likelihood that it will be required to sell the security, before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program), and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance - including insurance for individuals aged 50 to 64 years - and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund medical costs payable, rate stabilization fund (RSF) liabilities, and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes from its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis, based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms, and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates between two and five months after billing. As of December 31, 2017 and 2016, total pharmaceutical manufacturer rebates receivable included in other current receivables in the Consolidated Balance Sheets amounted to \$3.8 billion and \$3.3 billion, respectively.

As of December 31, 2017 and 2016, the Company's Medicare Part D receivables amounted to \$0.5 billion and \$1.5 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services, and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic lives.

Goodwill

As UHS is defined by its legal structure, and is not managed by individual product lines, the Company represents a single reporting unit for goodwill impairment testing purposes.

To determine whether goodwill is impaired, annually or more frequently if needed, the Company may perform a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of the reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing.

When performing quantitative testing, the Company first estimates the fair value of its reporting unit using discounted cash flows. To determine fair value, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill is calculated and compared to the carrying amount of goodwill, to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2017.

Other Intangible Assets

The Company's other intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of other intangible assets during the year ended December 31, 2017.

Other Current Liabilities

Other current liabilities include health savings account deposits (\$6.4 billion and \$5.7 billion as of December 31, 2017 and 2016, respectively), deposits under the Medicare Part D program (\$1.5 billion and \$0.7 billion as of December 31, 2017 and 2016, respectively), the RSF associated with the AARP Program, program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits, and customer balances.

Policy Acquisition Costs

The Company's short-duration health insurance contracts typically have a one-year term, and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short-duration customer contracts are charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31:

(in millions)	2017	2016
Redeemable noncontrolling interests, beginning of period	\$ 1,269	\$ 1,078
Net earnings	74	42
Acquisitions	268	21
Redemptions	(311)	(123)
Distributions	(41)	(10)
Fair value and other adjustments	42	261
Redeemable noncontrolling interests, end of period	<u>\$ 1,301</u>	<u>\$ 1,269</u>

Share-Based Compensation

The Company recognizes compensation expense for UHG's share-based awards, including stock options, stock-settled stock appreciation rights (SARs), and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period – generally, the vesting period – of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to five years, and compensation expense related to restricted shares is based on the share price at date of grant. Stock options and SARs vest ratably, primarily over four years, and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model.

Under UHG's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase UHG's stock at a discounted price, which is 85% of the lower of the market price of UHG's common stock at the beginning or at the end of the six-month purchase period.

Share-based compensation expense for all programs is recognized in selling, general and administrative expenses in the Consolidated Statements of Operations.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year, with a corresponding deferred cost that is amortized to selling, general and administrative expenses in the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities, and the corresponding deferred cost is recorded in prepaid expenses and other current assets in the Consolidated Balance Sheets. A provision in the 2016 Federal Budget imposed a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" (ASU 2016-02). Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities, and instead expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. Companies are required to adopt the new standard using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption of ASU 2016-02 is permitted. When adopted, the Company does not expect ASU 2016-02 to have a material impact on its results of operations, equity or cash flows. The impact of ASU 2016-02 on the Company's consolidated financial position will be based on leases outstanding at the time of adoption.

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). The new guidance changes the current accounting related to (i) the classification and measurement of certain equity investments, (ii) the presentation of changes in the fair value of financial liabilities measured under the fair value option that are due to instrument-specific credit risk, and (iii) certain disclosures associated with the fair value of financial instruments. Most notably, ASU 2016-01 requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The Company adopted ASU 2016-01 effective January 1, 2018 as required. ASU 2016-01 did not have a material impact on the Company's consolidated financial position, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (Topic 606)", as modified by subsequently issued ASUs 2015-14, 2016-08, 2016-10, 2016-12, and 2016-20 (collectively ASU 2014-09). ASU 2014-09 superseded existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Company early adopted the new standard effective January 1, 2017, as allowed, using the modified retrospective approach. A significant majority of the Company's revenues are not subject to the new guidance. The adoption of ASU 2014-09 did not have a material impact on the Company's consolidated financial position, results of operations, equity or cash flows as of the adoption date or for the year ended December 31, 2017.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2017				
Debt securities — available-for-sale:				
U.S. government and agency obligations	\$ 2,276	\$ 1	\$ (24)	\$ 2,253
State and municipal obligations	6,110	83	(28)	6,165
Corporate obligations	11,304	51	(37)	11,318
U.S. agency mortgage-backed securities	3,458	6	(29)	3,435
Non-U.S. agency mortgage-backed securities	879	3	(5)	877
Total debt securities — available-for-sale	24,027	144	(123)	24,048
Equity securities	1,417	7	(40)	1,384
Debt securities — held-to-maturity:				
U.S. government and agency obligations	180	-	(1)	179
State and municipal obligations	2	-	-	2
Corporate obligations	250	-	-	250
Total debt securities — held-to-maturity	432	-	(1)	431
Total investments	\$ 25,876	\$ 151	\$ (164)	\$ 25,863
December 31, 2016				
Debt securities — available-for-sale:				
U.S. government and agency obligations	\$ 1,817	\$ 1	\$ (24)	\$ 1,794
State and municipal obligations	5,500	33	(80)	5,453
Corporate obligations	9,058	36	(46)	9,048
U.S. agency mortgage-backed securities	2,520	6	(36)	2,490
Non-U.S. agency mortgage-backed securities	848	3	(9)	842
Total debt securities — available-for-sale	19,743	79	(195)	19,627
Equity securities	1,475	48	(47)	1,476
Debt securities — held-to-maturity:				
U.S. government and agency obligations	177	-	-	177
State and municipal obligations	5	-	-	5
Corporate obligations	221	-	-	221
Total debt securities — held-to-maturity	403	-	-	403
Total investments	\$ 21,621	\$ 127	\$ (242)	\$ 21,506

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2017.

The amortized cost and fair value of debt securities as of December 31, 2017, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	\$ 3,040	\$ 3,036	\$ 107	\$ 106
Due from one year to five years	8,904	8,881	108	108
Due from five years to ten years	5,866	5,899	88	88
Due after ten years	1,882	1,920	129	129
U.S. agency mortgage-backed securities	3,458	3,435	-	-
Non-U.S. agency mortgage-backed securities	877	877	-	-
Total debt securities	<u>\$ 24,027</u>	<u>\$ 24,048</u>	<u>\$ 432</u>	<u>\$ 431</u>

The fair value of available-for-sale investments with gross unrealized losses by major security type, and length of time that individual securities have been in a continuous unrealized loss position, was as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2017						
Debt securities — available-for-sale:						
U.S. government and agency obligations	\$ 1,091	\$ (7)	\$ 862	\$ (17)	\$ 1,953	\$ (24)
State and municipal obligations	2,055	(16)	654	(11)	2,709	(27)
Corporate obligations	5,112	(20)	981	(16)	6,093	(36)
U.S. agency mortgage-backed securities	1,497	(10)	981	(21)	2,478	(31)
Non-U.S. agency mortgage-backed securities	353	(3)	113	(2)	466	(5)
Total debt securities — available-for-sale	<u>\$ 10,108</u>	<u>\$ (56)</u>	<u>\$ 3,591</u>	<u>\$ (67)</u>	<u>\$ 13,699</u>	<u>\$ (123)</u>
Equity securities	<u>\$ 94</u>	<u>\$ (4)</u>	<u>\$ 100</u>	<u>\$ (36)</u>	<u>\$ 194</u>	<u>\$ (40)</u>
December 31, 2016						
Debt securities — available-for-sale:						
U.S. government and agency obligations	\$ 1,388	\$ (24)	\$ -	\$ -	\$ 1,388	\$ (24)
State and municipal obligations	3,385	(80)	4	-	3,389	(80)
Corporate obligations	4,102	(44)	116	(2)	4,218	(46)
U.S. agency mortgage-backed securities	1,888	(33)	69	(3)	1,957	(36)
Non-U.S. agency mortgage-backed securities	455	(7)	77	(2)	532	(9)
Total debt securities — available-for-sale	<u>\$ 11,218</u>	<u>\$ (188)</u>	<u>\$ 266</u>	<u>\$ (7)</u>	<u>\$ 11,484</u>	<u>\$ (195)</u>
Equity securities	<u>\$ 90</u>	<u>\$ (5)</u>	<u>\$ 87</u>	<u>\$ (42)</u>	<u>\$ 177</u>	<u>\$ (47)</u>

The Company's unrealized losses from all securities as of December 31, 2017 were generated from approximately 11,000 positions out of a total of 24,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases, and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2017, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

The Company's investments in equity securities consist of investments in employee savings plan related investments, and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors. Additionally, as of December 31, 2017, the Company's investments included \$894 million of equity method investments in operating businesses in the health care sector.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

<u>(in millions)</u>	<u>For the Years Ended December 31,</u>	
	<u>2017</u>	<u>2016</u>
Total other-than-temporary impairments recognized in earnings	\$ (9)	\$ (45)
Gross realized losses from sales	(22)	(39)
Gross realized gains from sales	112	218
Net realized gains (included in investment and other income in the Consolidated Statements of Operations)	81	134
Income tax effect (included in provision for income taxes in the Consolidated Statements of Operations)	(31)	(48)
Realized gains, net of taxes	<u>\$ 50</u>	<u>\$ 86</u>

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements, or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers of any financial assets or liabilities between Levels 1, 2 or 3 during 2017 or 2016.

Nonfinancial assets and liabilities, or financial assets and liabilities that are measured at fair value on a nonrecurring basis, are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments recorded for these assets and liabilities during the years ended December 31, 2017 or 2016.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value, as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities – Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security, primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives security prices through recently reported trades for identical or similar securities and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes.

As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant, or third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures, and reviews of fair value methodology documentation provided by independent pricing services, have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets, but instead are priced using other observable inputs, are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based on recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing, and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management – Assets under management consist of debt securities and other investments held to fund costs associated with the AARP Program, and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Notes Payable to Related Party – The fair values of the Company's long-term notes payable to related party are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying value, for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2017				
Cash and cash equivalents	\$ 9,347	\$ 235	\$ -	\$ 9,582
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,058	195	-	2,253
State and municipal obligations	-	6,165	-	6,165
Corporate obligations	23	11,155	140	11,318
U.S. agency mortgage-backed securities	-	3,435	-	3,435
Non-U.S. agency mortgage-backed securities	-	877	-	877
Total debt securities — available-for-sale	2,081	21,827	140	24,048
Equity securities	1,228	14	142	1,384
Assets under management	1,117	1,984	-	3,101
Total assets at fair value	<u>\$ 13,773</u>	<u>\$ 24,060</u>	<u>\$ 282</u>	<u>\$ 38,115</u>
December 31, 2016				
Cash and cash equivalents	\$ 8,211	\$ 41	\$ -	\$ 8,252
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,630	164	-	1,794
State and municipal obligations	-	5,453	-	5,453
Corporate obligations	13	8,933	102	9,048
U.S. agency mortgage-backed securities	-	2,490	-	2,490
Non-U.S. agency mortgage-backed securities	-	842	-	842
Total debt securities — available-for-sale	1,643	17,882	102	19,627
Equity securities	1,045	13	418	1,476
Assets under management	1,064	2,041	-	3,105
Total assets at fair value	<u>\$ 11,963</u>	<u>\$ 19,977</u>	<u>\$ 520</u>	<u>\$ 32,460</u>

The following table presents a summary of fair value measurements by level and carrying value, for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices	Other		Total Fair Value	Total Carrying Value
	in Active Markets (Level 1)	Observable Inputs (Level 2)	Unobservable Inputs (Level 3)		
December 31, 2017					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	\$ 176	\$ 3	\$ -	\$ 179	\$ 180
State and municipal obligations	-	-	2	2	2
Corporate obligations	15	1	234	250	250
Total debt securities — held-to-maturity	\$ 191	\$ 4	\$ 236	\$ 431	\$ 432
Long-term notes payable to related party	\$ -	\$ 4,652	\$ -	\$ 4,652	\$ 4,430
December 31, 2016					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	\$ 177	\$ -	\$ -	\$ 177	\$ 177
State and municipal obligations	-	-	5	5	5
Corporate obligations	18	8	195	221	221
Total debt securities — held-to-maturity	\$ 195	\$ 8	\$ 200	\$ 403	\$ 403
Long-term notes payable to related party	\$ -	\$ 5,282	\$ -	\$ 5,282	\$ 5,014

The carrying amounts reported in the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31,	
	2017	2016
Land and improvements	\$ 86	\$ 70
Buildings and improvements	2,507	1,931
Computer equipment	1,781	1,967
Furniture and fixtures	781	601
Less: accumulated depreciation	(2,044)	(2,105)
Property and equipment, net	3,111	2,464
Capitalized software	3,195	2,802
Less: accumulated amortization	(1,041)	(981)
Capitalized software, net	2,154	1,821
Total property, equipment and capitalized software, net	\$ 5,265	\$ 4,285

Depreciation expense for property and equipment for the years ended December 31, 2017 and 2016 was \$712 million and \$623 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2017 and 2016 was \$490 million and \$420 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill were as follows:

<u>(in millions)</u>	<u>2017</u>	<u>2016</u>
Balance, beginning of period	\$ 40,045	\$ 37,883
Acquisitions	6,609	2,188
Adjustments, net	(68)	(26)
Balance, end of period	<u>\$ 46,586</u>	<u>\$ 40,045</u>

The gross carrying value, accumulated amortization, and net carrying value of other intangible assets were as follows:

<u>(in millions)</u>	<u>December 31, 2017</u>			<u>December 31, 2016</u>		
	<u>Gross Carrying Value</u>	<u>Accumulated Amortization</u>	<u>Net Carrying Value</u>	<u>Gross Carrying Value</u>	<u>Accumulated Amortization</u>	<u>Net Carrying Value</u>
Customer-related	\$ 10,370	\$ (3,384)	\$ 6,986	\$ 10,269	\$ (2,926)	\$ 7,343
Trademarks and technology	897	(415)	482	686	(318)	368
Other	188	(76)	112	114	(56)	58
Total	<u>\$ 11,455</u>	<u>\$ (3,875)</u>	<u>\$ 7,580</u>	<u>\$ 11,069</u>	<u>\$ (3,300)</u>	<u>\$ 7,769</u>

The acquisition-date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following, by year of acquisition:

<u>(in millions)</u>	<u>2017</u>		<u>2016</u>	
	<u>Fair Value</u>	<u>Weighted-Average Useful Life</u>	<u>Fair Value</u>	<u>Weighted-Average Useful Life</u>
Customer-related	\$ 324	13 years	\$ 772	17 years
Trademarks and technology	111	11 years	54	3 years
Other	79	6 years	22	5 years
Total acquired finite-lived intangible assets	<u>\$ 514</u>	<u>11 years</u>	<u>\$ 848</u>	<u>16 years</u>

Estimated full-year amortization expense relating to other intangible assets for each of the next five years ending December 31 is as follows:

<u>(in millions)</u>	<u>Estimated Amortization Expense</u>
2018	\$ 741
2019	679
2020	613
2021	559
2022	496

Amortization expense relating to other intangible assets was \$792 million and \$789 million for the years ended December 31, 2017 and 2016, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2017	2016
Balance, beginning of period	\$ 13,570	\$ 12,051
Acquisitions	83	-
Reported medical costs:		
Current year	112,042	98,240
Prior years	(473)	(138)
Total reported medical costs	<u>111,569</u>	<u>98,102</u>
Medical payments:		
Current year	(97,448)	(85,382)
Prior years	(12,415)	(11,201)
Total medical payments	<u>(109,863)</u>	<u>(96,583)</u>
Balance, end of period	<u>\$ 15,359</u>	<u>\$ 13,570</u>

For the year ended December 31, 2017, the medical cost reserve development was primarily driven by lower than expected health system utilization levels. For the year ended December 31, 2016, no individual factors were significant.

Medical costs payable included IBNR of \$9.8 billion and \$8.9 billion at December 31, 2017 and 2016, respectively. Substantially all of the IBNR balance as of December 31, 2017 relates to the current year.

The following table provides information about incurred and paid medical cost development as of December 31, 2017:

(in millions) Year	Net Incurred Medical Costs	
	For the Years Ended December 31,	
	2016	2017
2016	\$ 98,240	\$ 97,788
2017		112,042
Total		<u>\$ 209,830</u>

(in millions) Year	Net Cumulative Medical Payments	
	For the Years Ended December 31,	
	2016	2017
2016	\$ (85,382)	\$ (97,528)
2017		(97,448)
Total		<u>(194,976)</u>
Net remaining outstanding liabilities prior to 2016		<u>505</u>
Total medical costs payable		<u>\$ 15,359</u>

8. Long-Term Notes Payable to Related Party

Notes Payable – During 2015, the Company issued unsecured notes payable (Notes Payable) of \$4.75 billion to UHG, using the proceeds to partially fund an acquisition. In accordance with the terms of the Notes Payable, the Company converted \$182 million and \$264 million of accrued interest to principal at December 31, 2017 and 2016, respectively.

The Company's Notes Payable balances as of December 31, 2017 were comprised of the following:

<u>(in millions)</u>	<u>Principal, plus Accrued Interest</u>	<u>Interest Payable</u>
3.76% Fixed Rate Notes - due July 2025	\$ 2,189	Upon maturity
4.76% Fixed Rate Notes - due July 2045	2,241	Upon maturity
Long-term notes payable to related party	<u>\$ 4,430</u>	

Maturities of Notes Payable for the years ending December 31 are as follows:

<u>(in millions)</u>	<u>Maturities of Notes Payable</u>
2018	\$ -
2019	-
2020	-
2021	-
2022	-
Thereafter	4,430

9. Income Taxes

The Company's operations are included in the consolidated federal income tax return of UHG. Federal and state income taxes are paid to, or refunded by, UHG pursuant to the terms of a tax sharing agreement (TSA), under which taxes approximate the amount that would have been computed on a separate company basis. Under the terms of the TSA, the Company's share-based compensation-related tax benefits are reimbursed to UHG upon realization.

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses.

The components of the provision for income taxes for the years ended December 31 are as follows:

<u>(in millions)</u>	<u>2017</u>	<u>2016</u>
Current provision:		
Federal	\$ 3,702	\$ 4,381
State and local	356	274
Total current provision	4,058	4,655
Deferred (benefit) provision	(989)	162
Total provision for income taxes	<u>\$ 3,069</u>	<u>\$ 4,817</u>

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

<u>(in millions)</u>	<u>2017</u>		<u>2016</u>	
Tax provision at the U.S. federal statutory rate	\$ 4,280	35.0 %	\$ 4,177	35.0 %
Change in tax law	(1,202)	(9.8)	-	-
State income taxes, net of federal benefit	203	1.7	212	1.8
Share-based awards - excess tax benefit	(321)	(2.6)	(151)	(1.2)
Non-deductible compensation	168	1.4	125	1.0
Health insurance industry tax	-	-	547	4.6
Other, net	(59)	(0.6)	(93)	(0.8)
Provision for income taxes	<u>\$ 3,069</u>	<u>25.1 %</u>	<u>\$ 4,817</u>	<u>40.4 %</u>

The Company had federal and state income taxes payable of \$317 million included in accounts payable and accrued liabilities in the Consolidated Balance Sheets as of December 31, 2017. The Company had federal income taxes receivable of \$174 million included in other current receivables and state income taxes payable balances of \$146 million included in accounts payable and accrued liabilities in the Consolidated Balance Sheets as of December 31, 2016.

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

<u>(in millions)</u>	<u>2017</u>	<u>2016</u>
Deferred income tax assets:		
Accrued expenses and allowances	\$ 490	\$ 733
Net operating loss carry forwards	169	104
Share-based compensation	82	100
Nondeductible liabilities	173	235
Other	164	401
Subtotal	<u>1,078</u>	<u>1,573</u>
Less: valuation allowances	<u>(48)</u>	<u>(42)</u>
Total deferred income tax assets	<u>1,030</u>	<u>1,531</u>
Deferred income tax liabilities:		
Other intangible assets	(1,907)	(3,017)
Capitalized software	(524)	(670)
Depreciation and amortization	(258)	(352)
Prepaid expenses	(240)	(239)
Outside basis in partnerships	(290)	(137)
Total deferred income tax liabilities	<u>(3,219)</u>	<u>(4,415)</u>
Net deferred income tax liabilities	<u>\$ (2,189)</u>	<u>\$ (2,884)</u>

On December 22, 2017, the U.S. federal government enacted a tax bill, H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (Tax Reform). Tax Reform changed existing United States tax law including a reduction of the U.S. corporate tax rate. The Company re-measured deferred taxes as of the date of enactment which resulted in the \$1.2 billion reduction of net deferred income tax liabilities. The Company's measurement of the income tax effects of Tax Reform for the year ended December 31, 2017 is reasonably estimated and, therefore, included in these financial statements.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of \$227 million expire beginning in 2022 through 2037; state net operating loss carryforwards expire beginning in 2018 through 2037. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2017, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

<u>(in millions)</u>	<u>2017</u>	<u>2016</u>
Gross unrecognized tax benefits, beginning of period	\$ 116	\$ 91
Gross increases:		
Current year tax positions	229	37
Prior year tax positions	27	-
Gross decreases:		
Prior year tax positions	(33)	-
Settlements	(1)	-
Statute of limitations lapses	(4)	(12)
Gross unrecognized tax benefits, end of period	<u>\$ 334</u>	<u>\$ 116</u>

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by \$73 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. The Company had \$12 million and \$17 million of accrued interest and penalties for uncertain tax positions as of December 31, 2017 and 2016, respectively. These amounts are not included in the reconciliation above. As of December 31, 2017, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was \$326 million.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on UHG's consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, UHS is no longer subject to income tax examinations prior to the 2011 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2012 and forward.

10. Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries in the U.S. are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the U.S., most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary, and are limited based on the regulated subsidiary's level of statutory net income, and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered to be an "extraordinary dividend" and must receive prior regulatory approval.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately \$15.1 billion as of December 31, 2017. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately \$6.7 billion as of December 31, 2017.

Optum Bank, Inc. (the Bank), a subsidiary of UHS, must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, common equity Tier 1 risk-based capital, and total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2017, the Company believes the Bank met the FDIC requirements to be considered "Well Capitalized."

11. Share-Based Compensation and Other Employee Benefit Plans

The Company's outstanding UHG share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2017, UHG had 51 million shares available for future grants of share-based awards under the Plan. As of December 31, 2017, there were also 9 million shares of UHG common stock available for issuance under the ESPP.

Stock Options and SARs

The Company's portion of UHG stock option and SAR activity for the year ended December 31, 2017 is summarized in the table below:

	Shares (in millions)	Weighted- Average Exercise Price	Weighted- Average Remaining Contractual Life (in years)	Aggregate Intrinsic Value (in millions)
Outstanding, beginning of period	34	\$ 83		
Granted	13	107		
Exercised	(11)	53		
Forfeited	(1)	125		
Outstanding, end of period	<u>35</u>	100	6.6	\$ 4,172
Exercisable, end of period	14	\$ 64	4.8	\$ 2,269
Vested and expected to vest, end of period	34	99	6.6	4,104

Restricted Shares

Restricted share activity for the year ended December 31, 2017 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested, beginning of period	7	\$ 96
Granted	2	161
Vested	(3)	84
Nonvested, end of period	<u>6</u>	127

Other Share-Based Compensation Data

<u>(in millions, except per share amounts)</u>	<u>For the Years Ended December 31,</u>	
	<u>2017</u>	<u>2016</u>
Stock Options and SARs		
Weighted-average grant date fair value of shares granted, per share	\$ 29	\$ 20
Total intrinsic value of stock options and SARs exercised	1,389	528
Restricted Shares		
Weighted-average grant date fair value of shares granted, per share	\$ 161	\$ 114
Total fair value of restricted shares vested	435	267
Employee Stock Purchase Plan		
Number of shares purchased	2	2
Share-Based Compensation Items		
Share-based compensation expense, before tax	\$ 575	\$ 466
Share-based compensation expense, net of tax effects	497	400
Income tax benefit realized from share-based award exercises	425	227

<u>(in millions)</u>	<u>December 31,</u>
	<u>2017</u>
Unrecognized compensation expense related to share awards	\$ 554
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant date fair value for stock options and SARs were as follows:

	<u>For the Years Ended December 31,</u>	
	<u>2017</u>	<u>2016</u>
Risk-free interest rate	1.9% - 2.1%	1.2% - 1.4%
Expected volatility	18.5% - 20.7%	20.8% - 22.5%
Expected dividend yield	1.4% - 1.6%	1.8%
Forfeiture rate	5.0%	5.0%
Expected life in years	5.7	5.6 - 5.9

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of UHG's common stock and the implied volatility from exchange-traded options on UHG's common stock. Expected dividend yields are based on the per share cash dividend paid by UHG. UHG uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represent the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

UHG also offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2017 and 2016.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus, and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments, with an approximately equal amount in other liabilities, in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan, and were \$848 million and \$655 million as of December 31, 2017 and 2016, respectively.

12. Related-Party Transactions

Management Service Agreements – The Company provides administrative services to operate and manage the businesses of its subsidiaries and affiliates under management service agreements that require these subsidiaries and affiliates to pay the Company a monthly administrative fee. These fees cover employee compensation, occupancy, depreciation, marketing, utilization review and case management services, professional fees and other administrative services. Fees charged to the Company’s subsidiaries are eliminated in the Consolidated Financial Statements. Management contract and other administrative fees charged to affiliates were \$2.0 billion and \$1.8 billion in 2017 and 2016, respectively, and are included in service revenues in the Consolidated Statements of Operations.

Pharmacy Care Services – The Company’s pharmacy care services businesses provide services to other UHS subsidiaries and affiliates. Revenues attributable to UHS subsidiaries are eliminated in the Consolidated Financial Statements. Pharmacy revenues from affiliates were \$3.3 billion and \$2.9 billion in 2017 and 2016, respectively, and are included in product revenues in the Consolidated Statements of Operations.

Services Agreements – Effective July 2016, the Company executed services agreements (Agreements) with its affiliate (Affiliate), whereby each party provides specialized services to the other. Under the terms of the Agreements, the Affiliate provides operating services – including coordination of benefits, high dollar claim audits, audit recovery operations, payment integrity pipeline management, advanced research analytics, and other services – to UHS, while UHS provides business referrals and support services to the Affiliate. For the years ended December 31, 2017 and 2016, UHS recognized \$462 million and \$136 million in related services revenues, respectively, and was charged \$2.2 billion and \$594 million in selling, general and administrative expenses, respectively in the Consolidated Statements of Operations. Prepayments of \$2.6 billion and unearned revenues of \$800 million are included in Related-party receivables, net in the Consolidated Balance Sheets.

See Note 8 for details pertaining to the Company’s long-term notes payable to related party.

13. Commitments and Contingencies

Leases

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2017 and 2016 was \$641 million and \$554 million, respectively.

At December 31, 2017, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

<u>(in millions)</u>	<u>Future Minimum Lease Payments</u>
2018	\$ 473
2019	410
2020	361
2021	302
2022	248
Thereafter	801

Performance Guarantees and Other

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of and for the years ended December 31, 2017 and 2016.

As of December 31, 2017, the Company had outstanding, undrawn letters of credit with financial institutions of \$70 million, and surety bonds outstanding with insurance companies of \$1.4 billion, primarily to bond contractual performance.

Pending Acquisition

In December 2017, the Company entered into an agreement to acquire a company in the health care sector for approximately \$4.9 billion. The acquisition is expected to close later in 2018, subject to regulatory approval and other customary closing conditions.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries – including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators – relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers, and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against UHG and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that UHG, along with a number of other Medicare

Advantage plans, made improper risk adjustment submissions and violated the False Claims Act. On March 24, 2017, the DOJ intervened in a separate lawsuit initially asserted against UHG and filed by a whistleblower in 2009 concerning risk adjustment submissions by Medicare Advantage plans. On October 5, 2017, in one of the cases, the district court dismissed certain of DOJ's claims with prejudice, and dismissed all of DOJ's remaining claims with leave to file a further amended complaint; on October 12, the DOJ filed a notice of dismissal without prejudice of the case. The other case is now pending in the U.S. District Court for the Central District of California. The Company cannot reasonably estimate the outcome that may result from these matters given their current posture.

14. Subsequent Events

In preparing these Consolidated Financial Statements, management has evaluated and disclosed all material subsequent events up to February 26, 2018, the date that these Consolidated Financial Statements were issued.

* * * * *

2017 CONSOLIDATING SCHEDULES

United HealthCare Services, Inc. and Subsidiaries
Consolidating Balance Sheets
As of December 31, 2017

	United HealthCare Services, Inc.	United Behavioral Health	All Other Businesses	Eliminations	Consolidated UHS
Assets					
Current assets:					
Cash and cash equivalents	\$ 148,000,000	\$ 97,009,171	\$ 9,336,990,829	\$ -	\$ 9,582,000,000
Short-term investments	3,000,000	-	3,008,000,000	-	3,011,000,000
Accounts receivable, net	59,000,000	9,123,543	8,600,876,457	-	8,669,000,000
Current maturities of long-term notes receivable from related party	-	-	206,000,000	(206,000,000)	-
Other current receivables, net	203,000,000	20,904,060	5,549,095,940	-	5,773,000,000
Assets under management	-	-	3,101,000,000	-	3,101,000,000
Related-party receivables, net	-	247,409,614	8,145,590,386	(6,686,000,000)	1,707,000,000
Prepaid expenses and other current assets	387,000,000	711,801	2,162,288,199	-	2,550,000,000
Total current assets	800,000,000	375,158,189	40,109,841,811	(6,892,000,000)	34,393,000,000
Long-term investments	977,000,000	-	22,770,000,000	-	23,747,000,000
Property, equipment and capitalized software, net	2,169,000,000	28,028,419	3,347,971,581	(280,000,000)	5,265,000,000
Goodwill	9,038,000,000	22,501,842	37,525,498,158	-	46,586,000,000
Other intangible assets, net	213,000,000	93,348	7,366,906,652	-	7,580,000,000
Equity in net assets of subsidiaries	62,943,000,000	578,935	(578,935)	(62,943,000,000)	-
Other assets	52,000,000	-	1,950,000,000	-	2,002,000,000
Total assets	\$ 76,192,000,000	\$ 426,360,733	\$ 113,069,639,267	\$ (70,115,000,000)	\$ 119,573,000,000
Liabilities, redeemable noncontrolling interests and equity					
Current liabilities:					
Medical costs payable	\$ -	\$ 224,180,598	\$ 15,134,819,402	\$ -	\$ 15,359,000,000
Accounts payable and accrued liabilities	3,758,000,000	47,978,401	9,465,021,599	-	13,271,000,000
Unearned revenues	52,000,000	3,686,230	1,944,313,770	-	2,000,000,000
Current maturities of long-term notes payable to related party	206,000,000	-	-	(206,000,000)	-
Related-party payables, net	6,686,000,000	-	-	(6,686,000,000)	-
Other current liabilities	639,000,000	78,160,476	11,156,839,524	-	11,874,000,000
Total current liabilities	11,341,000,000	354,005,705	37,700,994,295	(6,892,000,000)	42,504,000,000
Long-term notes payable to related party, less current maturities	-	-	4,430,000,000	-	4,430,000,000
Deferred income taxes	257,000,000	10,826,882	1,921,173,118	-	2,189,000,000
Other liabilities	1,278,000,000	-	2,778,000,000	(280,000,000)	3,776,000,000
Total liabilities	12,876,000,000	364,832,587	46,830,167,413	(7,172,000,000)	52,899,000,000
Redeemable noncontrolling interests	-	-	1,301,000,000	-	1,301,000,000
Equity:					
Common stock	-	1,765	12,998,235	(13,000,000)	-
Additional paid-in capital	49,065,000,000	16,470,939	43,595,529,061	(43,612,000,000)	49,065,000,000
Retained earnings	14,298,000,000	45,055,975	19,322,944,025	(19,368,000,000)	14,298,000,000
Accumulated other comprehensive loss	(47,000,000)	(533)	(49,999,467)	50,000,000	(47,000,000)
Nonredeemable noncontrolling interest	-	-	2,057,000,000	-	2,057,000,000
Total equity	63,316,000,000	61,528,146	64,938,471,854	(62,943,000,000)	65,373,000,000
Total liabilities, redeemable noncontrolling interests and equity	\$ 76,192,000,000	\$ 426,360,733	\$ 113,069,639,267	\$ (70,115,000,000)	\$ 119,573,000,000

See Notes to the Consolidating Schedules

United HealthCare Services, Inc. and Subsidiaries
Consolidating Statements of Operations
For the Year Ended December 31, 2017

	United HealthCare Services, Inc.	United Behavioral Health	All Other Businesses	Eliminations	Consolidated UHS
Revenues:					
Premiums	\$ -	\$ 1,701,139,038	\$ 133,962,860,962	\$ -	\$ 135,664,000,000
Products	-	-	29,668,000,000	-	29,668,000,000
Services	14,688,000,000	484,480,689	14,561,519,311	(13,823,000,000)	15,911,000,000
Investment and other income	12,000,000	408,767	786,591,233	(10,000,000)	789,000,000
Total revenues	14,700,000,000	2,186,028,494	178,978,971,506	(13,833,000,000)	182,032,000,000
Operating costs:					
Medical costs	-	1,504,610,457	110,064,389,543	-	111,569,000,000
Selling, general and administrative expenses	14,106,000,000	536,610,407	28,037,389,593	(13,823,000,000)	28,857,000,000
Cost of products sold	-	-	27,184,000,000	-	27,184,000,000
Depreciation and amortization	428,000,000	10,022,769	1,555,977,231	-	1,994,000,000
Total operating costs	14,534,000,000	2,051,243,633	166,841,756,367	(13,823,000,000)	169,604,000,000
Earnings from operations	166,000,000	134,784,861	12,137,215,139	(10,000,000)	12,428,000,000
Interest expense - related-party	(10,000,000)	-	(202,000,000)	10,000,000	(202,000,000)
Earnings before income taxes	156,000,000	134,784,861	11,935,215,139	-	12,226,000,000
Benefit from (provision for) income taxes	254,000,000	(46,542,068)	(3,276,457,932)	-	(3,069,000,000)
Net earnings	410,000,000	88,242,793	8,658,757,207	-	9,157,000,000
Equity in undistributed income (loss) of subsidiaries	8,478,000,000	(11,757,850)	11,757,850	(8,478,000,000)	-
Earnings attributable to noncontrolling interests	-	-	(269,000,000)	-	(269,000,000)
Net earnings attributable to shareholder	\$ 8,888,000,000	\$ 76,484,943	\$ 8,401,515,057	\$ (8,478,000,000)	\$ 8,888,000,000

See Notes to the Consolidating Schedules

United HealthCare Services, Inc. and Subsidiaries
Consolidating Statements of Cash Flows
For the Year Ended December 31, 2017

	United HealthCare Services, Inc.	United Behavioral Health	All Other Businesses	Eliminations	Consolidated UHS
Operating activities:					
Net earnings	\$ 8,888,000,000	\$ 76,484,943	\$ 8,670,515,057	\$ (8,478,000,000)	\$ 9,157,000,000
Noncash items:					
Depreciation and amortization	428,000,000	10,022,769	1,555,977,231	-	1,994,000,000
Deferred income taxes	(144,000,000)	(3,447,552)	(841,552,448)	-	(989,000,000)
Share-based compensation	505,000,000	-	66,000,000	-	571,000,000
Equity in undistributed income of subsidiaries	(8,478,000,000)	11,757,850	(11,757,850)	8,478,000,000	-
Other, net	45,000,000	-	349,000,000	-	394,000,000
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:					
Accounts receivable	37,000,000	(1,438,421)	(942,561,579)	-	(907,000,000)
Other assets	(90,000,000)	5,504,743	(833,504,743)	-	(918,000,000)
Medical costs payable	-	(11,980,710)	1,589,980,710	-	1,578,000,000
Accounts payable and other liabilities	489,000,000	8,548,309	1,178,451,691	-	1,676,000,000
Unearned revenues	(4,000,000)	(343,670)	187,343,670	-	183,000,000
Related-party receivables/payables, net	5,180,000,000	105,692,821	(7,394,692,821)	-	(2,109,000,000)
Dividends received from subsidiaries	2,897,000,000	3,500,000	(3,500,000)	(2,897,000,000)	-
Cash flows from operating activities	<u>9,753,000,000</u>	<u>204,301,082</u>	<u>3,569,698,918</u>	<u>(2,897,000,000)</u>	<u>10,630,000,000</u>
Investing activities:					
Purchases of investments	(21,000,000)	-	(12,488,000,000)	-	(12,509,000,000)
Sales of investments	47,000,000	-	3,205,000,000	-	3,252,000,000
Maturities of investments	-	-	4,753,000,000	-	4,753,000,000
Cash assumed from (paid for) acquisitions, net	6,000,000	-	(201,000,000)	-	(195,000,000)
Purchases of property, equipment and capitalized software	(577,000,000)	(8,202,036)	(1,247,797,964)	-	(1,833,000,000)
Receivable from UHG	(1,427,000,000)	(200,404,690)	1,627,404,690	-	-
Capital contributions made to subsidiaries	(425,000,000)	(10,000,000)	10,000,000	425,000,000	-
Capital distributions received from subsidiaries	820,000,000	-	-	(820,000,000)	-
Repayments of notes receivable from related party	3,000,000	-	-	(3,000,000)	-
Issuance of notes payable to related party	-	-	(90,000,000)	90,000,000	-
Other, net	-	-	(155,000,000)	-	(155,000,000)
Cash flows used for investing activities	<u>(1,574,000,000)</u>	<u>(218,606,726)</u>	<u>(4,586,393,274)</u>	<u>(308,000,000)</u>	<u>(6,687,000,000)</u>
Financing activities:					
Cash dividends paid to shareholder	(3,671,000,000)	(103,500,000)	(2,793,500,000)	2,897,000,000	(3,671,000,000)
Capital distributions paid to shareholder	(2,750,000,000)	-	(820,000,000)	820,000,000	(2,750,000,000)
Capital contributions received from shareholder	9,000,000	-	416,000,000	(425,000,000)	-
Payable to UHG	(2,080,000,000)	-	3,641,000,000	-	1,561,000,000
Proceeds from issuance of (repayments of) notes payable to related party, net	90,000,000	-	(769,000,000)	(87,000,000)	(766,000,000)
Customer funds administered	143,000,000	-	2,943,000,000	-	3,086,000,000
Other, net	131,000,000	(3,712,765)	(200,287,235)	-	(73,000,000)
Cash flows (used for) from financing activities	<u>(8,128,000,000)</u>	<u>(107,212,765)</u>	<u>2,417,212,765</u>	<u>3,205,000,000</u>	<u>(2,613,000,000)</u>
Increase (decrease) in cash and cash equivalents	<u>51,000,000</u>	<u>(121,518,409)</u>	<u>1,400,518,409</u>	<u>-</u>	<u>1,330,000,000</u>
Cash and cash equivalents, beginning of period	<u>97,000,000</u>	<u>218,527,580</u>	<u>7,936,472,420</u>	<u>-</u>	<u>8,252,000,000</u>
Cash and cash equivalents, end of period	<u>\$ 148,000,000</u>	<u>\$ 97,009,171</u>	<u>\$ 9,336,990,829</u>	<u>\$ -</u>	<u>\$ 9,582,000,000</u>

See Notes to the Consolidating Schedules

United HealthCare Services, Inc. and Subsidiaries
Notes to the Consolidating Schedules

1. Description of Business

The descriptions below of UHS and certain of its subsidiaries expand upon the summarized description presented in Note 1 of Notes to the Consolidated Financial Statements. The Company conducts business activities through hundreds of diversified, affiliated companies, of which UHS and United Behavioral Health (individually and collectively, the Reporting Entities) are presented on a stand-alone basis in these Consolidating Schedules. Following are brief descriptions of the Reporting Entities' business activities:

- *United HealthCare Services, Inc.* – provides management, general administration and operational support services – including banking, human resources, tax and legal services – to affiliated entities, and premium and claims administration services to both affiliates and third parties.
- *United Behavioral Health* – with its subsidiaries, primarily engages in managed behavioral health care services for employers, insurers, and union trusts.

2. Basis of Presentation

The Reporting Entities' consolidating financial information has been derived from, and should be read in conjunction with, the attached Consolidated Financial Statements. Accounting policies for the Reporting Entities are the same as those described in Note 2 of Notes to the Consolidated Financial Statements.

3. Subsidiary and Related Party Transactions

Investment in Subsidiaries – Each Reporting Entity's investment in subsidiaries – if applicable – is stated at cost, plus equity in undistributed earnings of subsidiaries, and is included in equity in net assets of subsidiaries in the Consolidating Balance Sheets.

Net earnings/loss from subsidiaries is included in equity in undistributed income of subsidiaries in the Consolidating Statements of Operations.

Notes Payable to Related Party – In September 2015, UHS issued unsecured demand notes payable to a related party (the Lender). UHS may request additional loans from the Lender and may pre-pay the interest and/or principal at any time in whole or in part without premium or penalty.

UHS's demand notes payable to related party is included in current maturities of long-term notes payable to related party in the Consolidating Balance Sheets as of December 31, 2017, and consisted of the following:

<u>Interest Rate</u>	<u>Maturity Date</u>	<u>Principal Amount</u>	<u>Interest Payable</u>
USD LIBOR plus a variable spread - 0.2721% at December 31, 2017	On demand	\$ 206,000,000	On demand

Eliminations – Intercompany transactions and balances are eliminated in consolidation. Eliminations between UHS and its subsidiaries (including other Reporting Entities) are reflected in the "Eliminations" column in the Consolidating Schedules, while elimination of balances and activities between UHS subsidiaries are included in the "All Other Businesses" column.

Related-Party Receivables (Payables), net – Related-party receivables (payables) are presented net for each Reporting Entity in the Consolidating Balance Sheets.

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 13 of Notes to the Consolidated Financial Statements.

Attachment H.b

UnitedHealth Group 10K for

the Period Ending

December 31, 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2018

or

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	41-1321939 (I.R.S. Employer Identification No.)
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UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota (Address of principal executive offices)	55343 (Zip Code)
---	---------------------

(952) 936-1300

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, \$.01 PAR VALUE (Title of each class)	NEW YORK STOCK EXCHANGE, INC. (Name of each exchange on which registered)
--	--

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>	Non-accelerated filer	<input type="checkbox"/>
Smaller reporting company	<input type="checkbox"/>			Emerging growth company	<input type="checkbox"/>

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes No

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2018 was \$234,490,429,732 (based on the last reported sale price of \$245.34 per share on June 30, 2018, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2019, there were 959,538,515 shares of the registrant's Common Stock, \$.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2019 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. The terms “we,” “our,” “us,” “its,” “UnitedHealth Group,” or the “Company” used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes the provision of health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2018, we processed more than three-quarters of a trillion dollars in gross billed charges and we managed more than \$250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare’s market position is built on:

- strong local-market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum’s capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.3 million physicians and other health care professionals and more than 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under “Government Regulation” and in Part II, Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations.”

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. UnitedHealthcare Employer & Individual provides access to medical services for 27 million people on behalf of our customers and alliance partners, including employer customers serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees’ dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees’ dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual’s distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual’s diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual’s major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals’ responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual’s clinical programs include:

- wellness programs;
- decision support;

- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing, life, transportation, critical illness and disability product offerings using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 4.9 million people through its Medicare Advantage products as of December 31, 2018.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through our HouseCalls program, nurse practitioners performed 1.5 million in-home preventive care visits in 2018 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams

to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2018, UnitedHealthcare enrolled 9.0 million people in the Medicare Part D programs, including 4.7 million individuals in the stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.9 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 30% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2018, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and people without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF), Children's Health Insurance Programs (CHIP), Dual SNPs (DSNPs), Aged, Blind and Disabled and other federal, state and community health care programs. As of December 31, 2018, UnitedHealthcare Community & State participated in programs in 30 states and the District of Columbia, and served 6.5 million people; including 1 million people through Medicaid expansion programs in 15 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can affect people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% who are most at risk drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global serves 6.2 million people with medical benefits, residing principally in Brazil, Chile, Colombia and Peru but also in more than 130 other countries. UnitedHealthcare Global owns and operates more than 300 hospitals, specialty centers, primary care and emergency services clinics in South America and Portugal. UnitedHealthcare Global provides a comprehensive range of health and mobilization capabilities and supports the health systems of individual nations with support for improving health care financing and delivery. Clients include multi-national and local businesses, governments and individual consumers around the world.

Global Markets. UnitedHealthcare Global serves local populations in select markets around the world, primarily in Brazil; Chile; Colombia; Peru; and Portugal, by touching nearly every aspect of health care and leveraging expertise in clinical care management and health care data to improve outcomes, raise quality and constrain costs.

In Brazil, Amil provides health benefits to 4.1 million people through a broad network of owned and affiliated clinics, hospitals and care providers. Dental benefits are also provided to 2.2 million people. Amil's members have access to a provider network of physicians and other health care professionals, hospitals, laboratories and diagnostic imaging centers. Americas Serviços Médicos offers health care delivery in Brazil through hospitals, ambulatory clinics and surgery centers to Amil members and consumers served by the external payer market.

Empresas Banmédica provides health benefits and health care services to 2.1 million people in Chile, Colombia and Peru through a network of owned and affiliated clinics, hospitals and care providers. Empresas Banmédica owns and operates hospitals, clinics and outpatient centers.

Lusiadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

Global Solutions. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers.

Optum

Optum is a technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 93 million unique individuals. OptumHealth enables population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of more than 35,000 employed, managed or contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that improve the focus on patient health and outcomes, such as those emerging through

accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care. MedExpress' neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach and Surgical Care Affiliates' independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a substantially lower cost than a traditional in-patient hospital setting.

OptumServe provides a wide range of health services specifically tailored to active military and veterans and the agencies that support them.

OptumHealth serves people through population health services that meet both the preventive care and health intervention needs of consumers across the care continuum - physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 5.2 million health savings and other accounts approaching \$10 billion in assets under management as of December 31, 2018. During 2018, Optum Bank processed nearly \$160 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, the Department of Defense, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on technology, research and consulting and managed services that help improve the quality of care and drive greater efficiency in the health care system. Technology includes population health and risk analytics, administrative and clinical technology for claims editing, risk adjustment and payment integrity, health information and electronic data exchange and technology strategy and management. Research and consulting helps organizations reduce administrative costs and implement best practices to improve clinical performance. Managed services provides solutions such as revenue cycle management, risk analytics, payment integrity outsourcing and state Medicaid data and technology management. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2018 was \$17.0 billion, of which \$8.6 billion is expected to be realized within the next 12 months. The aggregate backlog includes \$6.2 billion related to intersegment agreements. OptumInsight's aggregate backlog at December 31, 2017, was \$15.0 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers meet these challenges, with particular focus on clinical performance and quality improvement, population health, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves three out of four U.S. health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and compounding pharmacies and through the provision of home infusion services. In 2018, OptumRx added capabilities in managing limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology as well as capabilities to serve the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2018, OptumRx managed \$91 billion in pharmaceutical spending, including \$40 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that affect member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care, using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and members.

As of December 31, 2018, OptumRx operated four home delivery pharmacies in the United States, which provide patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2018, OptumRx's specialty pharmacy operations included more than 70 specialty and infusion pharmacies located throughout the United States that are used for delivery of advanced medications to people with chronic or genetic diseases and disorders. OptumRx also operates community mental health facility pharmacies, which help align benefits, care management and pharmacy services for those living with complex, chronic medical and behavioral health issues.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust compliance.

The Tax Cuts and Jobs Act. In December 2017, the U.S. federal government enacted a tax bill (Tax Cuts and Jobs Act or Tax Reform). The Tax Cuts and Jobs Act changed existing United States tax law and included numerous provisions that affected our results of operations, financial position and cash flows. For instance, Tax Reform reduced the U.S. corporate income tax rate and changed business-related exclusions and deductions and credits.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation.

The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx's businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery, specialty and compounding pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our home delivery, specialty and compounding pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery, specialty and compounding pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Additionally, certain of our pharmacies that participate in programs for Medicare and state Medicaid providers are required to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve, which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, “Risk Factors” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2018, we employed 300,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2019, including the business experience of each executive officer during the past five years:

<u>Name</u>	<u>Age</u>	<u>Position</u>
Stephen J. Hemsley	66	Executive Chair of the Board
David S. Wichmann.....	56	Chief Executive Officer
Steven H. Nelson.....	59	Executive Vice President; Chief Executive Officer of UnitedHealthcare
Andrew P. Witty.....	54	Executive Vice President; Chief Executive Officer of Optum
John F. Rex	56	Executive Vice President; Chief Financial Officer
Thomas E. Roos.....	46	Senior Vice President; Chief Accounting Officer
Marianne D. Short	67	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	61	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Executive Chair of the Board of UnitedHealth Group and has served in that capacity since September 2017. Mr. Hemsley previously served as Chief Executive Officer from 2006 to August 2017. He has been a member of the Board of Directors since 2000.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June

2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Nelson is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since August 2017. Mr. Nelson served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement, from March 2014 to August 2017. He served as Chief Executive Officer of UnitedHealthcare Community & State from August 2012 to March 2014. From January 2008 to July 2012 he served as President of UnitedHealthcare Community & State and then as Chief Executive Officer of UnitedHealthcare Employer & Individual's West Region business.

Mr. Witty is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2018. He previously served as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, Mr. Witty was CEO and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at www.unitedhealthgroup.com to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words "believe," "expect,"

“intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer’s premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, or effectively price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2018 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2018 would have been reduced by approximately \$305 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Any such assessment could

expose our insurance entities and other insurers to the risk that they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified or repealed or replaced. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part; and a federal district court struck down the ACA in its entirety as unconstitutional in 2018. That opinion has been stayed and appealed. Further, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while the Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations that could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. For example, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and corporate integrity agreements. Additionally, such investigations, audits or reviews sometimes arise out of, or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we sustain cyber-attacks or other privacy or data security incidents that result in security breaches that disrupt our operations or result in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place that are intended to detect, contain and respond to data security incidents and that provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns that could negatively affect our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human error; malicious social engineering; or other events that could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use protected personal information and imposed additional compliance requirements on our business.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded

prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, goes into effect in 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the FDA and Boards of Pharmacy. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger

and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services that are useful and relevant to consumers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage, and we may face challenges from new technologies and market entrants that could affect our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or

otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, such actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2018. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2018, our goodwill and other intangible assets had a carrying value of \$68 billion, representing 45% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the financial covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary

information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2019, there were 11,948 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2018, our Board of Directors increased the Company's annual cash dividend rate to shareholders to \$3.60 per share compared to \$3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2018, we repurchased 3.3 million shares at an average price of \$256.15 per share. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock.

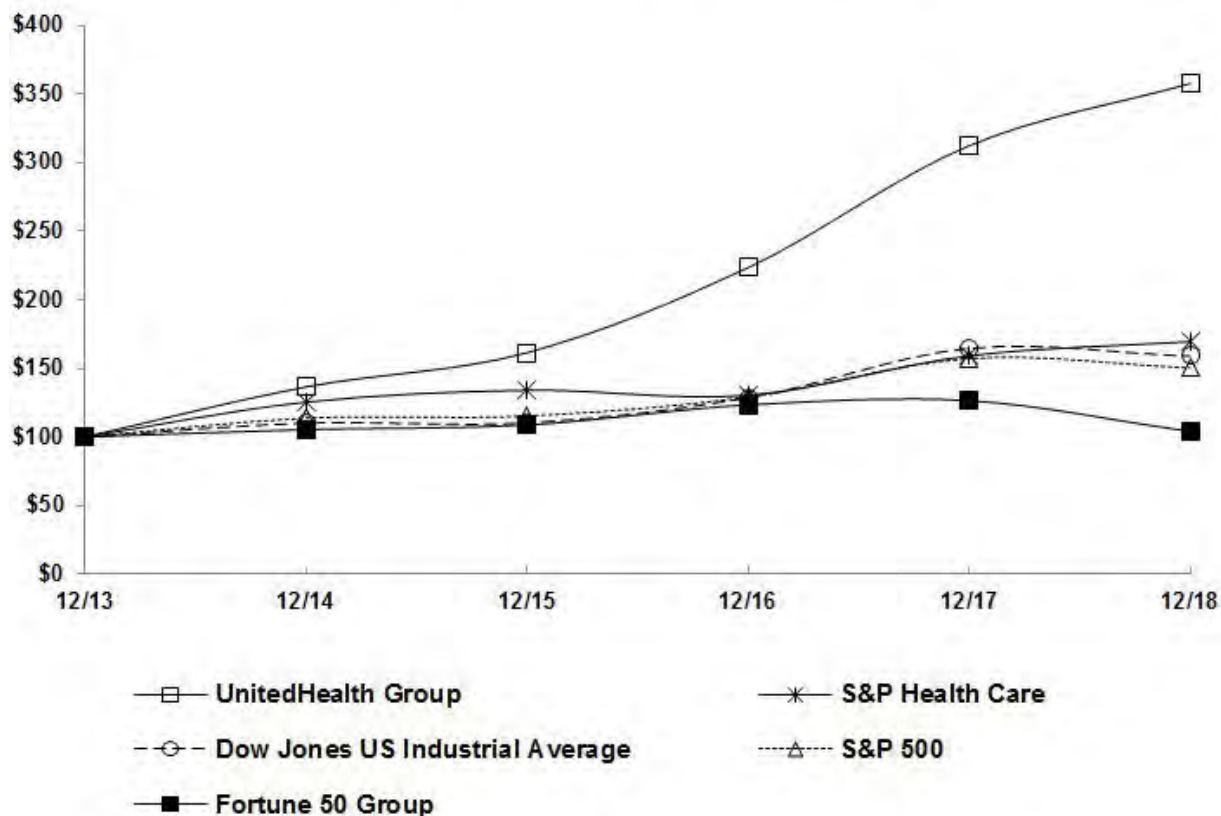
PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index, the S&P Health Care Index and the Dow Jones US Industrial Average Index for the five-year period ended December 31, 2018. We have also included the customized peer group of certain *Fortune 50* companies that we have compared ourselves to in prior years. We believe that these indices provide a more meaningful comparison than the previous subset of the Fortune 50 given our diverse businesses. The comparisons assume the investment of \$100 on December 31, 2013 in our common stock and in each index, and that dividends were reinvested when paid.

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. We are not included in this *Fortune 50* Group index. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies are weighted according to the stock market capitalizations of the companies at January 1 of each year.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index, the S&P 500 Index, and Fortune 50 Group



	12/13	12/14	12/15	12/16	12/17	12/18
UnitedHealth Group	\$ 100.00	\$ 136.46	\$ 161.37	\$ 223.35	\$ 312.29	\$ 357.64
S&P Health Care Index	100.00	125.34	133.97	130.37	159.15	169.44
Dow Jones US Industrial Average	100.00	110.04	110.28	128.47	164.58	158.85
S&P 500 Index	100.00	113.69	115.26	129.05	157.22	150.33
Fortune 50 Group	100.00	105.33	108.75	123.33	126.45	103.96

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Years Ended December 31,				
	2018	2017 (a)	2016	2015 (b)	2014
Consolidated operating results					
Revenues.....	\$ 226,247	\$ 201,159	\$ 184,840	\$ 157,107	\$ 130,474
Earnings from operations	17,344	15,209	12,930	11,021	10,274
Net earnings attributable to UnitedHealth Group common shareholders	11,986	10,558	7,017	5,813	5,619
Return on equity (c).....	24.4%	24.4%	19.4%	17.7%	17.3%
Basic earnings per share attributable to UnitedHealth Group common shareholders	\$ 12.45	\$ 10.95	\$ 7.37	\$ 6.10	\$ 5.78
Diluted earnings per share attributable to UnitedHealth Group common shareholders	12.19	10.72	7.25	6.01	5.70
Cash dividends declared per common share	3.45	2.875	2.375	1.875	1.405
Consolidated cash flows from (used for)					
Operating activities.....	\$ 15,713	\$ 13,596	\$ 9,795	\$ 9,740	\$ 8,051
Investing activities.....	(12,385)	(8,599)	(9,355)	(18,395)	(2,534)
Financing activities.....	(4,365)	(3,441)	(1,011)	12,239	(5,293)
Consolidated financial condition					
(as of December 31)					
Cash and investments	\$ 46,834	\$ 43,831	\$ 37,143	\$ 31,703	\$ 28,063
Total assets.....	152,221	139,058	122,810	111,254	86,300
Total commercial paper and long-term debt.....	36,554	31,692	32,970	31,965	17,324
Redeemable noncontrolling interests	1,908	2,189	2,012	1,736	1,388
Total equity	54,319	49,833	38,177	33,725	32,454

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to Tax Reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

This selected financial data should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements and Supplementary Data." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding

financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, “Risk Factors.”

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data analytics and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, “Business” and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2018 federal budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover a portion of calendar year 2019 reflected the impact of the moratorium. The industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in “Regulatory Trends and Uncertainties.”

We expect continued Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2018, we served nearly 17 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2018, our contracts with value-based elements totaled \$74 billion in annual spending, including \$18 billion through risk-transfer agreements.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business - Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2019 Medicare Advantage rates resulted in an increase in industry base rates of 3.4%, short of the industry forward medical cost trend, which creates continued pressure in the Medicare Advantage program.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products, such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

Tax Reform. Tax Reform was enacted by the U.S federal government in December 2017, changing existing United States tax law, including reducing the U.S. corporate income tax rate. In 2018, the impact of Tax Reform was partially offset by the return of the nondeductible Health Insurance Industry Tax.

Health Insurance Industry Tax. After a moratorium in 2017, the industry-wide amount of the Health Insurance Industry Tax in 2018 was \$14.3 billion, with our portion being \$2.6 billion. The return of the tax impacted year-over-year comparability of our financial results, including revenues, the medical care ratio (MCR), operating cost ratio and effective tax rate. A one year moratorium is imposed on the collection of the Health Insurance Industry Tax in 2019.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2018 year-over-year operating comparisons to 2017.

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased 12% and Optum revenues grew 11%.
- UnitedHealthcare's addition of 2.2 million people through acquisition and 250,000 through organic growth was offset by 2.9 million fewer people served as a result of completion of its commitment under the TRICARE military health care program.
- Earnings from operations increased by 14%, including increases of 7% at UnitedHealthcare and 23% at Optum.
- Diluted earnings per common share increased 14% to \$12.19.
- Cash flows from operations were \$15.7 billion, an increase of 16%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31,			Change		Change	
	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
Revenues:							
Premiums	\$ 178,087	\$ 158,453	\$ 144,118	\$ 19,634	12%	\$ 14,335	10%
Products.....	29,601	26,366	26,658	3,235	12	(292)	(1)
Services	17,183	15,317	13,236	1,866	12	2,081	16
Investment and other income	1,376	1,023	828	353	35	195	24
Total revenues	<u>226,247</u>	<u>201,159</u>	<u>184,840</u>	<u>25,088</u>	12	<u>16,319</u>	9
Operating costs:							
Medical costs	145,403	130,036	117,038	15,367	12	12,998	11
Operating costs.....	34,074	29,557	28,401	4,517	15	1,156	4
Cost of products sold	26,998	24,112	24,416	2,886	12	(304)	(1)
Depreciation and amortization.....	2,428	2,245	2,055	183	8	190	9
Total operating costs	<u>208,903</u>	<u>185,950</u>	<u>171,910</u>	<u>22,953</u>	12	<u>14,040</u>	8
Earnings from operations.....	17,344	15,209	12,930	2,135	14	2,279	18
Interest expense.....	(1,400)	(1,186)	(1,067)	(214)	18	(119)	11
Earnings before income taxes	15,944	14,023	11,863	1,921	14	2,160	18
Provision for income taxes.....	(3,562)	(3,200)	(4,790)	(362)	11	1,590	(33)
Net earnings	12,382	10,823	7,073	1,559	14	3,750	53
Earnings attributable to noncontrolling interests	(396)	(265)	(56)	(131)	49	(209)	373
Net earnings attributable to UnitedHealth Group common shareholders	<u>\$ 11,986</u>	<u>\$ 10,558</u>	<u>\$ 7,017</u>	<u>\$ 1,428</u>	14%	<u>\$ 3,541</u>	50%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	\$ 12.19	\$ 10.72	\$ 7.25	\$ 1.47	14%	\$ 3.47	48%
Medical care ratio (a)	81.6%	82.1%	81.2%	(0.5)%		0.9%	
Operating cost ratio.....	15.1	14.7	15.4	0.4		(0.7)	
Operating margin	7.7	7.6	7.0	0.1		0.6	
Tax rate.....	22.3	22.8	40.4	(0.5)		(17.6)	
Net earnings margin (b)	5.3	5.2	3.8	0.1		1.4	
Return on equity (c)	24.4%	24.4%	19.4%	— %		5.0%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2018 RESULTS OF OPERATIONS COMPARED TO 2017 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through risk-based products across our UnitedHealthcare benefits businesses; pricing trends, including the Health Insurance Industry Tax in 2018; and growth across the Optum business, primarily due to expansion and growth in care delivery, pharmacy care services, managed services and advisory services.

Medical Costs and MCR

Medical costs increased due to growth in people served through risk-based products and medical cost trends. The MCR decreased due to the revenue effects of the Health Insurance Industry Tax, which more than offset business mix changes and a lower level of favorable reserve development.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31,			Change		Change	
	2018	2017	2016	2018 vs. 2017		2016 vs. 2015	
Revenues							
UnitedHealthcare	\$ 183,476	\$ 163,257	\$ 148,581	\$ 20,219	12%	\$ 14,676	10%
OptumHealth	24,145	20,570	16,908	3,575	17	3,662	22
OptumInsight	9,008	8,087	7,333	921	11	754	10
OptumRx	69,536	63,755	60,440	5,781	9	3,315	5
Optum eliminations	(1,409)	(1,227)	(1,088)	(182)	15	(139)	13
Optum	101,280	91,185	83,593	10,095	11	7,592	9
Eliminations	(58,509)	(53,283)	(47,334)	(5,226)	10	(5,949)	13
Consolidated revenues	<u>\$ 226,247</u>	<u>\$ 201,159</u>	<u>\$ 184,840</u>	<u>\$ 25,088</u>	12%	<u>\$ 16,319</u>	9%
Earnings from operations							
UnitedHealthcare	\$ 9,113	\$ 8,498	\$ 7,307	\$ 615	7%	\$ 1,191	16%
OptumHealth	2,430	1,823	1,428	607	33	395	28
OptumInsight	2,243	1,770	1,513	473	27	257	17
OptumRx	3,558	3,118	2,682	440	14	436	16
Optum	8,231	6,711	5,623	1,520	23	1,088	19
Consolidated earnings from operations	<u>\$ 17,344</u>	<u>\$ 15,209</u>	<u>\$ 12,930</u>	<u>\$ 2,135</u>	14%	<u>\$ 2,279</u>	18%
Operating margin							
UnitedHealthcare	5.0%	5.2%	4.9%	(0.2)%		0.3%	
OptumHealth	10.1	8.9	8.4	1.2		0.5	
OptumInsight	24.9	21.9	20.6	3.0		1.3	
OptumRx	5.1	4.9	4.4	0.2		0.5	
Optum	8.1	7.4	6.7	0.7		0.7	
Consolidated operating margin	7.7%	7.6%	7.0%	0.1 %		0.6%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31,			Change		Change	
	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
UnitedHealthcare Employer & Individual	\$ 54,761	\$ 52,066	\$ 53,084	\$ 2,695	5%	\$ (1,018)	(2)%
UnitedHealthcare Medicare & Retirement	75,473	65,995	56,329	9,478	14	9,666	17
UnitedHealthcare Community & State	43,426	37,443	32,945	5,983	16	4,498	14
UnitedHealthcare Global	9,816	7,753	6,223	2,063	27	1,530	25
Total UnitedHealthcare revenues	<u>\$ 183,476</u>	<u>\$ 163,257</u>	<u>\$ 148,581</u>	<u>\$ 20,219</u>	12%	<u>\$ 14,676</u>	10%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31,			Change		Change	
	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
Commercial:							
Risk-based.....	8,495	8,420	8,820	75	1 %	(400)	(5)%
Fee-based	18,420	18,595	18,900	(175)	(1)	(305)	(2)
Fee-based TRICARE	—	2,850	2,860	(2,850)	(100)	(10)	—
Total commercial.....	26,915	29,865	30,580	(2,950)	(10)	(715)	(2)
Medicare Advantage	4,945	4,430	3,630	515	12	800	22
Medicaid.....	6,450	6,705	5,890	(255)	(4)	815	14
Medicare Supplement (Standardized).....	4,545	4,445	4,265	100	2	180	4
Total public and senior.....	15,940	15,580	13,785	360	2	1,795	13
Total UnitedHealthcare - domestic medical	42,855	45,445	44,365	(2,590)	(6)	1,080	2
International	6,220	4,080	4,220	2,140	52	(140)	(3)
Total UnitedHealthcare - medical	49,075	49,525	48,585	(450)	(1)%	940	2 %
Supplemental Data:							
Medicare Part D stand-alone	4,710	4,940	4,930	(230)	(5)%	10	— %

The overall increase in people served through risk-based benefit plans in the commercial group market was due to growth in services to small groups. Fee-based commercial group business declined primarily due to customers converting their retirees to Medicare Advantage plans, as well as certain customers expanding the number of carriers and reconfiguring geographies served. Medicare Advantage increased year-over-year due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by states adding new carriers to existing programs, reduced enrollment from state efforts to manage eligibility status and the sale of our New Mexico Medicaid plan. Medicare Supplement growth reflected strong customer retention and new sales. International growth was primarily driven by an acquisition in the first quarter.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served across its risk-based businesses, a higher revenue membership mix, rate increases for underlying medical cost trends and the impact of the return of the Health Insurance Industry Tax. UnitedHealthcare's operating margin decreased slightly due to the performance of our traditional community-based TANF Medicaid business.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below, as well as productivity and overall cost management initiatives.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery and behavioral health, digital consumer engagement and health financial services.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in data analytics product and service offerings and managed services as well as organic and acquisition-related growth in advisory services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to growth in specialty pharmacy, home delivery services, and overall prescription growth. OptumRx fulfilled 1,343 million and 1,298 million adjusted scripts in 2018 and 2017, respectively.

2017 RESULTS OF OPERATIONS COMPARED TO 2016 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across the Optum business. The increase was partially offset by revenue decreases due to the withdrawals of the ACA-compliant products in the individual market and the effects of the Health Insurance Industry Tax moratorium.

Medical Costs and MCR

Medical costs increased due to risk-based membership growth and medical cost trends. The MCR increased due to the effects of the Health Insurance Industry Tax moratorium, offset primarily by the reduction in individual ACA business, medical management initiatives and an increase in favorable medical cost reserve development.

Income Tax Rate

Our effective tax rate decreased primarily due to the impact of Tax Reform and the Health Insurance Tax moratorium. The provision for income taxes included a \$1.2 billion benefit from the revaluation of net deferred tax liabilities.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue increase was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends, which were partially offset by the reduction of people served in ACA-compliant individual products and the impact of the Health Insurance Industry Tax moratorium.

The increase in UnitedHealthcare's earnings from operations was led by diversified growth and increased operating margin. The 2016 results included losses in ACA-compliant individual products and guaranty fund assessments.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management services and business process services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to client and consumer growth. In 2017, OptumRx fulfilled 1.3 billion adjusted scripts compared to 1.2 billion in 2016.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of

statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In both 2018 and 2017, our U.S. regulated subsidiaries paid their parent companies dividends of \$3.7 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31,			Change	Change
	2018	2017	2016	2018 vs. 2017	2017 vs. 2016
Sources of cash:					
Cash provided by operating activities.....	\$ 15,713	\$ 13,596	\$ 9,795	\$ 2,117	\$ 3,801
Issuances of long-term debt and commercial paper, net of repayments	4,134	—	990	4,134	(990)
Proceeds from common share issuances.....	838	688	429	150	259
Customer funds administered	—	3,172	1,692	(3,172)	1,480
Other	—	—	37	—	(37)
Total sources of cash.....	<u>20,685</u>	<u>17,456</u>	<u>12,943</u>		
Uses of cash:					
Cash paid for acquisitions, net of cash assumed.....	(5,997)	(2,131)	(1,760)	(3,866)	(371)
Cash dividends paid	(3,320)	(2,773)	(2,261)	(547)	(512)
Common share repurchases	(4,500)	(1,500)	(1,280)	(3,000)	(220)
Repayments of long-term debt and commercial paper, net of issuances	—	(2,615)	—	2,615	(2,615)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)	(40)	(318)
Purchases of investments, net of sales and maturities	(4,099)	(4,319)	(5,927)	220	1,608
Other	(1,743)	(539)	(581)	(1,204)	42
Total uses of cash.....	<u>(21,722)</u>	<u>(15,900)</u>	<u>(13,514)</u>		
Effect of exchange rate changes on cash and cash equivalents.....	(78)	(5)	78	(73)	(83)
Net (decrease) increase in cash and cash equivalents.....	<u>\$ (1,115)</u>	<u>\$ 1,551</u>	<u>\$ (493)</u>	<u>\$ (2,666)</u>	<u>\$ 2,044</u>

2018 Cash Flows Compared to 2017 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings in 2018 and the impact to 2017 cash flows from operating activities due to a change in net deferred tax liabilities from Tax Reform, partially offset by changes in working capital accounts.

Other significant changes in sources or uses of cash year-over-year included net issuances of debt in 2018 compared to net repayments in 2017, an increase in cash paid for acquisitions, increased share repurchases and a decrease in customer funds administered due to the timing of government payments.

2017 Cash Flows Compared to 2016 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings and changes in working capital accounts, partially offset by the change in net deferred tax liabilities driven by tax reform.

Other significant changes in sources or uses of cash year-over-year included net repayments of debt compared to 2016 net proceeds from debt issuances, which were partially offset by lower net purchases of investments.

Financial Condition

As of December 31, 2018, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of \$44.7 billion included \$10.9 billion of cash and cash equivalents (of which \$925 million was available for general corporate use), \$31.9 billion of debt securities and \$2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of “Double A” as of December 31, 2018. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders’ equity ratio of not more than 60%. As of December 31, 2018, our debt to debt-plus-shareholders’ equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 “Financial Statements and Supplementary Data.”

Credit Ratings. Our credit ratings as of December 31, 2018 were as follows:

	Moody’s		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt.....	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper.....	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Dividends. In June 2018, our Board increased our annual cash dividend rate to shareholders to \$3.60 per share from \$3.00 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2018, under our various contractual obligations and commitments:

(in millions)	2019	2020 to 2021	2022 to 2023	Thereafter	Total
Debt (a).....	\$ 3,463	\$ 8,970	\$ 7,396	\$ 37,988	\$ 57,817
Operating leases	669	1,103	761	1,343	3,876
Purchase and other obligations (b).....	1,216	2,205	808	175	4,404
Other liabilities (c)	1,206	260	257	5,213	6,936
Redeemable noncontrolling interests (d).....	1,276	380	25	227	1,908
Total contractual obligations	<u>\$ 7,830</u>	<u>\$ 12,918</u>	<u>\$ 9,247</u>	<u>\$ 44,946</u>	<u>\$ 74,941</u>

- (a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for more detail.
- (b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2018.
- (c) Includes obligations associated with contingent consideration and payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments, unrecognized tax benefits, and various long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions, future settlements, unrecognized tax benefits and other liabilities have been classified as “Thereafter.”
- (d) Includes commitments for redeemable shares of our subsidiaries. When the timing of the redemption is indeterminable, the commitment has been classified as “Thereafter.”

Pending Acquisitions. In December 2017, we entered into an agreement to acquire a company in the health care sector for a total of approximately \$4.3 billion, which is not reflected in the table above.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2018, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 “Financial Statements and Supplementary Data” for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2018, our days outstanding in medical payables was 50 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2018, 2017 and 2016 included favorable medical cost development related to prior years of \$320 million, \$690 million and \$220 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2018:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	\$ 550
(0.50)	366
(0.25)	182
0.25	(181)
0.50	(362)
0.75	(541)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2018:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	\$ 703
2	469
1	234
(1)	(234)
(2)	(469)
(3)	(703)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2018; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2018 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2018 net earnings would have increased or decreased by approximately \$140 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Revenues

We derive a substantial portion of our revenues from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS’ retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. For more detail on premium revenues, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.” Risk adjustment data for our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us.

Goodwill and Intangible Assets

Goodwill. We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: customer and/or membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends and the “Medical Costs Payable” critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.

- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. As of October 1, 2018, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

Intangible Assets. Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2018.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers that constitute our client base. As of December 31, 2018, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2018, we had \$14 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2018, \$9 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2018, \$30 billion of our investments were fixed-rate debt securities and \$32 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2018 and 2017 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

December 31, 2018				
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2 %	\$ 276	\$ 189	\$ (2,242)	\$ (5,017)
1	138	94	(1,140)	(2,724)
(1)	(138)	(94)	1,118	3,155
(2)	(276)	(189)	2,196	6,953
December 31, 2017				
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	\$ 300	\$ 170	\$ (1,958)	\$ (4,546)
1	150	85	(933)	(2,460)
(1)	(150)	(85)	950	2,923
(2)	(197)	(133)	1,773	6,414

- (a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2017, the assumed hypothetical change in interest rates does not reflect the full 200 basis point reduction in interest income or interest expense in 2017, as the rate cannot fall below zero.
- (b) As of December 31, 2018 and 2017, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2018, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately \$600 million and \$1.4 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2018, we had \$2.0 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 12, 2019 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinions

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

February 12, 2019

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	\$ 10,866	\$ 11,981
Short-term investments	3,458	3,509
Accounts receivable, net of allowances of \$712 and \$641	11,388	9,568
Other current receivables, net of allowances of \$502 and \$440	6,862	6,262
Assets under management.....	3,032	3,101
Prepaid expenses and other current assets	3,086	2,663
Total current assets.....	38,692	37,084
Long-term investments	32,510	28,341
Property, equipment and capitalized software, net of accumulated depreciation and amortization of \$4,141 and \$3,694	8,458	7,013
Goodwill.....	58,910	54,556
Other intangible assets, net of accumulated amortization of \$4,592 and \$4,309.....	9,325	8,489
Other assets	4,326	3,575
Total assets	\$ 152,221	\$ 139,058
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	\$ 19,891	\$ 17,871
Accounts payable and accrued liabilities	16,705	15,180
Commercial paper and current maturities of long-term debt.....	1,973	2,857
Unearned revenues.....	2,396	2,269
Other current liabilities	12,244	12,286
Total current liabilities	53,209	50,463
Long-term debt, less current maturities	34,581	28,835
Deferred income taxes	2,474	2,182
Other liabilities.....	5,730	5,556
Total liabilities.....	95,994	87,036
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,908	2,189
Equity:		
Preferred stock, \$0.001 par value - 10 shares authorized; no shares issued or outstanding ..	—	—
Common stock, \$0.01 par value - 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings.....	55,846	48,730
Accumulated other comprehensive loss.....	(4,160)	(2,667)
Nonredeemable noncontrolling interests	2,623	2,057
Total equity.....	54,319	49,833
Total liabilities, redeemable noncontrolling interests and equity	\$ 152,221	\$ 139,058

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31,		
	2018	2017	2016
Revenues:			
Premiums.....	\$ 178,087	\$ 158,453	\$ 144,118
Products	29,601	26,366	26,658
Services	17,183	15,317	13,236
Investment and other income	1,376	1,023	828
Total revenues.....	226,247	201,159	184,840
Operating costs:			
Medical costs.....	145,403	130,036	117,038
Operating costs	34,074	29,557	28,401
Cost of products sold.....	26,998	24,112	24,416
Depreciation and amortization	2,428	2,245	2,055
Total operating costs.....	208,903	185,950	171,910
Earnings from operations	17,344	15,209	12,930
Interest expense	(1,400)	(1,186)	(1,067)
Earnings before income taxes	15,944	14,023	11,863
Provision for income taxes	(3,562)	(3,200)	(4,790)
Net earnings	12,382	10,823	7,073
Earnings attributable to noncontrolling interests.....	(396)	(265)	(56)
Net earnings attributable to UnitedHealth Group common shareholders	\$ 11,986	\$ 10,558	\$ 7,017
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic.....	\$ 12.45	\$ 10.95	\$ 7.37
Diluted.....	\$ 12.19	\$ 10.72	\$ 7.25
Basic weighted-average number of common shares outstanding	963	964	952
Dilutive effect of common share equivalents	20	21	16
Diluted weighted-average number of common shares outstanding	983	985	968
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents.....	6	5	3

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31,		
	2018	2017	2016
Net earnings	\$ 12,382	\$ 10,823	\$ 7,073
Other comprehensive (loss) income:			
Gross unrealized (losses) gains on investment securities during the period ..	(294)	209	(73)
Income tax effect	67	(72)	26
Total unrealized (losses) gains, net of tax	(227)	137	(47)
Gross reclassification adjustment for net realized gains included in net earnings	(62)	(83)	(166)
Income tax effect	14	30	60
Total reclassification adjustment, net of tax	(48)	(53)	(106)
Total foreign currency translation (losses) gains	(1,242)	(70)	806
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	10,865	10,837	7,726
Comprehensive income attributable to noncontrolling interests	(396)	(265)	(56)
Comprehensive income attributable to UnitedHealth Group common shareholders	\$ 10,469	\$ 10,572	\$ 7,670

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock			Accumulated Other Comprehensive Income (Loss)				Total Equity
	Shares	Amount	Additional Paid-In Capital	Retained Earnings	Net Unrealized Gains (Losses) on Investments	Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	
Balance at January 1, 2016.....	953	\$ 10	\$ 29	\$ 37,125	\$ 56	\$ (3,390)	\$ (105)	\$ 33,725
Adjustment to adopt ASU 2016-09				28				28
Net earnings.....				7,017			40	7,057
Other comprehensive (loss) income					(153)	806		653
Issuances of common stock, and related tax effects	9	—	191					191
Share-based compensation			455					455
Common share repurchases.....	(10)	—	(316)	(964)				(1,280)
Cash dividends paid on common shares (\$2.375 per share)				(2,261)				(2,261)
Acquisition of redeemable noncontrolling interest shares			(143)					(143)
Redeemable noncontrolling interest fair value and other adjustments.....			(216)					(216)
Distributions to nonredeemable noncontrolling interest							(32)	(32)
Balance at December 31, 2016.....	952	10	—	40,945	(97)	(2,584)	(97)	38,177
Net earnings.....				10,558			194	10,752
Other comprehensive income (loss)					84	(70)		14
Issuances of common stock, and related tax effects	26	—	2,225					2,225
Share-based compensation			582					582
Common share repurchases.....	(9)	—	(1,500)					(1,500)
Cash dividends paid on common shares (\$2.875 per share)				(2,773)				(2,773)
Acquisition of redeemable noncontrolling interest shares			283					283
Redeemable noncontrolling interest fair value and other adjustments.....			113					113
Acquisition of nonredeemable noncontrolling interests.....							2,112	2,112
Distributions to nonredeemable noncontrolling interest							(152)	(152)
Balance at December 31, 2017.....	969	10	1,703	48,730	(13)	(2,654)	2,057	49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings.....				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases.....	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares (\$3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interests fair value and other adjustments			(163)					(163)
Acquisition of nonredeemable noncontrolling interests.....							521	521
Distributions to nonredeemable noncontrolling interests.....							(228)	(228)
Balance at December 31, 2018.....	960	\$ 10	\$ —	\$ 55,846	\$ (264)	\$ (3,896)	\$ 2,623	\$ 54,319

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31,		
	2018	2017	2016
Operating activities			
Net earnings	\$ 12,382	\$ 10,823	\$ 7,073
Noncash items:			
Depreciation and amortization.....	2,428	2,245	2,055
Deferred income taxes	42	(965)	81
Share-based compensation.....	638	597	485
Other, net	(71)	217	(82)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable.....	(1,351)	(1,062)	(1,357)
Other assets	(750)	(630)	(1,601)
Medical costs payable.....	1,831	1,284	1,849
Accounts payable and other liabilities.....	526	930	1,494
Unearned revenues.....	38	157	(202)
Cash flows from operating activities	15,713	13,596	9,795
Investing activities			
Purchases of investments	(14,010)	(14,588)	(17,547)
Sales of investments	3,641	4,623	7,339
Maturities of investments	6,270	5,646	4,281
Cash paid for acquisitions, net of cash assumed.....	(5,997)	(2,131)	(1,760)
Purchases of property, equipment and capitalized software.....	(2,063)	(2,023)	(1,705)
Other, net	(226)	(126)	37
Cash flows used for investing activities	(12,385)	(8,599)	(9,355)
Financing activities			
Common share repurchases	(4,500)	(1,500)	(1,280)
Cash dividends paid.....	(3,320)	(2,773)	(2,261)
Proceeds from common stock issuances.....	838	688	429
Repayments of long-term debt.....	(2,600)	(4,398)	(2,596)
Repayments of commercial paper, net.....	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt.....	6,935	5,291	3,968
Customer funds administered	(131)	3,172	1,692
Other, net	(1,386)	(413)	(581)
Cash flows used for financing activities.....	(4,365)	(3,441)	(1,011)
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78
(Decrease) increase in cash and cash equivalents	(1,115)	1,551	(493)
Cash and cash equivalents, beginning of period	11,981	10,430	10,923
Cash and cash equivalents, end of period.....	\$ 10,866	\$ 11,981	\$ 10,430
Supplemental cash flow disclosures			
Cash paid for interest	\$ 1,410	\$ 1,133	\$ 1,055
Cash paid for income taxes.....	3,257	4,004	4,726
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	\$ —	\$ 2,164	\$ —

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, “UnitedHealth Group” and “the Company”) is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company’s best estimates and judgments. The Company’s most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers’ health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company’s customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans’ Star ratings.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company’s Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS’ risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for the Company’s plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company’s OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and compounding pharmacy facilities. Product

revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2018 and 2017, accounts receivables related to products and services were \$3.9 billion and \$3.7 billion, respectively. In 2018 and 2017, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2018 or 2017.

For the years ended December 31, 2018 and 2017, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 13 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2018.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost

trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2018 and 2017, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to \$4.2 billion and \$3.8 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment.....	3 to 10 years
Buildings.....	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2018.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2018.

Other Current Liabilities

Other current liabilities include health savings account deposits (\$7.5 billion and \$6.4 billion as of December 31, 2018 and 2017, respectively), deposits under the Medicare Part D program, the RSF associated with the AARP Program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2018 and 2017:

<u>(in millions)</u>	<u>2018</u>	<u>2017</u>
Redeemable noncontrolling interests, beginning of period.....	\$ 2,189	\$ 2,012
Net earnings.....	123	71
Acquisitions.....	102	565
Redemptions.....	(90)	(309)
Distributions.....	(53)	(38)
Fair value and other adjustments.....	(363)	(112)
Redeemable noncontrolling interests, end of period.....	<u>\$ 1,908</u>	<u>\$ 2,189</u>

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to five years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options and SARs vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A one year moratorium on the collection of the Health Insurance Industry Tax will occur in 2019.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11 and 2018-20 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, the Company elected to not

recognize lease assets and lease liabilities and expense the leases over a straight-line basis for the term of those leases. ASU 2016-02 requires new disclosures that depict the amount, timing and uncertainty of cash flows pertaining to an entity's leases. The Company adopted ASU 2016-02 on January 1, 2019, using the cumulative effect upon adoption approach. The adoption resulted in no material impact to the Company's balance sheet, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). Most notably, the new guidance requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The Company adopted ASU 2016-01 on a prospective basis effective January 1, 2018, as required, and reclassified \$24 million from accumulated other comprehensive income to retained earnings.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities - available-for-sale:				
U.S. government and agency obligations	\$ 3,434	\$ 13	\$ (42)	\$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities - available-for-sale	<u>32,240</u>	<u>101</u>	<u>(443)</u>	<u>31,898</u>
Debt securities - held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities - held-to-maturity	<u>621</u>	<u>1</u>	<u>(2)</u>	<u>620</u>
Total debt securities	<u>\$ 32,861</u>	<u>\$ 102</u>	<u>\$ (445)</u>	<u>\$ 32,518</u>
December 31, 2017				
Debt securities - available-for-sale:				
U.S. government and agency obligations	\$ 2,673	\$ 1	\$ (30)	\$ 2,644
State and municipal obligations	7,596	99	(35)	7,660
Corporate obligations	13,181	57	(44)	13,194
U.S. agency mortgage-backed securities	3,942	7	(38)	3,911
Non-U.S. agency mortgage-backed securities	1,018	3	(6)	1,015
Total debt securities - available-for-sale	<u>28,410</u>	<u>167</u>	<u>(153)</u>	<u>28,424</u>
Debt securities - held-to-maturity:				
U.S. government and agency obligations	254	1	(1)	254
State and municipal obligations	2	—	—	2
Corporate obligations	280	—	—	280
Total debt securities - held-to-maturity	<u>536</u>	<u>1</u>	<u>(1)</u>	<u>536</u>
Total debt securities	<u>\$ 28,946</u>	<u>\$ 168</u>	<u>\$ (154)</u>	<u>\$ 28,960</u>

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2018.

The Company held \$2.0 billion of equity securities as of December 31, 2018 and December 31, 2017. The Company's investments in equity securities primarily consist of employee savings plan related investments, Brazilian real denominated

fixed-income funds and dividend paying stocks, with readily determinable fair values. Additionally, the Company's investments included \$1.5 billion and \$0.9 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2018 and 2017, respectively.

The amortized cost and fair value of debt securities as of December 31, 2018, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less.....	\$ 3,560	\$ 3,551	\$ 150	\$ 150
Due after one year through five years.....	12,432	12,297	213	212
Due after five years through ten years.....	7,362	7,270	129	129
Due after ten years.....	2,563	2,570	129	129
U.S. agency mortgage-backed securities.....	4,947	4,852	—	—
Non-U.S. agency mortgage-backed securities.....	1,376	1,358	—	—
Total debt securities.....	<u>\$ 32,240</u>	<u>\$ 31,898</u>	<u>\$ 621</u>	<u>\$ 620</u>

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2018						
Debt securities - available-for-sale:						
U.S. government and agency obligations	\$ 998	\$ (7)	\$ 1,425	\$ (35)	\$ 2,423	\$ (42)
State and municipal obligations.....	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations.....	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities.	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities.....	622	(7)	459	(13)	1,081	(20)
Total debt securities - available-for-sale.....	<u>\$ 12,355</u>	<u>\$ (156)</u>	<u>\$ 11,002</u>	<u>\$ (287)</u>	<u>\$ 23,357</u>	<u>\$ (443)</u>
December 31, 2017						
Debt securities - available-for-sale:						
U.S. government and agency obligations	\$ 1,249	\$ (8)	\$ 1,027	\$ (22)	\$ 2,276	\$ (30)
State and municipal obligations.....	2,599	(21)	866	(14)	3,465	(35)
Corporate obligations.....	5,901	(23)	1,242	(21)	7,143	(44)
U.S. agency mortgage-backed securities.	1,657	(12)	1,162	(26)	2,819	(38)
Non-U.S. agency mortgage-backed securities.....	411	(3)	144	(3)	555	(6)
Total debt securities - available-for-sale.....	<u>\$ 11,817</u>	<u>\$ (67)</u>	<u>\$ 4,441</u>	<u>\$ (86)</u>	<u>\$ 16,258</u>	<u>\$ (153)</u>

The Company's unrealized losses from all securities as of December 31, 2018 were generated from approximately 19,000 positions out of a total of 31,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2018, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

There was no transfers in or out of Level 3 financial assets or liabilities during the year ended December 31, 2018 or 2017.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the year ended December 31, 2018 or 2017.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds are estimated using valuation techniques that rely heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2018				
Cash and cash equivalents	\$ 10,757	\$ 109	\$ —	\$ 10,866
Debt securities - available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations.....	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities.....	—	1,358	—	1,358
Total debt securities - available-for-sale	3,099	28,626	173	31,898
Equity securities.....	1,832	13	—	1,845
Assets under management.....	1,086	1,938	8	3,032
Total assets at fair value.....	<u>\$ 16,774</u>	<u>\$ 30,686</u>	<u>\$ 181</u>	<u>\$ 47,641</u>
Percentage of total assets at fair value	<u>35%</u>	<u>65%</u>	<u>—%</u>	<u>100%</u>
December 31, 2017				
Cash and cash equivalents	\$ 11,718	\$ 263	\$ —	\$ 11,981
Debt securities - available-for-sale:				
U.S. government and agency obligations	2,428	216	—	2,644
State and municipal obligations	—	7,660	—	7,660
Corporate obligations.....	65	12,989	140	13,194
U.S. agency mortgage-backed securities	—	3,911	—	3,911
Non-U.S. agency mortgage-backed securities.....	—	1,015	—	1,015
Total debt securities - available-for-sale	2,493	25,791	140	28,424
Equity securities.....	1,784	14	194	1,992
Assets under management.....	1,117	1,984	—	3,101
Total assets at fair value.....	<u>\$ 17,112</u>	<u>\$ 28,052</u>	<u>\$ 334</u>	<u>\$ 45,498</u>
Percentage of total assets at fair value	<u>38%</u>	<u>61%</u>	<u>1%</u>	<u>100%</u>

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2018					
Debt securities - held-to-maturity	\$ 260	\$ 65	\$ 295	\$ 620	\$ 621
Long-term debt and other financing obligations	\$ —	\$ 37,944	\$ —	\$ 37,944	\$ 36,554
December 31, 2017					
Debt securities - held-to-maturity	\$ 267	\$ 4	\$ 265	\$ 536	\$ 536
Long-term debt and other financing obligations	\$ —	\$ 34,504	\$ —	\$ 34,504	\$ 31,542

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2018	December 31, 2017
Land and improvements	\$ 566	\$ 405
Buildings and improvements	4,470	3,664
Computer equipment	1,984	1,829
Furniture and fixtures	1,525	1,208
Less accumulated depreciation	(2,787)	(2,488)
Property and equipment, net	5,758	4,618
Capitalized software	4,054	3,601
Less accumulated amortization	(1,354)	(1,206)
Capitalized software, net	2,700	2,395
Total property, equipment and capitalized software, net	\$ 8,458	\$ 7,013

Depreciation expense for property and equipment for the years ended December 31, 2018, 2017 and 2016 was \$924 million, \$799 million and \$698 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2018, 2017 and 2016 was \$606 million, \$550 million and \$475 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2017	\$ 23,854	\$ 6,322	\$ 4,449	\$ 12,959	\$ 47,584
Acquisitions	690	5,189	1,221	—	7,100
Foreign currency effects and adjustments, net	(60)	(23)	4	(49)	(128)
Balance at December 31, 2017	24,484	11,488	5,674	12,910	54,556
Acquisitions	2,723	471	106	1,881	5,181
Foreign currency effects and adjustments, net	(807)	(12)	(8)	—	(827)
Balance at December 31, 2018	\$ 26,400	\$ 11,947	\$ 5,772	\$ 14,791	\$ 58,910

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2018			December 31, 2017		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related.....	\$ 11,622	\$ (3,908)	\$ 7,714	\$ 10,832	\$ (3,743)	\$ 7,089
Trademarks and technology.....	1,122	(512)	610	1,054	(432)	622
Trademarks and other indefinite-lived.....	745	—	745	561	—	561
Other	428	(172)	256	351	(134)	217
Total	<u>\$ 13,917</u>	<u>\$ (4,592)</u>	<u>\$ 9,325</u>	<u>\$ 12,798</u>	<u>\$ (4,309)</u>	<u>\$ 8,489</u>

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2018		2017	
	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related.....	\$ 1,355	17 years	\$ 324	13 years
Trademarks and technology.....	122	4 years	367	11 years
Other	97	9 years	82	6 years
Total acquired finite-lived intangible assets	<u>\$ 1,574</u>	<u>16 years</u>	<u>\$ 773</u>	<u>11 years</u>

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2019	\$ 889
2020	795
2021	724
2022	632
2023	593

Amortization expense relating to intangible assets for the years ended December 31, 2018, 2017 and 2016 was \$898 million, \$896 million and \$882 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2018	2017	2016
Medical costs payable, beginning of period	\$ 17,871	\$ 16,391	\$ 14,330
Acquisitions	339	83	—
Reported medical costs:			
Current year	145,723	130,726	117,258
Prior years.....	(320)	(690)	(220)
Total reported medical costs	<u>145,403</u>	<u>130,036</u>	<u>117,038</u>
Medical payments:			
Payments for current year.....	(127,155)	(113,811)	(101,696)
Payments for prior years.....	(16,567)	(14,828)	(13,281)
Total medical payments	<u>(143,722)</u>	<u>(128,639)</u>	<u>(114,977)</u>
Medical costs payable, end of period	<u>\$ 19,891</u>	<u>\$ 17,871</u>	<u>\$ 16,391</u>

For the years ended December 31, 2018 and 2016, no individual factors significantly impacted medical cost reserve development. For the year ended December 31, 2017, medical cost reserve development was primarily driven by lower than expected health system utilization levels.

Medical costs payable included IBNR of \$13.2 billion and \$12.3 billion at December 31, 2018 and 2017, respectively. Substantially all of the IBNR balance as of December 31, 2018 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2018:

(in millions) Year	Net Incurred Medical Costs	
	For the Years ended December 31,	
	2017	2018
2017	\$ 130,726	\$ 130,441
2018		145,723
Total		\$ 276,164

(in millions) Year	Net Cumulative Medical Payments	
	For the Years ended December 31,	
	2017	2018
2017	\$ (113,811)	\$ (129,778)
2018		(127,155)
Total		(256,933)
Net remaining outstanding liabilities prior to 2017		660
Total medical costs payable		\$ 19,891

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2018			December 31, 2017		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper.....	\$ —	\$ —	\$ —	\$ 150	\$ 150	\$ 150
6.000% notes due February 2018.....	—	—	—	1,100	1,101	1,106
1.900% notes due July 2018.....	—	—	—	1,500	1,499	1,501
1.700% notes due February 2019.....	750	750	749	750	749	747
1.625% notes due March 2019.....	500	500	499	500	501	497
2.300% notes due December 2019.....	500	494	497	500	495	501
2.700% notes due July 2020.....	1,500	1,498	1,494	1,500	1,496	1,517
Floating rate notes due October 2020.....	300	299	298	300	299	300
3.875% notes due October 2020.....	450	443	456	450	446	467
1.950% notes due October 2020.....	900	897	884	900	895	892
4.700% notes due February 2021.....	400	398	412	400	403	425
2.125% notes due March 2021.....	750	747	734	750	746	744
Floating rate notes due June 2021.....	350	349	347	—	—	—
3.150% notes due June 2021.....	400	399	400	—	—	—
3.375% notes due November 2021.....	500	489	503	500	493	516
2.875% notes due December 2021.....	750	735	748	750	741	760
2.875% notes due March 2022.....	1,100	1,051	1,091	1,100	1,054	1,114
3.350% notes due July 2022.....	1,000	997	1,005	1,000	996	1,033
2.375% notes due October 2022.....	900	894	872	900	893	891
0.000% notes due November 2022.....	15	12	13	15	12	12
2.750% notes due February 2023.....	625	602	611	625	606	626
2.875% notes due March 2023.....	750	750	739	750	762	759
3.500% notes due June 2023.....	750	746	756	—	—	—
3.500% notes due February 2024.....	750	745	755	—	—	—
3.750% notes due July 2025.....	2,000	1,989	2,025	2,000	1,987	2,108
3.700% notes due December 2025.....	300	298	303	—	—	—
3.100% notes due March 2026.....	1,000	995	965	1,000	995	1,007
3.450% notes due January 2027.....	750	746	742	750	745	776
3.375% notes due April 2027.....	625	619	611	625	618	642
2.950% notes due October 2027.....	950	938	898	950	937	947
3.850% notes due June 2028.....	1,150	1,142	1,163	—	—	—
3.875% notes due December 2028.....	850	842	861	—	—	—
4.625% notes due July 2035.....	1,000	992	1,060	1,000	991	1,165
5.800% notes due March 2036.....	850	838	1,003	850	837	1,105
6.500% notes due June 2037.....	500	492	638	500	491	698
6.625% notes due November 2037.....	650	641	841	650	641	923
6.875% notes due February 2038.....	1,100	1,076	1,437	1,100	1,075	1,596
5.700% notes due October 2040.....	300	296	355	300	296	389
5.950% notes due February 2041.....	350	345	426	350	345	466
4.625% notes due November 2041.....	600	588	627	600	588	685
4.375% notes due March 2042.....	502	484	503	502	483	555
3.950% notes due October 2042.....	625	607	596	625	607	650
4.250% notes due March 2043.....	750	734	744	750	734	822
4.750% notes due July 2045.....	2,000	1,973	2,116	2,000	1,972	2,362
4.200% notes due January 2047.....	750	738	745	750	738	808
4.250% notes due April 2047.....	725	717	719	725	717	798
3.750% notes due October 2047.....	950	933	869	950	933	969
4.250% notes due June 2048.....	1,350	1,329	1,349	—	—	—
4.450% notes due December 2048.....	1,100	1,087	1,132	—	—	—
Total commercial paper and long-term debt.....	\$ 35,667	\$ 35,234	\$ 36,591	\$ 31,417	\$ 31,067	\$ 34,029

The Company's long-term debt obligations also included \$1.3 billion and \$625 million of other financing obligations, of which \$229 million and \$107 million were current as of December 31, 2018 and 2017, respectively.

Maturities of long-term debt for the years ending December 31 are as follows:

<u>(in millions)</u>	
2019	\$ 1,973
2020	3,350
2021	3,350
2022	3,215
2023	2,325
Thereafter	22,775

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has \$3.5 billion five-year, \$3.5 billion three-year and \$3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2018, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2018, annual interest rates would have ranged from 3.2% to 3.6%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2018.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

<u>(in millions)</u>	<u>2018</u>	<u>2017</u>	<u>2016</u>
Current Provision:			
Federal	\$ 2,897	\$ 3,597	\$ 4,302
State and local	219	314	312
Foreign	404	254	95
Total current provision	<u>3,520</u>	<u>4,165</u>	<u>4,709</u>
Deferred provision (benefit)	42	(965)	81
Total provision for income taxes	<u>\$ 3,562</u>	<u>\$ 3,200</u>	<u>\$ 4,790</u>

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2018		2017		2016	
Tax provision at the U.S. federal statutory rate	\$ 3,348	21.0%	\$ 4,908	35.0%	\$ 4,152	35.0%
Change in tax law	—	—	(1,199)	(8.6)	—	—
State income taxes, net of federal benefit.....	168	1.0	197	1.4	205	1.7
Share-based awards - excess tax benefit.....	(161)	(1.0)	(319)	(2.3)	(158)	(1.3)
Non-deductible compensation	117	0.7	175	1.3	128	1.1
Health insurance industry tax	552	3.5	—	—	645	5.4
Foreign rate differential	(203)	(1.3)	(282)	(2.0)	(105)	(0.9)
Other, net	(259)	(1.6)	(280)	(2.0)	(77)	(0.6)
Provision for income taxes	<u>\$ 3,562</u>	<u>22.3%</u>	<u>\$ 3,200</u>	<u>22.8%</u>	<u>\$ 4,790</u>	<u>40.4%</u>

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2018	2017
Deferred income tax assets:		
Accrued expenses and allowances	\$ 551	\$ 544
U.S. federal and state net operating loss carryforwards.....	190	216
Share-based compensation	91	97
Nondeductible liabilities	184	169
Non-U.S. tax loss carryforwards.....	426	445
Other-domestic	306	167
Other-non-U.S.	337	198
Subtotal.....	<u>2,085</u>	<u>1,836</u>
Less: valuation allowances.....	<u>(84)</u>	<u>(64)</u>
Total deferred income tax assets	<u>2,001</u>	<u>1,772</u>
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,131)	(1,998)
Non-U.S. goodwill and intangible assets	(709)	(602)
Capitalized software.....	(603)	(530)
Depreciation and amortization	(266)	(236)
Prepaid expenses	(152)	(223)
Outside basis in partnerships.....	(300)	(279)
Other-non-U.S.	(314)	(86)
Total deferred income tax liabilities.....	<u>(4,475)</u>	<u>(3,954)</u>
Net deferred income tax liabilities	<u>\$ (2,474)</u>	<u>\$ (2,182)</u>

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of \$99 million expire beginning in 2022 through 2037 and \$17 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2019 through 2038. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2018, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2018	2017	2016
Gross unrecognized tax benefits, beginning of period	\$ 598	\$ 263	\$ 224
Gross increases:			
Current year tax positions.....	487	356	37
Prior year tax positions.....	87	40	24
Gross decreases:			
Prior year tax positions.....	(84)	(33)	(4)
Settlements	(20)	(24)	(6)
Statute of limitations lapses.....	(12)	(4)	(12)
Gross unrecognized tax benefits, end of period.....	<u>\$ 1,056</u>	<u>\$ 598</u>	<u>\$ 263</u>

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by \$118 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2018, 2017 and 2016, the Company recognized \$6 million, \$14 million and \$11 million of interest and penalties, respectively. The Company had \$95 million and \$84 million of accrued interest and penalties for uncertain tax positions as of December 31, 2018 and 2017, respectively. These amounts are not included in the reconciliation above. As of December 31, 2018, there were \$716 million of unrecognized tax benefits that, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2018 and 2017 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2012 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2013 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries in the United States are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For both the years ended December 31, 2018 and 2017, the Company's regulated subsidiaries paid their parent companies dividends of \$3.7 billion, including \$1.1 billion of extraordinary dividends.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of \$23.7 billion as of December 31, 2018. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately \$10.3 billion as of December 31, 2018.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2018, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in

open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2018 and 2017 is as follows:

(in millions, except per share data)	Years Ended December 31,	
	2018	2017
Common share repurchases, shares	19	9
Common share repurchases, average price per share	\$ 236.72	\$ 173.54
Common share repurchases, aggregate cost	\$ 4,500	\$ 1,500
Board authorized shares remaining	94	42

Dividends

In June 2018, the Company's Board of Directors increased the Company's annual dividend rate to shareholders to \$3.60 per share compared to \$3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2018, the Company had 42 million shares available for future grants of share-based awards under the Plan. As of December 31, 2018, there were also 7 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2018 is summarized in the table below:

	Shares (in millions)	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (in years)	Aggregate Intrinsic Value (in millions)
Outstanding at beginning of period	37	\$ 102		
Granted	7	229		
Exercised	(8)	78		
Forfeited	(1)	162		
Outstanding at end of period	35	131	6.5	\$ 4,114
Exercisable at end of period	16	87	5.0	2,560
Vested and expected to vest, end of period	34	129	6.5	4,072

Restricted Shares

Restricted share activity for the year ended December 31, 2018 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	7	\$ 128
Granted	2	229
Vested	(3)	119
Nonvested at end of period	6	163

Other Share-Based Compensation Data

(in millions, except per share amounts)	For the Years Ended December 31,		
	2018	2017	2016
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	\$ 43	\$ 29	\$ 20
Total intrinsic value of stock options and SARs exercised.....	1,431	1,473	595
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	229	163	115
Total fair value of restricted shares vested	\$ 521	\$ 460	\$ 274
Employee Stock Purchase Plan			
Number of shares purchased.....	2	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax.....	\$ 638	\$ 597	\$ 485
Share-based compensation expense, net of tax effects.....	587	531	417
Income tax benefit realized from share-based award exercises.....	239	431	236

(in millions, except years)	December 31, 2018
Unrecognized compensation expense related to share awards	\$ 628
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2018	2017	2016
Risk-free interest rate	2.6% - 3.1%	1.9% - 2.1%	1.2% - 1.4%
Expected volatility.....	18.7% - 19.3%	18.5% - 20.7%	20.8% - 22.5%
Expected dividend yield	1.3% - 1.5%	1.4% - 1.6%	1.8%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.6	5.7	5.6 - 5.9

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2018, 2017 and 2016.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were \$988 million and \$865 million as of December 31, 2018 and 2017, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2018, 2017 and 2016 was \$751 million, \$710 million and \$608 million, respectively.

As of December 31, 2018, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2019	\$ 669
2020	592
2021	511
2022	423
2023	338
Thereafter	1,343

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2018, 2017 or 2016.

As of December 31, 2018, the Company had outstanding, undrawn letters of credit with financial institutions of \$83 million and surety bonds outstanding with insurance companies of \$1.3 billion, primarily to bond contractual performance.

Pending Acquisition

In December 2017, the Company entered into an agreement to acquire a company in the health care sector for a total of approximately \$4.3 billion.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. Those motions were argued in September 2018. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits and health care delivery.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth serves the physical, emotional and health-related financial needs of individuals, enabling population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and compounding pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 30%, 28% and 25% for 2018, 2017 and 2016, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96%, 96% and 97% of consolidated total revenues for 2018, 2017 and 2016, respectively. Long-lived fixed assets located in the United States represented approximately

76% and 77% of the total long-lived fixed assets as of December 31, 2018 and 2017, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	Optum						Corporate and Eliminations	Consolidated
	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2018								
Revenues - unaffiliated customers:								
Premiums	\$ 174,282	\$ 3,805	\$ —	\$ —	\$ —	\$ 3,805	\$ —	\$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues - unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues - affiliated customers....	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues.....	\$ 183,476	\$ 24,145	\$ 9,008	\$ 69,536	\$ (1,409)	\$ 101,280	\$ (58,509)	\$ 226,247
Earnings from operations	\$ 9,113	\$ 2,430	\$ 2,243	\$ 3,558	\$ —	\$ 8,231	\$ —	\$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes.....	\$ 9,113	\$ 2,430	\$ 2,243	\$ 3,558	\$ —	\$ 8,231	\$ (1,400)	\$ 15,944
Total assets.....	\$ 82,938	\$ 29,837	\$ 11,039	\$ 33,912	\$ —	\$ 74,788	\$ (5,505)	\$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428
2017								
Revenues - unaffiliated customers:								
Premiums	\$ 154,709	\$ 3,744	\$ —	\$ —	\$ —	\$ 3,744	\$ —	\$ 158,453
Products	—	44	106	26,216	—	26,366	—	26,366
Services	7,890	4,013	2,849	565	—	7,427	—	15,317
Total revenues - unaffiliated customers	162,599	7,801	2,955	26,781	—	37,537	—	200,136
Total revenues - affiliated customers....	—	12,429	5,127	36,954	(1,227)	53,283	(53,283)	—
Investment and other income	658	340	5	20	—	365	—	1,023
Total revenues.....	\$ 163,257	\$ 20,570	\$ 8,087	\$ 63,755	\$ (1,227)	\$ 91,185	\$ (53,283)	\$ 201,159
Earnings from operations	\$ 8,498	\$ 1,823	\$ 1,770	\$ 3,118	\$ —	\$ 6,711	\$ —	\$ 15,209
Interest expense	—	—	—	—	—	—	(1,186)	(1,186)
Earnings before income taxes.....	\$ 8,498	\$ 1,823	\$ 1,770	\$ 3,118	\$ —	\$ 6,711	\$ (1,186)	\$ 14,023
Total assets.....	\$ 76,676	\$ 26,931	\$ 11,273	\$ 29,551	\$ —	\$ 67,755	\$ (5,373)	\$ 139,058
Purchases of property, equipment and capitalized software	737	510	588	188	—	1,286	—	2,023
Depreciation and amortization	758	380	614	493	—	1,487	—	2,245
2016								
Revenues - unaffiliated customers:								
Premiums	\$ 140,455	\$ 3,663	\$ —	\$ —	\$ —	\$ 3,663	\$ —	\$ 144,118
Products	1	48	103	26,506	—	26,657	—	26,658
Services	7,514	2,498	2,670	554	—	5,722	—	13,236
Total revenues - unaffiliated customers	147,970	6,209	2,773	27,060	—	36,042	—	184,012
Total revenues - affiliated customers....	—	10,491	4,559	33,372	(1,088)	47,334	(47,334)	—
Investment and other income	611	208	1	8	—	217	—	828
Total revenues.....	\$ 148,581	\$ 16,908	\$ 7,333	\$ 60,440	\$ (1,088)	\$ 83,593	\$ (47,334)	\$ 184,840
Earnings from operations	\$ 7,307	\$ 1,428	\$ 1,513	\$ 2,682	\$ —	\$ 5,623	\$ —	\$ 12,930
Interest expense	—	—	—	—	—	—	(1,067)	(1,067)
Earnings before income taxes.....	\$ 7,307	\$ 1,428	\$ 1,513	\$ 2,682	\$ —	\$ 5,623	\$ (1,067)	\$ 11,863
Total assets.....	\$ 70,505	\$ 18,656	\$ 9,017	\$ 29,066	\$ —	\$ 56,739	\$ (4,434)	\$ 122,810
Purchases of property, equipment and capitalized software	640	345	571	149	—	1,065	—	1,705
Depreciation and amortization	724	297	559	475	—	1,331	—	2,055

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2018 and 2017 is as follows:

(in millions, except per share data)	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2018				
Revenues	\$ 55,188	\$ 56,086	\$ 56,556	\$ 58,417
Operating costs	51,135	51,882	51,966	53,920
Earnings from operations.....	4,053	4,204	4,590	4,497
Net earnings	2,924	3,010	3,284	3,164
Net earnings attributable to UnitedHealth Group common shareholders	2,836	2,922	3,188	3,040
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.94	3.04	3.31	3.16
Diluted	2.87	2.98	3.24	3.10
2017				
Revenues	\$ 48,723	\$ 50,053	\$ 50,322	\$ 52,061
Operating costs	45,310	46,322	46,234	48,084
Earnings from operations.....	3,413	3,731	4,088	3,977
Net earnings	2,191	2,350	2,561	3,721
Net earnings attributable to UnitedHealth Group common shareholders	2,172	2,284	2,485	3,617
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.28	2.37	2.57	3.73
Diluted	2.23	2.32	2.51	3.65

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2018. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2018.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2018

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013)*. Based on our assessment and the COSO criteria, we believe that, as of December 31, 2018, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2018, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the “Company”) as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2018, of the Company and our report dated February 12, 2019, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company’s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2018. Our responsibility is to express an opinion on the Company’s internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company’s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company’s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company’s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

February 12, 2019

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 12, 2019, including their name and principal occupation or employment:

William C. Ballard, Jr.

Former Of Counsel
Bingham Greenebaum Doll LLP

F. William McNabb III

Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Richard T. Burke

Lead Independent Director
UnitedHealth Group

Valerie Montgomery Rice, M.D

President and Dean
Morehouse School of Medicine

Timothy P. Flynn

Retired Chair
KPMG International

Glenn M. Renwick

Chair
Fiserv, Inc.

Stephen J. Hemsley

Executive Chair
UnitedHealth Group

David S. Wichmann

Chief Executive Officer
UnitedHealth Group

Michele J. Hooper

President and Chief Executive Officer
The Directors' Council

Gail R. Wilensky, Ph.D.

Senior Fellow
Project HOPE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at www.unitedhealthgroup.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance - Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2018, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights (in millions)	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (in millions)
Equity compensation plans approved by shareholders ⁽¹⁾	33	\$ 135	49 ⁽³⁾
Equity compensation plans not approved by shareholders ⁽²⁾	—	—	—
Total ⁽²⁾	33	\$ 135	49

- (1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.
- (2) Excludes 1,676,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of \$59 and an average remaining term of approximately 5 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.
- (3) Includes 7 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2018, and 42 million shares available under the 2011 Stock Incentive Plan as of December 31, 2018. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading “Security Ownership of Certain Beneficial Owners and Management” in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings “Certain Relationships and Transactions” and “Corporate Governance” in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading “Disclosure of Fees Paid to Independent Registered Public Accounting Firm” in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements and Supplementary Data*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2018 and 2017.
- Consolidated Statements of Operations for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017, and 2016.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I - Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

- (b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

- 3.1 Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
- 3.2 Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on August 16, 2017)
- 4.1 Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
- 4.2 Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
- 4.3 Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1998, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
- 4.4 Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
- *10.1 UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2018
- *10.2 Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
- *10.3 Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
- *10.4 Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)

- *10.5 Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
- *10.6 Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
- *10.7 Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
- *10.8 Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
- *10.9 Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
- *10.10 Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
- *10.11 Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
- 10.12 Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
- *10.13 Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
- *10.14 Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
- *10.15 Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
- *10.16 Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
- *10.17 UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
- *10.18 First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
- *10.19 Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
- *10.20 Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
- *10.21 Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
- *10.22 Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
- *10.23 Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
- *10.24 Seventh Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.24 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016)

- *10.25 Eighth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 4.9 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-224254, filed on April 12, 2018)
- *10.26 Summary of Non-Management Director Compensation, effective as of October 1, 2018
- *10.27 UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
- *10.28 Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
- *10.29 First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
- *10.30 Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
- *10.31 Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
- *10.32 Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
- *10.33 Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.34 Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.35 Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.36 Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.37 The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
- *10.38 The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
- *10.39 Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
- *10.40 Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
- *10.41 Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
- *10.42 Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
- *10.43 Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
- *10.44 Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)

- *10.45 Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
- *10.46 Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
- *10.47 Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
- *10.48 Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
- *10.49 Amended and Restated Employment Agreement, effective as of March 24, 2015, between United HealthCare Services, Inc. and Steven H. Nelson (incorporated by reference to Exhibit 10.51 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2017)
- *10.50 Employment Agreement, effective as of June 3, 2018, between United HealthCare Services, Inc. and Andrew Witty
- 11.1 Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
- 21.1 Subsidiaries of UnitedHealth Group Incorporated
- 23.1 Consent of Independent Registered Public Accounting Firm
- 24.1 Power of Attorney
- 31.1 Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
- 32.1 Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
- 101 The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018, filed on February 12, 2019, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I - Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, and for each of the three years in the period ended December 31, 2018, and the Company's internal control over financial reporting as of December 31, 2018, and have issued our reports thereon dated February 12, 2019; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

February 12, 2019

Schedule I

**Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets**

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	\$ 434	\$ 359
Other current assets	197	575
Total current assets	631	934
Equity in net assets of subsidiaries	83,244	76,231
Long-term notes receivable from subsidiaries	4,461	4,278
Other assets	972	839
Total assets	\$ 89,308	\$ 82,282
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	\$ 618	\$ 502
Current portion of notes payable to subsidiaries	714	466
Commercial paper and current maturities of long-term debt	1,744	2,749
Total current liabilities	3,076	3,717
Long-term debt, less current maturities	33,490	28,318
Long-term notes payable to subsidiaries	560	1,518
Other liabilities	486	953
Total liabilities	37,612	34,506
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, \$0.001 par value -10 shares authorized; no shares issued or outstanding	—	—
Common stock, \$0.01 par value - 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Total UnitedHealth Group shareholders' equity	51,696	47,776
Total liabilities and shareholders' equity	\$ 89,308	\$ 82,282

See Notes to the Condensed Financial Statements of Registrant

Schedule I

**Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income**

(in millions)	For the Years Ended December 31,		
	2018	2017	2016
Revenues:			
Investment and other income	\$ 194	\$ 527	\$ 522
Total revenues.....	194	527	522
Operating costs:			
Operating costs	35	—	(22)
Interest expense	1,285	1,114	995
Total operating costs.....	1,320	1,114	973
Loss before income taxes	(1,126)	(587)	(451)
Benefit for income taxes.....	251	214	165
Loss of parent company	(875)	(373)	(286)
Equity in undistributed income of subsidiaries	12,861	10,931	7,303
Net earnings	11,986	10,558	7,017
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	\$ 10,469	\$ 10,572	\$ 7,670

See Notes to the Condensed Financial Statements of Registrant

Schedule I

**Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows**

(in millions)	For the Years Ended December 31,		
	2018	2017	2016
Operating activities			
Cash flows from operating activities	\$ 6,099	\$ 2,021	\$ 4,294
Investing activities			
Issuances of notes to subsidiaries	(1,420)	—	(824)
Repayments of notes to subsidiaries	1,419	2,071	—
Cash paid for acquisitions	(4,066)	(2,313)	(2,292)
Return of capital to parent company	4,196	3,375	2,143
Capital contributions to subsidiaries	(1,259)	(959)	(765)
Other, net	4	—	168
Cash flows (used for) from investing activities	(1,126)	2,174	(1,570)
Financing activities			
Common stock repurchases	(4,500)	(1,500)	(1,280)
Proceeds from common stock issuances	838	688	429
Cash dividends paid	(3,320)	(2,773)	(2,261)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Repayments of long-term debt	(2,600)	(3,472)	(2,596)
(Repayments) proceeds of notes from subsidiary	(1,127)	1,704	(30)
Other, net	(923)	(446)	(421)
Cash flows used for financing activities	(4,898)	(4,016)	(2,573)
Increase in cash and cash equivalents	75	179	151
Cash and cash equivalents, beginning of period	359	180	29
Cash and cash equivalents, end of period	\$ 434	\$ 359	\$ 180
Supplemental cash flow disclosures			
Cash paid for interest	\$ 1,294	\$ 1,062	\$ 974
Cash paid for income taxes	2,379	3,455	4,557
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	\$ —	\$ 2,164	\$ —
Conversion of note receivable from subsidiaries to equity	—	4,378	—

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant (Parent Company Only) UnitedHealth Group Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were \$5.6 billion, \$3.4 billion and \$3.7 billion in 2018, 2017 and 2016, respectively. Additionally, \$4.2 billion, \$3.4 billion and \$2.1 billion in cash were received as a return of capital to the parent company during 2018, 2017 and 2016, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled \$1.3 billion and \$625 million at December 31, 2018 and 2017, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	\$ 1,750
2020	3,150
2021	3,150
2022	3,015
2023	2,125
Thereafter	22,477

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 12, 2019

UNITEDHEALTH GROUP INCORPORATED

By /s/ DAVID S. WICHMANN
David S. Wichmann
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ DAVID S. WICHMANN David S. Wichmann	Director and Chief Executive Officer (principal executive officer)	February 12, 2019
/s/ JOHN F. REX John F. Rex	Executive Vice President and Chief Financial Officer (principal financial officer)	February 12, 2019
/s/ THOMAS E. ROOS Thomas E. Roos	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 12, 2019
* William C. Ballard, Jr.	Director	February 12, 2019
* Richard T. Burke	Director	February 12, 2019
* Timothy P. Flynn	Director	February 12, 2019
* Stephen J. Hemsley	Director	February 12, 2019
* Michele J. Hooper	Director	February 12, 2019
* F. William McNabb III	Director	February 12, 2019
* Valerie Montgomery Rice	Director	February 12, 2019
* Glenn M. Renwick	Director	February 12, 2019
* Gail R. Wilensky	Director	February 12, 2019

*By /s/ MARIANNE D. SHORT
Marianne D. Short,
As Attorney-in-Fact

Attachment

Section II.6

Summit County Business License
(Optum)

NOTICE:

This license **MUST** be posted in a conspicuous place and is not transferable

Business License

The below named person or firm is hereby granted a license to do business as stated below in Summit County Utah, subject to the provisions of the Business License Code of Summit County and subsequent amendments relating to the above for the period indicated:

Name: United Behavioral Health, Inc

To: Richard A Elorreaga
2525 Lake Park Blvd
West Valley City UT 84120



License Number: 6528

Date Issued: 02/25/2019

Expires: 01/15/2020

Fee: 200.00

Location: 2525 Lake Park Blvd

Type of Business: Behavioral Health Services

Kellie Robinson

Deputy Clerk

Kent Hoggan

County Clerk

April 1, 2019

Mr. Clay Coleman
Summit County Procurement Manager
Summit County Health Department
650 Round Valley Drive
Park City, UT 84060
ccoleman@summitcounty.org
anewman@summitcounty.org

Re: Summit County Utah Substance Disorder Treatment & Mental Health Services for Medicaid, Uninsured, and Non-Medicaid Summit County Residents RFP #SUCO20197552
Response to Questions for United Behavioral Health, Inc.

Dear Mr. Coleman:

Thank you for the opportunity to clarify our response for the Summit County Mental Health and Substance Abuse Local Contracted Provider (LCP) Contract. We have included our responses to the 12 questions below.

1. Please explain the full extent the University Neuropsychiatric Institute (UNI) plays within your bid. Is there a guarantee of admittance for Summit County residents at UNI?

Response

We currently work with UNI to provide acute in-patient services for children, adolescents and adults, as well as additional services, such as Electroconvulsive Therapy (ECT); female adolescent Dialectical Behavior Therapy (DBT) residential treatment; crisis line; warm lines; Mobile Crisis Outreach Team (MCOT); and receiving center. We will expand our contract with UNI to include services for Summit County clients, such as those listed above, as agreed upon with Summit County.

Regarding whether there is a guarantee of admittance for Summit County residents at UNI, the answer is yes, there is a guarantee of admittance for Summit County residents who seek services at UNI and for whom UNI is the most appropriate level of care, unless UNI is at maximum capacity and does not have a bed available. In addition, we have contracts with Jordan Valley Medical Center-West Valley, and St. Mark's Hospital for Adult Inpatient Care. Should our in-network facilities be at capacity or should an out-of-network facility be the right choice for the client, regardless of age, we will implement a Single Case Agreement (SCA) with a qualified provider.

2. Is the University of Utah Health Plans covered under your network? The Committee is looking for clarification on what University of Utah services, such as the indicated inpatient care at UNI, are part of your network. Will this included coverage of physical health services provided by the U at Redstone?

Response

We currently provide the behavioral health services for Medicaid members whose physical health is covered by the University of Utah Health Plans, as the University of Utah's Medicaid ACO, *Healthy U*, is one of four ACOs providing physical health services in Salt Lake County. We have a collaborative relationship with Healthy U, coordinating the physical and behavioral health care services of Salt Lake County Medicaid clients.

As noted above, we work with UNI to provide a variety of behavioral health services for Salt Lake County residents and UNI will provide these same services for Optum's Summit County clients.

We currently contract with the U at Redstone for both behavioral and physical health services for our commercial clients and, on award to serve as the LCP for Summit County; we would seek to broaden this relationship to include behavioral health services for clients covered under Medicaid and other County programs.

With respect to “coverage of physical health services provided by Redstone,” if “coverage” means paying for physical health services delivered by Redstone to LCP clients, that would not be paid for by their Medicaid ACO, we are happy to discuss this with the County to understand the funding source for such physical health services and expectations for Optum as the LCP.

If coverage means something different, we look forward to further discussion to clarify expectations.

3. *Within your bid, you talk about any savings from the capitated payments being placed into a Community Reinvestment Fund and also being given out as bonuses to network providers. Please clarify this discrepancy. Is there a percentage break you are planning to use and if so, what is that break?*

Response

All savings will be put into the Community Reinvestment Fund, and it will be at the County’s discretion to determine how to distribute those dollars, e.g., whether to use that money to incentivize providers, build extra capacity, support jail diversion efforts, or to provide supported employment, supported housing, transportation, or training.

4. *Given the need for your own space, how do you plan on providing space for your network providers, such as Sundance Behavioral Resources?*

Response

County-provided space will be prioritized for provider use.

Many of the providers in our network, such as Sundance Behavioral Resources, have agreed to expand capacity and provide services from their own locations in Summit County, upon award of this contract to Optum.

We look forward to working with the County and providers to ensure that we maximize the value of physical space made available by the County.

5. *Please provide details on how UAs will be conducted in terms of collection to ensure samples are actual and from the assigned probationary individual in accordance with Utah Code.*

We will identify specific providers who can provide this service, such as Psychiatric and Behavioral Solutions (PBS), who have experience ensuring that UA samples are actual and from the assigned probationary individuals in accordance with Utah Code. We are in conversations with PBS and other providers to provide these services in Summit County.

As the LCP, Optum Summit County will oversee this process to assure compliance with Utah Code R523-15 for Drug Testing by ensuring that providers have policies and procedures to address: selection of participants, frequency of testing, screening and confirmation, collection and handling, verifying integrity, chain of custody, documentation standards, training requirements, disclosure of results, potential consequences for a positive test, right to request a confirmation test, and procedures to ensure the safety of staff and participants.

Specific assurances of an accurate sample draw could include, but will not be limited to, the following:

- Testing occurs randomly and up to three times per week (as determined by Summit County Felony Drug Court policy and/or Judge).
- Same sex staff at the facility would perform visual verification of the client's midsection to ensure they are not hiding urine or items to alter the sample on their person.
- Same sex staff will observe the sample being taken after instructing the client to wash their hands and empty their pockets.
- Receive the container of urine from the client and prepare (including measuring temperature, providing identifying information and locking up) the sample for pick up by the assigned lab.

Optum has a national contract with virtually every lab in Utah and will have specific pick up times from the identified providers by the chosen lab (such as Quest or LabCorp).

We acknowledge that UA testing support is one of the Ancillary County Supports mentioned in the RFP, and we look forward to working with the County and the drug court(s) to ensure we have locations in Summit County where individuals can provide samples in accordance with Utah code and drug court requirements.

6. *Within your bid, you propose an increased usage of telehealth services. Please provide an estimation of the percentage of services, especially for outpatient, incarcerated, Jail, and school-based services telehealth will play verses treatment from a "live" clinician.*

Response

Telehealth services can help ensure timely access to needed behavioral health services in cases when a "live" clinician is not immediately available. Telehealth can be accessed in the following ways:

- Provided by the client's current behavioral health practitioners delivering medically necessary covered services, in accordance with Utah Medicaid rules and regulations applicable to telehealth services. These would be billed by the provider just as any other service would be billed.
- Via Optum's virtual visit telehealth platform, available to be scheduled by the client, with a Utah licensed behavioral health clinician contracted with Optum as a virtual visit provider, delivering medically necessary covered services. The rendering provider would bill Optum directly for this service. Information pertaining to the visit would be available to any provider seeing the client in an office based setting.

Predicting volumes for telehealth services is difficult and will be impacted by the number of providers with the necessary infrastructure and interest in delivering such services, as well as the willingness of clients to access telehealth services.

Suitability for telehealth services in school-based settings is something we will discuss with school staff and providers delivering services in schools. Our providers and staff will work with school staff to develop a schedule to deliver face to face services in schools, and we expect that the vast majority of students would be treated in this manner. Virtual visits could work in school settings and may be an option if a student has an urgent need and the regular provider is not available. We would only offer telehealth services if school staff and our providers agree that it will be beneficial for their school and students.

Suitability for telehealth services for incarcerated/jailed individuals is something we would want to discuss with jail staff and our providers treating incarcerated clients. Our provider(s) and staff will work with jail staff to develop a schedule to treat incarcerated clients and we expect the majority of individuals would be treated face to face in the jail.

7. Will you be able to provide all outpatient services within Summit County? (Exceptions allowed in emergencies)

Response

Yes, we will be able to provide all standard outpatient services within Summit County, including outpatient care, case management, psychotropic medication management, incarcerated services, and crisis care. We have commitments from both agencies and individual providers that are currently located, or are in the process of locating space, in Summit County to provide outpatient services. Please see the detailed grid in our response to Question #9 below.

8. Will you be able to provide all psychiatric medication management services within Summit County? (Exceptions allowed in emergencies)

Response

Yes, we will be able to provide psychiatric medication management services within Summit County. We have commitments from agencies that are in the process of locating space within Summit County, to provide services which include psychiatric medication management. We are committed to expanding our network of providers for medication management services as needed by the community. Please see the detailed grid in our response to Question #9 below.

9. Several times in your bid you talk about services provided in Summit County and services in the valley. Please provide a specific list of services to be provided in Summit County vs. services provided in the valley.

Response

Optum has examined all levels of care provided in our behavioral health networks and have reached out to our providers to identify those that are committing to providing services in Summit County and those willing to provide services for Summit County members in Salt Lake County.

We would appreciate the opportunity to work collaboratively with Summit County stakeholders to identify additional and current providers who could be of value to the clients in Summit County.

Below are levels of care for both Mental Health and Substance Use treatment levels based on commitments from our provider network.

Levels of Care by Service Area	Age: Child (C), Youth (Y), Adult (A), Senior(S)	Willing to provide services to Summit County clients	Locations from which services would be provided
Mental Health Related Disorders			
Inpatient Hospitalization	C/Y	UNI, SCA's with other providers	Salt Lake County
	A	UNI, University of Utah Medical Center, St. Marks Hospital, Jordan West Valley	Salt Lake County
Residential Treatment	C/Y	New Beginnings, Division of Youth Services (FAST)	Salt Lake County

Levels of Care by Service Area	Age: Child (C), Youth (Y), Adult (A), Senior(S)	Willing to provide services to Summit County clients	Locations from which services would be provided
	A	CORE I, CORE II, Highland Ridge Summit Sub- Acute Unit	Salt Lake County
Outpatient	C/Y	Summit Community Counseling, Psychiatric and Behavioral Solutions (PBS) Hopeful Beginnings, Sun Dance Behavioral, Multi-Cultural Counseling Center and various smaller providers	Summit and Salt Lake Counties
	A	Summit Counseling, PBS, Hopeful Beginnings, Sun Dance Behavioral, VOA (Cornerstone), Multi-Cultural Counseling, and various smaller providers	Summit and Salt Lake Counties
	S	Summit Counseling, PBS, Hopeful Beginnings, Sun Dance Behavioral, and various smaller providers	Summit and Salt Lake Counties
24 Hour Crisis Care	C/Y	Hopeful Beginnings, Summit Community Counseling, Division of Youth Services	Summit County
	A	Hopeful Beginnings, Summit Community Counseling	Summit County
Psychotropic Medication Management	C/Y	Odyssey House, First Step House, House of Hope, Clinical Consultants, SunDance, Hopeful Beginnings, Psychiatric and Behavioral Solutions, Other smaller providers	Summit and Salt Lake Counties
	A	Odyssey House, First Step House, House of Hope, Clinical Consultants, SunDance, Hopeful Beginnings, Psychiatric and Behavioral Solutions, Other smaller providers	Summit and Salt Lake Counties
Psychoeducation and Psychosocial Rehabilitation	C/Y	Hopeful Beginnings, Summit Community Counseling, Odyssey House, Youth Empowerment	Summit County

Levels of Care by Service Area	Age: Child (C), Youth (Y), Adult (A), Senior(S)	Willing to provide services to Summit County clients	Locations from which services would be provided
	A	VOA, Summit Community Counseling, Psychiatric and Behavioral Solutions, Alliance House	Summit County and Salt Lake County
Case Management	C/Y	PBS, Asian Association, Summit Counseling, Hopeful Beginnings, Youth Services	Summit County
	A	Silverado, PBS, VOA, Asian Association	Summit County
Adult Community Supports	A	Summit County Housing Authority, Summit County Senior Citizen Services, Adult Protective Services	Summit and Salt Lake Counties
Respite Care	C/Y	Summit Community Counseling , Hopeful Beginnings	Summit County
Peer Services and Supports	C/Y	Hopeful Beginnings	Summit County (Family Resource Facilitators)
	A	Asian Association, Asian Association, SunDance,	Summit and Salt Lake Counties
Consultation and Education Services	C/Y	Optum Team	Summit and Salt Lake Counties
	A	Optum Team	Summit and Salt Lake Counties
Services to Incarcerated Individuals	A/S	Psychiatric and Behavioral Solutions, Summit Community Counseling, Hopeful Beginnings	Summit County
Outplacement Services	All	Network	Summit and Salt Lake Counties
Unfunded Clients	All	Network	Summit and Salt Lake Counties
School Based Services	Y	Hopeful Beginnings, Odyssey House	Summit County

Levels of Care by Service Area	Age: Child (C), Youth (Y), Adult (A), Senior(S)	Willing to provide services to Summit County clients	Locations from which services would be provided
Other Services	All	Summit County Mental Wellness Alliance, The Christian Center, CONNECT Summit County, Alcoholics Anonymous, Narcotics Anonymous, National Alliance of Mentally Ill, The Senior Center	Summit County
Justice Reinvestment Initiative (JRI)		Optum Team in conjunction with Network Providers and Community Stakeholders	Summit County
Substance -Related Disorders			
SUD Screening and Assessment Services	All	Clinical Consultants, Odyssey House, First Step House, Volunteers of America, Asian Association of Utah, Ascendant, Psychiatric and Behavioral Solutions, House of Hope, Project Reality, Salt Lake County Youth Services	Summit and Salt Lake Counties
SUD Detoxifications Services	A/S	Volunteers of America	Salt Lake County
Residential SUD Treatment Services	A/S	First Step House, House of Hope, Odyssey House	Salt Lake County
Outpatient (Non-Methadone 0 ASAM 1.0)	Y	Clinical Consultants, Odyssey House, Volunteers of America, Ascendant, Psychiatric and Behavioral Solutions, Project Reality, Asian Association, First Step House, House of Hope, Salt Lake County Division of Youth Services	Summit and Salt Lake Counties
	A	Clinical Consultants, Odyssey House, Volunteers of America, Ascendant, Psychiatric and Behavioral Solutions	Summit and Salt Lake Counties
Outpatient (Methadone - ASAM 1.0)	Y/A	Project Reality	Salt Lake County
Office-Based Opioid Treatment (Vivitrol, Naltrexone, Buprenorphine)	All	Clinical Consultants, Project Reality, Odyssey House	Salt Lake County

Levels of Care by Service Area	Age: Child (C), Youth (Y), Adult (A), Senior(S)	Willing to provide services to Summit County clients	Locations from which services would be provided
Intensive Outpatient (2.5 or 2.1)	Y	Volunteers of America, Salt Lake County Division of Youth Services, Odyssey House	Salt Lake County
	A	Odyssey House, First Step House, House of Hope	Salt Lake County
Recovery Support Services	All	USARA, Alcoholics Anonymous (AA), Narcotics Anonymous, NAMI	Summit and Salt Lake Counties
Peer Support Services	A/S	Odyssey House, First Step House, Volunteers of America	Summit and Salt Lake Counties
Opioid Treatment Funds (STR and SOR)		Project Reality	Salt Lake County
Services to Persons Incarcerated in the Summit County Jail	A/S	Psychiatric and Behavioral Solutions	Summit County
Integrated Care	All	Odyssey House (Martindale Clinic), Fourth Street Clinic (Wasatch Homeless Health Care)	Salt Lake County
Women's Treatment	All	House of Hope, Volunteers of America, Odyssey House	Salt Lake County
Adolescent (Youth) Treatment	Y	Salt Lake County Division of Youth Services, Psychiatric and Behavioral Solutions, Asian Association, Volunteers of America, Odyssey House	Summit and Salt Lake Counties
Drug Court	All	Psychiatric and Behavioral Solutions	Summit County
Justice Reinvestment Initiative (JRI)		Optum Team in conjunction with Network Providers and Community Stakeholders	Summit County

10. On Attachment B, are the “Position Totals” salary only, or salary & benefits?

Response

Amounts shown on Attachment B as “Position Totals” include both salary and benefits.

11. Please clarify the extent and service type you propose to provide in the Summit County Jail?

Response

We will provide all routine and urgent behavioral health services for incarcerated individuals in the Summit County Jail through face to face visits with our contracted providers. Crisis assessments will either be done face to face or via telehealth with our local providers, who will work with jail staff to ensure the client is connected with needed services and supports.

Our providers will work with jail staff to set up regularly scheduled hours to visit incarcerated individuals. As noted above, if jail staff and our local providers believe a telehealth visit could be an effective option, to the extent that there is an urgent need and a local provider is not immediately available, we will make a virtual visit available.

12. What is your distinction between “Urgent Care” and “Crisis Care”?

Response

We consider “crisis care” to be emergent care requiring treatment provided face to face within one hour or telephonically within 30 minutes as required by Utah Medicaid Timely Access Standards. Crisis care is offered when, as determined by clinical triage, a person is experiencing an acute psychiatric condition that is interfering with current functioning.

“Urgent Care,” as determined by clinical triage, is defined as care provided that requires prompt attention but not of such seriousness as to require crisis care. Per Utah Medicaid guidelines, urgent care requires an in-person mental health evaluation to be rendered within five business days.

Please let us know if we can clarify any additional responses or answer any other questions. Inquiries can be directed to Blaine Bergeson at blaine.bergeson@optum.com, or (602) 821-4631.

Best regards,

Blaine Bergeson

Blaine Bergeson
VP Business Development-Public Sector



March 13, 2019

Dear Review Committee,

University of Utah Health Plans (UUHP) is pleased to provide you with our bid for Summit County behavioral health services. As outlined in our proposal response, UUHP intends to collaborate closely with Summit County to build a strong behavioral health service platform for Summit County residents, giving them improved access to quality behavioral health services. In collaboration with the county, we're confident access to quality behavioral health services will be optimized; thereby improving the overall health of the 41,000 residents of Summit County.

UUHP understands that funding for behavioral health services is finite, and every dollar plays an important role in ensuring clients receive needed services. To maximize every dollar available to Summit County, UUHP's proposal is data driven and scalable; driven by Summit County's priorities, budget, and client utilization needs. To assist Summit County in capturing as much funding as possible, the University of Utah will also explore an Intergovernmental Transfer of its own money, which could infuse additional funding into Summit County's behavioral health program, subject to state and federal approval.

UUHP has a close partnership with the University of Utah Neuropsychiatric Institute (UNI). UNI has committed to collaborate closely with UUHP and Summit County to deliver the services outlined in the RFP. UUHP's partnership with UNI gives Summit County unique access to UNI's providers, resident physicians, telehealth services, and crisis services.

The mission of the University of Utah Health Plans is to serve the people of Utah by improving health and quality of life, providing access to the highest quality of care, and delivering exceptional value to our members, clients, and the community. Partnering with Summit County to deliver behavioral health services aligns closely with this mission and our goals. We look forward to the opportunity to review our proposal and capabilities with you in the near future.

UUHP operates on behalf of the University of Utah and is a body politic and corporate of the State of Utah. UUHP is willing to enter into an agreement with Summit County. UUHP agrees to conform to County assurances, excluding where exceptions are identified. I am authorized to commit UUHP to this proposal.

Best Regards,

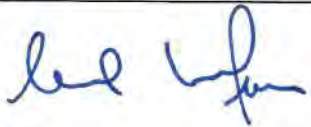
A handwritten signature in blue ink, appearing to read 'Chad Westover', is written over the 'Best Regards,' text.

Chad Westover
CEO, University of Utah Health Plans
6053 Fashion Square Drive, Suite 110
Murray Utah, 84107
(801)-587-6480

Attachment A
Agency Confirmation
Mental Health & SUD Contract 2019

Legal Name of Agency:			
University of Utah Health Plans			
Doing Business As (if applicable):			
Address:	City	State	Zip Code
6053 Fashion Square Drive, Suite 110	Salt Lake City	UT	84107
RFP Contact Person		Telephone Number	
Julie Ewing		801-213-0178	
E-Mail:			
julie.ewing@utah.edu			

I certify that to the best of my knowledge the information contained in this proposal is accurate and complete and that I have the legal authority to commit this organization to a contractual agreement. I realize the final funding for any service is based upon funding levels and the approval of the Summit County Council.

Agency's Authorized Representative	Date
Chad Westover	3-12-19
	Title or Position with Agency
	Chief Executive Officer
Signature of Authorized Representative	
	

Additional Individual to keep informed of the RFP Status.	
RFP Contact Person	Telephone Number
Jennifer Muhlstein	801-587-2827
E-Mail:	
Jennifer.Muhlstein@hsc.utah.edu	



Summit County RFP Executive Summary

INTRODUCTION

University of Utah Health Plans (UUHP) was formed in 1998 as a strategic initiative of University of Utah Health. We are specialists in health plan administration. We currently administer medical, behavioral health, and pharmacy benefits. Our health plan administration includes fully insured and self-funded employer groups, Marketplace plans, as well as government programs including Medicare and Medicaid. Our status as a not-for-profit, government agency allows us to be unapologetically member-oriented. We currently serve 201,000 members, 1,500 of those in Summit County.

UUHP's mission is to serve the people of Utah by improving health and quality of life, providing access to the highest quality of care, and delivering exceptional value to our members, clients, and the community. To enhance value and ensure excellence in patient care, education, and research, we are integrated with the University of Utah and University Health. A partnership with Summit County aligns well with our mission and we are eager to bring UUHP's expertise to Summit County.

OUR PROPOSED SOLUTION FOR SUMMIT COUNTY

UUHP's proposal centers on four components:

- Community Partnership
- Medicaid Managed Care and State Match Funding Assistance
- Unique Provider-Partnership with the University Neuropsychiatric Institute and the University of Utah Department of Psychiatry
- Mandated Services and Division Directives using a Collaborative, Strategic, and Phased Approach

We believe successful implementation of these four components will lead to increased healthcare access and better health outcomes for Summit County residents.

Community Partnership

The first and most important component of UUHP's proposal is community partnership. We are committed to being a partner to Summit County and to assist in implementing its Strategic Plan. We understand that cities like Park City, Kamas, and Coalville each have unique behavioral health needs and a one-size-fits-all approach will not be effective. We believe that the effectiveness, affordability, and success of our solutions hinge on developing good relationships with the Summit County community. The first step in most of our proposal responses is working with a community partner to assess Summit County's behavioral health needs and available services to identify gaps in care we can address.

UUHP will assign a program manager to liaise with the Summit County Community and oversee the Summit County contract. Our program manager will also work with community groups like CONNECT Summit County, and the Summit County Mental Wellness Alliance to ensure that our efforts are meeting community needs.

We will also assign one of our Nurse Care Managers to review, assess, and develop relationships with community resources. Having a care manager closely connected to the Summit County community will ensure that Summit County clients who require care management are connected to every available resource.

Medicaid Managed Care and State Match Funding Assistance

UUHP has partnered with Utah Medicaid for more than 20 years. We understand Medicaid requirements and can administer the Medicaid services in compliance with Medicaid regulations, ensuring that Medicaid funding to Summit County will be secure and not subject to disallowance. Our understanding of Medicaid funding and its position as a government agency also allows us to offer Summit County an opportunity for state-match funding assistance. This matching assistance is further outlined in *Attachment I*.

Medicaid Managed Care: UUHP has been a Medicaid Managed Care Plan since 1998. We are contracted with Utah Medicaid as an ACO and currently deliver services to 49,000 Medicaid members statewide. As a Medicaid ACO, we deliver Medicaid physical health services to 300 residents of Summit County. UUHP's managed care model incorporates care management to improve healthcare outcomes for Medicaid members, which in turn, drives down the members' healthcare costs. We also use strategic utilization review policies and procedures to ensure that providers are delivering appropriate, medically necessary care to members while avoiding unnecessary denials.

UUHP is proposing to act as Summit County's Prepaid Mental Health Plan (PMHP), and will ensure that Medicaid-eligible individuals have access to Medicaid covered services through a network of enrolled Medicaid providers. UUHP proposes to will deliver these services on a capitated risk basis, subject to the conditions more fully outlined in *Attachment I*.

State Match Funding Assistance: UUHP is in a unique position to be able to offer an additional Medicaid funding arrangement to enhance overall support for Summit County behavioral health program while limiting the financial burden to Summit County. The full details of this funding proposal are outlined in *Attachment I*.

Unique Provider-Partnership with the University Neuropsychiatric Institute and University of Utah Department of Psychiatry

UUHP has secured a significant partnership with the University Neuropsychiatric Institute (UNI) and the Department of Psychiatry to deliver services under this RFP. UNI has committed to collaborate with UUHP and Summit County to build the provider network and other infrastructure required to meet Summit County's behavioral health needs. This partnership with UNI will give Summit County extraordinary access to UNI's specialized services, including, but not limited to, the following:

- UNI has a strong telehealth network to deliver services to Summit County's hard-to-reach communities. Telehealth services can also be utilized to deliver services to individuals in the Summit County jail.
- UNI operates the GATE program, a web-based consultation model that extends mental health services to children and adults through patient-centered consultations between primary care physicians and psychiatric specialists.
- The UNI Receiving Center offers up to 23 hours of services including therapeutic crisis management, an assessment based on strengths and psychiatric needs, medication intervention, and wellness recover/discharge planning.
- The UNI Same-Day Psychiatry Clinic provides same-day appointments, Monday through Friday.
- UNI operates SafeUT, a statewide, text-based service that provides real-time crisis intervention and confidential tip reporting for Utah's youth. UNI is willing to explore workflows to coordinate any Summit County-related tips back to Summit County schools for intervention and follow-up.

- When Summit County develops its MCOT team, UNI can arrange for providers to serve as back-up members of that team.
- UNI provides immediate peer support and crisis intervention through its Warm Line and Crisis Line, and includes a dedicated number for UUHP members allowing for expedited coordination with our behavioral therapy care managers.

Despite nationwide shortages of behavioral health providers, UNI oversees a strong network of behavioral health providers and is regarded as Utah's leading behavioral health experts. UNI also has the ability to coordinate with physicians, clinicians and physician residents training at the University of Utah to deliver services in Summit County. Our hope is that by exposing resident physicians to Summit County's communities, these physicians will be inclined to stay in those communities once their residency is completed.

Mandated Services and Division Directives using a Collaborative, Strategic, and Phased Approach

UUHP understands that funding for behavioral health services is finite and every dollar plays an important role in ensuring clients receive needed services. To maximize every dollar available to Summit County, UUHP's proposal is data driven and scalable; driven by Summit County's priorities, budget, and client utilization.

UUHP, in collaboration with UNI and additional community providers, is confident that our combined resources are sufficient to assist Summit County meet its Mandated Service requirements and Division Directives over a period of 12 to 24 months after contract execution. The details of how UUHP will meet the Mandated Service requirements and Division Directives are outlined in our responses in Form A, Form B, and *Attachment 1*. UUHP proposes that some of these services be reimbursed on a Fee-For-Service basis and others be reimbursed through an administrative contract, as detailed in Form A, Form B, and *Attachment 1*.

CONCLUSION

University of Utah Health Plans is uniquely positioned to provide access to world-class behavioral health care to Summit County residents. Through our collaboration with UNI, we can ensure residents receive the appropriate care where and when they need it. We have the infrastructure in place to administer claims accurately and timely. Moreover, we have expert knowledge of the Medicaid program to ensure our programs are fully compliant with Medicaid requirements. We are a trusted resource in the community with a rich history of community partnerships.

University of Utah Health Plans is committed to be a health care partner distinguished by collaboration, excellence, leadership, and respect.

More than insurance—this is personal.

RFP # SUCO20197552

FORM A - GOVERNANCE & OVERSIGHT NARRATIVE

Submitting Agency (LCP): University of Utah Health Plans

Instructions:

The following form is modeled off of the annual Area Plan the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County and the RFP process. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form A is limited to a maximum of 40 pages.** Refer to Section VII of the RFP to ensure all required services and metrics are provided in your provided responses. FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here:

https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for the fiscal year. Funding contracts are for July 1st to June 30th.

1) LCP Qualifications

Is the LCP a licensed non-profit or governmental agency (Special Service District) eligible to receive Medicaid funding?
Yes. UUHP operates on behalf of the University of Utah and is a body politic and corporate of the State of Utah.
Does the LCP have at least ten years of experience providing mental health services?
Yes. UUHP will have network providers with at least ten years of experience providing mental health services.
Does the LCP have at least ten years of experience providing substance abuse services?
Yes. UUHP will have network providers with at least ten years of experience providing substance abuse services.
Does the LCP have at least five years of experience providing case management to children, youth, adults and families
Yes. UUHP has been providing case management services since its founding in 1998.
LCP will provide evidence of being licensed in the State of Utah, Department of Human Services and Office of Licensing to provide the requested services.
The University of Utah is licensed as a TPA in the State of Utah, license number 486410. UUHP is authorized to provide Medicaid managed care services in accordance with 42 CFR 438 116.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

2) Experience and Capability

Provide your mission statement and describe how it supports the community behavioral health model of service.

UUHP strongly supports a community-based approach to behavioral health care. Integrating behavioral health services into a community lends to the destigmatization of mental health and substance use disorders. A local provider network ensures individuals can access needed care, which improves the overall health of a community.

UUHP's mission supports the community behavioral health model of service. UUHP's mission is to serve the people of Utah by improving health and quality of life, providing access to the highest quality of care, and delivering exceptional value to our members, clients, and the community. To enhance value and ensure excellence in patient care, education, and research, we are integrated with the University of Utah and University Health.

UUHP's mission statement aligns closely with the mission statement outlined in Summit County's Mental Wellness Strategic Plan. Both mission statements focus on improving quality of life and increasing access to service.

Describe, in detail, your experience with providing the services outlined in this RFP.

UUHP was formed in 1998 as a strategic initiative of University of Utah Health. We are specialists in health plan administration. We currently administer medical, behavioral health, and pharmacy benefits. Our health plan administration includes fully insured and self-funded employer groups, Marketplace plans, as well as government programs including Medicare and Medicaid. Our status as a not-for-profit government agency allows us to be unapologetically member-oriented. We currently serve 201,000 members; 1,500 of those in Summit County. UUHP's Marketplace and Group plans include behavioral health benefits, and we have experience providing case management services to individuals with behavioral health needs.

We are contracted with Utah Medicaid as an ACO and provide services to 49,000 Medicaid members statewide, including 300 members in Summit County. As a contracted ACO, UUHP can meet all state Medicaid requirements. UUHP has the ability to exchange enrollment and encounter data files with Utah Medicaid. UUHP can and does operate a Medicaid Managed Care plan in compliance with applicable Medicaid regulations.

Our close partnership with the University Neuropsychiatric Institute (UNI) and the University of Utah's Department of Psychiatry allows us to have access to some of the leading behavioral health providers in the state, as well as the ability to develop creative solutions to address behavioral therapy needs.

All of our operations are Utah-based and we employ nearly 300 local staff who provide customer service, provider relations, care management, utilization review, pharmacy management, compliance, and IT services to support our mission.

If you currently serve as an LCP in a Mental Health or Subsistence Abuse District contiguous to Summit County, this lend to improving services in Summit County?

UUHP is not currently an LCP in a contiguous county.

Currently, the Department will provide space for clinicians in the Kamas (2 offices and a private waiting area) and Coalville (1 office space and shared waiting area) Health Department Offices. Space in Park City will be available, located at a central transit hub, the Summer for 2020. During the interim, temporary space has been secured for 12 months. Will you require this Park City space, or will you plan on finding your own Park City / Kimball Junction offices?

UUHP will have providers with offices in Summit County. UUHP would be interested in utilizing the space available in Kamas and Coalville. UUHP is also interested in utilizing the space in Park City once it becomes available in 2020.

Describe LCP's experience and capability to deliver, track, and bill Medicaid services and manage operations.

UUHP has more than 20 years of experience delivering, tracking, and billing Medicaid services, as well as managing operations. UUHP is contracted as an ACO with Utah Medicaid and has been a Medicaid ACO since 2013. We deliver physical health services to UUHP Medicaid members statewide. Currently, we serve 49,500 Medicaid members, including 300 in Summit County. UUHP also acts as the Third Party Administrator for the H.O.M.E. program, which is a Medicaid program that delivers integrated services to Medicaid members who have co-occurring behavioral health and mental health needs. UUHP has experience in providing all Medicaid required reports, and has the ability to accept electronic enrollment files from Medicaid and transmit required encounter data to Utah Medicaid. All of our operations are Utah-based. UUHP employs over 200 staff that support our Medicaid operations.

Describe LCP's experience with Quality Management, including a plan capable of adhering to DSAMH documentation standard and requirements.

- Staffing, supervision, training, retention, and leadership,
- Systems of quality assurance as it relates to clinical chart documentation and compliance,
- Capacity and plan to perform quality improvement activities, data entry, data and outcome tracking and program evaluation

UUHP has significant experience in quality management and operates an NCQA-accredited Marketplace plan. UUHP has an ongoing, comprehensive Quality Improvement Program based on and aligned with the National Quality Strategy, the Triple Aim, the State of Utah Medicaid Managed Care Quality Strategy, CMS guidelines and University of Utah Health's strategic goals. UUHP believes that the Quality Improvement Program is an integral part of business operations; our quality program is embedded throughout all UUHP departments and applies to all of UUHP's lines of business. UUHP operates a Quality Improvement Council, chaired by UUHP's Chief Medical Officer. The Quality Improvement Council oversees implementation of the Quality Improvement Program and works to ensure that UUHP members are receiving the highest possible quality of care. UUHP's quality improvement efforts also extend to its provider Credentialing and Sanction Committees which ensure that any complaints about provider care are appropriately documented and addressed.

Describe LCP's experience with Quality Management, including staffing, supervision, training and leadership.

UUHP's Quality team is a staff of six people who oversee UUHP's quality program, and work in close collaboration with our Care Management team. The Quality team reports to our Director of Clinical Operations, working in conjunction with the Chief Medical Officer.

Describe LCP's experience with Quality Management, including systems of quality assurance as it relates to clinical chart documentation and compliance.

UUHP's Medicaid, Marketplace, and commercial lines of business are required to conduct HEDIS reporting. Some HEDIS measures are calculated using a contracted provider's medical charts. At the end of the HEDIS reporting period, if UUHP has identified that there are providers whose medical charts are insufficient, a member of the Quality team will go on-site to the provider and provide education to the provider on how to improve their medical charting.

Describe LCP's experience with Quality Management, including capacity and plan to perform quality improvement activities, data entry, data and outcome tracking and program evaluation.

UUHP has a robust data analytics program that supports its Quality Management Program. UUHP uses its data analytics to identify members who may be in need of case management.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

3) Staffing and Administration

Describe, in detail, LCP's Organizational Structure, including:

1. Staffing capacity to perform all functions in this RFP,
2. Mental Health Treatment Staffing Plan showing proposed treatment FTEs by profession and where reporting structure, clinical supervisor to staff ratios, staff to client ratios, professional credentialing and staff specialization.
3. SUD Treatment Staffing Plan showing proposed treatment FTEs by profession and where reporting structure, clinical supervisor to staff ratios, staff to client ratios, professional credentialing and staff specialization.
4. QM Staffing Plan including staff for QI activities, data entry, data and outcomes tracking, and program evaluation functions.
5. Staff Supervision Model that includes a description of the role of the clinical supervisor(s) in staff coaching, client care, and QI and service utilization activities.
6. Treatment Services Staff Training Schedule and Technical Assistance Plan

UUHP's administrative structure includes a staff of nearly 300 people. UUHP intends to utilize a contracted network to deliver services to Summit County. The utilization data provided in this RFP was not sufficient for UUHP to determine staffing ratios and provide the detailed information as requested above. However, UUHP has a close relationship with the University Neuropsychiatric Institute (UNI) and the University of Utah Department of Psychiatry. UUHP intends to work collaboratively with Summit County, UNI, and the Department of Psychiatry to identify areas of need in Summit County and ensure there are sufficient providers to meet Summit County residents' utilization needs.

Describe, in detail, LCP's communication plan and ability to inform and communicate with the public and beneficiaries regarding services.

UUHP has a skilled Marketing Department that UUHP will use to inform and communicate with the public and beneficiaries regarding available services. UUHP's Marketing team can develop websites, print materials, and attend community events as mutually agreed upon by UUHP and Summit County. UUHP will create a website for Summit County clients describing available services and linking clients to available UUHP and community resources. UUHP will develop a member handbook for Medicaid-eligible enrollees which will provide them with information relative to their benefit. If Summit County determines that there is a need for in-person classes UUHP and UNI staff may also be made available to participate in community discussions or training.

Describe, in detail, LCP's plan and ability to recruit and retain quality staff members, including those able to provide competent, culturally aware, and linguistically accurate care in Spanish.

UUHP will use its Healthy U provider network which is comprised of U Health, UNI, Sundance Behavioral Resources, and local Summit County mental health and substance use providers. UUHP will work collaboratively with Summit County to determine where Spanish-speaking treatment needs exist and work with UNI and other network providers to identify any network providers who may be able to assist in filling those voids either in-person, through interpretive services, or via telehealth. UUHP has already recruited several Spanish-speaking providers for the Healthy U provider network in Summit County. Ongoing, UNI has also committed to recruit Spanish-Speaking providers that will be available to clients in Summit County. UUHP's staff undergoes

cultural competency training on a yearly basis and UUHP already provides cultural sensitivity and diversity training to network providers. UUHP's Healthy U provider network has had very limited turn-over since its inception, outside normal activity such as retirement. We believe the very limited number of provider network terminations is due to UUHP's exceptional provider relations and customer service departments. Expedited claims processing time contributes to the provider network's satisfaction with UUHP as an administrator.

Describe, in detail, LCP's support programs located outside of the District

UUHP's support programs and contracted providers located outside of Summit County include the following:

University Neuropsychiatric Institute: Offers inpatient mental and behavioral health services for adults, adolescents, and children; and inpatient detox services for adults.

Consult/Rapid Access Clinic: A PCP-referral based clinic providing medication management and one-time psychiatric assessments for adults, adolescents, and children.

Girls Transition Center: A residential treatment facility for adolescent females ranging in age from 12-17. GTC offers an intermediate, secure residential treatment program for teenage girls either in transition or needing focused care. This program works in conjunction with the Division of Child and Family Services or Juvenile Justice Service.

Receiving Center (located at UNI): Offers up to 23 hours of services including therapeutic crisis management, an assessment based on strengths and psychiatric needs, medication intervention, and wellness recovery/discharge planning. (Note that these services are not reimbursable by Medicaid.)

Recovery Clinic: Offers addiction recovery and a robust MAT program.

Recovery Works: Provides adult IOP services.

Same Day Psychiatry Clinic (located at UNI): Offers same-day appointments, Monday-Friday, for ages 5 and older.

UNI Downtown Behavioral Health Clinic: Offers mental health therapy for individuals 4 years of age and older.

CrisisLine: Available 24/7 and staffed by licensed clinicians for individuals who are in emotional or psychiatric distress.

WarmLine: Available 24/7, offering peer support for individuals who are in emotional or psychiatric distress.

SafeUT: Mobile app download that provides crisis text and tip line providing real-time intervention to youth.

GATE Program: A web-based consultation model which extends mental health services to children and adults through patient-centered consultations between primary care physicians and psychiatric specialists.

Describe, in detail, LCP's ability to ensure that all services outlined in this RFP are provided by staff with required credentials and licenses.

UUHP credentials network providers according to standards specified by NCQA and Medicaid credentialing requirements. Providers are primary-source verified by UUHP's Credentialing Verification Organization (CVO) who verifies (as applicable by provider type): Licensure, Accreditation, CLIA, DEA, Education, Board Certification, Work History, Malpractice History, Certificate of Insurance, National Practitioner Data Bank, Office of Inspector General, System for Award Management. In some situations, UUHP may delegate credentialing to a provider practice which in turn, must meet the same NCQA and Medicaid credentialing standards, and must be audited by UUHP on an annual basis.

Providers are re-credentialed by UUHP every three to five years depending on the provider type and applicable licensures are reverified.

Credentialing activities are approved through the UUHP Credentialing Committee, chaired by the Assistant Chief Medical Officer, and comprised of local community providers representing multiple specialties alongside legal and risk management representation.

LCP meets the minimum General Insurance requirements of this RFP as outlined in Section 2-IV-G: Yes/No

Yes.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) LCP's Audited Financial Statement

Describe, in detail, LCP's overall organizational structure, including:

- LCP's audited financial statements as Attachment H and provide written explanation of any of the following findings:
 - Auditor presents a qualified audit opinion,
 - Balance sheet liability exceed assets,
 - There are overdue payments due to a State or Federal agency,
 - There is a Federal or State account currently in collections,
 - There is current pending litigation for fraud, misrepresentation, errors or omissions involving one or more current or former employees of the organization,

- Auditor notes or footnotes that indicate:
 - Organizational instability or uncertainty as to its ability to continue in its current business,
 - Overdue State/Federal amounts,
 - Pending litigation involving organizations' employees, management, director or Board of Directors.

UUHP operates on behalf of the University of Utah, a body politic and corporate of the State of Utah.

There are no auditor findings or footnotes requiring explanation.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

5) Access & Eligibility for Mental Health and/or Substance Abuse Clients

How will you inform the public on what services are available?

UUHP has a skilled Marketing Department that UUHP will use to inform and communicate with the public and beneficiaries regarding available services. UUHP's Marketing team can develop websites, print materials, and attend community events as mutually agreed upon by UUHP and Summit County. UUHP will create a website for Summit County clients describing available services and linking clients to available UUHP and community resources. UUHP will develop a member handbook for Medicaid-eligible enrollees which will provide them with information relative to their benefit. If Summit County determines that there is a need for in-person classes, UUHP and UNI staff may also be made available to participate in community discussions or training.

What are your projected days and hours of operations, including holidays?

UUHP offers customer service Monday-Friday from 8 a.m. to 6 p.m., excluding national holidays and the day after Thanksgiving. Clients in crisis may also call the CrisisLine which is available 24-hours a day, 7-days a week, and has appointment scheduling capabilities.

Describe LCP's format or scheduling appointments, including any triage measures used to reduce wait-times.

UUHP has an access-assistance team who assists clients in scheduling appointments with providers. Clients in crisis may also call the CrisisLine which is available 24-hours a day, 7-days a week, and has appointment scheduling capabilities.

UNI's Same Day Psychiatry Clinic offers same-day appointments, Monday-Friday.

The UNI Consult Clinic will provide a one-time psychiatric assessment for individuals with a referring physician who completes a referral form and agrees to receive and implement treatment recommendations from the clinic's psychiatrists.

The UNI Same Day Psychiatric Clinic provides same-day appointments on a first-come, first-serve basis for medication management and counseling services.

What are the criteria used to determine who is eligible for a public subsidy?

Prior to September 1, 2019, UUHP will work collaboratively with Summit County staff to:
(1) Assess the existing sliding fee schedule used by the incumbent provider and determine if it is still appropriate for UUHP's network model; and
(2) Determine whether, from an administrative perspective, the sliding fee scale determinations for Summit county patients are best made by network providers, UUHP staff, or Summit County staff. UUHP anticipates that the sliding fee schedule will be determined based off an individual's income, number of dependents, residency, and insurance availability.

Has the LCP met the services and metrics of this required service?

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6) Subcontractor Monitoring

Describe how subcontractors are selected and what criteria is utilized.

UUHP network provider applications are considered based on several criteria, including but not limited to: network adequacy requirements based on state/federal guidelines, network adequacy needs based on the current or expected population of a given geographic area, network adequacy based on provider type or specialty, scope of services, referral patterns, quality measures where appropriate, published patient surveys, and credentialing requirements. In limited situations, UUHP may exclude or remove providers from its panel for cause or as needed for business or other reasons. In all situations, network providers must be approved by and through UUHP's credentialing process and committee. UUHP's credentialing process meets Medicaid and NCQA's provider credentialing requirements.

Describe how monitoring will be conducted, what items will be monitored, and how required documentation will be kept up-to-date for subcontractors.

UUHP will work in partnership with Summit County and DSAMH to develop an audit protocol and audit schedule to ensure providers are meeting applicable record keeping requirements. UUHP has an existing schedule for provider credentialing and recredentials each provider every three to five years, depending on the provider type. UUHP has a mechanism to monitor client complaints regarding providers and refers such complaints to its Provider Sanctions Committee for review and follow-up. UUHP has an existing database, called Genie, which tracks provider demographics, credentialing deadlines and associated documents, complaints, and license

information. UUHP has a regular monitoring process to ensure all appropriate credentialing-related documentation is current and no new sanctions have been filed or imposed.

What services outlined in this RFP will you require subcontractors for?

UUHP's provider network will be a contracted network. UUHP reserves the right to enter into additional subcontracts, as needed, to meet the requirements of this RFP.

Has the LCP met the services and metrics of this required service?

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7) Transition and Implementation Plan (Unless current LCP)

Describe your plan for hiring and on-boarding staff to serve Summit County. Include details on any plans to retain current clinicians and case managers to maintain continuity of care.

UUHP's initial provider recruitment efforts will be directed to providers who have experience treating individuals in Summit County. UUHP will then look to supplement that network with services delivered via telehealth, providers available with UNI's network, and Residents in training at the University of Utah.

To ensure continuity of care (and depending on the needs of the clients), UUHP's Care Management team will work individually with members to either transition the clients to providers on UUHP's network or initiate single case agreements with the client's existing provider(s). UUHP's Care Management team works closely with its Provider Contracting department to refer providers for network participation as well.

UUHP plans to hire a program manager who will oversee the program and develop relationships with community partners within Summit County. Additionally, UUHP's Provider Relations department has a consultant who works directly with Summit County network providers, serving as a local resource for education, on-boarding, claims resolution, etc.

UUHP expects that its existing Care Management staff can provide services for purposes of this contract, and will monitor case management utilization and add additional staff as appropriate.

Describe your plan for transferring of all files related to the care of clients, including IT Infrastructure development.

UUHP currently has the ability to accept Medicaid electronic enrollment files and to submit encounter data to Medicaid. UUHP will work with Summit County and DSAMH to determine the nature of the interface required for DSAMH-required reporting. If additional interfaces (rather than a data file transfer) are required, UUHP reserves the right to price this out separately as a cost of implementation during the contract negotiation.

Describe your plan for mitigating client attrition due to LCP change.

UUHP will work collaboratively with the current LCP and Summit County to ensure Summit County clients currently in treatment have continuity of care to the fullest extent possible. In order for UUHP to do this effectively, UUHP will need a list from the existing LCP of their patients currently in treatment, as well as the names of their treating providers. Depending on the needs of the existing clients, UUHP will either transition the clients to providers on UUHP's network or enter into network provider agreements or single case agreements with the client's existing providers. UUHP will also require information regarding clients currently being case managed by the current LCP; UUHP's team of case managers will work to ensure current treatment plans are uninterrupted to the fullest extent possible.

Has the LCP met the services and metrics of this required service?

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- END OF FORM A-

ATTACHMENT B: Budget and Staffing

UUHP's proposal and its associated costs and staffing depends upon the scope of the work and available funding negotiated in collaboration with Summit County. Accordingly, UUHP is unable to provide a detailed budget. At minimum, UUHP expects that there will be involvement from at least three staff members during implementation which is reflected in the included spreadsheet. UUHP expects that additional members of its 300 member workforce will also assist in contract activities, but has not included those costs pending negotiation with Summit County.

Additionally, because UUHP intends to use a contracted provider network salary costs are unavailable.

Classification	Title	License/Certification	FTE	Benefit Percentage	Funded from Contract	Percentage	Funding from LCP	Percentage	Position Total
Administration	Program Manager	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Case Management	Nurse Case Manager	RN	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Administrative and Clinical	Dynamic Site Manager	LCSW	1	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Adult and Child Outpatient Mental Health Services	CSW or LCSW	3 or 4	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Adult and Child Outpatient Substance use services, including IPO Program	CSW or LCSW	3 or 4	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Drug Court	CSW or LCSW	1 or 2	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Spanish Speaking Services	CSW or LCSW	2 or 3	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	All Program	Psychologist	1	TBD	TBD	TBD	TBD	TBD	TBD
Case Management	All Program	RN	1	TBD	TBD	TBD	TBD	TBD	TBD
Administration	Office Manager	TBD	1	TBD	TBD	TBD	TBD	TBD	TBD
Administration	Support Staff	TBD	2	TBD	TBD	TBD	TBD	TBD	TBD
Peer Support	Peer Counselor	TBD	2	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Medication Provider	APRN	1.5	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Medication Provider, Adult	Psychiatrist	1	TBD	TBD	TBD	TBD	TBD	TBD
Clinician	Medication Provider, Child	Psychiatrist	0.5	TBD	TBD	TBD	TBD	TBD	TBD

RFP # SUCO20197552

FORM B - MENTAL HEALTH BUDGET NARRATIVE

Submitting Agency (LCP): University of Utah Health Plans

Instructions:

The following form is modeled off of the annual **Mental Health Area Plan** the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

If you are unable to provide a service, please indicate the reasons why. If you feel you need to amend your ability to meet the service, provide detailed rationale along with the proposed amended delivery.

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form B is limited to a maximum of 40 pages.** Refer to Section 1-VII of the RFP to ensure **all required services and metrics are provided in your provided responses.** FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for FY20. Funding contracts are for July 1st to June 30th.

The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. Final numbers will be known by July, 2019.

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

Projected FY20 Mental Health Funding from Contracted Sources: \$1,300,000

Inpatient Services: *Inpatient services refer to inpatient hospital services overseen by a psychiatrist for includes treatment for serious mental disorder. Inpatient psychiatric services vary from short-term or outpatient therapy for low-risk patients to long term care or permanent care such as routine assistance treatment, or a specialized and controlled environment.*

1) Adult Inpatient:

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$84,500	Form A1 - Projected Clients Served in FY19 Area Plan	7
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$90,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	7
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
UUHP has an existing contract and relationship with the University Neuropsychiatric Institute (UNI). UNI is a long-standing licensed psychiatric hospital with 178 licensed beds – 83 staffed adult beds. Inpatient Services will be provided at UNI including mental health and substance use (including detox) admissions. Additionally, UNI has board-certified geriatric psychiatrists to provide services to inpatient geriatric psychiatric admissions, If beds are unavailable at UNI, UUHP would coordinate single case agreements with other facilities to provide services.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.			
Has the LCP met the services and metrics of this required service?			
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2) Children/Youth Inpatient

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - FY19 Amount Budgeted:	\$85,250	Form A1 - FY19 Projected clients Served:	5
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$86,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	5

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has an existing contract and relationship with University Neuropsychiatric Institute (UNI). UNI is a long-standing licensed psychiatric hospital with 178 licensed beds – 66 staffed adolescent and child beds. Inpatient Services will be provided at UNI including mental health admissions. If beds are unavailable, UUHP would coordinate single case agreements with other facilities to provide services.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

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Residential Care: *Residential Care is a structured service setting or program that provides short-or long-term overnight care delivered in a specialty facility/hospital/center/clinic, specifically for the treatment of behavioral health clients. It is an intensive treatment setting or program distinct from a hospital inpatient setting or program, and provides supervised living coupled with supportive mental health services. Residential Habilitation is a bundled service which includes personal care, homemaker services, nutritional meals and snacks, medication oversight (to the extent permitted under state law), social and recreational activities and 24-hour onsite response to ensure the care, well-being, health and safety needs of the residents are met at all times.*

3) Adult Residential Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,000	Form A1 - Projected Clients Served in FY19 Area Plan	1
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$10,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	1

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP currently does not have a behavioral health residential care provider on its provider network. Given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the residential care. UUHP is happy to coordinate with local agencies such as The Clubhouse and Lion House.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) Children/Youth Residential Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$20,000	Form A1 - Projected Clients Served in FY19 Area Plan	2
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	0	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	0

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has an existing contract and relationship with University Neuropsychiatric Institute (UNI) which includes the Girls Transition Center (GTC). The GTC serves females between the ages of 12-17 years old, offering intermediate, secure residential treatment programs for teenage girls either in transition or needing focused care. For additional populations, UUHP currently does not have a behavioral health residential care provider on its provider network. Given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the residential care.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Outpatient Care: *Outpatient Care is a structured service setting or program that provides ambulatory (not overnight) care specifically for the treatment of behavioral health clients. Care is generally provided for visits of 3 hours or less in duration and 1 or 2 days per week or as needed.*

5) Adult Outpatient Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$365,241	Form A1 - Projected Clients Served in FY19 Area Plan	460
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$386,031	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	468

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has and will continue to develop its Healthy U provider network in Summit County for behavioral therapy services with additional services in Salt Lake County. The Healthy U provider network includes U Health, the University of Utah Department of Psychiatry, University Neuropsychiatric Institute (UNI), Sundance Behavioral Resources, and several directly contracted providers/clinics in Summit County for adult therapy. Network providers must meet UUHP’s credentialing requirements and must be approved by the UUHP Credentialing Committee. Additionally, providers complete an application including additional information about their practice and areas of interest. This additional information allows UUHP to not only help members understand access but helps direct members to the appropriate level of care and areas of interest, (e.g., trauma, anxiety, anger management).

UUHP will work directly with UNI to assess and remedy network gaps where needed and as feasible. Given the overall shortage of behavioral therapy access in Summit County and throughout Utah, UUHP and UNI will also offer telehealth capabilities including patient-to-provider visits. Additionally, UUHP offers the GATE (Giving Access To Everyone) program which expands access by creating relationships between primary care physicians and board certified psychiatrists. In this way, patients may conveniently stay with their local PCP who consults with a psychiatrist on individual cases.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Describe programmatic approach for serving individuals in the least restrictive level of care who are civilly committed. (Civil Commitment is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment in a hospital (inpatient), or in the community (outpatient). All citizens have civil liberties that need to be protected under both federal and state laws, so following “due process” is of paramount importance. Treatment is not punishment! The state may need to deprive someone of their civil liberties because they pose a danger to self or others due to mental illness.)

UUHP will work in partnership with Summit County and the State Hospital to determine how best to coordinate wrap-around services to ensure members are served in the least restrictive environment. We will work with our care managers to develop policies to ensure that the care managers recommend that clients be referred to the lowest level of care appropriate to the member.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Children/Youth Outpatient Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$262,725	Form A1 - Projected Clients Served in FY19 Area Plan	319
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$268,053	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	344

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has and will continue to develop its Healthy U provider network in Summit County for behavioral therapy services with additional services in Salt Lake County. The Healthy U provider network includes U Health, the University of Utah Department of Psychiatry, University Neuropsychiatric Institute (UNI), Sundance Behavioral Resources, and several directly contracted providers/clinics in Summit County with emphasis on child and adolescent outpatient therapy. Network providers must meet UUHP’s credentialing requirements and must be approved by the UUHP Credentialing Committee. Additionally, providers complete an application including additional information about their practice and areas of interest. This additional information allows UUHP to not only help members understand access but helps direct members to the appropriate level of care and areas of interest (e.g., trauma, anxiety, anger management).

UUHP will work directly with UNI to assess and remedy network gaps where needed and as feasible. Given the overall shortage of behavioral therapy access in Summit County and throughout Utah, UUHP and UNI will also offer telehealth capabilities including patient to provider visits. Additionally, UUHP offers the GATE (Giving Access To Everyone) program which expands access by creating relationships between primary care physicians including pediatricians and triple board certified child psychiatrists. In this way, children and adolescents may conveniently stay with their local pediatrician who consults with a psychiatrist on individual cases.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

24-Hour Crisis Care: Crisis Care is defined as a 24-hour, 365-day service available during a personal or social situation where mental distress is a significant contributing factor. Crisis is a behavioral change that brings the user to the attention of crisis services and this for example might result from relapse of an existing mental illness. The crisis is the impact of the change on the user and the disruption it causes to their life and social networks.

For this RFP, the LCP is required to have full and timely coverage, 24/7, for crisis incidents in the Summit County Jail. For all other incidents, the LCP is required to respond during business hours. Incidents outside of these hours will be handled through the State Crisis-Line, Mobile Crisis Outreach Teams (MCOTs), and the Summit County Stabilization Team. Please note, once the LCP is selected, they will work with the Department to greater define their role with Crisis Care. The current expectation is a 60/40 split between the County and LCP for FY20. Per Crisis-Line and MCOT legislation passed in 2018, a local crisis-line is not required, but a plan for warm handoff is. The local director of the LCP will play a critical role in the oversight of this service and will serve on the Crisis Care Committee comprised of first responders, law enforcement, the Department, and the Park City Hospital.

7) Adult 24-Hour Crisis Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$11,392	Form A1 - Projected Clients Served in FY19 Area Plan	47
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$21,501	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	75
<p>Describe access to crisis services during daytime work hours, after hours, weekends, and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify proposed activities and where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>UUHP has an existing provider contract and relationship with UNI which includes the UNI Receiving Center, UNI Same Day Psychiatric Clinic, UNI Consult / Rapid Access Clinic, CrisisLine, WarmLine and SafeUT. These programs and clinics provide immediate crisis support and have demonstrated a 94% diversion rate. Additionally, the UNI Telehealth program may be utilized for crisis services if needed. UNI's services are staffed by board-certified specialists along with certified peer support specialists, licensed clinical social workers, and residents. UNI is regarded as a leader in crisis diversion services and works directly with state, county, local EMS, and school authorities in developing crisis programs. In order to determine the best solution for Summit County, additional data is needed regarding utilization, a description of the types of medical services expected to be provided as services to address a crisis, location in the county where crisis services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with 24-hour crisis care; if awarded the contract, UUHP and Summit County will determine during contract negotiation how those resources will be utilized within Summit County's available funding.</p>			
<p>Provide specifics, including timeline, of crisis services for incarcerated individuals.</p>			
<p>The data provided is not enough information for UUHP to offer a detailed solution or timeline. UUHP needs additional information regarding utilization and available funding to determine an appropriate solution. UUHP may be able to coordinate with its provider-partner UNI to provide a solution such as tele-crisis services or to subcontract with UNI to provide these services. UUHP proposes that during contract negotiation, UUHP and Summit County work out the details for this program.</p>			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

8) Children/Youth 24-Hour Crisis Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,620	Form A1 - Projected Clients Served in FY19 Area Plan	39
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$14,308	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	41

Describe access to crisis services during daytime work hours, after hours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify proposed activities and where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has an existing provider contract and relationship with UNI which includes the UNI Same Day Psychiatric Clinic, UNI Consult / Rapid Access Clinic, CrisisLine, WarmLine and SafeUT. These programs and clinics provide immediate crisis support and have demonstrated a 94% diversion rate. Additionally, the UNI Telehealth program may be utilized for crisis services if needed. UNI's services are staffed by board-certified specialists along with certified peer support specialists, licensed clinical social workers, and residents. UNI is regarded as a leader in crisis diversion services and works directly with state, county, local EMS, and school authorities in developing crisis programs. In order to determine the best solution for Summit County, additional information is needed regarding utilization, a description of the types of services expected to be provided as services to address a crisis, location in the county where crisis services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with 24-hour crisis care; if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources would be utilized within Summit County's available funding. Outside the criminal justice system, crisis services would be available at the UNI Day Treatment Center, Kids Program, Same Day Psychiatry Clinic, Rapid Access Consult Clinic, CrisisLine, WarmLine and through SafeUT.

Provide specifics, including timeline, of crisis services for youth during school hours school.

The data provided is not enough information for UUHP to offer a detailed solution and timeline. In order to determine the best solution for Summit County, additional information is needed regarding utilization, a description of the types of services expected to be provided as services to address a crisis, location in the county where crisis services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with 24-hour crisis care; if

awarded the contract, UUHP will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding. Additionally, the SafeUT crisis and tip line texting program could be further coordinated with Summit County's local schools, including notification to schools of respective crisis or tip line concerns. UUHP proposes that during contract negotiation UUHP and Summit County work collaboratively to determine Summit County's needs and develop a timeline to meet those needs.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Psychotropic Medication Management: *Psychotropic Medication Management is the level of outpatient treatment where the sole service rendered is by a qualified psychiatrist or psychiatric APRN (Advanced Practice Registered Nurse), who is the initial evaluator of the patient's need for psychotropic medications, the provision of a prescription and as-needed, ongoing, medical monitoring/evaluation related to the patient's use of the psychotropic medication. Interactive psychotherapy is not being rendered at this time by the physician/prescriber, but may be provided by another clinician. The LCP is expected to provide a minimum of 40 hours of access a week to a psychiatrist and/or psychiatric APRN for Psychotropic Medication Management.*

9) Adult Psychotropic Medication Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$122,815	Form A1 - Projected Clients Served in FY19 Area Plan	213
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$147,260	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	215

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. Address how the LCP plans to expedite wait-times for appointments.

UUHP can provide this service through UNI's Consult / Rapid Access Clinic, Receiving Center, and Same Day Psychiatric Clinic, as well as through Sundance Behavioral Resources and Redstone Clinic. UUHP anticipates its network is sufficient for providing services to Medicaid members. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists. Additionally, the GATE program quickly connects primary care physicians with psychiatric specialists who are available for medication management consultation.

The data provided is not enough information for UUHP to offer a detailed solution. In order to determine the

best solution for Summit County, additional information is needed regarding utilization, location in the county where psychotropic medication management services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this care and, if awarded the contract, would determine during contract negotiation how those resources will be utilized within Summit County's funding sources.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

10) Children/Youth Psychotropic Medication Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$30,583	Form A1 - Projected Clients Served in FY19 Area Plan	47
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$46,503	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	48

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. Address how the LCP plans to expedite wait times for appointments.

UUHP can provide this service through UNI's Consult / Rapid Access Clinic and Same Day Psychiatric Clinic, as well as through Sundance Behavioral Resources and Redstone Clinic. UUHP anticipates its network is sufficient for providing services to Medicaid members. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists. Additionally, the GATE program quickly connects pediatricians with psychiatric specialists who are available for medication management consultation.

The data provided is not enough information for UUHP to offer a detailed solution. In order to determine the best solution for Summit County, information is needed regarding utilization, location in the county where medication management services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and, if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Psychoeducational Services & Psychosocial Rehabilitation: *Psychoeducational Services & Psychosocial Rehabilitation focuses on a patient's current life and relationships within the family, social, and work environments through one-on-one conversations with a therapist. The goal is to identify and resolve problems with insight, as well as build on strengths.*

11) Adult Psychoeducation Services & Psychosocial Rehabilitation

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$20,071	Form A1 - Projected Clients Served in FY19 Area Plan	165
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$25,357	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	167

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP will provide this service through its contracted network providers, primarily Sundance Behavioral Resources and Redstone clinic. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists. Additionally, the Warm Line provides certified peer support which could be utilized for patients or family members needing additional support. Funding for staffing of the Warm Line may need to increase, dependent on significant increases in volumes and utilization.

The data provided is not enough information for UUHP to offer a detailed solution. In order to determine the best solution for Summit County, additional information is needed regarding utilization, location in the county where services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and, if awarded the contract, will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

12) Children/Youth Psychoeducation Services & Psychosocial Rehabilitation

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$5,080	Form A1 - Projected Clients Served in FY19 Area Plan	21
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$7,724	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	38

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP will provide this service through its contracted network providers, primarily Sundance Behavioral Resources and Redstone clinic. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists.

The data provided is not enough information for UUHP to offer a detailed solution. In order to determine the best solution for Summit County, additional information is needed regarding utilization, location in the county where medication management services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and, if awarded the contract, will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Case Management: Case Management is an intensive service that is a key part of the continuum of mental health care and supports for persons with serious mental illness. Case management involves building a caring, trusting relationship with the client, promoting independence through the coordination of appropriate services, and providing on-going, long-term support as needed to function in the least restrictive, most natural environment and achieve an improved quality of life. Case management emphasizes frequent contact, small caseloads (<100 cases) and high intensity of care designed to improve planning for and responsiveness to the consumer's multiple service needs. The case manager coordinates required services from across the mental health system as well as

other service systems (e.g., criminal justice, social services) as the consumer's service needs change. Intensive case managers fulfill a vital function for clients by working with them to realize personal recovery goals and providing the support and resources that the consumer needs to achieve goals, stabilize his/her life and improve his/her quality of life.

13) Adult Case Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$70,525	Form A1 - Projected Clients Served in FY19 Area Plan	375
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$84,048	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	389
<p>Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>UUHP Care Management staff will provide case management services. During contract negotiation, UUHP will work with Summit County to negotiate the payment structure for case management services. Some case management services delivered to Medicaid Eligible individuals may be included as part of the capitation rate; others will need to be paid separately. During contract negotiation, UUHP and the County will negotiate a per-member case management rate for unfunded clients.</p> <p>UUHP has 20 staff members assigned to conduct case management. UUHP uses a robust analytics software tool to analyze claims data and identify clients whose utilization patterns suggest they need case management. UUHP's care managers are broken out into teams: Adult, Child, U Baby, Transitions, and Behavioral. The Transitions team helps members as they move from one care setting to another by assisting with a safe discharge, coordinating with post-discharge care, answering questions about medications, and making sure members have follow-up appointments with the right providers. The Behavioral team uses an integrated approach to assist members with behavioral and/or substance use disorders navigate their psychiatric and medical needs.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change). Provide the expected number of case managers to be provided.</p>			
<p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			
<p align="center">- COMMITTEE USE ONLY -</p>			

14) Children/Youth Case Management

LCP Amount Budgeted:		LCP Projected Clients	
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		Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$54,408	Form A1 - Projected Clients Served in FY19 Area Plan	104
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$61,979	Form A1 - Actual FY18 Clients Serviced as Reported by Current LCP (VBH)	104
<p>Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>UUHP Care Management staff will provide case management services. During contract negotiation, UUHP will work with Summit County to negotiate the payment structure for case management services. Some case management services delivered to Medicaid-eligible individuals may be included as part of the capitation rate; others will need to be paid separately. During contract negotiation UUHP and the County will negotiate a per-member case management rate for unfunded clients.</p> <p>UUHP has 20 staff members assigned to conduct case management. UUHP uses a robust analytics software to analyze claims data and identify clients whose utilization patterns suggest they need case management. UUHP's care managers are broken out into teams: Adult, Child, U Baby, Transitions, and Behavioral. The Transitions team helps members as they move from one care setting to another by assisting with a safe discharge, coordinating with post-discharge care, answering questions about medications, and making sure members have follow-up appointments with the right providers. The Behavioral team uses an integrated approach to assist members with behavioral and/or substance use disorders navigate their psychiatric and medical needs.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change). Provide the expected number of case managers to be provided</p>			
<p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			
<p align="center">- COMMITTEE USE ONLY -</p>			

Adult Community Supports: *Adult Community Supports is independent, normal housing with flexible, individualized supportive services that allow individuals to maintain as much independence as possible.*

15) Adult Community Supports

		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$509	Form A1 - Projected Clients Served in FY19 Area Plan	2

Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$509	Form A1 - Actual FY18 Clients Serviced as Reported by Current LCP (VBH)	2
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
UUHP currently does not have a provider on its provider network. Given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the residential care.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Respite Services: *Respite Services are services are designed to prevent unnecessary hospitalizations or out of home placements for those receiving mental health services. These services are provided by highly trained staff and licensed foster care providers.*

16) Respite Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$9,916	Form A1 - Projected Clients Served in FY19 Area Plan	25
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$9,421	Form A1 - Actual FY18 Clients Serviced as Reported by Current LCP (VBH)	24
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
UUHP currently does not have a provider on its provider network. Given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the respite care.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Peer Support Services: Peer Support Services are provided by mental health clients and include mental health treatment and/or support services, such as social clubs, peer-support groups, and other peer-organized or consumer-run activities.

17) Adult Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$11,054	Form A1 - Projected Clients Served in FY19 Area Plan	223
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$12,643	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	223

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has certified peer specialists integrated in its community services through the WarmLine. The data provided is not enough information for UUHP to offer a complete solution. In order to determine the best solution for Summit County, additional information is needed regarding utilization, location in the county where peer support services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

How is adult peer support supervision provided? Who provides the supervision? What training do supervisors receive?

Peer Specialists work with licensed clinicians and have access to them 24/7 to staff a case. All peer service providers are certified by the state.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

18) Children/Youth Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$18,965	Form A1 - Projected Clients Served in FY19 Area Plan	23
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$6,322	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	15

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP has certified peer specialists integrated in its community services through the WarmLine. The data provided is not enough information for UUHP to offer a detailed solution. In order to determine the best solution for Summit County, additional information is needed regarding utilization, location in the county where peer support services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding. UUHP is more than willing to work with organizations such as the Hope Squad to provide education and to collaborate care as needed.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

How are Family Resource Facilitator (FRF) peer support supervision provided? Who provides the supervision? What training do supervisors receive?

UUHP currently does not have any FRF peer support, but will work with the county to develop resources. In order to determine the best solution for Summit County, additional information is needed regarding utilization, location in the county where FRF services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding.

Has the LCP met the services and metrics of this required service?

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Consultation & Education Services: *Consultation and Education Services address specific behaviors by assessing and address the client's needs by developing an individualized plan with providers and additional*

support team members (Parents, teachers, employers, friends, etc.). A plan includes specific strategies for addressing the concerning behaviors.

19) Adult Consultation & Education Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	No Data – Mandated Service Currently Not Provided	Form A1 - Projected Clients Served in FY19 Area Plan	No Data – Mandated Service Currently Not Provided
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	No Data – Mandated Service Currently Not Provided	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	No Data – Mandated Service Currently Not Provided
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
<p>UUHP, through its partnerships with UNI and the University of Utah Department of Psychiatry, have access to Utah’s behavioral health experts. UUHP will work collaboratively with Summit County to identify where consultative and educational service needs exists and coordinate with UNI to deliver the services. Depending on the nature of the educational need, UUHP may negotiate an administrative rate for the educational service. UUHP and UNI are happy to work with support groups such as CONNECT Summit County to arrange articles, workshops and seminars.</p>			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
<p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

20) Children/Youth Consultation & Education Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	No Data – Mandated Service Not Provided	Form A1 - Projected Clients Served in FY19 Area Plan	No Data – Mandated Service Not Provided
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	No Data – Mandated Service Not Provided	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	No Data – Mandated Service Not Provided

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP, through its partnerships with UNI and the University of Utah Department of Psychiatry, have access to Utah's behavioral health experts including triple board certified child psychiatrists. UUHP will work collaboratively with Summit County to identify where consultative and educational service needs exists and coordinate with UNI to deliver the services. Depending on the nature of the educational need, UUHP may negotiate an administrative rate for the educational service. UUHP and UNI are happy to work with support groups such as CONNECT Summit County to arrange articles, workshops and seminars.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

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Services to Incarcerated Persons: *Services to Incarcerated Persons include access to a psychiatrist or psychiatric APRN to consult on treatment, medications, and diagnosis within the Summit County Jail along with general mental health services.*

21) Services to Incarcerated Persons

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,187	Form A1 - Projected Clients Served in FY19 Area Plan	237
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$12,150	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	242

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

The data provided is not enough information for UUHP to offer a detailed solution. In order to find the best solution for Summit County, UUHP will need additional information regarding utilization and available funding to determine an appropriate solution. UUHP will be able to coordinate with its provider-partner UNI to provide a solution and the solution may include a subcontract with UNI to provide these services for both in-jail services and telehealth options. Currently, UNI's forensic psychiatrist provides services to the Salt Lake County jail system and would consider providing services to Summit County jail as well.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Outplacement Services: *Outplacement Services include assisting individuals with finding work; assessing individuals' skills, attitudes, behaviors, and interest relevant to work; providing vocational rehabilitation and/or other training; and providing work opportunities.*

22) Outplacement Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$18,591	Form A1 - Projected Clients Served in FY19 Area Plan	4
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$18,617	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

The data provided is not enough information for UUHP to offer a detailed solution. In order to find the best solution for Summit County, UUHP will need additional information regarding utilization and available funding to determine an appropriate solution. UUHP may be able to coordinate with its provider-partner UNI, with resources available through the University of Utah's colleges and schools to provide a solution or subcontract with another provider to deliver these services.

Describe how you will collaborate with the Division of Workforce Services and the Summit County Clubhouse to meet this Mandated Service.

The program manager assigned to oversee this contract will be responsible for developing a collaborative relationship with the Division of Workforce Services and the Summit County Clubhouse to meet the mandated service.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Unfunded Clients: *Unfunded Clients are those individuals covered under the State’s General Fund which do not qualify for Medicaid, have insurance, or are able to self-pay.*

23) Unfunded Clients

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$41,569	Form A1 - Projected Clients Served in FY19 Area Plan	36
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$43,053	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	59
Describe the activities and means you will undertake to ensure full access to the Mandated Services listed in this RFP are made available to Unfunded Clients.			
<p>UUHP will work with its contracted network providers to find providers willing to provide services to unfunded clients and work directly with local organizations such as the Christian Center, Jewish Family Service, and People’s Health Clinic. UUHP will also provide case management services for unfunded clients in order to assist them in case management. UUHP proposes that all unfunded case management be provided on a fee-for-service basis, including UUHP’s case management services.</p>			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
<p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

School-Based Services: *School-based mental health services are those delivered by the LCP in the three school districts. (North Summit School District, South Summit School District, and Park City School District). School-based mental health programs will provide services for youth 18 years of age and younger who are currently enrolled in the public-school system. For purposes of these monies, state regulated charter schools are considered to be part of the public-school system. The goal of these coordinated services will be to prevent youth who may be at-risk for developing a mental illness from disrupting his or her school placement. The services will be focused on maintaining the youth/child in their regular school setting, providing services in the school and collaborating with school staff.*

24) School Based Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	Service Provided but Data Not Available	Form A1 - Projected Clients Served in FY19 Area Plan	Service Provided but Data Not Available
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	Service Provided but Data Not Available	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	Service Provided but Data Not Available
<p>Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>The data provided is not enough information for UUHP to offer a detailed solution. In order to determine the best solution for Summit County, additional information is needed regarding utilization, a description of the types of services expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with meeting this requirement and if awarded the contract, UUHP and Summit County will determine during contract negotiation how to best serve this need within Summit County's available funding.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).</p>			
<p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease at this time. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
<p>Describe how you will coordinate care with local school district personnel and guardians.</p>			
<p>UUHP, UNI, and the appropriate Summit County Health Department staff member will meet with North Summit School District, South Summit School District, Park City School District, and the Weilenmann School of Discovery to discuss the school-based needs of each of these entities. UUHP, Summit County, and the Districts/School of Discovery will work collaboratively to develop a plan to meet identified needs within each of the Districts/School of Discovery. UNI's current SafeUT program, providing crisis and tip line texting availability to students, could be coordinated with the local schools in Summit County to increase awareness, coordination, and intervention for their respective students.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			
<p align="center">- COMMITTEE USE ONLY -</p>			

25) Other Services (Refer to section 1-VII-N)

<p>Describe how you will insure that services are delivered in Spanish by means of a qualified and culturally competent clinician. How will you recruit and retain a minimum of 2 Spanish speaking clinicians and additional support staff?</p>
<p>As a longstanding Medicaid ACO, UUHP is experienced in assessing member preferences, including language preferences, and developing culturally sensitivity training for providers. The current proposed Healthy U provider network for Summit County behavioral therapy services includes two Spanish-speaking providers to</p>

date. UUHP, through its collaboration with UNI, can potentially develop a Spanish-speaking telehealth (virtual visit) program. Finally, UUHP has multiple interpreting services agreements in place with agencies who will provide either telephonic or on-site interpreting services for patients and providers. UUHP monitors performance of these interpreting agencies through our collaboration with U Health, as well as through member complaints.

Describe how you will insure collaborative efforts with other community partners. (*Summit County Health Department, CONNECT Summit County, Summit County Mental Wellness Alliance, Summit County Sheriff's Department, Summit County Jail, Summit County Attorney's Office, Park City Police Department, IHC, UNI, School Districts, Non-Profits, and local government*)

UUHP is committed to being a partner to Summit County and to assist in implementing its Strategic Plan. We understand that cities like Park City, Kamas, and Coalville each have unique behavioral health needs and a one-size-fits-all approach will not be effective. We believe that the effectiveness, affordability, and success of our solutions hinge on developing good relationships with the Summit County community. The first step in most of our proposal responses is working with a community partner to assess Summit County's behavioral health needs and available services to identify gaps in care we can address.

UUHP will assign a program manager to liaise with the Summit County Community and oversee the Summit County contract. Our program manager will also work with community groups like CONNECT Summit County and the Summit County Mental Wellness Alliance to ensure that our efforts are meeting community needs.

We will also assign one of our Nurse Care Managers to review, assess, and develop relationships with community resources. Having a care manager closely connected to the Summit County community will ensure that Summit County clients who require case management are connected to every available resource.

Describe how you will insure clinician and case manager retention to maintain continuity of care.

Historically, UUHP and its network of providers has a low turnover rate. In 2017, the turnover rate for UUHP staff was 5.6%; the turnover rate for UUHP's clinical operations group (which houses UUHP's care managers) was 6.91%. UUHP's Healthy U provider network has had very limited turn-over since its inception, outside normal activity such as retirement. We believe the very limited number of provider network terminations is due to the efforts of UUHP's exceptional provider relations and customer service departments. Expedited claims processing time contributes to the provider network's satisfaction with UUHP as an administrator.

How will LCP will provide Peer Specialists/Family Resource Facilitators for Peer Support Services.

UUHP has certified peer specialists integrated in its community services through the WarmLine. The data provided in this RFP regarding Summit County's Peer Support and Family Resource Facilitators is not enough information for UUHP to offer a complete solution to Summit's Peer Support needs. In order to determine the best solution for Summit County, additional information is needed regarding utilization, location in the county where peer support is expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County during contract negotiation to determine how those resources will be utilized within Summit County's available funding.

Describe how you will insure that any transition in LCPs will minimize the effects on the continuity of care of current LCP clients. Have you a plan to incorporate current LCP clinicians /staff into your organization.

UUHP's initial provider recruitment efforts will be directed to providers who have experience treating individuals in Summit County. UUHP will then look to supplement that network with services delivered via telehealth, providers available within UNI's network, and Residents in training at the University of Utah.

To ensure continuity of care, (and depending on the needs of the clients) UUHP's Care Management team will work individually with members to either transition the clients to providers on UUHP's network or initiate single case agreements with the client's existing provider(s). UUHP's Care Management team works closely with its Provider Contracting department to refer providers for network participation as well.

Has the LCP met the services and metrics of this required service?

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26) Quality & Access

Describe how LCP will provide open and timely access to services while maintaining the highest quality of care. Include specifics for services provided in Park City, Kamas, and Coalville. (Current levels in Kamas are 1 fulltime and 2 part-time clinicians, and 1 part-time clinician in Coalville. Space for both locations provided by the Department.)

UUHP will work collaboratively with Summit County to assess Summit County's provider network and client utilization of services to determine the appropriate staffing levels needed by the community. UUHP will leverage the provider resources available through UNI and the University of Utah Department of Psychiatry to provide staffing to Park City, Kamas, and Coalville. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists or other clinicians depending on member needs. Given the shortage of behavioral therapy providers in Summit County and throughout Utah, UUHP will work collaboratively with UNI to offer telehealth services in addition to face-to-face visits, where appropriate.

Identify process activities focused on Implementation of this document for Summit County.

UUHP will work with Summit County to develop a joint work plan and timeline for implementation.

Identify process activities focused on Training of Evidence Based Practices in accordance with DSAMH guidelines and directives.

UUHP will work with its providers to ensure they are using DSAMH's preferred practice guidelines. UUHP will utilize providers from UNI to provide training to providers on these preferred practice guidelines, should funding be available to do so.

Identify marketing and public relations activities focused on educating and developing a community based behavioral health service organization.

UUHP has a skilled Marketing Department that UUHP can leverage to educate the Summit County community on UUHP's community-based behavioral health services. UUHP's Marketing team can develop websites, print materials, and attend community events as mutually agreed upon by UUHP and Summit County. UUHP will create a website for Summit County clients describing available services and linking clients to available UUHP and community resources. UUHP will develop a member handbook for Medicaid-eligible enrollees to provide them with information relative to their benefit. Any marketing or public relations requested by Summit County outside of the website and the Medicaid member handbook will be funded by Summit County at a mutually agreed upon rate.

Identify activities focused on increased service capacity.

UUHP will work collaboratively with Summit County to assess Summit County's provider network and client utilization of services to determine the appropriate staffing levels needed to increase service capacity. UUHP will leverage the provider resources available through UNI and the University of Utah Department of Psychiatry

to provide staffing to Park City, Kamas, and Coalville. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists or other clinicians depending on member needs. Given the shortage of behavioral therapy providers in Summit County and throughout Utah, UUHP will work collaboratively with UNI to offer telehealth services in addition to face-to-face visits, where appropriate. Additionally, UUHP will offer the GATE program which provides psychiatric consultative resources to primary care physicians, including pediatricians, thereby allowing patients to remain with their primary care provider for medication management or assessments. Resources such as telehealth, GATE, and the Warm Line (peer support) will help “off-load” the access barriers to behavioral therapists by allowing those therapists to focus on more complex cases.

Identify process improvement activities focused on Increased Access for Medicaid & Non-Medicaid Funded Individuals.

UUHP will work collaboratively with Summit County to assess Summit County’s needs with regard to increased access for Medicaid- and Non-Medicaid- funded individuals. UUHP will then review its provider network and client utilization of services to determine the appropriate staffing levels needed to increase access for Medicaid- and Non-Medicaid-funded individuals. UUHP will leverage the provider resources available through UNI and the University of Utah Department of Psychiatry to provide staffing to Park City, Kamas, and Coalville. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville, utilizing Attending/Resident Psychiatrists. As previously mentioned, UUHP believes creative solutions are necessary to improve access for behavioral therapy services (mental health and substance use). Through UUHP’s partnership with UHealth, UNI and the University of Utah Department of Psychiatry, UUHP is committed to exploring creative solutions such as increased telehealth capability, integration between behavioral health and primary care, peer supported services and potential technology-enabled apps or texting solutions.

Identify process improvement activities focused on efforts to respond to community input/need

We are committed to being a partner to Summit County and to assist in implementing its Strategic Plan. We understand that cities like Park City, Kamas, and Coalville each have unique behavioral health needs and a one-size-fits-all approach will not be effective. We believe that the effectiveness, affordability, and success of our solutions hinge on developing good relationships with the Summit County community. The first step in most of our proposal responses is working with a community partner to assess Summit County’s behavioral health needs and available services to identify gaps in care we can address.

UUHP will assign a program manager to liaise with the Summit County Community and oversee the Summit County contract. Our program manager will also work with community groups like CONNECT Summit County, and the Summit County Mental Wellness Alliance to ensure that our efforts are meeting community needs.

We will also assign one of our Nurse Care Managers to review, assess, and develop relationships with community resources. Having a care manager closely connected to the Summit County community will ensure that Summit County clients who require case management are connected to every available resource.

Identify process improvement activities focused on Coalition Development

Before it can offer process improvement ideas, UUHP will need to meet with Coalition members to listen to their recommendations and discover where UUHP can step in as a community partner.

Describe how mental health needs for people in Nursing Facilities will be met. (Summit County has one Nursing Facility located in Oakley.)

UUHP care managers will work with the nursing facility to identify needs and develop a payment arrangement with the nursing facility. UUHP will use a contracted provider to provide this service. UNI’s provider network

includes a geriatric psychiatrist in addition to two geriatric neuropsychiatrists that, based on need and assessment, may be able to provide mental health needs for individuals in nursing facilities.

Has the LCP met the services and metrics of this required service?

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27) Integrated Care

Describe how you will develop partnerships with the Department, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.

UUHP is an accountable care organization (ACO) and can provide integrated services to members of our ACO who reside in Summit County. UUHP also has connections with care managers who work with the other ACOs and we can leverage those associations to provide integrated care coordination. UUHP has a robust care management program that focuses on all aspects of the health care continuum including wellness, disease management, complex care management and care coordination. Collaboration with community partners as well as local and state government agencies is integral to provide “wrap around” services for our members. UUHP takes ownership to identifying resources and key contacts in the counties they serve to address physical, behavioral, and social needs of the population. UUHP is committed to partnering with the community and local agencies to provide optimal service.

Describe plans to integrate care and ensure that clients have their physical, mental and substance use disorder needs met, including screening and treatment and recovery support.

UUHP has a strong commitment to the integration of physical and behavioral health and uses a “whole person” model of care management. The Care Management team understands that behavioral health issues, including substance use disorders, impact physical health and vice versa. The Behavioral Health Care Management team is skilled at building relationships and assessing their client’s need. Once needs are identified, the team works with the member to develop a plan of care. Based on the needs of the client, referrals are made to in-network providers for behavioral health including screening, treatment setting (outpatient, inpatient, intensive outpatient, partial hospitalization, residential treatment) and recovery support. Medical needs and insurance status is also assessed. If the client has medical health insurance coverage, we will work with the client and the carrier to get the physical care that is required to achieve maximum health. If the client does not have medical insurance, the team assists them to find available resources in the community. Social determinants of health are also assessed and assistance is provided to the member to address their needs. This may include connecting the client with food resources, transportation, etc. The Care Management team follows the client throughout the care continuum.

Describe plans to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

UUHP has a Well You wellness platform that has the ability to communicate digitally with members. Invitations to complete a health risk assessment (HRA) are sent to new members. The questions evaluate behavioral health, substance use, physical and social determinants of risks. Based on the answers from the assessment, the Care Management team will reach out to the member via phone, email, or mail to address the needs identified by the HRA. Members requiring patient education can receive evidence-based education via the portal from the HealthWise educational library. The HealthWise library has education on multiple topics including diabetes, asthma, pregnancy, HIV, TB, etc. The platform also has the capability to help the member with wellness activities and can track steps, sleep, set up challenges, etc. HRAs can also be completed by phone or mail. Members may also be referred to providers and/or community resources depending on their needs. One example of a community resource available in Summit County is the Living Well with Chronic Conditions Program workshops. These are free to the community and focus on building self-management skills.

Recovery Plus: Describe your plan to reduce tobacco and nicotine use and how the LCP will maintain a tobacco free environment. SUD Target= reduce tobacco and nicotine use by 5%.

UUHP identifies tobacco users through claims data and health risk assessments. The Care Management team reaches out to members via phone, mail, and email to assess readiness to change and educate about services available to assist with smoking cessation. Medicaid members are eligible for tobacco cessation services through the Utah Department of Health. Nicotine replacement medications are available to Medicaid members at no charge. If a person is identified as a smoker and would like assistance, the Care Management team will assist with connecting them to community resources including the Utah Department of Health, Way to Quit line, and other community resources. University of Utah, U Health, and U of U Health Plans are tobacco free campuses.

Has the LCP met the services and metrics of this required service?

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28) Children/Youth Mental Health Early Intervention

Describe the *Family Resource Facilitation with Wraparound* activities you propose to undertake and identify where services are provided. Describe how you intend to partner with other Department of Human Services child serving agencies. For each service, identify whether you will provide services directly or through a contracted provider.

UUHP will work collaboratively with Summit County to assist in Wraparound Facilitation and will assign a Nurse Care Manager to attend USH Adult and Child Continuity of Care meetings. UUHP will use a subcontracted provider to provide the service.

Do you agree to abide by the Mental Health Early Intervention Family Resource Facilitation and Wraparound Agreement? YES/NO

UUHP has not been provided a copy of this agreement. UUHP may be willing to abide by this agreement, but would like to review the agreement.

Has the LCP met the services and metrics of this required service?

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29) Children/Youth Mental Health Early Intervention

Describe the *Early Intervention* activities you propose to undertake and how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider.

UUHP, UNI, and Summit County will work collaboratively to determine Summit County's Mental Health Early Intervention service needs. UUHP, UNI, and Summit County will review the available funding and service network to determine how to meet those needs. UUHP will use a contracted provider to provide any services.

Describe outcomes that you will gather and report on.

UUHP does not yet have any outcome measures identified. UUHP will work with Summit County to develop appropriate outcome measures.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

30) Suicide Prevention, Intervention & Postvention

Describe the proposed role the LCP will play in working with the community for suicide prevention. (Summit County utilizes the ChooseLife program developed by the National Health Service – Scotland.)

UUHP does not have any specific role identified. UUHP will work with Summit County and its community partners to determine what role is appropriate for UUHP to play in Summit County's suicide prevention efforts. Given its partnership with UNI, UUHP will work collaboratively with UNI to further develop suicide prevention efforts and education.

Describe the proposed role the LCP will play in working with the community for suicide intervention and postvention. (Summit County utilizes the ChooseLife program developed by the National Health Service – Scotland.)

UUHP does not currently have a specific role identified. UUHP will work with Summit County and its community partners to determine what role is appropriate for UUHP to play in Summit County's Suicide intervention and postvention efforts. Given its relationship with UNI, UUHP will work collaboratively with UNI to further develop suicide intervention efforts such as enhanced collaboration with Summit County schools, the SafeUT texting app, and promotion and use of CrisisLine. Specifically related to school-aged individuals, the UNI SafeUT program can be utilized to coordinate and notify schools of crisis and suicide concerns for their respective students.

Describe how you will collaborate with emergency services (Park City Hospital, UNI, MCOT, Stabilization Team, etc.) to coordinate follow-up care after emergency room visits for suicide related events; both general collaboration efforts as well as specific efforts for your clients.

UUHP will work with Summit County, Park City Hospital, UNI, MCOT, and the stabilization team to determine where UUHP can assist in coordinating follow up care after emergency room visits for suicide-related events, both as it specifically relates to general collaboration efforts and specific client events.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

31) Justice Reinvestment Initiative

Identify key staff members who will be part of the JRI Implementation Team and their qualifications.

UUHP has not identified key staff members at this time. UUHP will assign a Program Manager to participate in JRI Implementation.

Describe the evidence-based mental health screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.

UUHP does not yet have any of the above services specifically identified. UUHP will work with Summit County to address Summit County's needs.

Identify your outcome measures.

UUHP does not yet have any outcome measures identified. UUHP will work with Summit County to develop appropriate outcome measures.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

- END OF FORM B-

RFP # SUCO20197552

FORM C - SUBSTANCE USE DISORDER TREATMENT BUDGET NARRATIVE

Submitting Agency (LCP): University of Utah Health Plans

Instructions:

The following form is modeled off of the annual **Substance Use Disorder (SUD) Area Plan** the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

If you are unable to provide a service, please indicate the reasons why. If you feel you need to amend your ability to meet the service, provide detailed rationale along with the proposed amended delivery.

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form A is limited to a maximum of 40 pages.** Refer to Section 1-VII of the RFP to ensure **all required services and metrics are provided in your provided responses.** FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for FY20. Funding contracts are for July 1st to June 30th.

The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. Final numbers will be known by July, 2019.

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

Projected FY19 Mental Health Funding from Contracted Sources: \$700,000

1) SUD Screening and Assessment Services (S2BI, BSTAD, NMASSIST, AUDI Test-C, TAPS, NIAA, SKINNER, etc.)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$3,000	Form B - Projected Clients Served in FY19 Area Plan	15
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$30,000	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	175
Describe activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
University of Utah Health Plans (UUHP) will provide this service through its contracted provider network. Additionally, where network gaps may exist, UUHP through its integration with U Health, could provide SUD screening and assessments at Redstone Clinic if needed.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

2) SUD Detoxification Services (ASAM IV-D, III.7-D, III.2-D, I-D or II-D)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$7,841	Form B - Projected Clients Served in FY19 Area Plan	3
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$7,841	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	2
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide detox services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
UUHP's provider-partner, University Neuropsychiatric Institute (UNI) has a contractual agreement with Volunteers of America which can provide this service. UUHP will work with UNI to include Summit County residents in this agreement. To the extent that these services are covered by Medicaid, UUHP will cover these services through the capitation rate, or have contracted providers bill these services to Medicaid, as appropriate.			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

If this service is not provided by the LCP in Summit County, where are individuals accessing detox services?

Medical detox services will be provided at UNI and other detox services will be provided at Volunteers of America.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

3) Residential SUD Treatment Services (ASAM III.7, III.5, III.3, III.1)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	19,842	Form B - Projected Clients Served in FY19 Area Plan	2
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$39,683	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4

Describe the activities you propose and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP currently does not have a behavioral health residential care provider on its provider network; however, is working closely with a local RTC to provide this service. If unable to secure a provider contract, given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the residential care.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) Outpatient (Non-methadone – ASAM I)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$440,957	Form B - Projected Clients Served in FY19 Area Plan	314
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$431,003	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	279
<p>Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			
<p>The data provided is not enough information for UUHP to offer a detailed solution, although UUHP believes it can arrange for a solution with further collaboration with Summit County. In order to determine the appropriate solution, additional data is needed regarding utilization, a description of the types of medical services expected to be provided as services to address a crisis, location in the county where crisis services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those services will be utilized within Summit County's available funding. It is possible that, to provide this service, UNI may require use of Summit County's available space; however, this need could be assessed during contract negotiation.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).</p>			
<p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			
<p>- COMMITTEE USE ONLY -</p>			

5) Outpatient (Methadone - ASAM I)

LCP Amount Budgeted:		LCP Projected Clients Served:See	
Form B - FY19 Amount Budgeted:	\$2,000	Form B - Projected Clients Served in FY19 Area Plan	1
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$2,000	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	1
<p>Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. If you will not be providing or subcontracting for this service, describe future plans.</p>			

UUHP currently does not have an outpatient methadone provider on its provider network and prefers Suboxone therapy. Given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the treatment.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Office-based Opioid Treatment - (Vivitrol, Naltrexone, Buprenorphine)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$33,917	Form B - Projected Clients Served in FY19 Area Plan	49
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$0	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	0

Describe activities you propose to ensure access to Buprenorphine, Vivitrol and Naltrexone and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. If you will not be providing or subcontracting for this service, describe future plans.

The data provided is not enough information for UUHP to offer a detailed solution, although UUHP believes it can arrange for a solution with further collaboration with Summit County. In order to determine the appropriate solution, additional data is needed regarding utilization, a description of the types of medical services expected to be provided as services to address a crisis, location in the county where services are expected to be provided, and a description of the applicable funding sources for these services.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

7) Intensive Outpatient (ASAM II.5 or II.1)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$175,797	Form B - Projected Clients Served in FY19 Area Plan	118
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$140,064	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	95
<p>Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider.</p> <p>The data provided is not enough information for UUHP to offer a detailed solution, although UUHP believes it can arrange for a solution with further collaboration with Summit County. In order to determine the appropriate solution, additional data is needed regarding utilization, a description of the types of services expected to be provided, location in the county where services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service up to four nights a week, and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.</p>			
<p>Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).</p> <p>The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.</p>			
<p>Has the LCP met the services and metrics of this required service?</p>			
<p align="center">- COMMITTEE USE ONLY -</p>			

8) Recovery Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$5,543	Form B - Projected Clients Served in FY19 Area Plan	6
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$3,342	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4
<p>Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.</p>			

UUHP currently does not have an RSS provider on its provider network. Given the low utilization, UUHP would collaborate with Summit County staff to fill this need using single case agreements, assuming that funding was in place to pay for the residential care.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

9) Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$12,799	Form B - Projected Clients Served in FY19 Area Plan	35
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$8,775	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	20

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

The data provided is not enough information for UUHP to offer a complete solution; however, UUHP has certified peer specialists integrated in its community outreach crisis services through the WarmLine. In order to determine the best solution, additional information is needed regarding utilization, location in the county where peer support services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

How is peer support supervision provided? Who provides the supervision? What training do supervisors receive?

Peer Specialists work with licensed clinicians and have access to them 24/7 to staff a case. All peer service providers are certified by the state.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

10) Opioid Treatment Funds (STR & SOR)

The allowable uses for this funding are described in the SFY 18 Division Directives:

1. **Contract with Opioid Treatment Programs (OTP);**
2. **Contracts for Office Based Treatment (OBT) providers to treat Opioid Use Disorder (OUD) using Medication Assisted Treatment (MAT);**
3. **Provision of evidence based-behavioral therapies for individuals with OUD;**
4. **Support innovative telehealth in rural and underserved areas;**
5. **Implement or expand access to clinically appropriate evidence-based practices (EBPs) for OUD;**
6. **Provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings;**
7. **Enhance or support the provision of peer and other recovery supports.**

Describe the activities you propose and identify where services will be provided.

The data provided is not enough information for UUHP to offer a complete solution. In order to determine the best solution, additional information is needed regarding utilization, location in the county where services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service including robust MAT outpatient services. If awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

How will you identify, engage and retain individuals in your area with opioid use disorders?

The data provided is not enough information for UUHP to offer a complete solution. In order to determine the best solution, additional information is needed regarding utilization, location in the county where services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service, and UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Describe how your plan will improve access and outcomes for individuals with OUD in your community.

The data provided is not enough information for UUHP to offer a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, location in the county where services are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

For each service, identify whether you will provide services directly or through a contracted provider. List all contracted providers that will provide these services.

The data provided is not enough information for UUHP to offer a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, location in the county where services are

expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

11) Quality & Access Improvements

Describe how you will increase access to treatment?

UUHP will work collaboratively with Summit County to assess Summit County's provider network and client utilization of services, to determine the appropriate staffing levels needed to increase service capacity. UUHP will leverage the provider resources available to it through UNI and the University of Utah Department of Psychiatry to provide staffing to Park City, Kamas, and Coalville. In the second contract year, UUHP will work to provide this service in the space made available by Summit County in Kamas and Coalville utilizing Attending/Resident Psychiatrists.

Describe your plan to improve the quality of care.

UUHP will work collaboratively with Summit County to assess Summit County's desired quality outcomes and develop a plan to track those quality outcomes.

Describe Implementation and Training of Evidence Based Practices to Ensure Fidelity.

UUHP will work with its providers to ensure that they are using DSAMH's preferred practice guidelines. UUHP will utilize providers from UNI to provide training to its providers on these preferred practice guidelines, should funding be available to do so. UUHP will work with Summit County and DSAMH to develop a plan to ensure providers are performing services to fidelity.

Describe Clinical Supervision Protocol or Plan.

UUHP does not currently have a clinical supervision protocol plan, UUHP will develop one in collaboration with UUHP and DSAMH.

How do you evaluate client outcomes?

UUHP does not yet have any outcome measures identified. UUHP will work with Summit County to develop appropriate outcome measures.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

12) Services to Persons Incarcerated in the Summit County Jail

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

UUHP anticipates that it will be able to deliver services to Summit County Jail inmates through telehealth or through expanding these services to the residents program. The data provided, however, is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the services which are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Describe your proposed crisis coverage plan for 24/7, 365-day coverage within the Summit County Jail. If you plan to subcontract, please describe your oversight plan to ensure full coverage in the Summit County Jail.

UUHP anticipates that it will be able to deliver services to Summit County Jail inmates through telehealth or through expanding these services to the residents program. The data provided is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the services which are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, will determine during contract negotiation how those services will be utilized within Summit County's available funding.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

13) Integrated Care

Describe how you plan to partner with the Department, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers to integrate client care between behavioral health and physical health.

UUHP is an accountable care organization (ACO) and can provide integrated services to members of our ACO who reside in Summit County. UUHP also has connections with care managers who work with the other ACOs and we can leverage those to provide integrated care coordination. UUHP has a robust care management program that focuses on all aspects of the health care continuum including wellness, disease management, complex care management and care coordination. Collaboration with community partners as well as local and state government agencies is integral to provide "wrap around" services for our members. UUHP takes ownership to identifying resources and key contacts in the counties they serve to address physical, behavioral and social needs of the population. UUHP is committed to partnering with the community and local agencies to provide optimal service.

Describe your efforts to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy, Nicotine).

UUHP has a Well You wellness platform that has the ability to communicate digitally with members. Invitations to complete a health risk assessments (HRA) are sent to new members. The questions evaluate behavioral health, substance use, physical and social determinant of risks. Based on the answers from the assessment the care management team will reach out to the member via phone, email or mail to address the needs identified by the HRA. Members requiring patient education can receive evidence-based education via the portal from the HealthWise educational library. The HealthWise library has education on multiple topics including diabetes, asthma, pregnancy, HIV, TB, etc. The platform also has the capability to help the member with wellness activities and can track steps, sleep, set up challenges, etc. HRAs can also be completed over the phone as well as submitted via mail. Members may also be referred to providers and /or community resources depending on their needs. One example of a community resource available in Summit County is the Living Well with Chronic Condition Workshop. It is free to the community and focuses on building self-management skills.

Recovery Plus: Describe your plan to reduce tobacco and nicotine use and how you will maintain a tobacco free environment. SUD Target= reduce tobacco and nicotine use by 5% as set by DSAMH.

UUHP has a Well You wellness platform that has the ability to communicate digitally with members. Invitations to complete a health risk assessments (HRA) are sent to new members. The questions evaluate behavioral health, substance use, physical and social determinant of risks. Based on the answers from the assessment the care management team will reach out to the member via phone, email or mail to address the needs identified by the HRA. Members requiring patient education can receive evidence-based education via the portal from the HealthWise educational library. The HealthWise library has education on multiple topics including diabetes, asthma, pregnancy, HIV, TB, etc. The platform also has the capability to help the member with wellness activities and can track steps, sleep, set up challenges, etc. HRAs can also be completed over the phone as well as submitted via mail. Members may also be referred to providers and /or community resources depending on their needs. One example of a community resource available in Summit County is the Living Well with Chronic Condition Workshop. It is free to the community and focuses on building self-management skills.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

14) Women's Treatment

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$198,995	Form A1 - Projected Clients Served in FY19 Area Plan	113
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$212,761	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	113

Describe the evidence-based services provided for women including gender-specific substance use disorder treatment and other therapeutic interventions that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting.

UUHP expects that it can find resources to provide these services, by making connections with the University of Utah's OBGYN department, with services to be delivered in the Redstone clinic. UUHP has screening tools integrated into this clinic that can be used to evaluate behavioral health concerns. The data provided, however, is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the services which are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service including providers focused on addiction during pregnancy and withdrawal management. If awarded the contract, UUHP will determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Describe the therapeutic interventions for children of clients in treatment that addresses their developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect.

UUHP does not have any identified intervention at this time. The data provided is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the services which are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP will work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Describe case management, childcare, and transportation services for women the LCP is able to provide to ensure they have access to the services you provide.

UUHP has a team of Care Managers who can provide comprehensive case management for women. UUHP does not currently have access to childcare or transportation services but will work with the Summit County community partners to find community partners who can provide these services.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

15) Adolescent (Youth) Treatment

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$65,207	Form A1 - FY19 Projected clients Served:	23
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$66,610	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	31

Describe the evidence-based services provided for adolescents and families. Identify your plan for incorporating the 10 Key Elements of Quality Adolescent SUD Treatment: (1)

1. Screening / Assessment,
2. Attention to Mental Health,
3. Comprehensive Treatment,
4. Developmentally Informed Programming,
5. Family Involvement,
6. Engage and Retain Clients,

- 7. Staff Qualifications / Training,
- 8. Continuing Care / Recovery Support,
- 9. Person-First Treatment,
- 10. Program Evaluation.

UUHP expects that it can find resources to provide these services. UUHP has screening tools integrated into this clinic that can be used to evaluate behavioral health concerns. The data provided is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the services which are expected to be provided, and a description of the applicable funding sources for these services. UUHP's provider-partner UNI has resources available to assist with this service and if awarded the contract, UUHP would work with Summit County to determine during contract negotiation how those resources will be utilized within Summit County's available funding.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

The utilization data provided is not detailed enough for UUHP to project any expected increase or decrease. UUHP reserves the right to change its cost assessments as additional data is gathered. UUHP will provide services to Summit County clients contingent upon the availability of appropriate funding and cannot guarantee services if there is not funding available to reimburse for client services.

Describe collaborative efforts with other state child serving agencies (DCFS, DJJS, SOC, DSPD, Juvenile Court) and any significant programmatic changes from the previous year.

N/A

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

16) Drug Court

Form B - FY19 Amount Budgeted: Felony	\$61,791	LCP Amount Budgeted: Felony	
Form B - FY19 Amount Budgeted: Family Dep.	0	LCP Amount Budgeted: Family Dep.	
Form B - FY19 Amount Budgeted: Juvenile	0	LCP Amount Budgeted: Juvenile	
Form B - FY19 Recovery Support Budgeted	\$5,543	LCP Amount Budgeted: Recovery Support	

Describe your experience with Drug Court programs.

UUHP has no experience with Drug Court programs at this time.

Identify the service you will provide directly or through a contracted provider for the Drug Court Program.

UUHP will utilize a contracted provider to deliver Drug Court services.	
Describe MAT services to be provided as part of the Drug Court Program. Will services be provided directly or by a contracted provider (list contracted providers).	
UUHP anticipates that it will be able to provide these services through UNI. UNI operates an outpatient MAT clinic and IOP that can be leveraged to provide services in Summit County on a negotiated/agreed upon basis. UUHP will work with Summit County to determine the structure and funding for this arrangement during contract negotiation.	
Describe drug testing services you propose to undertake. For each service, identify whether you will provide services directly or through a contracted provider. (The Department provides additional funding for Drug Court UAs.)	
UUHP expects that it can find resources to conduct drug testing as needed by Summit County. The data provided is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the types of drug test which are expected to be provided, and a description of the applicable funding sources for these services. UUHP will work with Summit County to determine the best solution within the available funding.	
Are you able to meet a 72-hour testing period from collection to results being delivered to appropriate staff?	
UUHP believes it can find the resources to comply with this timeline.	
Outline drug court fees assessed to the client in addition to treatment fees.	
UUHP will work collaboratively with Summit County to determine the appropriate fees to be collected. UUHP proposes that the County and UUHP work together to determine whether fee schedule maintenance and collection of fees are more appropriately handled by UUHP or the County. UUHP reserves the right to negotiate an additional administrative rate if it is determined that UUHP is the party that should collect the fees.	
Describe any significant programmatic changes from the previous year.	
N/A.	
Describe the Recovery Support Services you will provide with Drug Court RSS funding. (These services must be services that are approved on the DC RSS service list)	
UUHP expects that it can find resources to provide RSS services. The data provided is not enough information for UUHP to propose a fully detailed solution. In order to determine the best solution, additional information is needed regarding utilization, the types of drug test which are expected to be provided, and a description of the applicable funding sources for these services. UUHP will work with Summit County to determine the best solution within the available funding.	
Has the LCP met the services and metrics of this required service?	
- COMMITTEE USE ONLY -	

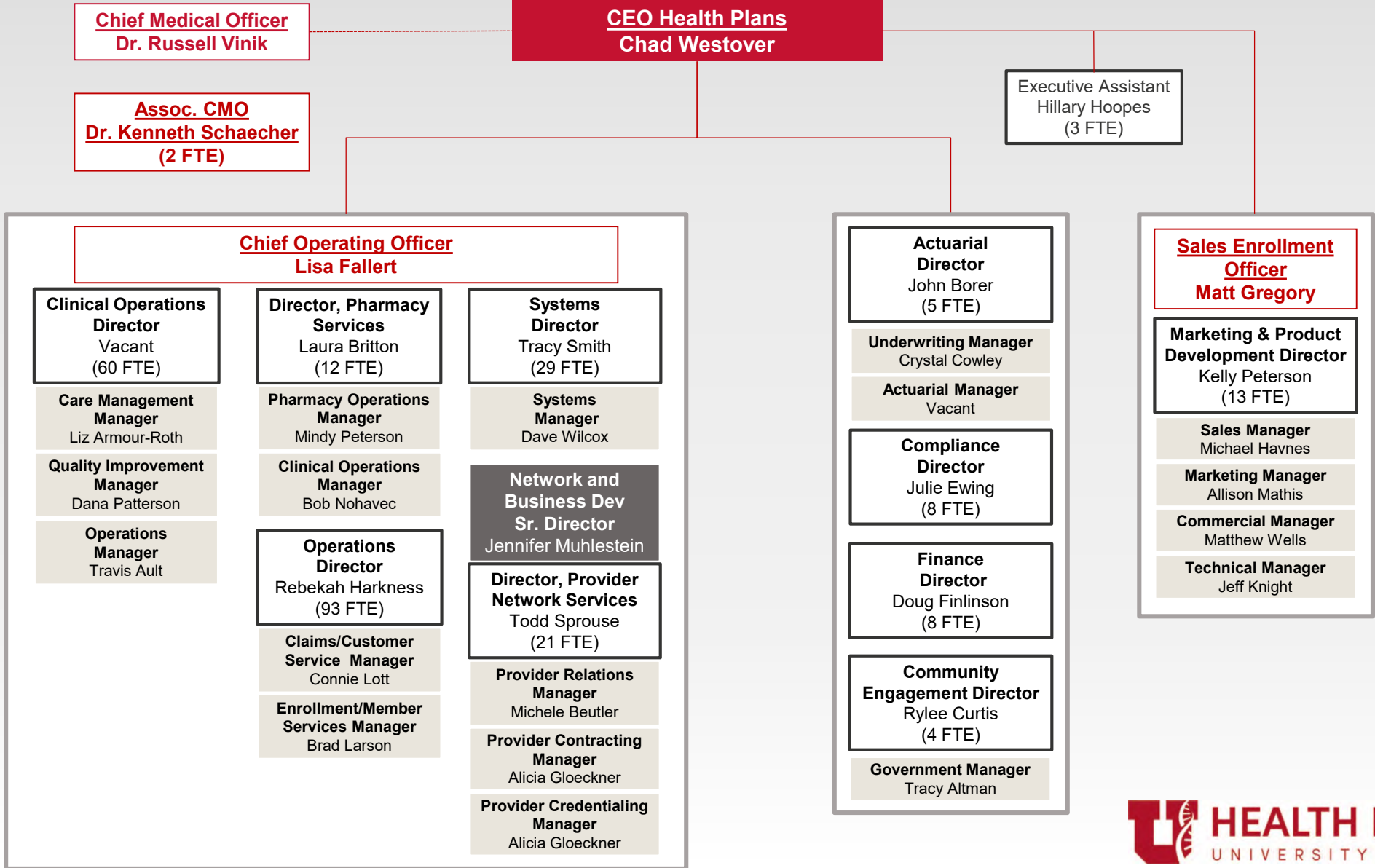
17) Justice Reinvestment Initiative (JRI)

Form B - FY19 Amount Budgeted:	\$18,000	LCP Amount Budgeted:	
---------------------------------------	-----------------	-----------------------------	--

Describe your experience with JRI.
UUHP has no JRI experience at this time.
Describe the evidence-based substance abuse screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.
UUHP will work collaboratively with Summit County and DSAMH to develop these services.
Identify training and/or technical assistance needs.
UUHP has no identified training and/or technical assistance needs.
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

- END OF FORM C-

University of Utah Health Plans Organization Chart





Christopher Gauger, LCSW

Office Location: 3100 W. Pinebrook Road

Park City, Utah 84098

Phone: 307-254-1818

3/1/19

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of 3/1/19, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Christopher Gauger, LCSW, Owner/President CG Mental Health, Inc. ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated 3/1/19 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

A handwritten signature in blue ink that reads "Chris Gauger LCSW".

By: _____

Christopher Gauger, LCSW

CG Mental Health, Inc.

A handwritten signature in blue ink that reads "Chad Westover".

By: _____

Chad Westover, CEO

Corinna A Porter Phd. LLC

875 S 600 W Suite 212

Heber City, UT 84032

March 1, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Corinna A. Porter, PhD LLC ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated: July 22, 2016 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: 

Corinna A Porter

University of Utah Health Plans

By: 

Chad Westover, CEO

Elizabeth Doshier, LCSW 435.513.2280 elizabethdoshier@gmail.com
5532 Lillehammer Lane, Suite 200, PO Box 983765 Park City, UT 84098

March 5, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 5, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Elizabeth Doshier, LCSW ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: Elizabeth Doshier, LCSW
Elizabeth Doshier, LCSW

University of Utah Health Plans

By: Chad Westover
Chad Westover, CEO

Expansive Horizons Counseling

450 West 910 South Ste. 104, Heber City, UT 84032
228 West 200 South Suite 2E Kamas, UT 84036
Phone 801.360.6955 Fax 435.604.7631

2/26/2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of **March 1, 2019**, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Expansive Horizons Counseling ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated **2/26/2019** ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and


Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By:


NAME Liza Sanderson

University of Utah Health Plans

By:


Chad Westover, CEO

Expansive Horizons Counseling

450 West 910 South Ste. 104, Heber City, UT 84032
228 West 200 South Suite 2E Kamas, UT 84036
Phone 801.360.6955 Fax 435.604.7631

2/26/2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of **March 1, 2019**, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Expansive Horizons Counseling ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated **2/26/2019** ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: 

By: 

NAME

Liza Sanderson

Chad Westover, CEO

FOUR SEASONS THERAPY
2760 WEST RASMUSSEN RD.
SUMMIT CENTER BUILDING D, SUITE 200
84098 (435)901-1670

Tax ID# 26-3379177
NPI # 1467576561

March 5, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

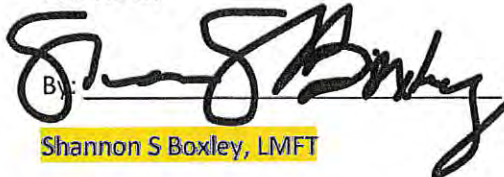
This Letter of Intent (LOI) is made and entered into effective as of **March 5, 2019**, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and **Shannon S Boxley** ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.


Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: 
Shannon S Boxley, LMFT

University of Utah Health Plans

By: 
Chad Westover, CEO

Gale & Associates Center for Assessment and Psychotherapy PLLC
2760 W Rasmussen Road D210 Park City, UT 84098
Phone: 435-645-9240 Fax: 866-376-8067
Galeandassociates.net

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID
BEHAVIORAL THERAPY NETWORK

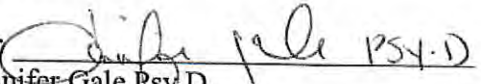
This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Gale & Associates Center for Assessment and Psychotherapy ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: 
Jennifer Gale Psy.D.
Gale & Associates PLLC

University of Utah Health Plans

By: 
Chad Westover, CEO

Harmony Family Therapy

Nancy Sutton, LMFT
PO Box 529
Midway, UT 84049

March 13, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of **March 13, 2019**, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Nancy Sutton, LMFT ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated **March 13, 2019** ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: Nancy Sutton, LMFT

NAME

University of Utah Health Plans

By:  _____

Chad Westover, CEO



INNERWELL

— PSYCHOTHERAPY —

MIND • BODY • SPIRIT

March 1, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY
NETWORK

This Letter of Intent (LOI) is made and entered into effective as of **March 1, 2019**, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and **Debra Ayer, LCSW** ("Provider"). Whereas, Provider and University entered into a Provider Agreement dated **November 11, 2017** ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services. Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019. IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: _____
NAME

By: _____
Chad Westover, CEO

DATE: 3/5/2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 5, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Grey Walter ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: _____

Grey Walter

By: _____

Chad Westover, CEO



Jewish Family Service

www.jfsutah.org

1111 East Brickyard Road, Suite 218 • Salt Lake City, Utah 84106 • 801.746.4334 • 801.746.4337 FAX
650 Round Valley Drive • Park City, Utah 84060 • 435.640 6697 • www.jfsutah.org

2/27/19

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Ellen Silver, LCSW

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of February 27, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Jewish Family Service ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: *Ellen Silver*

By: *Chad Westover*

Ellen Silver
Executive Director

Chad Westover, CEO



MAZON

A Jewish Response
To Hunger



Strengthening Individuals and Families of all backgrounds through Counseling, Advocacy, Care Management, and Education

John R. Taylor, Ph.D.

Licensed Clinical Psychologist
Summit Center Professional Building
2750 Rasmussen Road, Suite H - 105
Park City, Utah 84098
(435) 647-2911

March 12, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This letter of intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and John R. Taylor ("Provider").


Whereas, Provider and University entered into a Provider Agreement dated [DATE] ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: 

University of Utah Health Plans

By: 

Chad Westover, CEO

LIFE CHANGES COUNSELING

2 SOUTH MAIN ST. SUITE 2B HEBER CITY, UTAH 84032 PH- 801-923-5530



03/01/2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of **March 1, 2019**, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and **Melynda Vincent** ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated **[DATE]** ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: Melynda Vincent LCSW
Melynda Vincent LCSW, MPA MPA

By: Chad Westover
Chad Westover, CEO

Roxi Nelson | LCSW
Park City Therapist

Mountain Strength Wellness Center
Counseling and Psychotherapy
435-615-7600

February 27, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Roxi Nelson ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated [February 27, 2019] ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: 

By: 

Roxi Nelson

Chad Westover, CEO

Pamela C. Wilkison, Ph. D.
Licensed Psychologist

Specializing in Early Childhood and Family Psychological Services

3-1-19

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Pamela C. Wilkison, Ph.D. ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated March 1, 2019 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and


Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: 

By: 

Pamela C. Wilkison, Ph. D.

Licensed Psychologist

Chad Westover, CEO

Park City Therapy

March 4, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 4, 2019 by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Park City Therapy ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER University of Utah Health Plans

By: DAWilson

Dodi Wilson, CMHC

By:  _____

Chad Westover, CEO



SIRAJ PALETTA, MA, LCMHC

PATHWAYS OF HEALING, LLC
MIND, BODY, SPIRIT, INTEGRATED THERAPY

P.O. Box 682879
Park City, Utah 84068

PROVIDER LETTERHEAD / LOGO

DATE 03/01/2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and PROVIDER NAME ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: Caroline Siraj Paletta
LCMHC

NAME

By: Chad Westover

Chad Westover, CEO

DR. PATRICIA A. LINDSAY, PH.D.
CLINICAL PSYCHOLOGIST

FACSIMILE TRANSMITTAL SHEET

TO: Brenda Owens FROM: Patricia A. Lindsay, Ph.D.
 COMPANY: _____ DATE: 3/12/19
 FAX NUMBER: 801-281-6721 TOTAL NO. OF PAGES INCLUDING COVER: 2
 PHONE NUMBER: 801-587-2447 SENDER'S REFERENCE NUMBER: _____
 RE: _____ YOUR REFERENCE NUMBER: _____

- URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

This Facsimile may contain confidential and privileged information. It is intended only for the use of the individual or agency to which it is addressed.

If you have received this communication in error, please notify us immediately by phone and return the original message to us at the address below via U.S. Mail.

1743 WEST REDSTONE CTR. DR., SUITE 115, PARK CITY, UTAH 84098
(435) 658-9297, FAX (435) 658-9298

Patricia A. Lindsay, Ph.D. Clinical Psychologist

March 6, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL
THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and PROVIDER NAME ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated [DATE] ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: _____
Patricia A Lindsay, Ph.D.
Licensed Clinical Psychologist

University of Utah Health Plans

By:  _____
Chad Westover, CEO



University of Utah Redstone Health Clinic
1743 W Redstone Center Dr., #115, Park City, UT. 84098
Phone (435) 658-9297 Fax (435) 658-9298



February 28, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Red Willow Counseling and Recovery ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: [Signature]
James Ott, ED

University of Utah Health Plans

By: [Signature]
Chad Westover, CEO

1425 South 700 East Salt Lake City, Utah 84105
801 | 556-6007 james@redwillowcounseling.com

Small text at the bottom of the page containing legal disclaimers and contact information.

Sarah Rothstein, LLC

2760 Rasmussen Rd

Building D, Suite 202

Park City, UT 84098



February 27, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Sarah Rothstein ("Provider").

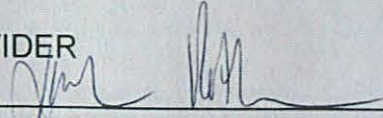
Whereas, Provider and University entered into a Provider Agreement dated February 28, 2019 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

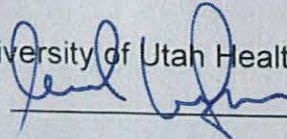
IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By:  _____

Sarah Rothstein

University of Utah Health Plans

By:  _____ Chad Westover, CEO

PROVIDER LETTERHEAD / LOGO

DATE 2/27/19

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and PROVIDER NAME ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated [DATE] ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: [Signature]

By: [Signature]

NAME Teresa Rummicki
Solstice Counseling & Wellness
722 W 100 S, Ste. 1
Heber City, UT 84032

Chad Westover, CEO

Drs: SHAWN MILLER
CHRISTIAN MONSM

Audrey DuRoss, LCSW

Summit Counseling

3070 Rasmussen Rd. Suite #121

Park City, UT 84098

3/1/19

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY
NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Audrey DuRoss("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically to provision of behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

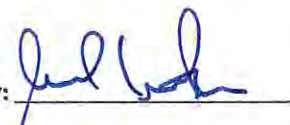
IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By:  , LCSW

Audrey DuRoss, LCSW

By: 

Chad Westover, CEO



March 12, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 12, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Summit Community Counseling ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated March 12, 2019 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: Brandi Perry
Brandi Perry

By: Chad Westover
Chad Westover, CEO

Karen Malm PhD

02/28/19

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Andrew J. Nichols Ph.D. (dba: Summit Neuropsychology, PLLC) ("Provider").

Whereas, Provider and University desire to enter into a Provider Agreement with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans, specifically, to provision of psychological/neuropsychological assessment, and behavioral therapy services.

Whereas, both parties agree to develop a Provider Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER University of Utah Health Plans

By: **Andrew J. Nichols Ph.D.**
Digitally signed by Andrew J. Nichols Ph.D.
DN: cn=Andrew J. Nichols Ph.D., o=Summit Neuropsychology, ou, email=dr.nichols@summitneuropsychology.com, c=US
Date: 2019.02.28 10:13:53 -07'00'

By: 
NAME Chad Westover, CEO

March 8, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 8, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Sundance Behavioral Resources ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated December 12, 2016 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

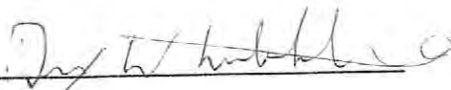
Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

Sundance Behavioral Resources

University of Utah Health Plans

By: 

Dex Whitehead, Director

By: 

Chad Westover, CEO

SYNERGISM COUNSELING



February 27, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of February 27, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and Michelle Greene, dba Synergism Counseling ("Provider").

Whereas, Provider and University entered into a Provider Agreement dated February 27, 2019 ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

University of Utah Health Plans

By: Michelle Greene

Michelle Greene, Owner/Therapist

By: Chad Westover

Chad Westover, CEO



University Neuropsychiatric Institute
501 Chipeta Way
Salt Lake City, UT 84108
801.583.2500

February 26, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 1, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and University Neuropsychiatric Institute ("Provider").


Whereas, Provider and University entered into a Provider Agreement ("Agreement") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreement to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Both parties agree to develop an amendment to the Agreement for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

PROVIDER

By: 

Ross Van Vranken, CEO

Date: 2-28-2019

University of Utah Health Plans

By: 

Chad Westover, CEO

Date: 3/13/2019



March 7, 2019

LETTER OF INTENT REGARDING PARTICIPATION IN THE
UNIVERSITY OF UTAH HEALTH PLANS' HEALTHY U MEDICAID BEHAVIORAL THERAPY NETWORK

This Letter of Intent (LOI) is made and entered into effective as of March 7, 2019, by and between the University of Utah, a body politic and corporate of the State of Utah on behalf of its University of Utah Health Plans ("University"), and its University of Utah Hospitals & Clinics and its University of Utah Medical Group (collectively, "Provider").

Whereas, Provider and University entered into Provider Agreements for Provider's hospitals and clinics and medical group (collectively, "Agreements") with respect to the provision of certain health care services for the enrolled members of University of Utah Health Plans; and

Whereas, Provider and University desire to amend Agreements to include the Healthy U Medicaid network specific to provision of behavioral therapy services.

Parties agree to develop Amendments to the Agreements for the inclusion of Healthy U Medicaid, contingent upon Summit County's awarding of the Medicaid Behavioral Therapy contract to University, no later than August 15, 2019.

IN WITNESS WHEREOF, the Parties hereto, through their respective representatives thereunto duly authorized, have entered into this Letter of Intent as of the effective date mentioned above.

University of Utah Hospitals & Clinics

By: 

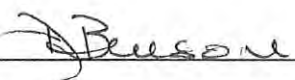
Charlton Park, CFO, CAO

University of Utah Health Plans

By: 

Chad Westover, CEO

University of Utah Medical Group

By: 

Dayle Benson, DHA, Executive Director

Attachment E

Complete the following worksheet for each entity you currently or are planning on subcontracting with to provide services under this contract. If you currently are not in a relationship with an entity, but are anticipating you will for this Contract, include a letter of intent with this form stating so.

Entity Contracted	Service(s) Provided	Type of Organization	Location of Services Being Provided Under this Contract
EXAMPLE	EXAMPLE	EXAMPLE	EXAMPLE
Blessing Mental Health	Outpatient	Non-Profit 501c3	1100 Old Town, Park City, UT 84098
Dr. Nate Tate, Psychiatrist	Medication Management	Individual Contractor	1200 Twain Rd., Coalville UT, 84017
Rutan Behavioral Health Center	Inpatient	Non-Profit 501c3	6 Moline Dr., Salt Lake City UT,
Kim Bester, LCSW	School Based Services	Individual Contractor	12 Quincy Dr., Kamas UT,
Entity Contracted	Service(s) Provided	Type of Organization	Location of Services Being Provided Under this Contract
CG Mental Health, Chris Gauger, LCSW	Counseling Spanish Speaking	S Corporation	2700 Homestead Rd, Park City, UT 84098
Corinna A Porter, PhD	Child & adolescent Psychologist	Individual/Sole Proprietor	150 N Main St #206, Heber City, UT 84032
Elizabeth Doshier, LCSW	Outpatient Counseling ages 6 - 65+	Individual/Sole Proprietor	5532 Lillehammer Lane #200 Park City, UT 84098
Expansive Horizons Counseling	Individual & couples psychotherapy	S Corporation	220 W 200 S, Kamas, UT 84036
Four Seasons Therapy	Marriage & Family Therapy	Individual/Sole Proprietor	2760 W Rasmussen Rd, Park City, UT 84098
Gale and Associates	Pediatric Neuro Psychological Assessment & Autism Diagnostic Assessment	Not on file	2760 Rasmussen Rd #D-210, Park City, UT 84098
Harmony Family Therapy, Nancy Sutton	Marriage & Family Therapy	Limited liability company	171 S 80 E, Midway, UT 84049
Innerwell Psychotherapy, Debra Ayer	Adults, adolescents, couples	Individual/Sole Proprietor	3100 Pinebrook Rd, Park City, UT 84098
Insight Psychotherapy	Outpatient Mental Health, ages 11 -65+ / LGBTQ	Individual/Sole Proprietor	1912 Sidewinder Dr, Park City, UT 84060
Jewish Family Service	Outpatient Mental Health Counseling Refugee Assistance Spanish Speaking	Non-Profit 501c3	650 Round Valley Dr, Park City, UT 84060
John R Taylor PhD	Outpatient Mental Health Counseling	TBD	136 Heber Ave #204, Park City, UT 84060
Life Changes Counseling	Adult, Child, Family Counseling Behavioral Assessments	TBD	2 S Main St #2B, Heber City, UT 84032

	PsychoSocial Assessments		
Nelson Roxi, Mountain Strength Wellness Center	Counseling age 10 and up	Individual/Sole Proprietor	3100 Pinebrook Rd #2250, Park City, UT 84098
Pamela C Wilkison PhD	Clinical child & adolescent psychologist	Individual/Sole Proprietor	2700 Homestead Rd, Park City, UT 84098
Park City Therapy	Outpatient, Alcohol Abuse, Anxiety, Depression, Hypnotherapy	Individual/Sole Proprietor	1901 Prospector Avenue #22 Park City, Utah 84060
Pathways of Healing	Outpatient Transpersonal Psychotherapist, LGBTQ sensitive	Individual/Sole Proprietor	50 Shadow Ridge, Park City, UT 84060
Patricia Lindsay PhD (LOI returned – missed signature)	Clinical Psychologist	S Corporation	1743 W Redstone Center Dr, Park City, UT 84098
Red Willow Counseling & Recovery	Outpatient Mental health counseling and addiction psychotherapy	S Corporation	1901 Prospector Ave, Park City, UT 84060
Sarah Rothstein LCSW	General Counseling	Individual/Sole Proprietor	2760 Rasmussen Rd, Park City, UT 84098
Solstice Counseling and Wellness	Counseling age 6 and up		722 W 100 S #1, Heber City, UT 84032
Sundance Behavioral Resources	All ages Counseling Medication Management Will consider SUD	TBD	Developing Summit County location
Summit Community Counseling (Karen W Malm, Phd)	All areas of counseling	S Corporation	150 N Main St #204-6, Heber City, UT 84032
Summit Counseling (Audrey DuRoss, LCSW)	Outpatient Counseling ages 6 - 65+	Individual/Sole Proprietor	3070 Rasmussen Rd, Park City, UT 84098
Summit Neuropsychology	6 - 65+. Brain Injuries & Symptoms. Cognitive Impairments	Individual/Sole Proprietor	1389 Center Dr, Park City, UT 84098
Summit Pediatrics	Individual and Group Therapy Parent Training Medication Management Evaluations Children, Adolescents	C Corporation	750 Round Valley Dr #102, Park City, UT 84060
Synergism Counseling Michelle Greene MSW	Anxiety counseling	S Corporation	425 E 1200 S #L4 Heber City, UT 84032
UNI Comprehensive Assessment Treatment	Assessment and treatment, 5-17 years old	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108

UNI Consult Clinic (Rapid Access Clinic)	PCP referral based Medication Management Adult, Adolescent, Child	Non-Profit 501c3	525 E 100 S, SLC, UT 84102
UNI Crisis Line	Crisis Intervention Suicide Prevention Emotional Support and Assistance Referral Information	Non-Profit 501c3	Hot Line
UNI Day Treatment – Kidstar	5-12 year old Day Treatment	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108
UNI Day Treatment – Teenscope	12-18 years old Day Treatment	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108
UNI Downtown Behavioral Health Clinic	Ages 4+ Mental Health	Non-Profit 501c3	525 E 100 S, SLC, UT 84102
UNI GATE	PCP consultation with adult/child psychiatrist Medication Management Support	Non-Profit 501c3	Electronic Consultation
UNI Girls Transition Center	Residential Treatment Females 12-17 years old Enter program through Division of Child and Family Services or Juvenile Justice Services	Non-Profit 501c3	51 W 3900 S, SLC, UT
University Neuropsychiatric Institute	Inpatient Adult, Child, Adolescent, Geriatric Mental Health Substance Use Detox – Adult	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108
UNI Receiving Center	Short-term crisis management Psychiatric assessment Medication intervention Adult	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108
UNI Recovery Clinic	Addiction Recovery MAT	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108
UNI Recovery Works	IOP, Adult	Non-Profit 501c3	501 Chipeta Way, SLC, UT 84108 (Note: Could offer in Summit County)
UNI SafeUT	Crisis and Tip Line Suicide Prevention School Support	Non-Profit 501c3	Texting Crisis and Tip Line
UNI Same Day Psychiatric Clinic	Ages 5+	Non-Profit 501c3	525 E 100 S, SLC, UT 84102 (Thursdays)

	Same day appointment Medication Management Counseling		501 Chipeta Way, SLC, UT 84108
UNI Telehealth	Jail counseling & crisis (potential) Crisis Counseling Serves Utah State Prison	Non-Profit 501c3	Virtual Visit
UNI Warm Line	Certified Peer Specialists Emotional Support	Non-Profit 501c3	Hot Line
University of Utah Hospitals & Clinics	Inpatient (Medical/Trauma)	Non-Profit 501c3	50 N Medical Dr, SLC, UT 84132
University of Utah Medical Group	Mental Health Substance Use Addiction Psychiatry Geriatric Psychiatry Women's Services Adult, Adolescent, Children	Other: State Government Entity (Non-Profit)	50 N Medical Dr, SLC, UT 84132
University of Utah – Community Clinics	Counseling available through Social Workers	Other: State Government Entity (Non-Profit)	Various along the Wasatch Front
University of Utah Medical Group – Farmington Clinic	Addiction psychiatry Geriatric psychiatry Adult/Adolescent	Other: State Government Entity (Non-Profit)	291 S 200 W, Farmington, UT
University of Utah Medical Group – Redstone Clinic	Counseling available through Social Workers and Residents University Department of Psychiatry willing to staff based on needs assessment – potentially include SUD Screening & Assessment, SUD therapy (non-methadone), etc.	Other: State Government Entity (Non-Profit)	1743 W Redstone Center Dr, Park City, UT 84098

ATTACHMENT F: Annual Report

UUHP's Annual Reporting is done through the University of Utah's annual report. The Annual Report is also UUHP's most recent audited financial report and is attached as *Attachment H*.

ATTACHMENT G: Copy of FY18 DSAMH Audit

UUHP is not currently serving as an LCP.

ATTACHMENT H: UUHP's Most Recent Audited Financial Statement



2018

ANNUAL FINANCIAL REPORT
THE UNIVERSITY OF UTAH
A COMPONENT UNIT OF THE STATE OF UTAH

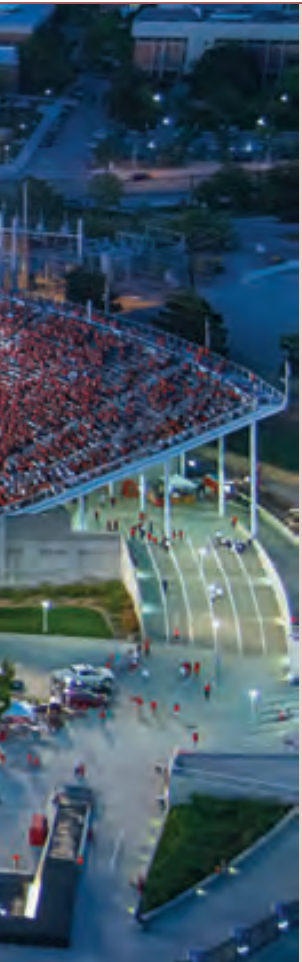






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Message from the President Ruth V. Watkins

Dear colleagues,

I am pleased to present the University of Utah's annual statement for fiscal year 2018. The details of this report demonstrate a consistent and reliable trajectory: the University of Utah is in a strong financial position. It is truly because of the strength of our financial foundation that we continue to move the needle in all aspects of our institution.

As Utah's flagship institution of higher education, we continue to grow in national recognition. This year, we hired more than 150 new faculty who join in our mission to engage in exceptional teaching, groundbreaking research and caring for our community. Across our entire organization, we consistently receive national and international attention for the quality and impact of our research findings and published scholarship. We could not sustain these pioneering research efforts without the tremendous support our faculty generate through external funding. This year, we broke our record as our sponsored project awards totaled more than half a billion dollars.

Student success is at the heart of our mission as a university. Inquisitive, smart, creative students come here to become world-class change agents, innovators and leaders. As our organization has grown, our student population has grown with us. Today, our student body is more diverse. They are more prepared academically. They are graduating sooner and at higher rates. As a top-tier university with tuition among our national peers, we are proud of the quality education we offer our students at a cost they can afford.

University of Utah Health continues to achieve noteworthy success in clinical care, scientific discovery and interdisciplinary education, building on the remarkable momentum of the past seven years. Unlike many academic medical centers across the nation, U of U Health is able to deliver innovative patient care through its proximal connection with the groundbreaking medical and scientific research and education that happen on our health campus. For the past eight years in a row, U of U Health ranked in the top 10 for clinical



quality among academic medical centers nationally. With nearly two million patient visits per year and an extensive affiliate network, access to U of U Health is available across the Mountain West. We accomplish all of this as we also develop and train the health care providers of the future.

Our campus facilities also continue to grow, thanks to the generous support of our donors and the Utah Legislature. This year, we celebrated the opening of the newly remodeled Cleone Peterson Eccles Alumni House and the new Carolyn and Kem Gardner Commons. Additionally, we have broken ground on two new clinical facilities—the Ambulatory Care Complex and the Craig H. Neilsen Rehabilitation Hospital. We are grateful for the many donors whose generosity allowed us to create numerous new scholarships, fellowships and endowed positions that benefit our students and faculty.

While we are the University of Utah, we are also the University for Utah. Our firm financial standing gives us the ability to reach into the future, to innovate, to discover, and especially to serve the great people of this state. As President Abraham Lincoln said, “the best way to predict your future is to create it.”

It is an honor to work with you to create the future of the University of Utah, for Utah.

Sincerely,

Ruth V. Watkins



OFFICE OF THE
STATE AUDITOR

INDEPENDENT STATE AUDITOR'S REPORT

To the Board of Trustees, Audit Committee
and
Dr. Ruth V. Watkins, President
University of Utah

Report on the Financial Statements

We have audited the accompanying financial statements of the University of Utah (University), a component unit of the State of Utah, as of and for the year ended June 30, 2018, and the related notes to the financial statements, which collectively comprise the University's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We did not audit the financial statements of the University of Utah Hospitals and Clinics (UUHC), ARUP Laboratories, Inc. (ARUP), University of Utah Research Foundation (UURF), or University of Utah Health Insurance Plans (UUHIP), which represent 33 percent, 26 percent, and 51 percent, respectively, of the assets, net position, and revenues of the University. Those statements were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for UUHC, ARUP, UURF, and UUHIP, is based solely on the reports of the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement. The financial statements of ARUP were not audited in accordance with Government Auditing Standards.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audit and the reports of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the University as of June 30, 2018, and the changes in its financial position and its cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

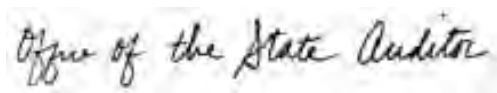
Accounting principles generally accepted in the United States of America require that Management's Discussion and Analysis and the University's Schedule of Proportionate Share of the Net Pension Liability and Schedule of Defined Benefit Pension Contributions, included in the Required Supplementary Information listed in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the University's basic financial statements. The Message from the President and the listing of Governing Boards and Officers are presented for purposes of additional analysis and are not a required part of the basic financial statements. This message and listing have not been subjected to the auditing procedures applied in the audit of the basic financial statements, and accordingly, we do not express an opinion or provide any assurance on them.

Other Reporting Required by Government Auditing Standards

In accordance with Government Auditing Standards, we have also issued our report dated October 15, 2018 on our consideration of the University's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the University's internal control over financial reporting and compliance.

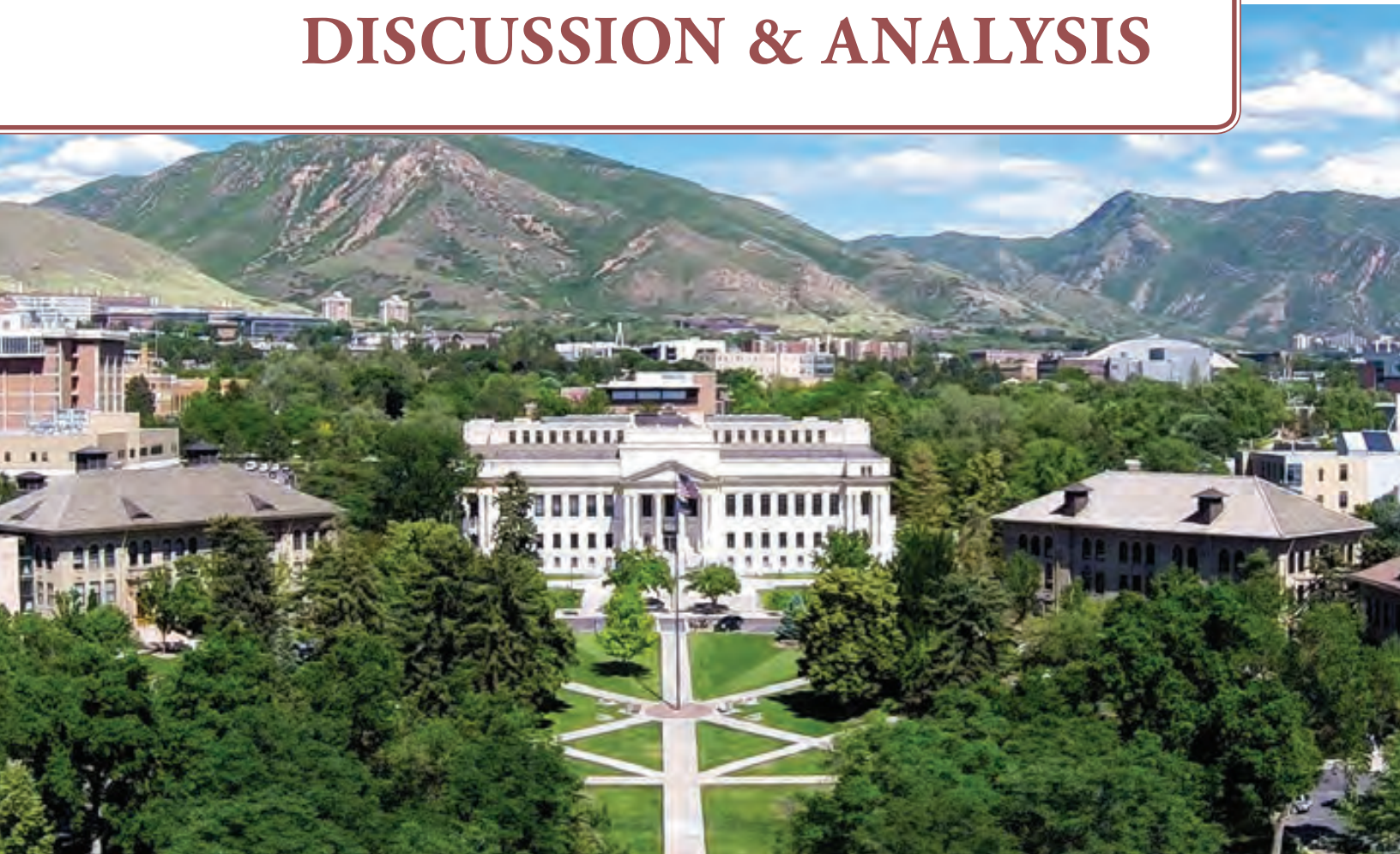


Office of the State Auditor
October 15, 2018



MANAGEMENT'S DISCUSSION & ANALYSIS

TM



INTRODUCTION

The following discussion and analysis provides an overview of the financial position and activities of the University of Utah (University) and its component units for the year ended June 30, 2018, with selected comparative information for prior fiscal years. This discussion has been prepared by management and should be read in conjunction with the Financial Statements and the Notes to the Financial Statements, which follow this discussion and analysis.

The University of Utah's Financial Statements include revenues, expenses, assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position for the entire University entity, including the University of Utah Hospitals and Clinics (UUHC), which is part of University of Utah Health Care, as well as the balances and activities of three component units: the University of Utah Research Foundation (UURF), ARUP Laboratories, Inc. (ARUP) and University of Utah Health Insurance Plans (UUHIP). UURF specializes in the transfer of patented technology to business entities as well as the leasing and administration of Research Park (a research park located on land owned by the University) and other buildings. ARUP is a national clinical and esoteric reference laboratory. UUHIP is a licensed non-profit health insurance provider. More information about these entities and their inclusion in the financial statements may be found in Note 1—*Summary of Significant Accounting Policies – Reporting Entity*.

ABOUT THE UNIVERSITY OF UTAH

Founded in 1850, the University of Utah is the state's oldest and most comprehensive institution of higher education and is the flagship institution of the state

system of higher education. The University offers over 100 major subjects at the undergraduate and graduate level, including law and medicine, to 32,000 students from across the United States and world, preparing students to live and compete in the global workplace. With more than 30,000 employees, it is one of the state's largest employers.

University of Utah Health Care is the only academic medical center in the state of Utah and is nationally ranked. It is also one of only three facilities in the state of Utah that the American College of Surgeons has recognized as a Level 1 trauma center and has also received the National Cancer Institute Cancer Center designation.

The financial statements that follow provide additional information on the resources available to the University to accomplish its multi-dimensional mission, and to achieve its goals and objectives, including the many exciting things described above. For more information about the University and its programs and initiatives, please visit www.utah.edu.

OVERVIEW AND ANALYSIS OF THE FINANCIAL STATEMENTS

The financial statements are prepared in accordance with Governmental Accounting Standards Board (GASB) principles. Three financial statements are presented: the Statement of Net Position; the Statement of Revenues, Expenses, and Changes in Net Position; and the Statement of Cash Flows. The Notes to the Financial Statements are an integral part of the statements and provide additional details and information important to an understanding of the University's financial position and results of operations.

The Statement of Net Position presents the financial position of the University at the end of the fiscal year and includes all assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position of the University. Net position is one indicator of the current financial condition of the University. Assets, deferred outflows of resources, liabilities, and deferred inflows of resources are generally measured using current values except for capital assets, which are stated at historical cost less accumulated depreciation.

The Statement of Revenues, Expenses, and Changes in Net Position presents the University's results of operations for the fiscal year. The net difference between revenues and expenses, and other changes, is the increase (or decrease) in net position for the year. The change in net position is an indicator of whether the overall financial condition has improved or worsened during the year.

The Statement of Cash Flows provides additional information about the University's financial results by reporting the major sources and uses of cash by type of activity—as well as providing a reconciliation to the net operating loss.

The results of operations reflect the University's focus on maintaining its national standards academically, in research, and in health care in a competitive environment. At the same time, the University is addressing constrained base state appropriations and rising health care, regulatory and facility costs with productivity gains to help preserve access to affordable higher education and health care services.

STATEMENT OF NET POSITION

A condensed statement of net position for the past five fiscal years is shown in *Figure 1* below:

Figure 1

Condensed Statement of Net Position
- as of June 30 (in thousands)¹

	2018	2017	2016	2015	2014
Current assets	\$2,057,009	\$1,759,605	\$1,687,992	\$1,672,391	\$1,554,857
Noncurrent assets					
Capital assets, net	3,323,706	2,959,044	2,718,265	2,504,854	2,412,729
Other noncurrent assets	2,108,022	2,068,089	1,887,210	1,726,576	1,500,050
Total Assets	7,488,737	6,786,738	6,293,467	5,903,821	5,467,636
Deferred Outflow of Resources	83,134	76,912	75,957	29,249	3,310
Current liabilities	704,687	685,374	698,355	643,914	582,192
Noncurrent liabilities	1,223,800	1,208,732	1,131,565	1,042,931	774,439
Total Liabilities	1,928,487	1,894,106	1,829,920	1,686,845	1,356,631
Deferred Inflow of Resources	75,898	28,990	17,798	12,810	
Net investment in capital assets	2,320,870	2,037,151	1,784,592	1,641,064	1,633,385
Restricted, nonexpendable	604,497	564,118	524,471	518,706	501,907
Restricted, expendable	757,165	576,934	510,895	449,189	522,044
Unrestricted	1,884,954	1,762,352	1,701,748	1,624,456	1,456,979
Total Net Position	\$5,567,486	\$4,940,555	\$4,521,706	\$4,233,415	\$4,114,315

¹ As reported in each year's published audited financial statements



Total net position increased 12.7% from the prior year and 35.3% over the periods shown—due to steady growth in most of the operating and nonoperating revenue categories. These increases indicate steady improvement in financial condition, reflecting the University’s prudent management of its resources—despite funding challenges. This surplus has been reinvested within the University to add to the margin of educational excellence, upgrade the University’s facilities, and provide a sensible reserve for contingencies. Capital assets increased 12.3% from the prior year primarily due to the addition of new buildings as well as building construction in progress. Liabilities increased 1.8% from the prior year primarily due to the issuance of two bonds offset by a reduction in the actuarial-determined net pension liability. Deferred Inflows of Resources increased 161.8% due to a change in projected and actual earnings on pension plan investments.

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

The results of the University’s operations for the fiscal year are shown in the Statement of Revenues, Expenses, and Changes in Net Position. A condensed statement of revenues, expenses, and changes in net position for the past five fiscal years is shown in *Figure 2* on page 10.

Revenues from tuition and fees increased 6.2% from the prior year—and 19.5% over the periods shown. This upward trend is reflective of the increases in enrollment and the students’ increased contribution toward the University’s budget.

Patient services revenues increased 0.8% from the prior year; and have increased 39.9% over the periods shown. This consistent growth reflects the UUHC’s commitment to grow in capacity and quality in servicing the health care needs of the intermountain region.



Figure 2

**Condensed Statement of Revenues, Expenses,
and Changes in Net Position – for the years
ended June 30 (in thousands)₁**

	2018	2017	2016	2015	2014
Operating revenues					
Tuition and fees, net	\$ 347,902	\$ 327,508	\$ 316,373	\$ 304,008	\$ 291,184
Patient services, net	2,209,201	2,192,329	1,998,637	1,816,284	1,579,004
Grants and contracts	455,950	397,813	367,738	362,634	364,975
Sales and services	991,457	900,958	821,071	740,220	671,311
Auxiliary and other	386,095	333,351	256,998	237,262	217,177
Total operating revenues	4,390,605	4,151,959	3,760,817	3,460,408	3,123,651
Operating expenses	4,585,138	4,364,965	3,965,735	3,703,864	3,386,191
Operating loss	(194,533)	(213,006)	(204,918)	(243,456)	(262,540)
Nonoperating revenues					
State appropriations	335,828	322,050	313,518	287,929	273,839
Gifts	158,773	117,949	90,869	101,312	77,056
Investment income	90,595	91,705	27,104	41,557	94,839
Other net nonoperating revenue (expense)	(7,327)	5,842	(5,889)	11,141	(18,795)
Total nonoperating revenues	577,869	537,546	425,602	441,939	426,939
Income before capital and permanent endowment additions	383,336	324,540	220,684	198,483	164,399
Capital and permanent endowment additions	205,242	94,309	67,607	53,970	50,192
Increase in net position	588,578	418,849	288,291	252,453	214,591
Net Position - beginning of year	4,978,908	4,521,706	4,233,415	3,980,962	3,899,724
Net Position - end of year	\$ 5,567,486	\$ 4,940,555	\$ 4,521,706	\$ 4,233,415	\$ 4,114,315

₁ As reported in each year's published audited financial statements

Grants and Contracts revenues increased 14.6% from the prior year due to growth in substantially all major research categories and sponsors' awards. Namely, federal research funding from National Institutes of Health; Department of Energy; Department of Defense; National Science Foundation and Department of Education. Additional research category increases were: Foundations and Associations; State of Utah governmental agencies; other Universities and Institutes of Higher Education; Private Industry; and Hospitals. The increases were partially offset by a net decrease in funding for sponsored research from various Research Institutions.

Sales and services revenue increased 10% from the prior year primarily due to growth in ARUP revenue, UUHC revenue and an increase in UUHIP premium revenue. Sales and services revenue maintained a consistent upward trend for the periods shown—increasing 47.7%. The largest contributor to the increase is growth in ARUP's revenues over the period.

Auxiliary and other income increased 15.8% from the prior year primarily due to revenue from UUHC.

With contributions from these significant sources, total operating revenues have increased 5.7% and 40.6%, from the prior year and for the periods shown, respectively.

Operating expenses have increased as well; 5% over the prior year and 35.4% for the periods shown. With

compensation and benefits representing 55% of total operating expenses for the current fiscal year, any change in that expense category can have significant impacts on total operating expenses. While salary increases have been modest, recruitment and retention of the University's excellent professors, researchers, and physicians requires the payment of competitive salaries. More detail on operating expenses appears below in *Figure 3*.

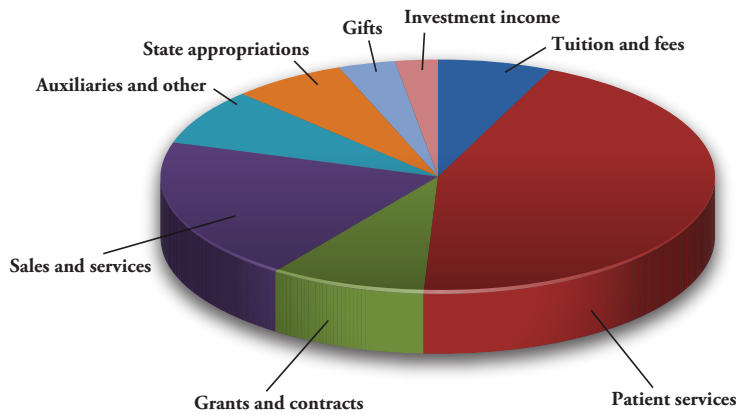
As a public university, the University of Utah receives funds from a variety of sources in support of its operations. While the Statement of Revenues, Expenses, and Changes in Net Position classifies certain funds as "nonoperating" for the purposes of financial reporting, such funds do, in fact, support the University's operations by covering costs such as salaries and benefits, travel, research expenses, and student aid.

State appropriations increased 4.3% from prior year which included funding to increase salaries, performance-based funding, and ongoing support for market demand programs. Gifts increased 34.6% primarily due to donor support for the David Eccles School of Business' creation of the Marriner S. Eccles Institute for Economic and Quantitative Analysis, support for the Medical Education and Discovery Building and the Rehabilitation Hospital. Investment income fluctuates from year to year, and reflects the impact of market performance. Fiscal year 2018 investment income decreased 1.2% from the prior year.

Figure 3

Total expenses (in thousands)	2018	2017	2016	2015	2014
Operating expenses					
Compensation and benefits	\$2,509,786	\$2,361,972	\$2,124,108	\$1,931,353	\$1,789,054
Component units	531,708	473,981	435,283	395,966	381,829
Supplies	567,176	530,338	498,101	432,171	374,681
Depreciation and amortization	222,591	222,143	204,396	189,481	198,696
Other	753,877	776,531	703,847	754,893	641,931
Total operating expenses	4,585,138	4,364,965	3,965,735	3,703,864	3,386,191
Nonoperating expenses					
Interest and other	41,942	39,140	40,552	34,805	65,070
Total expenses	\$4,627,080	\$4,404,105	\$4,006,287	\$3,738,669	\$3,451,261

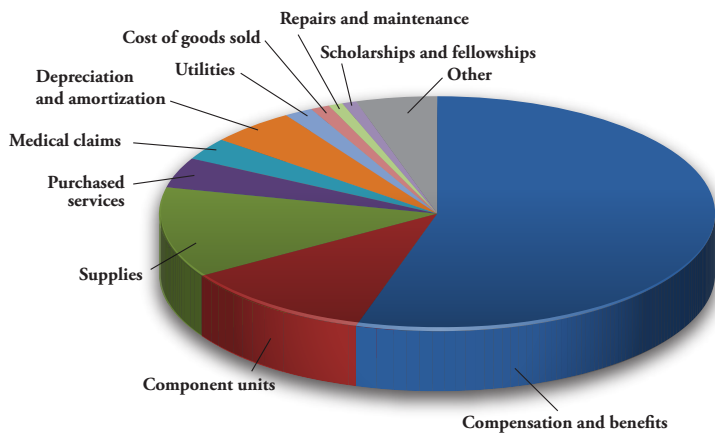
The graph below shows the various types of funding available to support the operations of the University:



**Sources of Revenue in Support of Operations
For the Year Ended June 30, 2018 (in thousands)**

Tuition and fees	\$347,902
Patient services	2,209,201
Grants and contracts	455,950
Sales and services	991,457
Auxiliaries and other	386,095
State appropriations	335,828
Gifts	158,773
Investment income & other	125,210

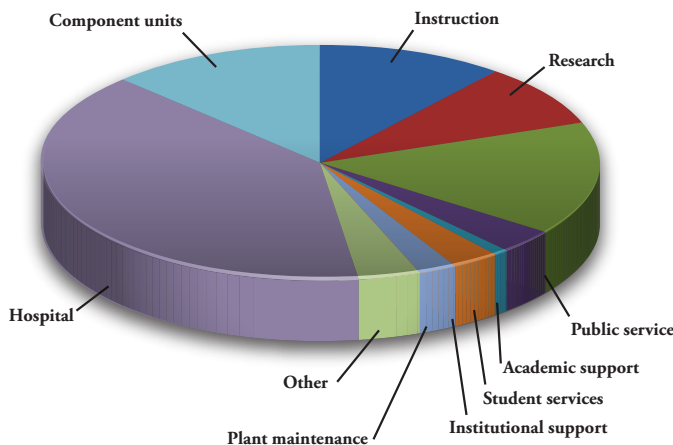
A graphical presentation of the University's operating expenses by natural classification appears below:



**Operating Expenses
For the Year Ended June 30, 2018 (in thousands)**

Compensation and benefits	\$2,509,786
Component units	531,708
Supplies	567,176
Purchased services	194,826
Medical claims	139,194
Depreciation and amortization	222,591
Utilities	86,676
Cost of goods sold	40,969
Repairs and maintenance	45,246
Scholarships and fellowships	31,152
Other	215,814

Note 18 provides more information regarding the classification of operating expenses by "function" (or purpose) as an alternative view to that which is presented on the face of the financial statements. A graphical presentation of the breakdown of operating expenses by functional classification follows:



**Functional Classification of Operating Expenses
For the Year Ended June 30, 2018 (in thousands)**

Instruction	\$505,157
Research	391,251
Public service	720,955
Academic support	149,060
Student services	39,028
Institutional support	118,514
Plant maintenance	103,051
Student aid	2,823
Other	162,498
Hospital	1,827,118
Component units	565,683

Figure 4

Condensed Statement of Cash Flows – for the years ended June 30 (in thousands)	2018	2017	2016	2015	2014
Cash flows provided/(used) by:					
Operating activities	(\$17,577)	(\$27,462)	\$23,692	\$20,282	(\$39,872)
Noncapital financing activities	486,181	476,027	465,142	450,662	386,924
Capital and related financing activities	(394,621)	(362,599)	(361,844)	(197,718)	(137,461)
Investing activities	(28,358)	(26,623)	(110,779)	(404,932)	(75,814)
Net increase (decrease) in cash	45,625	59,343	16,211	(131,706)	133,777
Cash - beginning of year	614,896	555,553	539,342	671,048	537,271
Cash - end of year	\$660,521	\$614,896	\$555,553	\$539,342	\$671,048

STATEMENT OF CASH FLOWS

A condensed version of the Statement of Cash Flows is shown in *Figure 4* above.

Cash flows from operating activities primarily consist of tuition and fees, patient services, grants and contracts, and auxiliaries. Significant sources of cash provided by noncapital financing activities, as defined by GASB, include state appropriations, federal Pell grants and private gifts.

Cash increased 7.4% from the prior year primarily due to a strategy of UUHC to increase days of cash on hand as well as UUHIP cash strategy to pay medical claims. The University actively manages its investment portfolio by balancing returns and liquidity, which may cause changes in cash balances. Cash and cash equivalents are held to the minimum needed to support operations, with any excess invested with varying maturity dates.

CAPITAL AND DEBT ACTIVITIES

- Some key construction projects were completed during the fiscal year, including the Gary L. and Ann T. Crocker Science Center at the George Thomas Building; Utility Distribution Infrastructure Replacement; Cleone Peterson Eccles Alumni House Renovation and Expansion; and the Orthopaedic Center Expansion. Ongoing projects include the Carolyn and Kem Gardner Commons, (replacing the Orson Spencer Hall); Robert H. and Katharine B. Garff Executive Education Building; Ambulatory Care Complex;

Rehabilitation Hospital; South Campus Housing and Dining; Health Sciences Energy Efficiency Improvement; and Medical Education & Discovery Building. All of the current projects will be completed over the next several years.

- During fiscal year 2018, the University issued two bond series. In September, the University issued \$155,930,000 of General Revenue and Refunding Bonds Series 2017A. Proceeds from these bonds were used towards the construction of a rehabilitation hospital, expansion of the University Guest House and, refunded a portion of the outstanding Series 2013A General Revenue bonds. In December, the University issued \$96,550,000 of General Revenue Refunding Bonds Series 2017B. Proceeds from these bonds were used to refund a portion of the University Hospital Revenue and Refunding Bonds Series 2011A, a portion of the University's General Revenue and Refunding Bonds Series 2014B and a portion of the University's General Revenue and Refunding Bonds Series 2015A-1.

Strong debt ratings carry substantial advantages for the University, such as continued and wider access to capital markets when the University issues debt, lower interest rates on bonds and the ability to negotiate favorable bond terms.

The University's Administration takes its role of financial stewardship seriously and works hard to manage its



financial resources effectively. Continued high debt ratings, currently Aa1 according to Moody's and AA+ according to S&P, for our General Revenue Bond System are important indicators of the University's success in this area.

OUTLOOK FOR THE COMING FISCAL YEAR

The University's enrollment for Fall 2018 increased from Fall 2017 by 0.7% with first-time freshmen up 3.3%. This is the largest freshman class with a total of 4,256 students. We are seeing the success of a change in recruiting efforts across the State. Enrollment at the undergraduate level is dependent on two factors, pool and participation, that are both heavily influenced by factors within the State. The available pool of potential students, age 18 through 29, is projected to climb steadily through 2023. Enrollment increases should stabilize and steadily increase based on the pool of potential Utah public school students.

During the 2018 legislative session, the University's recurring budget for 2018-2019 was increased by 8.1% compared to 2017-2018 which included funding to increase salaries, new student growth and capacity funding, and ongoing funds for performance. The economic growth in Utah is expected to moderate during 2018 with the job growth forecasted to increase at 2.8% for the year. Unemployment in Utah was 3.1% at the end of August 2018 as compared to 3.9% nationally. We are optimistic that the 2019 legislative session will continue to provide additional increases in funding.

During fiscal year 2018, the University raised \$281.5 million of committed gifts. The University continues to

benefit from the generosity of its donors and supporters and the number of active donors continues to increase. UUHC and ARUP continue to be recognized as leaders in their respective fields. The financial position for each is very strong and is expected to remain so. The University also remains very competitive in attracting research dollars and continues to see increases in sponsored project awards.

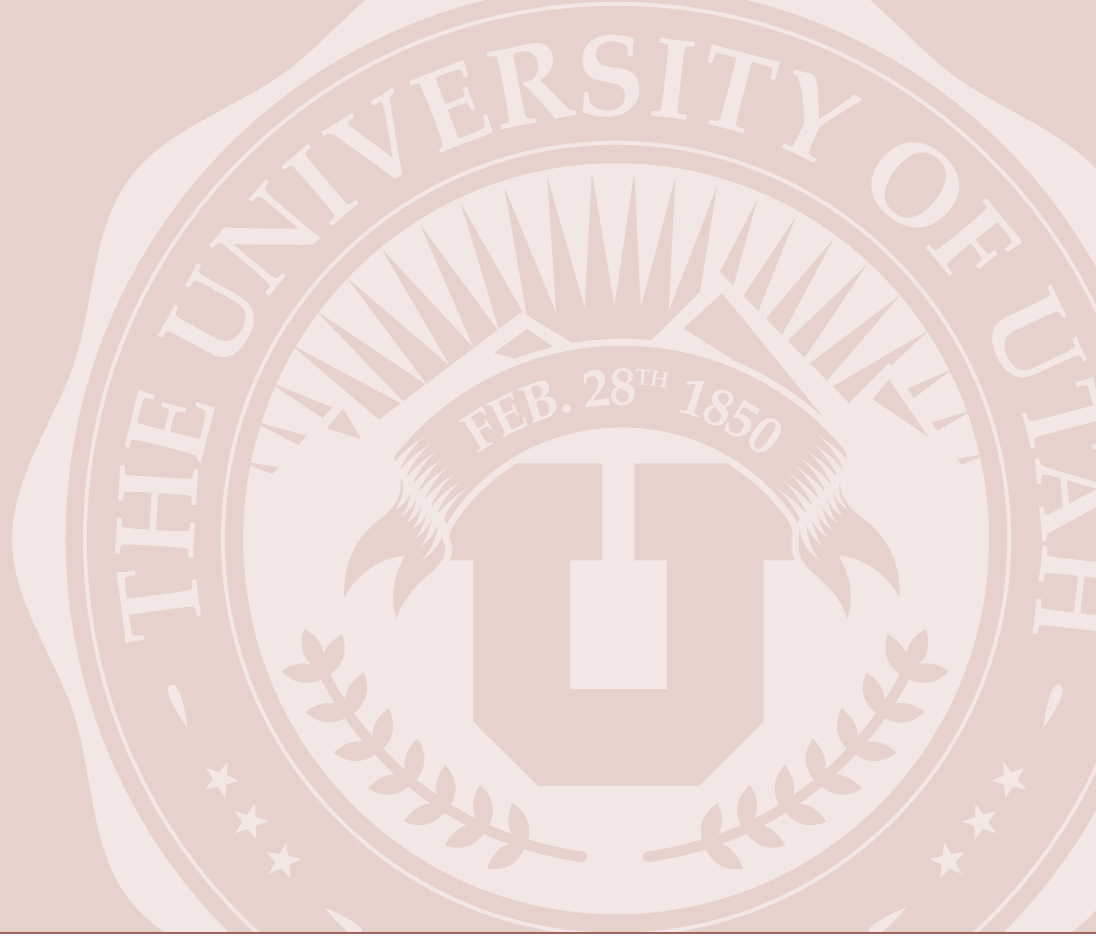
UUHIP added approximately 18,000 additional individual exchange members in 2018 due in part to Molina Healthcare exiting the individual market in the State of Utah. UUHIP anticipates that the 2018 commercial market will continue to remain competitive due to unique market forces in Utah.

There will be considerable uncertainty on the direction Federal regulation will go on the individual exchange, so UUHIP regularly monitors local and national developments for factors that may impact its performance. UUHIP's share of the large group and third-party administration market has continued to grow steadily in 2018.

The University exercises a prudent approach to the issuance of debt. With the need for expanded research, patient care, and student housing, comes the need to issue debt to support construction. Within the short-term, the University intends to undertake various construction projects, in most cases partially gift-funded, to support these critical areas. In addition, the University evaluates existing debt versus current interest rates to identify opportunities to refinance at better rates.

The University's endowment funds are managed so as to be available to mission-critical programs and initiatives – now and into the future. The University has invested in a portfolio of equity, fixed income and alternative assets whose valuations are impacted by market conditions, sometimes negatively in the short term. However, we believe our portfolio will provide solid financial footing for the University's endowments over the long term.

Overall, the University is in a sound financial position. The institution has strong strategic leadership and prudent financial management that work together to ensure its mission is met in the future.



FINANCIAL STATEMENTS



THE UNIVERSITY OF UTAH | Statement of Net Position

(in thousands of dollars)

As of June 30, 2018

ASSETS

Current Assets	
Cash and cash equivalents (Notes 2 & 4)	\$ 489,281
Short-term investments (Notes 2 & 4)	923,901
Receivables, net (Note 5)	527,465
Inventory (Note 1)	85,948
Other assets (Note 6)	30,414
<hr/> Total current assets	<hr/> 2,057,009
Noncurrent Assets	
Restricted cash and cash equivalents (Notes 2 & 4)	171,240
Restricted short-term investments (Notes 2 & 4)	3,226
Investments (Notes 3 & 4)	1,171,914
Restricted investments (Notes 3 & 4)	596,362
Restricted receivables, net (Note 5)	143,827
Donated property	1,263
Net pension asset	4
Other assets (Note 6)	20,186
Capital assets, net (Note 7)	3,323,706
<hr/> Total noncurrent assets	<hr/> 5,431,728
<hr/> Total assets	<hr/> 7,488,737

DEFERRED OUTFLOWS OF RESOURCES

Deferred loss on bond refunding (Note 1)	15,756
Deferred outflows related to pensions (Note 8)	67,378
<hr/> Total deferred outflows of resources	<hr/> 83,134

LIABILITIES

Current Liabilities	
Accounts payable (Note 5)	
to the State of Utah	43,979
to Others	152,967
Accrued payroll	160,595
Compensated absences and early retirement benefits (Notes 1 & 15)	66,934
Unearned revenue (Note 9)	73,689
Deposits and other liabilities (Notes 11 & 15)	132,443
Bonds, notes and contracts payable (Notes 14, 15, & 16)	74,285
<hr/> Total current liabilities	<hr/> 704,892
Noncurrent Liabilities	
Compensated absences and early retirement benefits (Notes 1 & 15)	27,005
Deposits and other liabilities (Notes 11 & 15)	16,720
Bonds, notes and contracts payable (Notes 14, 15, & 16)	
to the State of Utah (HCH Phase II Lease)	86,300
to Others	980,617
Net pension liability (Note 8)	112,953
<hr/> Total noncurrent liabilities	<hr/> 1,223,595
<hr/> Total liabilities	<hr/> \$ 1,928,487

Continued on next page...

The accompanying notes are an integral part of these financial statements

THE UNIVERSITY OF UTAH | Statement of Net Position (cont'd)

(in thousands of dollars)

As of June 30, 2018

DEFERRED INFLOWS OF RESOURCES

Deferred inflows related to bonds (Note 1)	\$ 1,531
Deferred inflows related to pensions (Note 8)	74,367
<u>Total deferred inflows of resources</u>	<u>75,898</u>

NET POSITION

Net investment in capital assets	2,320,870
Restricted for	
Nonexpendable	
Instruction	187,965
Research	62,759
Public service	92,837
Academic support	53,192
Scholarships	190,824
Other	16,920
Expendable	
Research	97,121
Public service	131,511
Academic support	49,058
Institutional support	154,504
Scholarships	76,066
Loans	32,566
Debt service	2,241
Capital additions	95,678
Insurance enterprises	22,386
Other	96,034
Unrestricted	1,884,954
<u>Total net position</u>	<u>\$5,567,486</u>

The accompanying notes are an integral part of these financial statements

THE UNIVERSITY OF UTAH | Statement of Revenues, Expenses, and Changes in Net Position

(in thousands of dollars)

For the Year Ended June 30, 2018

OPERATING REVENUES AND EXPENSES

Revenues	
Tuition and fees, net (Note 1)	\$ 347,902
Patient services, net (Notes 1 & 13)	2,209,201
Federal grants and contracts	304,456
State and local grants and contracts	17,731
Nongovernmental grants and contracts	133,763
Sales and services, net (Note 1)	991,457
Auxiliary enterprises, net (Note 1)	173,261
Other operating revenues	212,834
Total operating revenues	4,390,605
Expenses	
Compensation and benefits	2,509,786
Component units	531,708
Supplies	567,176
Purchased services	194,826
Medical claims	139,194
Depreciation and amortization	222,591
Utilities	86,676
Cost of goods sold	40,969
Repairs and maintenance	45,246
Scholarships and fellowships	31,152
Other operating expenses	215,814
Total operating expenses	4,585,138
Operating loss	(194,533)

NONOPERATING REVENUES (EXPENSES)

State appropriations	335,828
Government grants	34,615
Gifts	158,773
Investment income	90,595
Interest	(37,450)
Other	(4,492)
Total nonoperating revenues	577,869
Income before capital and permanent endowment additions	383,336

CAPITAL AND PERMANENT ENDOWMENT ADDITIONS

Capital appropriations	118,749
Capital grants and gifts	56,754
Additions to permanent endowments	29,739
Total capital and permanent endowment additions	205,242
Increase in net position	588,578

NET POSITION

Net position - beginning of year, as adjusted (Note 1)	4,978,908
Net position - end of year	\$ 5,567,486

The accompanying notes are an integral part of these financial statements

THE UNIVERSITY OF UTAH | Statement of Cash Flows

(in thousands of dollars)

For the Year Ended June 30, 2018

CASH FLOWS FROM OPERATING ACTIVITIES

Receipts from tuition and fees	\$ 347,169
Receipts from patient services	2,177,728
Receipts from grants and contracts	423,157
Receipts from auxiliary and educational services	1,166,391
Collection of loans to students	8,207
Payments to suppliers	(1,812,388)
Payments for compensation and benefits	(2,499,403)
Payments for scholarships and fellowships	(31,152)
Loans issued to students	(5,492)
Other	208,206
Net cash used by operating activities	(17,577)

CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES

State appropriations	335,828
Government grants	34,615
Federal direct loan receipts	145,587
Federal direct loan payments	(145,587)
Gifts	
Endowment	29,749
Nonendowment	83,487
Other	2,502
Net cash provided by noncapital financing activities	486,181

CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES

Proceeds from capital debt	241,817
Capital appropriations	29,945
Gifts	55,463
Purchase of capital assets	(569,706)
Principal paid on capital debt	(110,571)
Interest paid on capital debt	(41,569)
Net cash used by capital and related financing activities	(394,621)

CASH FLOWS FROM INVESTING ACTIVITIES

Proceeds from sales and maturities of investments	2,061,282
Receipt of interest and dividends on investments	57,658
Purchase of investments	(2,147,299)
Net cash used by investing activities	(28,358)
Net increase in cash	45,625

Cash - beginning of year 614,896

Cash - ending of year \$ 660,521

Continued on next page...

The accompanying notes are an integral part of these financial statements

THE UNIVERSITY OF UTAH | Statement of Cash Flows (cont'd)

(in thousands of dollars)

For the Year Ended June 30, 2018

RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED

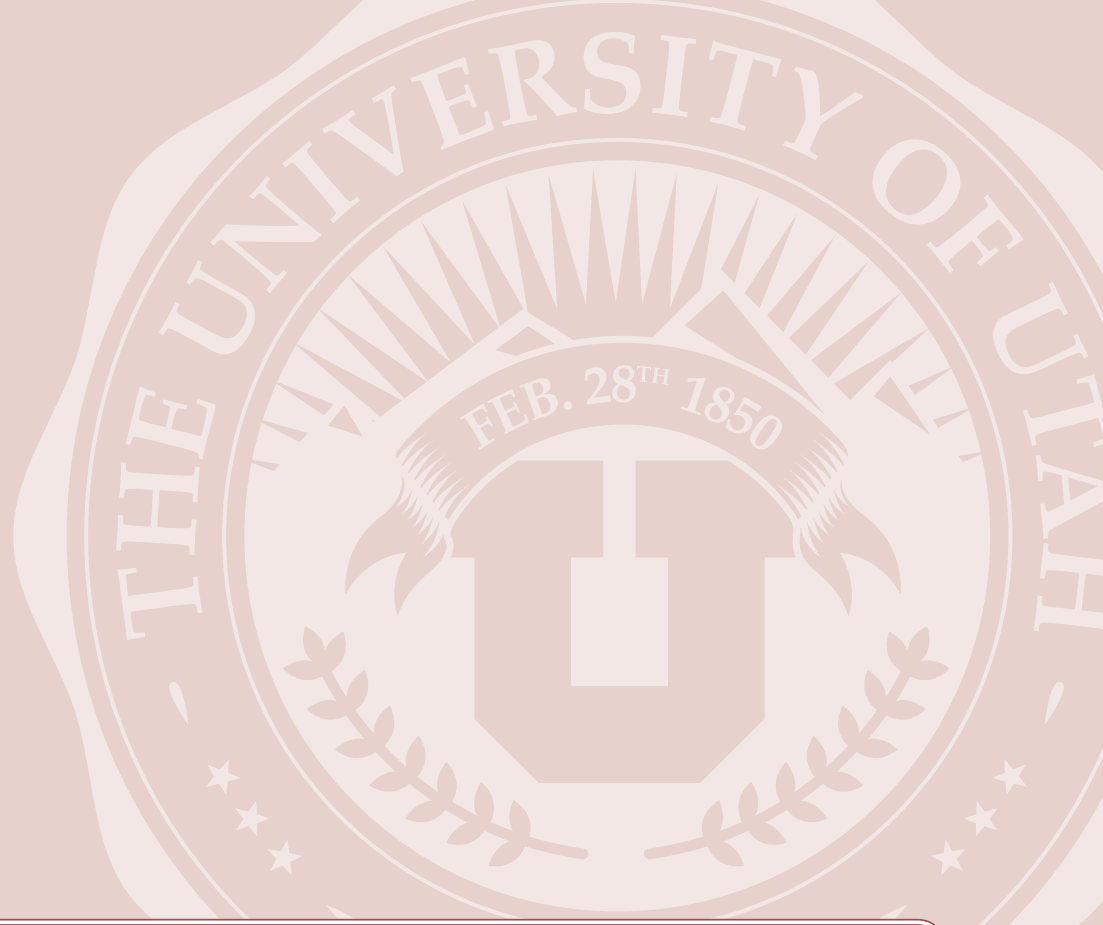
BY OPERATING ACTIVITIES

Operating loss	\$ (194,533)
Adjustments	
Depreciation and amortization expense	222,591
Change in assets, deferred outflows of resources, liabilities and deferred inflows of resources	
Receivables, net	(84,683)
Inventory	(12,670)
Other assets	3,873
Deferred outflows related to pensions	2,375
Accounts payable	18,024
Accrued payroll	10,980
Compensated absences and early retirement benefits	6,556
Unearned revenue	5,068
Deposits and other liabilities	14,369
Net pension liability	(55,062)
Deferred inflows related to pensions	45,535
Net cash used by operating activities	\$ (17,577)

NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES

Capital leases	\$ 13,871
Donated property and equipment	3,676
Completed construction projects transferred from State of Utah (Note 1)	88,804
Annuity and life income	69
Increase in fair value of investments	63,133
Total noncash investing, capital, and financing activities	\$ 169,553

The accompanying notes are an integral part of these financial statements



NOTES TO FINANCIAL STATEMENTS



1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Reporting Entity

The financial statements report the financial activity of the University of Utah (University), including the University of Utah Hospitals and Clinics (UUHC). The University is a component unit of the State of Utah (State).

Component units are entities that are legally separate from the University, but are financially accountable to the University, or whose relationships with the University are such that exclusion would cause the University's financial statements to be misleading or incomplete. University administrators hold a majority of seats on the boards of trustees of three other related entities representing component units of the University. Because the University appoints the majority of the three boards, is able to impose its will on these organizations, and the organizations almost exclusively benefit the University, the financial accountability criteria as defined by Governmental Accounting Standards Board (GASB) Statement No. 61, *The Financial Reporting Entity: Omnibus and amendment of GASB Statements No. 14 and No. 34* have been met and the three organizations are included as blended component units of the University. The component units of the University are the University of Utah Research Foundation (UURF), ARUP Laboratories, Inc. (ARUP) and University of Utah Health Insurance Plans (UUHIP). Copies of the financial report of each component unit can be obtained from the respective entity.

- UURF is a not-for-profit corporation governed by a board of directors who, with the exception of one director, are affiliated with the University. The operations of UURF include the leasing and administration of Research Park (a research park located on land owned by the University), the leasing of certain buildings, and the commercial development of patents and products developed by University personnel. As part of its mission to advance technology commercialization, UURF creates new corporate entities to facilitate the startup process. In general, these entities do not have assets. Expenses related to the companies are expensed as incurred. The fiscal year end for UURF is June 30. UURF is audited by

other independent auditors and their report, dated September 14, 2018, is issued under separate cover.

- ARUP is a not-for-profit corporation that provides clinical and anatomic pathology reference laboratory services to medical centers, hospitals, clinics and other clinical laboratories throughout the United States, including UUHC. ARUP contracts with the University of Utah School of Medicine Department of Pathology to provide pathology consulting services. The fiscal year end for ARUP is June 30. Other independent auditors audited ARUP and their report, dated August 31, 2018, is issued under separate cover.
- UUHIP is a not-for-profit corporation that provides individual and large group health insurance. UUHIP received its certificate of authority to offer health insurance in the State of Utah effective January 1, 2015 and started full operations in 2016. Also in 2016, it started building provider networks, processing payments and performing other administrative services for third parties. The fiscal year end for UUHIP is December 31. Other independent auditors audited UUHIP and their report, dated September 13, 2018, is issued under separate cover. Health insurance companies are subject to certain minimum surplus requirements as specified by the National Association of Insurance Commissioners (NAIC) and the Utah Insurance Department. Under those requirements, the amount of capital and surplus maintained by a health service insurance corporation is to be the greater of minimum Risk-Based Capital (RBC) or \$400,000. RBC is determined based on the various risk factors related to UUHIP's operations. Regulatory compliance is determined by a ratio of UUHIP's total adjusted capital, calculated in the manner prescribed by NAIC to its authorized control level RBC. If UUHIP drops below specific trigger levels, a specified corrective action is required. The minimum level of total adjusted capital before corrective action commences is twice the authorized control level RBC. UUHIP met both minimum surplus requirements with RBC exceeding the authorized control level and surplus exceeding \$400,000 at December 31, 2017.

All GASB pronouncements are applied by the University, UURE, ARUP and UUHIP in the accounting and reporting of their operations.

B. Basis of Accounting

All statements have been prepared using the economic resources measurement focus and the accrual basis of accounting. Operating activities include all revenues and expenses, derived on an exchange basis, used to support the instructional, research and public service efforts, and other University priorities. Significant recurring sources of the University’s revenues are considered nonoperating as defined by GASB Statement No. 34, *Basic Financial Statements – and Management’s Discussion and Analysis – for State and Local Governments*, and required by GASB Statement No. 35, *Basic Financial Statements – and Management’s Discussion and Analysis – for Public Colleges and Universities*. Operating revenues include tuition and fees, grants and contracts, patient services, and revenue from various auxiliary and public service functions. Nonoperating revenues include state appropriations, Pell grants and certain government grants, gifts, and investment income. Operating expenses include compensation and benefits, student aid, supplies, repairs and maintenance, utilities, etc. Nonoperating expenses primarily include interest on debt obligations.

When both restricted and unrestricted resources are available, such resources are tracked and spent at the discretion of the department subject to donor restrictions, where applicable.

In accordance with GASB Statement No. 33, *Accounting and Financial Reporting for Nonexchange Transactions*, the University recognizes gifts, grants, appropriations, and the estimated net realizable value of pledges as revenue as soon as all eligibility requirements imposed by the provider have been met.

Patient revenue of UUHC and the School of Medicine medical practice plan is reported net of third-party adjustments.

C. Investments

Investments are recorded at fair value in accordance with GASB Statement No. 72, *Fair Value Measurement and Application*. Accordingly, the change in fair value of investments is recognized as an increase or decrease to investment assets and investment income. The University distributes

earnings from pooled investments based on the average daily investment of each participating account; or for endowments, distributes according to the University’s spending policy.

A portion of the University’s endowment portfolio is invested in “alternative investments.” These investments, unlike more traditional investments, generally do not have readily obtainable market values and typically take the form of limited partnerships. See Note 4 for more information regarding these investments and the University’s outstanding commitments under the terms of the partnership agreements. The University values these investments based on the partnerships’ audited financial statements. If June 30 statements are available, those values are used preferentially. However, some partnerships have fiscal years ending at other than June 30. If June 30 valuations are not available, the value is progressed from the most recently available valuation taking into account subsequent calls and distributions.

D. Allowances

In accordance with GASB Statement No. 34, certain expenses are netted against revenues as allowances. The following schedule presents revenue allowances for the year ended June 30, 2018:

Revenue Allowances	
Tuition and fees	\$86,023,701
Patient services	90,098,603
Sales and services	8,742
Auxiliary enterprises	3,171,882

E. Inventories

The University Campus Store’s inventories are valued using the retail inventory method. All other inventories are stated at the lower of cost or market using the first-in, first-out method or, on a basis which approximates cost determined on the first-in, first-out method.

F. Research and Development Costs

Research and development costs of ARUP are expensed as incurred. These costs for the year ended June 30, 2018 were approximately \$12.4 million.

G. Compensated Absences & Early Retirement Benefits

Employees’ vacation leave, excluding UUHC, is accrued at a rate of eight hours each month for the first five years and increases to a rate of 16.67 hours

each month after fifteen years of service. There is no requirement to use vacation leave, but a maximum of thirty days plus one-year accrual may be carried forward at the beginning of each calendar year. Eligible employees are reimbursed for unused vacation leave upon termination and vacation leave is expended when used or reimbursed. The liability for vacation leave at June 30, 2018 was approximately \$43.7 million.

Employees earn sick leave at a rate of eight hours each month, with an accumulation limit of 1,040 hours. The University does not reimburse employees for unused sick leave. Each year, eligible employees may convert up to four days of unused sick leave to vacation leave based on their use of sick leave during the year. Sick leave is expended when used.

In addition, the University may provide early retirement benefits, if approved by the Administration and by the Board of Trustees; for certain employees who have attained the age of 60 with at least fifteen years of service and who have been approved for the University's early retirement program. Currently, 66 employees participate in the early retirement program. The University pays each early retiree an annual amount equal to the lesser of 20% of the retiree's final salary or their estimated social security benefit, as well as health care and life insurance premiums, which is approximately 50% of their early retirement salary, until the employee reaches full social security retirement age. In accordance with GASB Statement No. 47, *Accounting for Termination Benefits*, the amount recognized on the financial statements was calculated at the discounted present value of the projected future costs which includes an estimated annual increase of 2.5%. A discount rate of 1.8315% was used and is based on the average rate earned by the University on cash management investments for the fiscal year. For the year ended June 30, 2018, these expenditures were approximately \$3.3 million.

Employees of UUHC receive a combined accrual for paid time off in lieu of the separate vacation and sick accruals received by University employees. Accrual rates for paid time off begin at 13.33 hours per month and increase each five years until the maximum accrual of 20.00 hours per month is reached after ten years of service. The maximum number of hours which can be carried forward at the beginning of a calendar year is 520 hours for staff and 600 hours for managers and directors.

Employees who meet specified accrual balances have the option to receive an annual payout of up to 80 hours in May or November. Employees are paid for all unused paid time off hours upon termination. The cost of paid time off is accrued each month by the Hospital. The liability for paid time off at June 30, 2018 was approximately \$43.7 million.

H. Construction

The Utah State Division of Facilities Construction and Management (DFCM) administers most of the construction of facilities for state institutions, maintains records, and furnishes cost information for recording plant assets on the books of the University. Interest expense incurred for construction of capital facilities is capitalized on certain projects. Construction projects administered by DFCM are not recorded on the books of the University until the facility is available for occupancy.

I. Deferred Outflows and Inflows

In accordance with GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*, losses incurred due to refunding of bond debt are reported as deferred outflows rather than as reductions to bond liabilities, gains resulting from bond refinancing transactions are reported as deferred inflows. In accordance with GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*, deferred outflows and deferred inflows of resources related to pensions have been recorded. Further information regarding pension reporting is found in Note 8.

J. Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Utah Retirement Systems Pension Plan (URS) and additions to/deductions from URS's fiduciary net position have been determined on the same basis as they are reported by URS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

K. Adjustments to Beginning Net Position

For the year ended June 30, 2018, the University had two adjustments which increased the beginning net position by a combined \$38,352,810. Revenues

on certain grants and contracts were not being recognized in the correct period. The resulting adjustment increased net position by \$24,909,900. UUHIP was also added as a blended component unit which increased net position by \$13,442,910.

2. CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS

Cash and cash equivalents consists of cash and short-term investments with an original maturity of three months or less. Cash, depending on source of receipts, is pooled, except for cash and cash equivalents held by ARUP and UUHIP and, when legal requirements dictate the use of separate accounts. The cash balances are invested principally in short-term investments that conform to the provisions of the *Utah Code*. It is the practice of the University that the investments ordinarily be held to maturity at which time the par value of the investments will be realized.

The Utah State Treasurer's Office operates the Utah Public Treasurers' Investment Fund (PTIF) which is managed in accordance with the State of Utah Money Management Act (Act) and is available for investment of funds administered by any Utah public treasurer.

Short-term investments have original maturities longer than three months and remaining maturities of one year or less.

At June 30, 2018, cash and cash equivalents and short-term investments consisted of:

Cash and Cash Equivalents	
Cash	\$ 97,936,797
Money market funds	91,654,336
Repurchase agreements	122,900,000
Utah Public Treasurers' Investment Fund	344,786,965
Commercial paper	2,993,527
Time certificates of deposit	250,000
Total (fair value)	\$ 660,521,625

Short-term Investments	
Commercial paper	\$ 5,479,893
Time certificates of deposit	2,359,065
U.S. Treasuries	87,450,923
U.S. Agencies	766,955,020
Corporate notes	64,881,207
Total (fair value)	\$927,126,108

3. INVESTMENTS

Funds available for investment are pooled to maximize return and minimize administrative cost, except for funds that are authorized by the University administration to be separately invested or which are separately invested to meet legal or donor requirements. Investments received as gifts are recorded at fair value on the date of receipt. Other investments are also recorded at fair value.

University personnel manage certain portfolios, while other portfolios are managed by banks, investment advisors or through trust agreements.

According to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), Section 51-8 of the *Utah Code*, the institution may appropriate for expenditure or accumulate so much of an endowment fund as the University determines to be prudent for uses, benefits, purposes, and duration for which the endowment was established. The endowment income spending practice at June 30, 2018 was 4% of the twelve quarter moving average of the market value of the endowment pool. The spending practice is reviewed periodically and any necessary changes are made. In general, nearly all of the University's endowment is subject to spending restrictions imposed by donors.

The amount of net appreciation on investments of donor-restricted endowments available for authorization for expenditure at June 30, 2018 was approximately \$114,666,000. The net appreciation is a component of restricted expendable net position.

At June 30, 2018, the investment portfolio composition was as follows:

Investments	
Time certificates of deposits	\$ 9,199,176
U.S. Treasuries	4,937,891
U.S. Agencies	664,240,697
Municipal bonds	3,604,676
Corporate notes	37,762,562
Mutual funds	1,027,294,230
Common and preferred stocks	21,236,943
Total (fair value)	\$1,768,276,175

4. DEPOSITS AND INVESTMENTS

The State of Utah Money Management Council has the responsibility to advise the Utah State Treasurer



about investment policies, promote measures and rules that will assist in strengthening the banking and credit structure of the State, and review the rules adopted under the authority of the Act that relate to the deposit and investment of public funds.

Except for endowment funds, the University follows the requirements of the Act (*Utah Code*, Section 51, Chapter 7) in handling its depository and investment transactions. The Act requires the depositing of University funds in a qualified depository. The Act defines a qualified depository as any financial institution whose deposits are insured by an agency of the federal government and which has been certified by the State Commissioner of Financial Institutions as meeting the requirements of the Act and adhering to the rules of the Utah Money Management Council.

For endowment funds, the University follows the requirements of the UPMIFA, the State Board of Regents' Rule 541, *Management and Reporting of Institutional Investments* (Rule 541), and the University's investment policy and endowment guidelines.

ARUP and UUHIP follow their own investment policies.

Deposits

Custodial Credit Risk: Custodial credit risk for deposits is the risk that, in the event of a bank failure, the University's deposits may not be returned.

At June 30, 2018, the carrying amounts of the University's deposits and bank balances were \$97,505,372 and \$126,771,074, respectively. The Federal Deposit Insurance Corporation (FDIC) provides deposit insurance coverage up to \$250,000 for demand deposits and \$250,000 for time and savings deposits at each banking institution. As a result, the bank balances of the University were insured for \$1,584,347, by the FDIC. The bank balances in excess of \$1,584,347 were uninsured and uncollateralized, leaving \$125,186,727

exposed to custodial credit risk. The University's policy for reducing this risk of loss is to deposit all such balances in qualified depositories, as defined and required by the Act.

Investments

The Act defines the types of securities authorized as appropriate investments for the University's non-endowment funds and the conditions for making investment transactions. Investment transactions may be conducted only through qualified depositories, certified dealers, or directly with issuers of the investment securities.

These statutes authorize the University to invest in negotiable or nonnegotiable deposits of qualified depositories and permitted negotiable agreements; repurchase and reverse repurchase agreements; commercial paper that is classified as "first tier" by two nationally recognized statistical rating organizations; bankers' acceptances; obligations of the United States Treasury including bills, notes, and bonds; obligations, other than mortgage derivative products, issued by U.S. government sponsored enterprises (U.S. Agencies) such as the Federal Home Loan Bank System, Federal Home Loan Mortgage Corporation (Freddie Mac), or Federal National Mortgage Association (Fannie Mae); bonds, notes, and other evidence of indebtedness of political subdivisions of the State; fixed rate corporate obligations and variable rate securities rated "A" or higher, or the equivalent of "A" or higher, by two nationally recognized statistical rating organizations; shares or certificates in a money market mutual fund as defined in the Act; and the Utah State Public Treasurers' Investment Fund.

The Utah State Treasurer's Office operates the Public Treasurers' Investment Fund (PTIF). The PTIF is available for investment of funds administered by any Utah public treasurer and is not registered with the Securities and Exchange Commission (SEC) as an investment company. The PTIF is authorized and regulated by the Money Management Act (Utah Code, Title 51, Chapter 7). The Act established the Money Management Council which oversees the activities of the Utah State Treasurer and the PTIF and details the types of authorized investments. Deposits in the PTIF are not insured or otherwise guaranteed by the State of Utah, and participants share proportionally in realized gains or losses on investments.

The UPMIFA, Rule 541, and the University's endowment guidelines allow the University to invest endowment funds (including gifts, devises, or bequests of property of any kind from any source) in any of the above investments or any of the following subject to satisfying certain criteria: mutual funds registered with the SEC, investments sponsored by the Common Fund; any investment made in accordance with the donor's directions in a written instrument; investments in corporate stock listed on a major exchange (direct ownership); and any alternative investment funds that derive returns primarily from high yield and distressed debt (hedged or non-hedged), private capital (including venture capital and private equity), natural

resources, and private real estate assets or absolute return and long/short hedge funds.

Fair Value of Investments

The University measures and records its investments using fair value measurement guidelines established by generally accepted accounting principles. These guidelines recognize a three-tiered fair value hierarchy, as follows:

- *Level 1:* Quoted prices for identical investments in active markets;
- *Level 2:* Observable inputs other than quoted market prices; and,
- *Level 3:* Unobservable inputs.

At June 30, 2018, the University had the following recurring fair value measurements:

Investments by fair value level	Fair Value	Fair Value Measurements Using		
		Level 1	Level 2	Level 3
Debt securities				
Money market mutual funds	\$ 91,654,336	\$ 5,306,266	\$ 86,348,070	
Repurchase agreements	122,900,000		122,900,000	
Utah Public Treasurers' Investment Fund	344,786,965		344,786,965	
Commercial paper	8,473,420	2,993,527	5,479,893	
Time certificates of deposit	11,558,241		11,558,241	
U.S. Treasuries	92,388,814		92,388,814	
U.S. Agencies	1,431,195,717		1,431,195,717	
Corporate notes	102,643,769		102,643,769	
Municipal bonds	3,604,676		3,604,676	
Mutual bond funds	170,875,357		170,875,357	
Total debt securities	2,380,081,295	8,299,793	2,371,781,502	
Equity securities				
Common and preferred stocks	21,236,943	17,893,481		\$ 3,343,462
Mutual equity funds	442,322,080		442,322,080	
Total equity securities	463,559,023	17,893,481	442,322,080	3,343,462
Total investments by fair value level	2,843,640,318	26,193,274	2,814,103,582	3,343,462
Investments measured at net asset value (NAV)				
Hedged equity	50,384,777			
Private equity	84,246,265			
Credit sensitive fixed income	24,008,710			
Private real estate	16,887,833			
Private natural resources	69,538,179			
Diversifying strategies	169,031,029			
Total investments measured at the NAV	414,096,793			
Total investments measured at fair value	\$ 3,257,737,111	\$ 26,193,274	\$ 2,814,103,582	\$ 3,343,462

Debt and equity securities classified in Level 1 are valued using prices quoted in active markets for those securities. Debt and equity securities classified in Level 2 are valued using the following approaches:

- U.S. Treasuries, U.S. Agencies, and Commercial Paper: quoted prices for identical securities in markets that are not active;
- Corporate and Municipal Bonds and Negotiable Certificates of Deposit: quoted prices for similar securities in active markets;
- Repurchase Agreements: valued at purchase price due to very short term to maturity;
- Money Market, Bond, and Equity Mutual Funds: published fair value per share (unit) for each fund; and
- Utah Public Treasurers' Investment Fund: application of the June 30, 2018 fair value factor, as calculated by the Utah State Treasurer, to the University's ending balance in the Fund.

Equity securities, namely common and preferred stocks, classified as Level 3 are valued manually using various sources such as issuer, investment manager or default price if a price is not provided.

Investments valued using the net asset value (NAV) per share (or its equivalent) are considered "alternative investments" and, unlike more traditional investments, generally do not have readily obtainable market values and take the form of limited partnerships. The University values these investments based on the partnerships' audited financial statements. If June 30 statements are available, those values are used preferentially. However, some partnerships have fiscal years ending



at other than June 30. If June 30 valuations are not available, the value is progressed from the most recently available valuation taking into account subsequent calls and distributions. The following table presents the unfunded commitments, redemption frequency (if currently eligible), and the redemption notice period for the University's alternative investments measured at NAV:

Investments Measured at Net Asset Value (NAV)				
Investments	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Hedged equity	\$ 50,384,777		Monthly, quarterly	30–75 days
Private equity	84,246,265	\$ 52,162,375	N/A	N/A
Credit sensitive fixed income	24,008,710		Quarterly	90 days
Private real estate	16,887,833	6,306,397	N/A	N/A
Private natural resources	69,583,179	197,167,074	N/A	N/A
Diversifying strategies	169,031,029		Daily, quarterly, annually	0-90 days
Total alternative investments	\$ 414,096,793			
Total unfunded commitments		\$ 255,635,846		

Interest Rate Risk: Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. The University's policy for managing its exposure to fair value loss arising from increasing interest rates is to comply with the Act or the UPMIFA and Rule 541, as applicable. For non-endowment funds, Section 51-7-11 of the Act requires that the remaining term to maturity of investments may not exceed the period of availability of the funds to be invested. The Act further limits the remaining term to maturity on all investments in commercial paper, bankers' acceptances, fixed rate negotiable deposits and fixed rate corporate obligations to 270 days -15 months or less. The Act further limits the remaining term to maturity on all investments in obligations of the United States Treasury; obligations issued by U.S. government sponsored enterprises; and bonds, notes, and other evidence of indebtedness of political subdivisions of the State to 10 years. In addition, variable rate

negotiable deposits and variable rate securities may not have a remaining term to final maturity exceeding three years. For endowment funds, Rule 541 is more general, requiring only that investments be made as a prudent investor would, by considering the purposes, terms, distribution requirements, and other circumstances of the endowments and by exercising reasonable care, skill, and caution.

As of June 30, 2018, the University had debt investments with maturities as shown below in *Figure 1*.

Credit Risk: Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The University's policy for reducing its exposure to credit risk is to comply with the Act, the UPMIFA, and Rule 541, as previously discussed. ARUP and UUHIP manage their credit risk by requiring that 70% of their investment portfolio must be compliant with the Act.

Figure 1

Investment Type	Fair Value	Investment Maturities (in years)			
		Less than 1	1 - 5	6 - 10	More than 10
Money market mutual funds	\$ 91,654,336	\$ 91,654,336			
Repurchase agreements	122,900,000	122,900,000			
Utah Public Treasurers' Investment Fund	344,786,965	344,786,965			
Commercial paper	8,473,420	8,473,420			
Time certificates of deposit	11,558,241	2,359,065	\$ 9,199,176		
U.S. Treasuries	92,388,814	87,450,923	4,937,891		
U.S. Agencies	1,431,195,717	766,955,020	511,087,753	\$ 153,152,944	
Corporate notes	102,643,769	64,881,207	36,684,442	271,310	\$ 806,810
Municipal bonds	3,604,676		508,825	1,832,924	1,262,927
Mutual bond funds	170,875,357		29,099,434	141,775,923	
Totals	\$2,380,081,295	\$ 1,489,460,936	\$ 591,517,521	\$ 297,033,101	\$ 2,069,737

Figure 2

Investment Type	Fair Value	Quality Rating					
		AAA/A-1*	AA	A	BBB	Unrated	No Risk
Money market mutual funds	\$ 91,654,336	\$ 10,114,638				\$ 81,539,698	
Repurchase agreements – underlying:							
U.S. Agencies	122,900,000		\$ 122,900,000				
Utah Public Treasurers' Investment Fund	344,786,965					344,786,965	
Commercial paper	8,473,420	2,485,785		\$ 5,987,635			
Time certificates of deposit	11,558,241	2,652,897		3,451,953		5,453,391	
U.S. Treasuries	92,388,814						\$ 92,388,814
U.S. Agencies	1,431,195,717	626,190,736	782,371,922			22,633,059	
Corporate notes	102,643,769	2,985,919	33,089,990	55,773,303	\$ 10,523,247	271,310	
Municipal bonds	3,604,676	3,095,851	508,825				
Mutual bond funds	170,875,357		45,343,322			125,532,035	
Totals	\$2,380,081,295	\$ 647,525,826	\$ 984,214,059	\$ 65,212,891	\$ 10,523,247	\$ 580,216,458	\$ 92,388,814

*A-1 is Commercial paper, Certificates of deposit and Agency Note rating

At June 30, 2018, the University had debt investments with quality ratings as shown on page 29 in *Figure 2*.

Custodial Credit Risk: Custodial credit risk for investments is the risk that, in the event of a failure of the counterparty, the University will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. The University's policy for reducing its exposure to custodial credit risk is to comply with applicable provisions of the Act. As required by the Act, all applicable securities purchased were delivered versus payment and held in safekeeping by a bank. Also, as required, the ownership of book-entry-only securities, such as U.S. Treasury or Agency securities, by the University's custodial bank was reflected in the book-entry records of the issuer and the University's ownership was represented by a receipt, confirmation, or statement issued by the custodial bank.

At June 30, 2018, the University's custodial bank was both the custodian and the investment counterparty for \$1,520,498,877 of U.S. Treasury and Agency securities purchased by the University; and \$3,085,654 of U.S. Treasury and Agency securities were held by the custodial bank's trust department but not in the University's name.

Concentration of Credit Risk: Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The University's policy for reducing this risk of loss is to comply with the Rules of the Council or the UPMIFA and Rule 541, as applicable. Rule 17 of the Council limits non-endowment fund investments in a single issuer of commercial paper and corporate obligations to 5-10% depending upon the total dollar amount held in the portfolio at the time of purchase.

Foreign Currency Risk: Foreign currency risk is the risk that changes in exchange rates will adversely affect the fair value of an investment or a deposit. The University does not have a formal policy to limit foreign currency risk. At June 30, 2018, the University's exposure to foreign currency risk is \$7,665,064 in Private Real Estate investments that are held in Euro currency denomination.

For endowments, the University, under Rule 541, is permitted to establish its own investment policy

which adheres to the guidelines established by UPMIFA. Accordingly, the University's Pool Asset Allocation Guidelines allocates endowment funds in the following asset classes:

Asset Category	Target	Range
Global Equity	40%	30% - 50%
Public Equities	25%	15% - 50%
Hedged Equity*	5%	0% - 10%
Private Equity*	10%	0% - 15%
Global Fixed Income/Credit	20%	10% - 40%
Interest Rate Sensitive	11%	5% - 40%
Credit Sensitive*	9%	0% - 20%
Real Assets	20%	10% - 30%
Real Estate*	7%	0% - 15%
Natural Resources*	8%	0% - 10%
Infrastructure*	5%	0% - 10%
Diversifying Strategies*	20%	0% - 30%

* May include semi-liquid hedge funds or illiquid private capital funds.

The University diversifies assets among several investment managers of varying investment strategies. Diversification is an effective means of maximizing return while mitigating risk. At June 30, 2018, the University held more than 5% of its total investments in the Federal Home Loan Bank, the Federal Farm Credit Bank, the Federal Agricultural Mortgage Corporation, and the Federal Home Loan Mortgage Corporation. These investments represent 21.3%, 7.5%, 5.7%, and 5.3%, respectively, of the University's total investments.

5. RECEIVABLES AND ACCOUNTS PAYABLE

Accounts, pledges, and interest receivable include hospital patient accounts, medical services plan accounts, trade accounts, pledges, interest income on investments, and other receivables. Loans receivable predominantly consist of student loans.

Allowances for doubtful accounts are established by charges to operations to cover anticipated losses from accounts receivable generated by sales and services and student loans. Such accounts are charged to the allowance when collection appears doubtful. Any subsequent recoveries are credited to the allowance accounts. Allowances are not established for pledges or in those instances where receivables consist of amounts due from governmental units or where receivables are not material in amount.

The following schedule presents receivables at June 30, 2018, including approximately \$15.5 million and \$128.3 million of noncurrent loans, and pledges receivable, respectively:

Accounts	\$ 796,022,775
Grants and contracts	43,409,538
Loans	25,700,130
Pledges	152,038,587
Notes	171,325
Interest	8,613,792
	1,025,956,147
Less allowances for doubtful accounts	(354,664,672)
Receivables, net	\$ 671,291,475

The following schedule presents the major components of accounts payable at June 30, 2018:

Vendors	\$ 52,775,864
Interest	28,234,371
Payable to State	43,978,671
Other	71,957,046
Total accounts payable	\$ 196,945,952

6. OTHER ASSETS

Goodwill associated with the purchase of certain health clinics and prepaid rent to the State of Utah, for the Huntsman Cancer Hospital, is amortized using the straight-line method. The June 30, 2018 balance of prepaid rent to the State was \$18,725,419.

In the course of licensing intellectual property to business partners, the UURF may be granted an equity position in the entity the business partner has organized to commercialize University technology. The primary purpose of licensing University technology to the commercial entity, as well as, providing funding to the commercial entity, is to encourage research and positively impact the state, nation and world. The equity holdings the UURF is granted are a consequence of licensing University technology and do not meet the definition of investments for purposes of GASB 72 and thus, are classified as other assets in the Statement Net Position.

7. CAPITAL ASSETS

Buildings; infrastructure and improvements, which include roads, curb and gutter, streets and sidewalks, and lighting systems; land; equipment; library materials; and intangible assets (primarily software) are valued at historical cost or at acquisition value at the date of donation. Buildings, infrastructure and improvements, and additions to existing assets are capitalized when acquisition cost equals or exceeds \$250,000 for the University or \$5,000 for UUHC. Equipment is capitalized when acquisition costs exceed \$5,000 for the University or \$2,500 for UUHC. All costs incurred in the acquisition of library materials are capitalized. Purchased software is capitalized when acquisition costs are \$100,000 or greater and developed software is capitalized when development costs are \$1,000,000 or greater

<i>Figure 3</i>	Beginning Balance	Additions	Retirements	Ending Balance
Buildings	\$ 3,399,765,154	\$ 190,718,062	-	\$ 3,590,483,216
Infrastructure and improvements	349,020,574	96,932,633	\$ (3,366,498)	442,586,709
Land	44,130,425	12,149,782	-	56,280,207
Equipment (including intangibles)	1,135,305,505	98,251,963	(55,828,420)	1,177,729,048
Library materials	145,743,120	698,186	(204,965)	146,236,341
Art and special collections	76,924,037	3,382,797	(71,400)	80,235,434
Construction in progress	239,284,380	323,824,693	(139,979,978)	423,129,095
Total cost	5,390,173,195	725,958,116	(199,451,261)	5,916,680,050
Less accumulated depreciation				
Buildings	1,279,818,118	98,649,760	-	1,378,467,878
Infrastructure and improvements	212,127,600	20,599,968	(3,366,498)	229,361,070
Equipment	812,788,628	97,524,199	(52,999,255)	857,313,572
Library materials	126,394,584	1,641,513	(204,965)	127,831,132
Total accumulated depreciation	2,431,128,930	218,415,439	(56,570,718)	2,592,973,652
Capital assets, net	\$ 2,959,044,265	\$ 507,542,676	\$ (142,880,543)	\$ 3,323,706,398

for the University or \$2,500 for both purchased and developed software for UUHC. All campus land acquired through grants from the U.S. Government has been valued at \$3,000 per acre. Other land acquisitions have been valued at original cost or fair market value at the date of donation in the case of gifts. Buildings, improvements, land, and equipment of component units have been valued at historical cost.

Capital assets of the University and its component units are depreciated on a straight-line basis over their estimated useful lives. The estimated useful lives of University assets extend to forty years on buildings, fifteen years on infrastructure and improvements, twenty years on library books, from five to twenty years on equipment and from five to ten years on software. The estimated useful lives of component unit assets extend to fifty years on buildings and improvements and from three to eight years on equipment. Land, art and special collections, and construction in progress are not depreciated.

At June 30, 2018, the University had outstanding commitments for the construction and remodeling of University buildings of approximately \$62.6 million.

Capital assets at June 30, 2018, are shown in *Figure 3* on page 31.

8. PENSION PLANS AND RETIREMENT BENEFITS

As required by State law, eligible nonexempt employees (as defined by the U.S. Fair Labor Standards Act) of the University are covered by defined benefit plans sponsored by the Utah Retirement Systems (Systems) and eligible exempt employees (as defined by the U.S. Fair Labor Standards Act) are covered by defined contribution plans, such as the Teachers Insurance and Annuity Association (TIAA), the UUHC 401(a) Plan, the UUHC Hospital Plan Plus (HPP) Benefit Program, or Fidelity Investments (Fidelity). Eligible employees of ARUP are covered by a separate defined contribution pension plan and a profit sharing plan.

Defined Benefit Plans

Eligible plan participants are provided with pensions through the Utah Retirement Systems.

Utah Retirement Systems are comprised of the following Pension Trust Funds:

- Public Employees Noncontributory Retirement System (Noncontributory System) and the Public Employees Contributory Retirement System (Contributory System) both of which are cost-sharing, multiple-employer public employee retirement systems.
- The Public Safety Retirement System (Public Safety System) which is a cost-sharing, multiple-employer public employee retirement system.
- Tier 2 Public Employees Contributory Retirement System (Tier 2 Public Employees System), and the Tier 2 Public Safety and Firefighter Contributory Retirement System (Tier 2 Public Safety and Firefighter System) which are multiple employer, cost sharing, public employee retirement systems.

The Tier 2 Public Employee System and the Tier 2 Public Safety and Firefighter System were created July 1, 2011. All eligible employees who have no previous service credit with any of the Utah Retirement Systems prior to that date, are members of the Tier 2 Retirement Systems.

The Systems are established and governed by the respective sections of Title 49 of the Utah Code Annotated, 1953, as amended. The Systems' defined benefit plans are amended statutorily by the State Legislature. The Utah State Retirement Office provides for the administration of the Systems under the direction of the Utah State Retirement Board (Board) whose members are appointed by the Governor. The Systems are fiduciary funds defined as pension (and other employee benefit) trust funds and are a component unit of the State of Utah. Title 49 of the Utah Code grants the authority to establish and amend the benefit terms.

URS issues a publicly available financial report that can be obtained by writing to the Utah Retirement Systems at 560 East 200 South, Salt Lake City, UT 84102 or visiting the website www.urs.org.

The Systems provide retirement, disability, and death benefits. Retirement benefits are as follows:

<i>Summary of Benefits by System</i>				
System	Final Average Salary	Years of Service required and/or age eligible for benefit	Benefit percent per year of service	COLA**
Noncontributory System	Highest 3 years	30 years any age 25 years any age* 20 years age 60* 10 years age 62* 4 years age 65	2.0% per year all years	Up to 4%
Contributory System	Highest 5 years	30 years any age 25 years any age* 20 years age 60* 10 years age 62* 4 years age 65	1.25% per year to June 1975; 2.00% per year July 1975 to present	Up to 4%
Public Safety System	Highest 3 years	20 years any age 10 years age 60 4 years age 65	2.5% per year up to 20 years; 2% per year over 20 years	Up to 2.5% to 4% depending on the employer
Tier 2 Public Employees System	Highest 5 years	35 years any age 20 years age 60* 10 years age 62* 4 years age 65	1.5% per year all years	Up to 2.5%
Tier 2 Public Safety and Firefighter System	Highest 5 years	25 years any age 20 years age 60* 10 years age 62* 4 years age 65	1.5% per year all years	Up to 2.5%

* With actuarial reductions

** All post-retirement cost of living adjustments are non-compounding and are based on the original benefit. The cost-of-living adjustments are also limited to the actual Consumer Price Index (CPI) increase for the year, although unused CPI increases not met may be carried forward to subsequent years.

As a condition of participation in the Systems, employers and/or employees are required to contribute certain percentages of salary and wages as authorized by statute and specified by the Utah State Retirement Board. Contributions are actuarially determined as an amount that, when combined with employee contributions (where applicable) is expected to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded actuarial accrued liability. Contribution rates are as follows:

	Paid by Employer for Employee	Employer Contribution Rates
Noncontributory System		
State and School Division Tier 1	N/A	22.19%
Contributory System		
State and School Division Tier 1	6%	17.70%
State and School Division Tier 2*	N/A	18.44%
Public Safety System		
Public Safety Tier 1	N/A	41.35%
Public Safety Tier 2*	N/A	29.28%

* Tier 2 rates include a statutory required contribution to finance the unfunded actuarial liability of the Tier 1 plans.

For the year ended June 30, 2018, the University and employee contributions to the plans were as follows:

	Employer Contributions	Employee Contributions
Noncontributory System	\$25,003,713	N/A
Contributory System	754,331	-
Public Safety System	789,054	-
Tier 2 Public Employees System	5,444,034	-
Tier 2 Public Safety and Firefighter System	102,648	-
Total	\$32,093,780	\$ 0

Contributions reported are the URS Board approved required contributions. Contributions in the Tier 2 Systems are used to finance the unfunded liabilities in the Tier 1 Systems.

At June 30, 2018, the University's net pension asset and liability were as follows:

	Proportionate Share December 31, 2017	Proportionate Share December 31, 2016	Change Increase/(Decrease)	Net Pension Asset	Net Pension Liability
Noncontributory System	4.4314989%	4.7020251%	(0.2705262%)	-	\$ 108,366,198
Contributory System	20.1819859%	21.2554088%	(1.0734229%)	-	1,328,057
Public Safety System	1.7119332%	1.4847326%	0.2272006%	-	2,976,823
Tier 2 Public Employees System	3.1919359%	4.6076123%	(1.4156764%)	-	281,424
Tier 2 Public Safety and Firefighter System	0.3045036%	0.4372690%	(0.1327654%)	\$ 3,523	-
Total Net Pension Asset / Liability				\$ 3,523	\$ 112,952,502

The net pension asset and liability were measured as of December 31, 2017, and the total pension liability used to calculate the net pension asset and liability was determined by an actuarial valuation as of January 1, 2017 and rolled-forward using generally accepted actuarial procedures. The proportion of the net pension asset and liability is equal to the ratio of the employer's actual contributions to the Systems during the plan year over the total of all employer contributions to the System during the plan year.

For the year ended June 30, 2018, the University recognized pension expense of \$25,676,203 for the defined benefit pension plans.

At June 30, 2018, the University reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	\$ 55,323	\$ 6,617,732
Changes in assumptions	28,353,367	859,054
Net difference between projected and actual earnings on pension plan investments	22,036,263	55,084,868
Changes in proportion and differences between contributions and proportionate share of contributions	806,109	11,805,288
Contributions subsequent to the measurement date	16,127,057	-
Total	\$ 67,378,119	\$ 74,366,942

Contributions made between January 1, 2018 and June 30, 2018 of \$16,127,057 are reported as deferred outflows of resources related to

pensions. These contributions will be recognized as a reduction of the net pension liability in the upcoming fiscal year. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended December 31	Net Deferred Outflows/ (Inflows) of Resources
2018	\$ (1,407,040)
2019	1,139,907
2020	(11,110,829)
2021	(11,954,661)
2022	(62,165)
Thereafter	278,909

The total pension liability in the December 31, 2017 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.50 percent
Salary increases	3.25 – 9.75 percent, average, including inflation
Investment rate of return	6.95 percent, net of pension plan investment expense, including inflation

Mortality rates were developed from actual experience and mortality tables, based on gender, occupation, and age, as appropriate, with adjustments for future improvement in mortality based on Scale AA, a model developed by the Society of Actuaries.

The actuarial assumptions used in the January 1, 2017 valuation were based on the results of an actuarial experience study for the five-year period ending December 31, 2016.



The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class and is applied consistently to each defined benefit pension plan. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation.

The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized in the following table:

<i>Expected Return Arithmetic Basis</i>			
Asset Class	Target Asset Allocation	Real Return Arithmetic Basis	Long-Term expected portfolio real rate of return
Equity securities	40%	6.15%	2.46%
Debt securities	20%	0.40%	0.08%
Real assets	15%	5.75%	0.86%
Private equity	9%	9.95%	0.89%
Absolute return	16%	2.85%	0.46%
Cash and equivalents	0%	0.00%	0.00%
Totals	100%		4.75%
Inflation			2.50%
Expected arithmetic nominal return			7.25%

The 6.95% assumed investment rate of return is comprised of an inflation rate of 2.50%, a real return of 4.45% that is net of investment expense.

The discount rate used to measure the total pension liability was 6.95%. The projection of cash flows used to determine the discount rate assumes that employee contributions will be made at the current contribution rate and that contributions from all participating employers will be made at contractually required rates that are actuarially determined and certified by the URS Board.

Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability. The discount rate does not use the Municipal Bond Index Rate. The discount rate was reduced to 6.95 percent from 7.2 percent from the prior measurement period.

The following presents the proportionate share of the net pension liability (asset) calculated using the discount rate of 6.95%, as well as, what the proportionate share of the net pension liability (asset) would be if calculated using a discount rate that is one percentage point lower or one percentage point higher than the current rate:

	1% Decrease (5.95%)	Discount Rate (6.95%)	1% Increase (7.95%)
Proportionate Share of Net Pension Liability (Asset)			
Noncontributory System	\$ 236,609,255	\$108,366,198	\$ 1,180,810
Contributory System	17,502,236	1,328,057	(12,441,928)
Public Safety	6,185,789	2,976,823	341,427
Tier 2 Public Employees System	3,313,635	281,424	(2,056,845)
Tier 2 Public Safety and Firefighter System	31,201	(3,523)	(30,053)
Totals	\$ 263,642,116	\$ 112,948,979	\$(13,006,589)

Detailed information about the pension plan's fiduciary net position is available in the separately issued URS financial report.

Defined Contribution Plans

The University offers employees the choice between URS, TIAA, and Fidelity for individual retirement funds. Employees who participate in the State and School Noncontributory and Tier 2 pension plans also participate in qualified contributory 401(k) and 457 savings plans administered by the Utah Retirement Systems (Systems). The University contributes 1.5% and 1.58%, and 1.26%, respectively of participating employees' annual salaries to a 401(k) plan administered by the Systems. For employees participating in the Tier 2 Public Employee defined contribution plan and Tier 2 Public Safety and Firefighter defined contribution plan, the University is required to contribute 20.02% and 30.54%, respectively, of the employee's salary, of which 10% and 12%, respectively, is paid into the 401(k) 457 plan while the remainder is contributed to the Tier 1 Contributory Public Employee System, as required by law. During the year ended June 30, 2018, the University's contribution totaled \$2,948,385, which was included in the pension expense, and the participating employees' voluntary contributions totaled \$210,225. These plans are voluntary tax-advantaged retirement savings programs authorized under sections 401(k), 457(b) and 408 of the Internal Revenue code. Detailed information regarding plan provisions is available in the separately issued URS financial report.

TIAA and Fidelity provide individual retirement fund contracts with each participating employee. Employees may allocate contributions by the University to any or all of the providers and

the contributions to the employee's contract(s) become vested at the time the contribution is made. Employees are eligible to participate from the date of employment and are not required to contribute to the fund. Benefits provided to retired employees are based on the value of the individual contracts and the estimated life expectancy of the employee at retirement. For the year ended June 30, 2018, the University's contribution to these defined contribution pension plans was 14.20% of the employees' annual salaries. Additional contributions are made by the University based on employee contracts. The University has no further liability once contributions are made.

UUHC employees hired prior to January 1, 2001, who were not enrolled in the URS program, are enrolled in a 401(a) defined contribution plan that is administered by the UUHC Chief Human Resources Officer. The administrator has the authority to amend, modify, or terminate the plan. UUHC is required to contribute 14.2% of covered payroll to the plan for the employees covered under this plan. Hospital employees hired subsequent to December 31, 2000 are enrolled in a separate 401(a) plan, the Hospital Plan Plus (HPP) Benefit Program. UUHC contributes 6% for employees covered under this plan. In addition, these employees are eligible for a match on employee contributions to a 403(b) Match Plan up to 3% of salary and fully vest in the UUHC's contributions to both plans after six years of service. Plan member contributions were approximately \$26,530,000 for the year ended June 30, 2018.

The ARUP defined contribution pension and profit sharing plans provide retirement benefits for all employees. Employees may choose to pay into the federal social security tax system or to participate in an



enhanced ARUP retirement program. For those who choose to continue to pay social security taxes, ARUP makes contributions each pay period amounting to 5.00% of their compensation and ARUP continues to make matching social security tax contributions. For those who discontinue paying social security taxes, ARUP makes contributions each pay period amounting to 8.10% of their compensation and does not contribute any social security tax on their behalf. There are no minimum service and vesting requirements relating to pension contributions.

Contributions to the profit sharing plan are at the discretion of ARUP and are made subject to certain tenure-based and hours-worked thresholds. Employees are fully vested in the profit sharing plan after five years of service. Voluntary contributions to the profit sharing plan by employee participants totaled \$19,602,647 for the year ended June 30, 2018.

In addition, employees of the University may also contribute to 403(b), 457(b) traditional, Roth IRA, or a 401(k) plan. The total fiscal year 2018 employee contributions to these plans were \$86,751,984.

For the year ended June 30, 2018, the University's contributions to the defined contribution plans were equal to the required amounts, as shown in *Figure 4*.

<i>Figure 4</i>	2018
TIAA	\$ 87,145,285
Fidelity	84,185,043
401(a), Hospital Plan Plus, & 403(b)	44,583,000
Employer 401(k) Contributions	2,948,385
ARUP defined contribution plan	15,655,664
ARUP Profit sharing plan	12,616,940
Total employer contributions	\$ 247,134,317

9. UNEARNED REVENUE

Unearned revenue consists of summer session tuition and fees, advance payments on grants and contracts, advance ticket sales for various athletic and cultural events, and results of normal operations of auxiliary enterprises and service units.

10. FUNDS HELD IN TRUST BY OTHERS

Funds held in trust by others for the sole benefit of the University are neither in the possession of nor under the management of the University. These funds, which are not recorded on the University's financial records and which arose from contributions, are held and administered by external fiscal agents, selected by the donors, who distribute net income earned by such funds to the University, where it is recorded when received. The

fair value of funds held in trust at June 30, 2018 was \$140,337,076.

In addition, certain funds held in trust by others are comprised of stock, which is reported at a value of \$14,190,863 as of June 30, 2018, based on a predetermined formula. The fair value of this stock as of June 30, 2018 cannot be determined because the stock is not actively traded.

11. RISK MANAGEMENT AND INSURANCE

The University maintains insurance coverage for commercial general liability, automobile, errors and omissions, and property (building and equipment) through policies administered by the Utah State Division of Risk Management. Employees of the University and authorized volunteers are covered by workers' compensation and employees' liability through the Workers' Compensation Fund.

In addition, the University maintains self-insurance funds for health care, dental, and auto/physical damage, as well as hospital and physicians malpractice liability self-insurance funds. The malpractice liability self-insurance funds are held in trust with an independent financial institution in compliance with Medicare reimbursement regulations. Based on an analysis prepared by an independent actuary, the administration believes that the balance in the trust funds as of June 30, 2018, is adequate to cover any claims incurred through that date. The University and UUHC have a "claims made" umbrella health care professional malpractice insurance policy in an amount considered adequate by its respective administrations for catastrophic malpractice liabilities in excess of the trusts' fund balances, the coverage provides for \$15 million per claim and \$15 million in the aggregate.

The estimated self-insurance claims liability is based on the requirements of GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, as amended by GASB Statement No. 30, *Risk Financing Omnibus*, which requires that a liability for claims be reported if information prior to the issuance of the financial statements indicates that it is probable that a liability has been incurred at the date of the financial statements and the amount of the loss can be reasonably estimated.

Changes in the University's estimated self-insurance claims liability for the years ended June 30 is shown in *Figure 5*.

<i>Figure 5</i>	2018	2017
Estimated claims liability - beginning of year	\$ 84,541,532	\$ 84,151,807
Current year claims and changes in estimates	175,096,798	145,222,805
Claim payments, including related legal and administrative expenses	(176,188,022)	(144,833,080)
Estimated claims liability - end of year	\$ 83,450,308	\$ 84,541,532

The University has recorded the investments of the malpractice liability trust funds at June 30, 2018, and the estimated liability for self-insurance claims at that date in the Statement of Net Position. The income on fund investments, the expenses related to the administration of the self-insurance and malpractice liability trust funds, and the estimated provision for the claims liability for the year then ended are recorded in the Statement of Revenues, Expenses, and Changes in Net Position.

In 2016, UUHIP launched into the commercial health insurance market in Utah, specifically in the individual and large group market. UUHIP management does not believe it is subject to health insurer assessment under section 9010 of the Affordable Care Act (ACA) as a governmental entity associated with the University. To stabilize financial results, the federal government established the following permanent and transitional risk sharing programs with insurers of ACA-compliant plans:

- The permanent risk adjustment program redistributes insurer premiums based on qualitative market data.
- The transitional reinsurance program reimburses insurers of ACA-compliant plans for claimants exceeding specified limits and is a temporary provision that ended after December 31, 2016.
- The transitional risk corridors program shares excessive insurer gains or losses with the federal government and is a temporary provision that ended after December 31, 2016.

UUHIP has a reinsurance arrangement whereby premiums and benefits are ceded to another insurance company. The agreement is for certain



coverage that provides reinsurance protection for 100% of qualified health claims in excess of \$600,000 per occurrence. Premiums to reinsurers for reinsurance ceded reduced premium revenue by approximately \$428,000 during 2017. Excluding amounts recoverable under the ACA transitional reinsurance program, UUHIP had approximately \$1,930,050 in reinsurance recoupments that reduced health benefits during 2017. During the year ended December 31, 2017, UUHIP did not commute any ceded reinsurance nor did it enter into or engage in any loss portfolio transfer for any lines of business. Changes in UUHIP's estimated claims liability for the years ended December 31 is shown in *Figure 6*.

<i>Figure 6</i>	2017	2016
Estimated claims liability - beginning of year	\$ 2,553,007	-
Current year claims and changes in estimates	40,563,004	\$ 20,828,004
Claim payments, including related legal and administrative expenses	(38,322,214)	(18,274,997)
Estimated claims liability - end of year	\$ 4,793,797	\$ 2,553,007

12. INCOME TAXES

The University, as a political subdivision of the State, has a dual status for federal income tax purposes. The University is both an Internal Revenue Code (IRC) Section 115 organization and an IRC Section 501(c)

(3) charitable organization. This status exempts the University from paying federal income tax on revenue generated by activities which are directly related to the University's mission. This exemption does not apply to unrelated business activities. On these activities, the University is required to report and pay federal and state income tax.

UURF is not subject to income taxes under Section 501(c) (3) of the IRC. ARUP is also not subject to income taxes based on a private letter ruling from the Internal Revenue Service stating that certain income providing an essential governmental function is exempt from federal income taxes under IRC Section 115.

13. HOSPITAL REVENUE

A. Net Patient Service Revenue

UUHC reports net patient service revenue at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Charity care is excluded from net patient service revenue.

UUHC has third-party payor agreements with Medicare and Medicaid that provide for payments to



UUHC at amounts different from established rates. Inpatient acute care services rendered to Medicare and Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services rendered to Medicaid program beneficiaries and certain outpatient services and defined capital costs related to Medicare beneficiaries are paid on a cost reimbursement basis. Medicare reimbursements are based on a tentative rate with final settlement determined after submission of annual cost reports by UUHC and audits thereof by the Medicare fiscal intermediary.

The estimated final settlements for open years are based on preliminary cost findings after giving consideration to interim payments that have been received on behalf of patients covered under these programs.

B. Charity Care

UUHC maintains records to identify and monitor the level of charity care it provides. Based on established rates, the charges foregone as a result of charity care during the year ended June 30, 2018, were approximately \$87.5 million.

14. LEASES

A. Revenue

UURF receives lease revenues from noncancellable sublease agreements with tenants of the Research Park and from tenants occupying eight buildings owned by UURF. The lease revenue to be received

from these noncancellable leases for each of the subsequent five years is approximately \$11 million. Most lease revenue is subject to escalation based on changes in the Consumer Price Index (CPI). Since such escalations are dependent upon future changes in the CPI, these escalations, if any, are not reflected in the minimum noncancellable lease revenues listed above.

At June 30, 2018, the historical cost of land and buildings held for lease and the related accumulated depreciation was \$90.1 million and \$28.4 million, respectively.

B. Commitments

The University leases buildings and office and computer equipment. Capital leases are valued at the present value of future minimum lease payments. Assets associated with the capital leases are recorded as buildings and equipment together with the related long-term obligations. Assets currently financed as capital leases amount to \$80.9 million and \$138.8 million for buildings and equipment, respectively. Accumulated depreciation for these buildings and equipment was \$14.2 million and \$60.5 million, respectively. Operating leases and related assets are not recorded in the Statement of Net Position. Payments are recorded as expenses when incurred and amount to \$27.5 million for the University and \$1.0 million for component units for the year ended June 30, 2018. Total operating lease commitments for the University include approximately \$21.9 million of commitments to component units.

Future minimum lease commitments for operating and capital leases as of June 30, 2018 are shown in *Figure 7*.

Figure 7

Fiscal Year	Operating	Capital
2019	\$ 35,426,550	\$ 22,364,422
2020	26,316,304	26,509,527
2021	24,253,657	25,307,631
2022	20,171,541	23,324,358
2023	17,441,118	20,275,538
2024–2028	59,413,176	50,061,986
2029–2033	13,513,388	24,520,491
2034–2038	7,306,244	
2039–2043	4,546,909	
2044–2048	3,724,604	
2049–2053	787,478	
2054–2058	54,369	
Total future minimum lease payments	\$ 212,955,338	192,363,953
Amount representing interest		(30,043,817)
Present value of future minimum lease payments		\$ 162,320,136

15. BONDS PAYABLE AND OTHER LONG-TERM LIABILITIES

The long-term debt of the University consists of bonds payable, certificates of participation, capital lease obligations, compensated absences, net pension liability, and other obligations.

The State Board of Regents issues revenue bonds to provide funds for the construction and renovation of major capital facilities and the acquisition of capital equipment for the University. In addition, revenue bonds have been issued to refund other revenue bonds and capitalized leases.

The revenue bonds are special limited obligations of the University. The obligation for repayment is solely that of the University and payable from the net revenues of auxiliary enterprises and UUHC, student building fees, land grant income, and recovered indirect costs. Neither the full faith and credit nor the taxing power of the State or any other political subdivision of the State is pledged to the payment of the bonds, the distributions or other costs associated with the bonds.

During fiscal year 2018, the University issued two bond issues. In September, the University issued \$155,930,000 of General Revenue and Refunding Bonds Series 2017A. Proceeds from these bonds are to be used towards the construction of a rehabilitation hospital, expansion of the University Guest House and, were used to refund a portion of the outstanding Series 2013A General Revenue bonds. In December, the University issued \$96,550,000 of General Revenue Refunding Bonds Series 2017B. Proceeds from these bonds were used to refund a portion of the University Hospital Revenue and Refunding Bonds Series 2011A, a portion of General Revenue Commercial Paper Notes Series 2013B, a portion of the University's General Revenue and Refunding Bonds Series 2014B and a portion of the University's General Revenue and Refunding Bonds Series 2015A-1.



The following schedule lists the outstanding bonds payable and certificates of participation of the University at June 30, 2018:

Issue	Date Issued	Maturity Date	Interest Rate	Original Issue	Current Liability	Balance 6/30/2018(a)
Auxiliary and Campus Facilities						
Series 1998A - Revenue Refunding	7/1/98	2029	4.100% - 5.250%	\$120,240,000	\$ 38,291	\$ 30,905,048
Series 2010A - Revenue Refunding	5/11/10	2020	2.000% - 5.000%	23,515,000	177,661	355,322
Series 2010C - Revenue	12/28/10	2036	1.750% - 5.890%	42,525,000	1,490,000	37,085,000
Series 2012A - Revenue	7/10/12	2030	2.000% - 5.000%	46,235,000	2,158,665	9,078,621
Hospital Facilities						
Series 2006A - Revenue Refunding	10/26/06	2022	4.000% - 5.250%	77,145,000	1,230,367	9,684,108
Series 2009B - Taxable Revenue	12/17/09	2031	4.697% - 5.247%	41,785,000	2,410,000	39,450,000
Series 2010 - Revenue	8/2/10	2021	3.000% - 5.000%	36,120,000	2,022,330	8,250,978
Series 2011A - Revenue Refunding	5/24/11	2027	3.600%	20,145,000	1,240,000	3,865,000
Series 2011B - Revenue Refunding	7/28/11	2021	3.350% - 5.000%	66,480,000	3,244,230	10,002,923
Research Facilities						
Series 2009A - Revenue	8/26/09	2019	4.000% - 5.000%	19,080,000	2,376,472	2,376,472
Series 2009B - Taxable Revenue	8/26/09	2029	5.670% - 6.279%	27,730,000	-	27,730,000
General Revenue						
Series 2013A - Revenue	7/30/13	2043	5.000%	127,925,000	40,169	23,651,969
Series 2014A - Revenue Refunding	4/1/14	2027	4.000% - 5.000%	32,785,000	7,605,708	33,897,410
Series 2014B - Revenue Refunding	7/15/14	2038	2.000% - 5.000%	76,200,000	3,110,127	38,270,144
Series 2015A - Revenue Refunding	1/7/15	2034	1.500% - 5.000%	45,330,000	5,748,267	24,582,756
Series 2015B - Revenue Refunding	5/13/15	2035	3.000% - 5.000%	91,570,000	5,156,159	97,138,735
Series 2016A - Revenue Refunding	3/8/16	2036	3.000% - 5.000%	68,210,000	4,036,342	82,323,137
Series 2016B - Revenue Refunding	11/29/16	2036	2.000% - 5.000%	131,720,000	3,875,173	157,110,049
Series 2017A - Revenue Refunding	9/13/17	2039	4.000% - 5.000%	155,930,000	4,512,030	186,518,943
Series 2017B - Revenue Refunding	12/21/17	2038	3.000% - 5.000%	96,550,000	865,163	116,787,461
Certificates of Participation						
Series 2015	6/10/15	2026	1.800%	10,050,000	1,745,000	8,725,000
Total					\$ 53,082,154	\$947,789,076

(a) Includes unamortized premiums on refunding.

UURF has purchased four buildings with three mortgages that are guaranteed by the University, as well as, two Notes Payable to the University. The remaining amounts of the mortgages are \$1,327,346 at 8.87% interest, \$957,275 at 7.15% interest and

\$25,160,676 at 5.53% interest. The mortgages will be paid off on April 1, 2020, September 1, 2021 and September 30, 2028, respectively. The Notes call for annual payments at 4% and 2% interest until June and October 2024.

The following schedule summarizes the changes in long-term liabilities for the year ended June 30, 2018.

	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Bonds payable	\$ 845,999,355	\$ 300,459,249	\$ 207,394,528	\$ 939,064,076	\$ 51,337,154
Certificates of participation	11,477,369	-	2,752,369	8,725,000	1,745,000
Capital leases payable	173,695,201	13,871,054	25,246,119	162,320,136	17,871,329
Notes and contracts payable	75,583,627	2,174,118	46,664,305	31,093,440	3,331,778
Total long-term debt	1,106,755,552	316,504,421	282,057,321	1,141,202,652	74,285,261
Compensated absences	87,382,993	82,169,954	75,613,790	93,939,157	66,934,350
Net pension liability	168,014,659	-	55,062,156	112,952,503	-
Deposits & other liabilities	133,484,384	135,697,443	120,018,264	149,163,563	132,443,443
Total long-term liabilities	\$1,495,637,588	\$ 534,371,818	\$ 532,751,531	\$1,497,257,875	\$ 273,663,053

Maturities of principal and interest requirements for long-term debt payable are as follows:

Fiscal Year	Payments	
	Principal	Interest
2019	\$ 74,285,261	\$ 46,272,957
2020	82,157,645	43,914,327
2021	80,368,906	40,932,697
2022	81,562,986	38,131,741
2023	84,625,450	34,619,536
2024–2028	377,022,178	120,341,439
2029–2033	239,964,485	45,520,130
2034–2038	103,595,821	11,066,175
2039–2043	17,602,152	464,725
2044–2048	17,768	
Total	\$1,141,202,652	\$ 381,263,727

Interest related to bond systems with pledged revenues amounts to \$342,632,271 and is included in the interest amounts in the above schedule.

16. RETIREMENT OF DEBT

In the current and prior years, the University defeased certain revenue bonds by placing the proceeds of new bonds and various bond reserves in irrevocable trusts to provide for all future debt service payments on the old bonds. Accordingly, the trust account assets and the liability for the defeased bonds are not included in the University's financial statements. The total principal amount of defeased bonds held in irrevocable trusts at June 30, 2018 is \$380,995,000.

The University issued General Revenue Refunding Bonds Series 2017A and 2017B during the fiscal year to partially refund portions of outstanding bonds as described in Note 15. The refunding activity had limited impact on the retirement period but did result in a decrease of aggregate debt service payments of \$107,000 and a present value economic gain of approximately \$71,000.

17. PLEDGED BOND REVENUE

The University issues revenue bonds to provide funds for the construction and renovation of major capital facilities and the acquisition of capital equipment for the University. Investors in these bonds rely solely on the net revenue pledged by the general revenue of the University for the retirement of outstanding bonds payable.

Figure 8 presents the net revenue pledged and the principal and interest paid for the year ended June 30, 2018.

Figure 8	
Revenue	
Operating revenue	\$ 2,999,404,525
Nonoperating revenue	117,632,421
Total revenue	3,117,036,946
Expenses	
Operating expenses	2,694,568,514
Total expenses	2,694,568,514
Net pledged revenue	\$ 422,468,432
Principal and interest paid	\$ 74,466,956

18. FUNCTIONAL CLASSIFICATION OF EXPENSES

The following schedule presents, in thousands of dollars, operating expenses by functional classification for the year ended June 30, 2018:

Function	Compensation and Benefits	Supplies and Services	Utilities	Scholarships & Fellowships	Depreciation	Medical Claims	Component Units	Total
Instruction	\$ 393,003	\$ 49,083	\$ 2,291	\$ 60,780				\$ 505,157
Research	257,979	128,341	1,350	3,581				391,251
Public service	625,989	63,526	28,750	1,936	\$ 754			720,955
Academic support	105,726	41,342	1,379	613				149,060
Student services	26,151	11,761	716	400				39,028
Institutional support	129,272	(17,858)	5,772	1,328				118,514
Plant maintenance	38,025	46,690	18,328	8				103,051
Student aid	4,935	40,045	10	(42,167)				2,823
Other	71,001	(46,097)	10,373	4,673	122,548			162,498
Hospital	852,038	747,198	17,707		70,981	\$ 139,194		1,827,118
Component units	5,667				28,308		\$ 531,708	565,683
Total	\$2,509,786	\$1,064,031	\$ 86,676	\$ 31,152	\$ 222,591	\$ 139,194	\$ 531,708	\$4,585,138

19. JOINT VENTURES

The Utah Education Network (UEN) is a publicly funded consortium administered by the University supporting educational technology needs for Utah's public and higher education institutions, public libraries, and state agencies. UEN provides internet access for all Utah public middle schools, high schools, and higher education institutions.

UEN also operates a fully interactive distance learning network interconnecting public schools and higher education institutions statewide. State appropriation support of UEN amounted to \$26.8 million for the year ended June 30, 2018. UEN is not separately audited but is included in the audited financial statements of KUEN, a public broadcasting television station operated by the University. Copies of those statements can be obtained from KUEN's administrative offices.



20. BLENDED COMPONENT UNITS

The following schedules present, exclusive of eliminations, condensed statements of net position, changes in net position, and cash flows for UURF, ARUP and UUHIP. Amounts for UURF and ARUP are for the year ended June 30, 2018, and UUHIP are for the year ended December 31, 2017.

Condensed Statement of Net Position				
	UURF	ARUP	UUHIP	Total
ASSETS				
Current Assets				
Receivable from University		\$ 6,513,032		\$ 6,513,032
Other	\$ 11,672,291	307,905,354	\$ 35,774,621	355,352,266
Capital assets, net	66,747,941	230,835,043		297,582,984
Other noncurrent assets	8,244,190	3,501,898		11,746,088
Total assets	86,664,422	548,755,327	35,774,621	671,194,370
LIABILITIES				
Current liabilities				
Payable to University		8,363,408	5,951,361	14,314,769
Other	8,927,236	67,160,627	7,437,723	83,525,586
Noncurrent liabilities	30,216,966			30,216,966
Total liabilities	39,144,202	75,524,035	13,389,084	128,057,321
NET POSITION				
Net investment in capital assets	33,427,049	230,835,043		264,262,092
Restricted expendable			22,385,537	22,385,537
Unrestricted	14,093,171	242,396,249		259,489,420
Total net position	\$ 47,520,220	\$ 473,231,292	\$ 22,385,537	\$ 543,137,049

Condensed Statement of Revenues, Expenses, and Changes in Net Position				
	UURF	ARUP	UUHIP	Total
OPERATING REVENUES				
Leases	\$ 16,405,310			\$ 16,405,310
Royalties	8,614,915			8,614,915
Sales and services		\$ 638,736,255	\$ 50,033,621	688,769,876
Net increase in fair value of investments	118,568			118,568
Total operating revenues	25,138,793	638,736,255	50,033,621	713,908,669
OPERATING EXPENSES				
Operating expenses	15,817,097	523,504,287	49,392,932	588,714,216
Depreciation	2,043,185	26,264,870		28,308,055
Total operating expenses	17,860,282	549,769,157	49,392,832	617,022,271
Operating income	7,278,511	88,967,098	640,789	96,886,398
NONOPERATING REVENUES (EXPENSES)				
Investment income	85,961	5,253,542	301,838	5,641,341
Interest expense	(1,827,094)			(1,827,094)
Sale of equity investments	42,823			42,823
Contributions from (distributions to) the University	(448,056)	(63,072,943)	8,000,000	(55,520,999)
Total nonoperating revenues/(expenses)	(2,146,366)	(57,819,401)	8,301,838	(51,663,929)
Net increase in net position	5,132,145	31,147,697	8,942,627	45,222,469
NET POSITION				
Net position – beginning of year	42,388,075	442,083,595	13,442,910	497,914,580
Net position – end of year	\$ 47,520,220	\$ 473,231,292	\$ 22,385,537	\$ 543,137,049

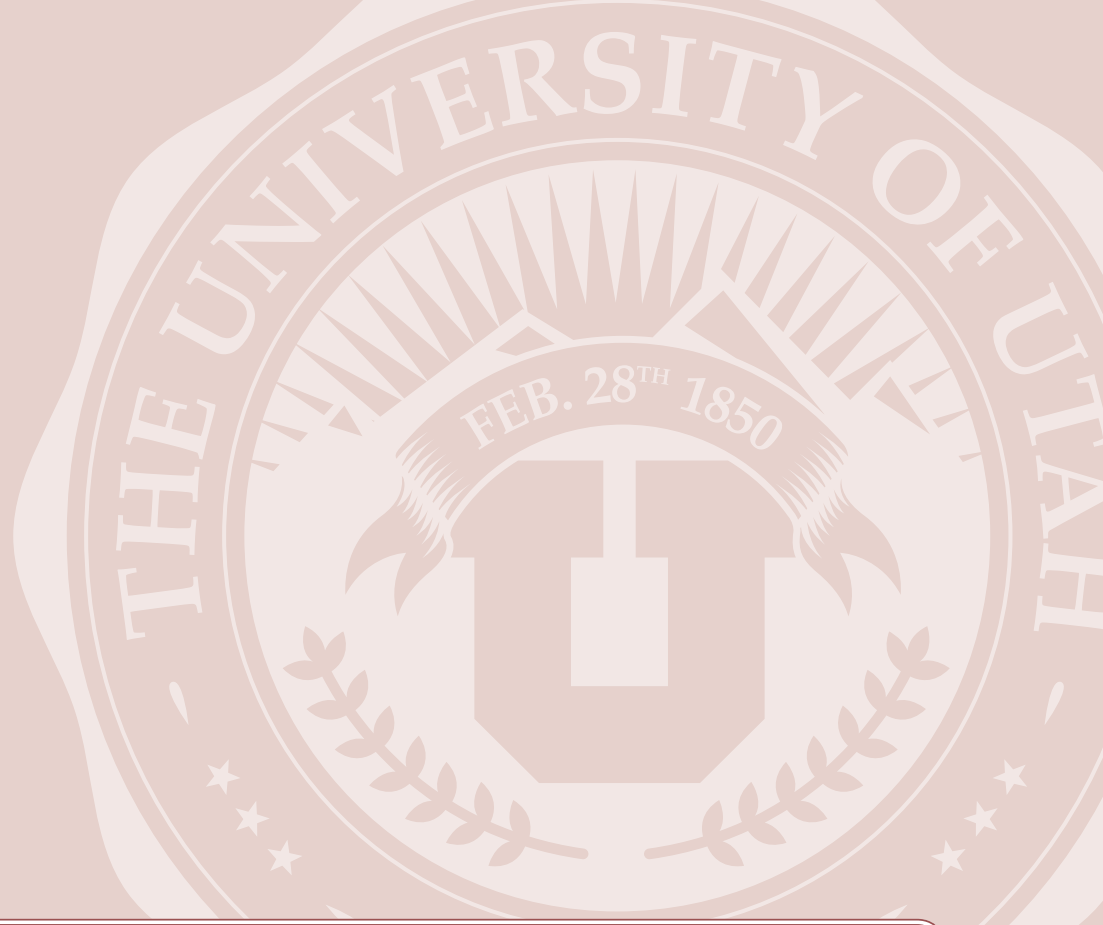
Condensed Statement of Cash Flows				
	UURF	ARUP	UUHIP	Total
Net cash provided by operating activities	\$ 10,950,959	\$ 101,091,710	\$ 7,014,589	\$ 119,057,258
Net cash provided/(used) by noncapital financing activities	(448,056)	(62,699,559)	8,000,000	(55,147,615)
Net cash used by capital and related financing activities	(12,793,585)	(38,558,038)		(51,351,623)
Net cash provided/(used) by investing activities	329,076	(5,617,966)	(5,769,283)	(11,058,173)
Net increase (decrease) in cash	(1,961,606)	(5,783,853)	9,245,306	1,499,847
Cash - beginning of year	15,171,690	11,627,478	562,532	27,361,700
Cash - end of year	\$ 13,210,084	\$ 5,843,625	\$ 9,807,383	\$ 28,861,547

21. SUBSEQUENT EVENTS

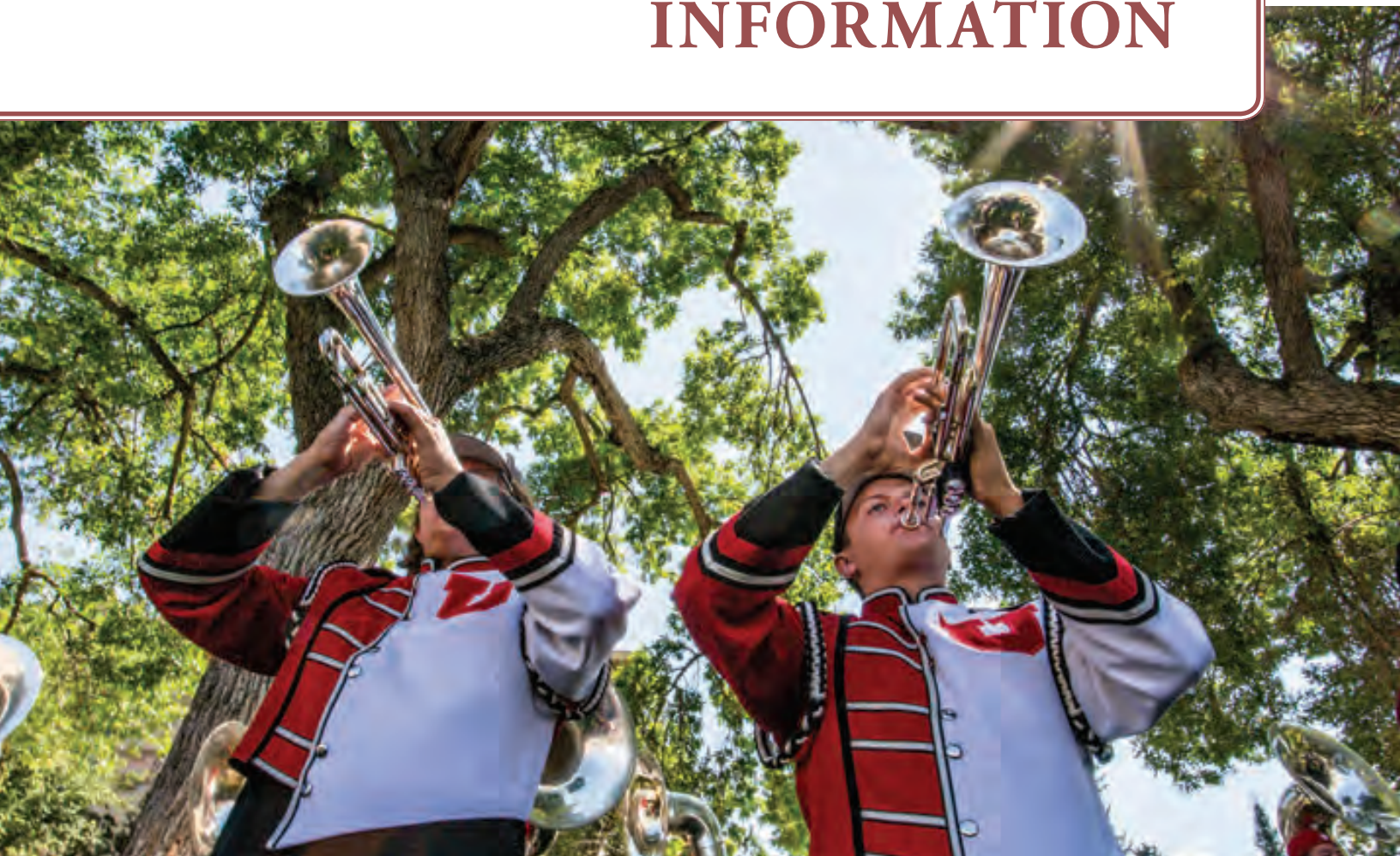
In July 2018, the University issued \$80.04 million of General Revenue Bonds, Series 2018A. Principal on the bonds is due annually commencing August 1, 2020 through June 30, 2040. Bond interest is due

semi-annually commencing February 1, 2019 at rates ranging from 4.00% to 5.00%. Proceeds from these bonds are to be used to finance a portion of the costs of constructing an expansion to existing student housing and dining facilities on the University main campus and, to pay costs of issuance.





REQUIRED SUPPLEMENTARY INFORMATION



University of Utah Proportionate Share of the Net Pension Liability Noncontributory, Contributory, & Tier 2 Public Employees Systems of the Utah Retirement Systems for the years ended December 31

	2017	2016	2015	2014
<i>Noncontributory System</i>				
Proportion of net pension liability (asset)	4.43149890%	4.72255030%	5.06361980%	5.10932610%
Proportionate share of net pension liability (asset)	\$ 108,366,198	\$ 153,053,931	\$ 159,062,799	\$ 128,373,118
Covered payroll	\$ 115,352,151	\$ 120,168,221	\$ 124,949,531	\$ 129,614,271
Proportionate share of net pension liability (asset) as a percentage of covered payroll	93.94%	127.37%	127.30%	99.00%
Plan fiduciary net position as a percentage of total pension liability	89.20%	84.90%	84.50%	87.20%
<i>Contributory System</i>				
Proportion of net pension liability (asset)	20.18198590%	20.57222910%	19.93038900%	18.75239770%
Proportionate share of net pension liability (asset)	\$ 1,328,057	\$ 11,272,710	\$ 12,489,421	\$ 2,056,560
Covered payroll	\$ 4,591,975	\$ 5,514,741	\$ 6,313,501	\$ 6,757,960
Proportionate share of net pension liability (asset) as a percentage of covered payroll	28.92%	204.41%	197.82%	30.40%
Plan fiduciary net position as a percentage of total pension liability	99.20%	93.40%	92.40%	98.70%
<i>Public Safety System</i>				
Proportion of net pension liability (asset)	1.71193320%	1.48473260%	1.41567170%	1.14690980%
Proportionate share of net pension liability (asset)	\$ 2,976,823	\$ 3,174,487	\$ 3,047,750	\$ 2,131,232
Covered payroll	\$ 2,272,929	\$ 2,087,879	\$ 1,951,440	\$ 1,637,085
Proportionate share of net pension liability (asset) as a percentage of covered payroll	130.97%	152.04%	156.18%	130.20%
Plan fiduciary net position as a percentage of total pension liability	87.40%	83.50%	82.30%	84.30%
<i>Tier 2 Public Employees System</i>				
Proportion of net pension liability (asset)	3.19193590%	4.60362900%	6.64369130%	6.78702880%
Proportionate share of net pension liability (asset)	\$ 281,424	\$ 513,532	\$ (14,503)	\$ (205,677)
Covered payroll	\$ 31,272,494	\$ 37,753,425	\$ 42,922,742	\$ 33,308,008
Proportionate share of net pension liability (asset) as a percentage of covered payroll	0.90%	1.36%	-0.03%	-0.60%
Plan fiduciary net position as a percentage of total pension liability	97.40%	95.10%	100.20%	103.50%
<i>Tier 2 Public Safety and Firefighter System</i>				
Proportion of net pension liability (asset)	0.30450360%	0.43726900%	0.39878160%	0.36002060%
Proportionate share of net pension liability (asset)	\$ (3,523)	\$ (3,796)	\$ (5,826)	\$ (5,326)
Covered payroll	\$ 321,462	\$ 361,284	\$ 237,408	\$ 148,982
Proportionate share of net pension liability (asset) as a percentage of covered payroll	(1.10%)	(1.05%)	(2.45%)	(3.60%)
Plan fiduciary net position as a percentage of total pension liability	103.00%	103.60%	110.70%	120.50%

*Note: The University implemented GASB Statement No. 68 in fiscal year 2015. Information on the University's portion of the plans' net pension liabilities (assets) is not available for periods prior to fiscal year 2015.

Changes in Assumptions:

As a result of an experience study conducted as of December 31, 2016, the Board adopted recommended changes to several economic and demographic assumptions that are used in the actuarial valuation. The assumption that had the largest impact on the Total Pension Liability (and actuarial accrued liability) included a decrease in the investment return assumption from 7.2% to

6.95%, a reduction in the price inflation assumption from 2.60% to 2.5% (which also resulted in a corresponding decrease in the cost-of-living-adjustment assumption for the funds with a 4.00% annual COLA max), and the adoption of an updated retiree mortality table that is developed using URS's actual retiree mortality experience. There were changes to several other demographic assumptions, but those changes had minimal impact on the Total Pension Liability (and actuarial accrued liability).

University of Utah — Schedule of Contributions for the years ended June 30

Noncontributory System	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009
Contractually Required Contribution	\$ 25,003,713	\$ 25,936,009	\$ 27,133,967	\$ 28,061,542	\$ 27,124,989	\$ 35,151,747	\$ 26,111,760	\$ 25,170,054	\$ 22,945,702	\$ 23,467,419
Contribution in Relation to the Contractually Required Contribution	(25,003,713)	(25,936,009)	(27,133,967)	(28,061,542)	(27,124,989)	(35,151,747)	(26,111,760)	(25,170,054)	(22,945,702)	(23,467,419)
Contribution Deficiency (Excess)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Covered Payroll	\$ 113,936,327	\$ 118,147,239	\$ 123,098,874	\$ 126,960,128	\$ 132,937,438	\$ 150,750,438	\$ 155,167,201	\$ 154,233,966	\$ 161,351,781	\$ 165,031,055
Contributions as a Percentage of Covered Payroll	21.9%	22.0%	22.0%	22.1%	20.4%	23.3%	16.8%	16.3%	14.2%	14.2%
Contributory System	2018	2017	2016	2015	2014¹	2013¹	2012¹	2011¹	2010¹	2009¹
Contractually Required Contribution	\$ 754,331	\$ 894,123	\$ 1,058,540	\$ 1,164,742	\$ 1,096,361	\$ 687,650	\$ 403,590	\$ 270,496	\$ 1,397,844	\$ 1,527,460
Contribution in Relation to the Contractually Required Contribution	(754,331)	(894,123)	(1,058,540)	(1,164,742)	(1,096,361)	(687,650)	(403,590)	(270,496)	(1,397,844)	(1,527,460)
Contribution Deficiency (Excess)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Covered Payroll	\$ 4,261,758	\$ 5,051,541	\$ 5,985,358	\$ 6,580,469	\$ 6,865,132	\$ 5,696,793	\$ 3,173,040	\$ 1,517,153	\$ 8,886,486	\$ 9,710,488
Contributions as a Percentage of Covered Payroll	17.7%	17.7%	17.7%	17.7%	16.0%	12.1%	12.7%	17.8%	15.7%	15.7%
Public Safety System	2018	2017	2016	2015	2014¹	2013¹	2012¹	2011¹	2010²	2009²
Contractually Required Contribution	\$ 789,054	\$ 739,683	\$ 682,809	\$ 550,177	\$ 486,603	\$ 468,024	\$ 427,891	\$ 407,628	N/A	N/A
Contribution in Relation to the Contractually Required Contribution	(789,054)	(739,683)	(682,809)	(550,177)	(486,603)	(468,024)	(427,891)	(407,628)		
Contribution Deficiency (Excess)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
Covered Payroll	\$ 2,220,291	\$ 2,212,011	\$ 2,117,893	\$ 1,707,174	\$ 1,642,290	\$ 1,611,246	\$ 1,635,298	\$ 1,244,666		
Contributions as a Percentage of Covered Payroll	35.9%	33.4%	32.2%	32.2%	29.6%	29.0%	26.2%	32.7%		
Tier 2 Public Employees System	2018	2017	2016	2015	2014¹	2013¹	2012¹	2011¹	2010³	2009³
Contractually Required Contribution	\$ 5,444,034	\$ 6,127,098	\$ 7,878,405	\$ 6,995,912	\$ 4,707,627	\$ 2,945,339	\$ 1,728,653	\$ 1,158,587	N/A	N/A
Contribution in Relation to the Contractually Required Contribution	(5,444,034)	(6,127,098)	(7,878,405)	(6,995,912)	(4,707,627)	(2,945,339)	(1,728,653)	(1,158,587)		
Contribution Deficiency (Excess)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
Covered Payroll	\$ 29,551,457	\$ 33,628,505	\$ 43,203,966	\$ 38,336,356	\$ 28,113,543	\$ 24,400,464	\$ 13,590,742	\$ 6,498,259		
Contributions as a Percentage of Covered Payroll ⁵	18.4%	18.2%	18.2%	18.2%	16.7%	12.1%	12.7%	17.8%		
Tier 2 Public Safety and Firefighter System	2018	2017	2016	2015	2014¹	2013¹	2012¹	2011⁴	2010⁴	2009⁴
Contractually Required Contribution	\$ 102,648	\$ 98,360	\$ 103,266	\$ 50,424	\$ 32,261	\$ 8,581	\$ 3,929	N/A	N/A	N/A
Contribution in Relation to the Contractually Required Contribution	(102,648)	(98,360)	(103,266)	(50,424)	(32,261)	(8,581)	(3,929)			
Contribution Deficiency (Excess)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
Covered Payroll	\$ 350,573	\$ 336,733	\$ 353,411	\$ 172,330	\$ 117,742	\$ 77,303	\$ 37,598			
Contributions as a Percentage of Covered Payroll ⁵	29.3%	29.2%	29.2%	29.3%	27.4%	11.1%	10.5%			

¹ Contractually Required Contributions, Contributions, and Covered Payroll include information for Tier 2 Employees. Prior to the implementation of GASB Statement No. 68, Tier 2 information was not separately available.

² The University of Utah began participating in Public Safety Systems in 2011.

³ The Tier 2 Public Employees System was created in 2011.

⁴ The University began contributing to the Tier 2 Public Safety and Firefighter System in 2012.

⁵ For employees participating in the Public Employees and Public Safety Firefighters Tier 2 Systems, the University is required to contribute 18.44% and 29.28%, respectively, of the employees' salaries to the Systems.

The University makes the required contributions by paying approximately 10% in to the Tier 2 Systems while the remainder is contributed to the Tier 1 Systems, as required by law.

The amounts reported here reflect the net contributions to the Tier 2 systems rather than the total required.

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ANNUAL FINANCIAL REPORT

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Attachment I - Additional Information

University of Utah Health Plans (UUHP) offers the following additional information to clarify its proposal.

Medicaid Managed Care and State Match Funding Assistance

UUHP has been a partner with Utah Medicaid since UUHP began operating as a Medicaid managed care plan in 1998. UUHP is currently contracted with the Utah Department of Health to operate as a Medicaid ACO. As a Medicaid ACO, UUHP delivers Medicaid physical health services to 300 residents of Summit County. If UUHP is awarded this contract with Summit County, those 300 residents of the county will be enrolled in the only fully integrated Medicaid managed care plan outside of the University-operated H.O.M.E. program.

Because UUHP is contracted as an ACO, UUHP can meet all state Medicaid requirements. UUHP has the ability to exchange enrollment and encounter data files with Utah Medicaid. UUHP is very familiar with Medicaid regulatory and reporting requirements, and will be able to ensure that Summit County is compliant with Medicaid requirements, thereby ensuring Summit County's continued access to Medicaid funding.

UUHP is willing to enter into a risk-based contract with Summit County for delivery of services to Medicaid members. To enter into this risk-based arrangement, UUHP requires the following:

- (1) The capitation rate paid by the state Medicaid agency must be paid, in full, to UUHP without any reduction by Summit County; and
- (2) Summit County must obtain all data necessary for UUHP to review the capitation rates and determine their actuarial soundness. This includes acquiring the utilization data (encounter data) from the state Medicaid agency, financial statements from the current LCP, and any additional information needed by UUHP to certify the actuarial soundness of the rates.

If UUHP's review of the utilization data and associated financial information reveals that the proposed capitation rates will not be actuarially sound, UUHP and Summit County will work with Utah Medicaid to find a mutually agreeable, actuarially sound capitation rate. If UUHP and Summit County cannot agree to a mutually agreeable, actuarially sound rate, UUHP and Summit County will negotiate a non-risk capitated arrangement or fee-for-service arrangement.

UUHP understands that, for purposes of this RFP, the only Medicaid-eligible individuals who will be eligible for enrollment with UUHP's managed care plan are those currently mandated to be enrolled by Utah Medicaid. Enrollment will not include the Targeted Adult Medicaid (TAM) population or individuals who will become eligible for Medicaid under the Medicaid expansion scheduled to take place on April 1, 2019. If additional populations are mandated to be enrolled in UUHP's Prepaid Mental Health Plan, UUHP reserves the right to renegotiate the capitation rate.

University of Utah State Match Funding Assistance

UUHP is in a unique position to offer an additional funding arrangement to enhance overall support for Summit County's behavioral health program while limiting the financial burden to Summit County. Under federal regulation (42 CFR 433.51), the University of Utah, as a public agency, has the ability to directly contribute seeding dollars for the non-federal share of Medicaid program expenditures.

The University and UUHP have successfully developed a seeding arrangement for the Medicaid ACO program in partnership with the Department of Health in order to draw down additional available federal funds for the benefit of the program. UUHP believes a similar approach will work for Summit County's behavioral health program.

The University of Utah is willing to contribute up to \$300,000 in funding to Summit County's behavioral health program as part of an Intergovernmental Transfer (IGT) to the Utah Department of Health. If this IGT arrangement is approved, the IGT funds and the federal matching funds could increase funding to Summit County's behavioral health program up to \$1 million. This arrangement will require approval by the state Medicaid agency as well as approval by the federal government. The University of Utah is willing to offer an IGT for the first year of the contract between Summit County and UUHP, and may be willing to offer an IGT arrangement in subsequent years, depending on the availability of funding.

Upon contract award, UUHP, Summit County, and the University of Utah will need to work collaboratively with the Utah Department of Health to effectuate such an arrangement. Because this IGT arrangement will be subject to state and federal approval, UUHP and the University of Utah cannot guarantee the additional funding or the amount of the funding. The actual total amount of funding that may be added to the Summit County behavioral health program will be subject to the federal financial participation rate, and the ability of the Utah Department of Health's contracted actuary to certify the program.

Division Directives

In collaboration with our provider-partner, University Neuropsychiatric Institute (UNI), we are confident that we have the resources to assist Summit County meet the State Mandated Services and Division Directives within 12 to 24 months of the proposed contract start date. As described below, our proposals to meet the State Mandated Service requirements and Division Directives involve a two-prong approach. First, UUHP, UNI, and Summit County will work together to gather data to assess utilization needs, location of those needs, and determine the available budget. Second, UUHP, UNI, and Summit County will work collaboratively to scale the proposed solution to address Summit County's needs within the county's budget.

Described below is how UUHP proposes to meet the requirements found in the RFP. These responses are high-level descriptions of UUHP's approach and should be read in conjunction with the information outlined in Form B and Form C. Each of these proposals is subject to UUHP verifying with Summit County during contract negotiation that sufficient funding exists to provide the solution. UUHP reserves the right to offer an alternate solution or enter into a subcontracted arrangement, as appropriate, if the available funding does not support the proposed solution.

Mandated Services

Substance Abuse Services: During contract negotiation, UUHP and Summit County will work together to compile utilization data for DUI, screening, assessment, education, and treatment services. Summit County and UUHP will also discuss the amounts of funding available to pay for these services. Based on this data, UUHP will determine whether the services can be performed by existing UUHP network providers or whether the services should be subcontracted to a different entity. If Summit County and UUHP cannot reach agreement on UUHP's proposed solution by the date of contract execution, UUHP and Summit County will explore a transitional subcontract with the existing provider(s) until a mutually agreeable solution can be reached.

Mental Health Services: During contract negotiation, UUHP and Summit County will perform an analysis of Summit County providers who may be available to provide these services, and identify where gaps exist by provider type and location. UUHP will leverage the provider offices which Summit County has available in Park City, Coalville and Kamas and staff those locations by using a combination of available area providers, physician residents, and telehealth.

Summit County Priority Needs: During contract negotiation, UUHP and Summit County will analyze the priority needs identified in the RFP. UUHP and Summit County will review existing provider availability and member utilization to determine where gaps exist by provider type and location. UUHP will leverage the provider offices available in Park City, Coalville and Kamas and staff those locations by using a combination of contracted area providers and physician residents, supplemented by telehealth.

DSAMH FY19 Directive: Combined Mental Health and Substance Abuse Directives

UUHP will ensure that its providers are meeting DSAMH's documentation requirements. In collaboration with Summit County and DSAMH, UUHP will develop an audit plan and audit protocols for its provider network to ensure that DSAMH's standards are being met. UUHP's quality team will conduct these audits on a mutually agreed upon schedule. UUHP will work with Summit County to determine where gaps exist in Summit County's Peer support network and find ways to address those gaps in service either through telehealth or other means.

DSAMH FY19 Directive: Suicide Prevention, Intervention, and Postvention

UUHP will work collaboratively with Summit County on its suicide prevention, intervention, and postvention efforts. UUHP, Summit County Department of Health, and Summit County jail staff will work collaboratively to develop a plan to meet the requirement that individuals entering a correctional institution have a safety plan in place before being turned over to the county jail. This plan will be based on projected utilization and availability of funding.

DSAMH FY19 Directive: Drug Testing Program Requirements

UUHP does not currently have a provider on its panel who can meet this RFP requirement. In order to meet this requirement, UUHP, Summit County Department of Health, and Summit Drug Court will work together to obtain data regarding the utilization of UAs by Summit County Drug Court. UUHP and Summit County will work collaboratively to find a provider who can meet Summit County's utilization needs within Summit County's budget, and UUHP will enter into a subcontractual arrangement with this provider. If a provider cannot be found prior to the contract effective date, UUHP and Summit County will explore options such as entering into a transitional contract with the current provider of this service or arranging for providers to deliver this service on a fee-for-service basis.

DSAMH FY19 Directive: Justice Reinvestment Initiative

The program manager assigned by UUHP to oversee the Summit County contract will participate in Justice Reform Initiative-related reform efforts. UUHP, UNI, the Summit County Department of Health, and Summit County Drug Court staff will work collaboratively to identify training needs and develop a training program for Drug Court staff.

DSAMH FY19 Directive: Juvenile Justice Reform

UUHP will participate in state and local Juvenile Justice Reform efforts to the extent appropriate and funded.

DSAMH FY19 Directive: Recovery Support Services

UUHP and Summit County will work together to identify existing Recovery Support Services (RSS) in Summit County. UUHP will educate its providers on the availability of RSS in Summit County so these services can be incorporated into an individual's care management plan. UUHP will also educate its providers on the availability of RSS in Summit County. UUHP, Summit County, and DSAMH will work together to develop the data file transfer to the Substance Abuse Mental Health Information System (SAMHIS). If the data file transfer requires additional hardware or more than 10 hours of programming time, UUHP and Summit County will negotiate a reasonable reimbursement rate for the development of this file transfer.

DSAMH FY19 Directive: Billing Requirements

UUHP and Summit County staff will work collaboratively to determine if UUHP or Summit Department of Health staff are best suited to conduct billing and invoicing to DSAMH. If it is determined that UUHP will be the party to conduct this work, UUHP and Summit County will negotiate an administrative agreement to cover UUHP's costs of administering this component of the program. If UUHP is conducting the data file transfer to the DSAMH KISSFLOW system, and this file transfer requires additional hardware or more than 10 hours of programming time, UUHP and Summit County will negotiate a reasonable reimbursement rate for the development of this file transfer.

DSAMH FY19 Directive: Mental Health Services Directives

UUHP agrees to only use State General Funds designated for "unfunded" clients when no funding is otherwise available. UUHP proposes that services to "unfunded" clients be reimbursed on a fee-for-service basis. UUHP will work with Summit County staff and its providers to utilize the OQ, and YOQ as appropriate. UUHP and its case managers will work collaboratively with other agencies and local non-profits to identify supported employment services. UUHP will work collaboratively with Summit County to assist in "Wraparound" facilitation and will assign a Nurse Care Manager to attend Utah State Hospital Adult and Child Continuity of Care meetings. UUHP will work collaboratively with the Summit County Health Department to determine whether UUHP staff or Summit County staff should be responsible for overseeing written requests for Children's Outplacement Funds and associated billing. If it is determined that UUHP should be the party to oversee Children's Outplacement funds and perform the associated billing, UUHP and Summit County will negotiate a mutually agreed upon administrative rate for this service. UUHP, UNI, and Summit County will work collaboratively to determine Summit County's Mental Health Early Intervention service needs. UUHP, UNI, and Summit County will review the available funding and service network to determine how to meet those needs. Through this collaboration, UUHP and Summit County will determine whether it is more appropriate for Summit County or UUHP to track and report on the TANF funds which are required to be reported to DSAMH.

DSAMH FY19 Directive: Substance Use Disorder Treatment Services Directives

UUHP and UNI will work collaboratively with Summit County and the Park City Hospital to develop Naloxone education, training, and assistance to individuals with Opioid Use Disorders. UUHP will work with Summit County to determine Summit County's methadone treatment utilization. Based upon this interaction, UUHP will propose a solution to meet Summit County's specific needs. Until a solution is provided, UUHP will either contract with existing providers in Summit County or assist clients in obtaining treatment in adjoining counties.

DSAMH FY19 Directive: Drug Court Program

UUHP will work collaboratively with Summit County to identify a provider to act as the primary therapist for the Summit County Drug Court Program within Summit County's budget. In the event that UUHP and Summit County cannot find providers qualified to perform this service prior to contract execution, UUHP may enter into a transitional contract with the existing provider. UUHP and Summit County will work closely with Summit County staff to identify Summit County's needs as it relates to the Drug Court program and leverage its provider network, case managers, and relationship with UNI staff to deliver needed services within Summit County's available funding.

DSAMH FY19 Directive: Women's SAPTBG Set Aside

UUHP and Summit County will work together to gather data relative to utilization of the Substance Abuse Prevention and Treatment Block Grant program, the specific services provided by the program, providers currently assisting with the delivery of services for this program, and the program's funding. Using this data, UUHP will propose a solution that will likely utilize its nurse case managers and UNI staff to assist in the delivery of services under this grant.

DSAMH FY19 Directive: General Funds for children living with parents receiving residential substance use disorder treatment services

UUHP and Summit County will work together to gather data relative to utilization of this program, the specific services provided by the program, providers currently assisting with the delivery of services for this program, and the program's funding. Using this data, UUHP will work with UNI and Summit County community partners to propose a solution that fits within Summit County's budget.

DSAMH FY19 Directive: Women's Funds

UUHP and Summit County will work together to gather data relative to utilization of this program, the specific services required by the program, providers currently assisting with the delivery of services for this program, and the program's funding. Using this data, UUHP will work in collaboration with women's health experts at UNI to deliver a solution that meets Summit County's needs and budget.

DSAMH FY19 Directive: Opioid Treatment and Recovery Support Funds

UUHP will work closely with Summit County to develop an opioid use disorder (OUD) needs assessment which will inform UUHP's budget and plan for delivering OUD services in Summit County. UUHP, through its partnership with UNI, will determine how best to utilize telehealth in underserved areas in Summit County for this purpose.

DSAMH FY19 Directive: School-Based Programs

UUHP, UNI, and the appropriate Summit County Health Department staff member(s) will meet with North Summit School District, South Summit School District, Park City School District, and the Weilenmann School of Discovery to discuss the school-based needs of each of these entities. UUHP, Summit County, and the Districts/School of Discovery will work collaboratively to develop a plan to meet identified needs within each of the Districts/School of Discovery.

County Specific Services

School-Based Clinician: UUHP's provider-partner, UNI, may have resources available to assist with meeting this requirement. If awarded the contract, UUHP and Summit County will determine during contract negotiation a plan for implementing this service and determine the appropriate costs based on the negotiated plan.

Spanish-Speaking Services: UUHP will work collaboratively with Summit County to determine where Spanish-speaking treatment needs exist and work with UNI and other network providers to identify any network providers who may be able to assist in filling those voids, either in-person or via telehealth. Ongoing, UNI has committed to recruit Spanish-speaking providers, which will be available to clients in Summit County via the UUHP network. UUHP and UNI can also coordinate interpretive services for members.

Extended Office Hours: UUHP has providers available in Salt Lake County who have hours that conclude at 8:00 p.m. or later. UUHP will work with its network providers to identify providers in Summit County who are able to have office hours that extend to 8:00 p.m.

Jail APRN: UUHP and Summit County will work together to gather data relative to the potential utilization of this service. UUHP will work with UNI to identify providers who can provide this service.

Summit County Strategic Plan: UUHP will work collaboratively with Summit County to implement Summit County's Strategic Plan. The program manager assigned by UUHP to oversee the Summit County contract will participate, as appropriate, in Committees organized by Summit County and its Community partners.

Summit County Stabilization Team: UUHP will work with Summit County to develop a plan to participate in Summit County's efforts to establish a County Stabilization team.

Exceptions to Assurances

Reimbursement Provisions: UUHP will enter into a capitated payment arrangement if the conditions found on page 1 of this Attachment are met.

Co-Pay: As stated throughout this RFP, UUHP will work collaboratively with Summit County to determine which programs are best suited for billing through UUHP and which services are appropriately billed through County resources. Because UUHP is utilizing a contracted network, UUHP will rely on contracted providers to bill applicable services.

Billing Reporting: UUHP currently has its own mechanism for reporting encounter data to the state. Because UUHP is utilizing a contracted network, where services are billable to Medicaid on a fee-for-service basis, individual providers will be responsible for billing Medicaid directly. UUHP does not intend to use the UWITS system for billing or encounter data reporting purposes.

UWITS Reporting: UUHP, Summit County, and DSAMH will work together to develop the data file transfer to UWITS. If the data file transfer requires additional hardware or more than 10 hours of programming time, UUHP and Summit County will negotiate a reasonable reimbursement rate for the development of this file transfer.

Compliance with Fiscal Audit Requirements: UUHP proposes that this audit be included in the year end audit conducted by University of Utah Health, and the due dates be changed to the University's timeline. If this solution is not acceptable, to the extent that an audit required for purposes of compliance with OMB Circular A-133 is performed by a CPA, UUHP and Summit County will negotiate a shared payment arrangement for the audit costs.

Compliance with Monitoring Activities: UUHP will participate with reasonable audit requests from the County, and requests that the County provides UUHP with 30-days' notice, before conducting an audit.

Financial Solvency: Instead of providing a separate account for purposes of this RFP, UUHP will ensure that within its existing accounts, there will always be enough liquid funds available to cover average expenses and salaries.

Termination: UUHP requires a 60-day without-cause termination that can be exercised by either UUHP or Summit County.

Utah Department of Human Services: UUHP will agree to be bound by the terms and conditions of the DHS agreement to the extent that the services it provides under this RFP are applicable. UUHP and Summit County will work together to determine which provisions are applicable to the work being performed by UUHP.

1. You are proposing a phased implementation of services upon award of the Summit County contract. Given this, how do you plan on ensuring delivery of the mandated services as required under Utah Code for the first year.

UUHP Response: UUHP will work collaboratively with Summit County to identify where gaps exist for coverage of the mandated services. UUHP and Summit County will then determine whether the gap be addressed by UUHP or Summit County through subcontracting, single case agreements, or transitional contracts with existing providers.

2. With regards to School-based services as mandated by state code, it was unclear how you plan to maintain services and continuity. Please provide more detail on how you plan to meet this critical mandate. Do you plan on keeping the current contractors or to bring in new clinicians to serve in the schools?

UUHP Response: UUHP understands that it is important not to break continuity of care where adolescents have established a relationship with someone they trust. If there are current clinicians serving the schools that can provide the required services within the available budget, UUHP would like to continue with those providers. In addition to the current services being offered in the schools, UUHP is interested in developing a workflow between SafeUT and Summit County clinicians to better address issues raised by the community's youth.

3. In your bid, you state that for several services you have yet to finalize service providers. Should the County have a preferred provider for a service are you willing to contract with those providers and panel not any currently covered under your plan?

UUHP Response: UUHP will absolutely consider Summit County's preferred providers for inclusion on UUHP's network, contingent upon passing UUHP's credentialing and other business requirements. UUHP reserves the right to make the final determination on the admission of network providers but fully intends to work collaboratively with Summit County, Summit County's partners, and the community to provide access to members.

4. With regards to inpatient services provided by the University Neuropsychiatric Institute, what assurances will you provide that qualifying Summit County residents will have access given the current waiting lists and capacity occupancy levels?

UUHP Response: If an individual needs inpatient services and beds are not available at UNI, UUHP will work with other providers, including out-of-network providers, to enter into single case agreements for those services. Additionally, UNI works directly with UUHP to prioritize inpatient admissions as best as possible including fast-tracking admissions where appropriate and feasible.

5. Currently, UNI has not been able to provide medication management for psychiatric services through the Redstone clinic. Are you proposing that this will change or will all medication management take place at the space provided by the County?

UUHP Response: UNI is able to provide adult medication management at Redstone Clinic, as well as child and adolescent medication management through Summit Pediatrics. Additionally, UNI has interested residents and fellows who are available to provide services at either the County's available space or the People's Health Clinic.

6. Several times in your bid you talk about services provided in Summit County and services provided in the valley. Please provide a specific list of services to be provided in Summit County vs. services provided in the valley.

UUHP Response: Please see Attachment E.

7. On attachment B it was unclear to the committee what direct staffing you would be providing in Summit county. Please list the University of Utah Health Plans staff positions you which would require space in Summit County.

UUHP Response: The staff positions which UUHP intends to place in Summit County depends on the nature of the office space in Summit County.

8. In attachment B, the committee was unclear on the compensation model you propose, please resubmit Attachment B with the corresponding information.

UUHP Response: Please see the Updated Attachment B included with this response.

9. Given the need for your own space, how do you plan on providing space for your network providers, such as Sundance Behavioral Resources, which is currently not located in Summit County?

UUHP Response: In UUHP's bid response, we stated "UUHP would be interested in utilizing the [county] space." As a point of clarification, UUHP is interested in this space on behalf of network providers such as Sundance Behavioral Resources and potentially UNI (in partnership with Sundance.) The majority of our network providers will provide their own space in Summit County. Sundance Behavioral Resources has been actively working on obtaining office space in Summit County, in anticipation of this behavioral health bid. Sundance is interested in utilizing the space the County has available as an immediate, interim solution. Additionally, as utilization trends and provider gaps are identified UUHP may want to utilize the space available in Summit County to fill those gaps.

10. Will you be able to provide all outpatient services within Summit County? (Exceptions allowed in Emergencies)

UUHP Response: Yes, UUHP's goal is to deliver all outpatient services within Summit County. UUHP cannot yet fully anticipate what the outpatient utilization will be in Summit County and we expect that, over time, we will need to adjust the provider network to compensate. As a

partner, UNI is fully committed to relocating clinicians to Summit County in support of UUHP, the County and the community.

11. Will you be able to provide all psychiatric medication management services within Summit county? (Exceptions allowed in emergencies).

UUHP Response: Yes, UUHP's goal is to provide all psychiatric medication management services within Summit County. UNI provides adult medication management at the Redstone Clinic and child/adolescent medication management through Summit Pediatrics. Additionally, UNI has interested residents and fellows who are available to provide services at either the County's available space or the People's Health Clinic. As a partner, UNI is fully committed to relocating clinicians to Summit County in support of UUHP, the County and the community.

12. What will the Summit county Program Manager's direct role be with regards to UNI? Will they be representing UNI on local coalitions in place of departing Dr. Jon-Kar Zubieta, or [will] Dr. Zubieta's replacement be taking that role?

UUHP Response: Both UUHP's Program Manager and UNI would like to be represented on local coalitions. With the departure of Dr. Jon-Kar Zubieta, Ross VanVranken, Executive Director of UNI, has committed to participate or will assign a designee from UNI if needed.

13. Within your bid, you propose an increased usage of telehealth services. Please provide an estimation of the percentage of services, especially for outpatient, incarcerated, Jail, and school-based services telehealth will play [versus] treatment from a "live" clinician.

UUHP Response: UUHP intends to use in-person visits as its primary venue for care. Telehealth visits will be used as 1) a stopgap measure to fill network needs until clinicians can be relocated to Summit County; 2) to provide after-hours, weekends and holiday access; 3) for immediate access needs such as crisis intervention. Until UUHP can better understand the utilization needs across Summit County, particularly for after-hours care, UUHP cannot assess what the percentage of the services will be delivered via telehealth; however, the intent is to use telehealth to enhance access for unique situations, not replace in-person visits.

14. With the passage of SB 96, all new enrollees for counties classified 2-6 (Summit is a class 3) will be funded through a capitated network, with only class 1 counties funded as a fee-for-service model. Given this, is the University of Utah Health Plans able to proceed with a 100% capitated plan with the majority of fund savings remaining with University of Utah Health Plans.

UUHP Response: UUHP has consulted with Utah Medicaid and confirmed that individuals who become will become eligible for Medicaid under SB 96, will not be mandatorily enrolled in a capitated managed care plan until 1/1/2020. Between 4/1/19 and 1/1/2020, individuals who become eligible as a result of SB 96 may receive services from any willing Medicaid provider, and the provider will be directly reimbursed by Medicaid on a fee-for-service basis.

On January 1, 2020, when the additional Medicaid members are mandatorily enrolled in a capitated managed care plan, UUHP will review the proposed capitation rates for actuarial soundness, and if the rates are found to be actuarially sound UUHP will continue to deliver services to those Medicaid members on a capitated basis.

Attachment E Reformatted – List of Network Providers & Services

Inpatient Care & Services
Located in Summit County
Located Outside Summit County
University Neuropsychiatric Institute (Salt Lake County)
NOTE: UUHP is willing to negotiate single case agreements when necessary.
Residential Care & Services
Located in Summit County
NOTE: UUHP is willing to negotiate single case agreements when necessary.
Located Outside Summit County
UNI Girls Transition Center (Salt Lake County)
NOTE: UUHP working with additional agencies in Salt Lake County
NOTE: UUHP is willing to negotiate single case agreements when necessary.
Outpatient Care
Located in Summit County
CG Mental Health
Elizabeth Doshier, LCSW
Expansive Horizons Counseling
Four Seasons Therapy
Gale and Associates
Innerwell Psychotherapy
Insight Psychotherapy
Jewish Family Services
John R. Taylor, PhD
Nelson Roxi, Mountain Strength Wellness Center
Pamela C. Wilkison, PhD
Park City Therapy
Pathways of Healing
Patricia Lindsay, PhD
Red Willow Counseling & Recovery
Sarah Rothstein, LCSW
Sundance Behavioral Resources (Contingent upon space – requesting County space)
Summit Counseling
Summit Neuropsychology
Summit Pediatrics
NOTE: UNI Recovery Works – (Currently located in Salt Lake County. Similar program could be offered in Summit County. Includes IOP.)
Located Outside Summit County
Corinna A. Porter, PhD (Wasatch County)
Harmony Family Therapy (Wasatch County)
Life Changes Counseling (Wasatch County)
Solstice Counseling and Wellness (Wasatch County)
Summit Community Counseling (Wasatch County)
Synergism Counseling (Wasatch County)
UNI Day Treatment – Kidstar (Salt Lake County)

UNI Day Treatment – Teenscope (Salt Lake County)
UNI Downtown Behavioral Health (Salt Lake County)
UNI Recovery Works (Salt Lake County)
Virtual
UNI GATE Program
UNI Telehealth
24 Hour Crisis Care
Located in Summit County
NOTE: UNI is willing to work with Summit County to provide back-up for MCOT services when needed.
Located Outside Summit County
UNI Consult Clinic (Salt Lake County) (Not 24 hour)
UNI Day Treatment Center (Salt Lake County) (Not 24 hour)
UNI Receiving Center (Salt Lake County) (Not 24 hour)
UNI Same Day Psychiatric Clinic (Salt Lake County) (Not 24 hour)
Virtual
UNI CrisisLine
UNI SafeUT
UNI Telehealth
UNI WarmLine
Psychotropic Medication Management
Located in Summit County
Summit Pediatrics
Sundance Behavioral Resources (Contingent upon space – requesting County space)
U Health Redstone Clinic
NOTE: UNI willing to expand its service offerings in Summit County
Located Outside Summit County
UNI Consult Clinic (Salt Lake County)
UNI Receiving Center (Salt Lake County)
UNI Same Day Psychiatric Clinic (Salt Lake County)
Virtual
UNI GATE Program
Psychoeducational Services & Psychosocial Rehab
Located in Summit County
Sundance Behavioral Resources (Contingent upon space – requesting County space)
U Health Redstone Clinic
NOTE: UNI willing to expand its service offerings in Summit County
Located Outside Summit County
Life Changes Counseling (Wasatch County)
Case Management
Located in Summit County

NOTE: UUHP is willing to provide in-home visits and work face-to-face with local Summit County agencies and providers to coordinate case management. UUHP is willing to explore providing on-site case management at U Health Redstone Clinic or in conjunction with Sundance Behavioral Resources.
Located Outside Summit County
UUHP Care Management Services (Salt Lake County)
Community Support Services
Located in Summit County
NOTE: UUHP would like to collaborate with Summit County on these services.
Located Outside Summit County
Consultation & Education Services
Located in Summit County
NOTE: UNI is willing to provide these services in Summit County in conjunction with the County's needs and recommendations.
Located Outside Summit County
Services to Incarcerated Persons
Located in Summit County
NOTE: UNI is willing explore providing these services in Summit County.
Located Outside Summit County
Virtual
UNI Telehealth
SUD
Located in Summit County
Park City Therapy
Red Willow Counseling and Recovery
Sundance Behavioral Resources (Willing to consider adding SUD services. Contingent upon space – requesting County space)
U Health Redstone Clinic (Willing to develop these services at Redstone Clinic)
Located Outside Summit County
UNI Recovery Clinic (Salt Lake County)
Peer Support Services
Located in Summit County
NOTE: UNI is willing to explore developing these services within Summit County.
Located Outside Summit County
Virtual
UNI WarmLine

ATTACHMENT B: Budget and Staffing

UUHP's proposal and its associated costs and staffing depends upon the scope of the work and available funding negotiated in collaboration with Summit County. Accordingly, UUHP is unable to provide a detailed budget. At minimum, UUHP expects that there will be involvement from at least two staff members during implementation which is reflected in the included spreadsheet. UUHP expects that additional members of its 300 member workforce will also assist in contract activities, but has not included those costs pending negotiation with Summit County.

Additionally, because UUHP intends to use a contracted provider network salary costs are unavailable.

Committee Total LCP RFP Scoring Sheet



SCORE: 57.52

Answer Scoring Criteria	
0	Response is unclear or has been skipped
1	Unable to provide the service required and failed to provide an explanation
2	Unable to provide the service required but provided an explanation
3	Meets basic requirement
4	Meets requirement with additional services provided to enhance delivery
5	Ability to meet services exceeds RFP expectations. <i>(Example would be the ability to provide 13 clinicians between Coalville and Kamas. If you award a 5, please be ready to provide rational on why.)</i>

SCORE: 55.15

Answer Scoring Criteria	
0	Response is unclear or has been skipped
1	Unable to provide the service required and failed to provide an explanation
2	Unable to provide the service required but provided an explanation
3	Meets basic requirement
4	Meets requirement with additional services provided to enhance delivery
5	Ability to meet services exceeds RFP expectations. <i>(Example would be the ability to provide 13 clinicians between Coalville and Kamas. If you award a 5, please be ready to provide rational on why.)</i>

DO NOT ENTER SCORES IN THIS SECTION...SEE BELOW
Automatic Scoring Section

FORM	Category	AVERAGE SCORE
A	Demonstration of Capacity & Qualifications	3.25
A	Staffing Levels Meet Community Need	3.17
A	Financial Documentation Inline <i>(X2 Weight)</i>	3.00
A	Transition Plan Ensures Continuity of Care	2.50
B	Inpatient Care & Services	2.92
B	Residential Care & Services	2.50
B	Outpatient Care	2.88
B	Crisis Care	3.08
B	Psychoeducational Services & Psychosocial Rehabilitation	2.42
B	Medication Management	2.83
B	Case Management	2.56
B	Community Support Services	2.75
B	Consultation & Education Services (Including School Based Services)	2.97
B	Services to Incarcerated Persons	2.92
B	Other Services Requested	3.25
C	SUD Screenings	2.83
C	SUD Treatment	2.79
C	Drug Court and Incarcerated Services	2.92
C	Other Services Requested	3.00
E	Indicated Network Partners Adequate to Meet Service Needs	3.00

DO NOT ENTER SCORES IN THIS SECTION...SEE BELOW
Automatic Scoring Section

FORM	Category	AVERAGE SCORE
A	Demonstration of Capacity & Qualifications	3.42
A	Staffing Levels Meet Community Need	3.17
A	Financial Documentation Inline <i>(X2 Weight)</i>	3.17
A	Transition Plan Ensures Continuity of Care	3.17
B	Inpatient Care & Services	3.25
B	Residential Care & Services	2.08
B	Outpatient Care	3.25
B	Crisis Care	3.25
B	Psychoeducational Services & Psychosocial Rehabilitation	2.25
B	Medication Management	2.58
B	Case Management	2.56
B	Community Support Services	2.17
B	Consultation & Education Services (Including School Based Services)	2.47
B	Services to Incarcerated Persons	2.00
B	Other Services Requested	2.92
C	SUD Screenings	2.83
C	SUD Treatment	2.54
C	Drug Court and Incarcerated Services	2.33
C	Other Services Requested	2.75
E	Indicated Network Partners Adequate to Meet Service Needs	3.00

Summit County Request for Proposals



Substance Use Disorder Treatment & Mental Health Services for Medicaid, Uninsured, and Non-Medicaid Summit County Residents

RFP # SUCO20197552

ISSUED: January 18th, 2019

CLOSED: 11:59pm on March 6th, 2019

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- Attachment C:** Request for Business Confidentiality
- Attachment E:** List of Network Providers

Section 1 – About The RFP

I.) INTRODUCTION

The Summit County Council (the “**Council**” or “**County**”), in its capacity as the Local Substance Abuse Authority and Local Mental Health Authority through statutory mandate of Utah Code Ann. (“**UCA**”) §§17-43-201 & 301 *et. seq.* (together, the “**Local Authority**”), is entering into a Request For Proposal process (the “**RFP**”), to solicit proposals from experienced and licensed entities in order that the Summit County Health Department (the “**Department**”), serving as the delegated Local Authority Agent of the County, may contract with a community focused behavioral health service which is an accessible, efficient, client centered, and integrated system of care for uninsured (Medicaid) individuals residing in Summit County. Serving as the Local Contracted Provider (the “**LCP**”), the selected “**Bidder**” will be responsible for attending to the multiple needs of individuals and families experiencing problems associated with mental health and substance abuse conditions. Included in this RFP are services mandated in UCA §§17-43-201 & 301 *et. seq.* for substance use disorder treatment (including services to individuals incarcerated in the Summit County Jail) (SUD) and mental health services for uninsured individuals and services not otherwise covered by Medicaid or through commercial insurance.

In this RFP, the term “**Behavioral Health Services**” refers to both SUD services and mental health services. In its capacity as the Local Authority, the County, through the Department, provides advocacy and coordination of behavioral health services in association with other public, non-profit, governmental, and private programs in Summit County by mandate UCA §§17-43-201 & 301 *et. seq.*. The Department is responsible for the planning and delivery of Behavioral Health Services for the residents of Summit County. The competitive selection process is the preferred method of source selection in public purchasing, and is conducted in accordance with Summit County Code, §1-16-7.

All inquiries or questions relating to this RFP must be addressed to Clay Coleman in the Summit County Procurement Office. All communications regarding this RFP will be conducted through the query system in SciQuest, the state procurement system. Phone calls or in person visits are prohibited. **Do not contact the County, Department or other County officers or employees.**

NOTE: Prevention services are not part of this RFP.

II) TERMS OF AGREEMENT

Contracts awarded subsequent to this RFP will be for a three-year period beginning September 1st, 2019 through August 30th, 2022; contracts may be renewed for an additional one-year period or extended to a renewable three-year contract. Decisions for contract renewal will be based on available funding, demonstrated adherence to guidelines stated within this RFP, the services outlined in the Summit County Area Plan, ability to meet established metrics, support of the Summit County Mental Wellness Strategic Plan, and compliance with best practices regarding engagement as outlined in the State Division of Substance Abuse and Mental Health (the “**DSAMH**”), Preferred Practice Guidelines. The Department will review the LCP’s performance yearly. Ability to meet metrics and remain in compliance with DSMAH’s annual directives as determined by the annual DSAMH and County audits will serve as a primary determinacy.

III.) WRITTEN AGREEMENT

The selected Bidder must be willing to enter into a written service contract with the County. A binding agreement between the County and selected Bidder will be dependent upon the negotiation, preparation, and execution of a formal contract. If Bidder wishes to alter any of the conditions present in the RFP, Attachments or Addendums issued, that item must be specifically mentioned in the proposal with a reasonable alternative presented.

IV.) PROJECTED RFP SCHEDULE

The current LCP contract concludes on August 31st, 2019. Required proposals are due no later than 11:59pm on March 6th, 2019 (the “**Proposal Deadline**”). Proposals received after the Proposal Deadline will not be considered. Should new legislation be passed which would alter any of the services or programs requested in this RFP during the upcoming 2019 Utah Legislative Session, the Department, in its sole and absolute discretion, may extend the Proposal Deadline.

The Pre-Proposal Meeting on January 30th, 2019 will take place at the Summit County Health Department located at 650 Round Valley Dr., Park City, UT 84060. Potential Bidders may elect to attend the meeting via Zoom. **To do so, visit <https://zoom.us/j/4353331500> on any internet browser or call (669) 900-6833 to participate via phone. If you have the Zoom app or call-in, you will need to enter Meeting ID: 7435-333-1500. Please note that this meeting will be recorded.**

Key Deadlines:

i. RFP Released	January 18 th , 2019
ii. Pre-Proposal Meeting	January 30 th , 2019
iii. Final Day to Submit Questions	February 27 th , 2019
iv. RFPs Due at 11:59pm, MST	March, 6th, 2019
v. Finalists Announced	March, 22 nd , 2019
vi. Finalist Presentations to Council	April 3 rd , 2019
vii. Workgroup Recommendation to Council	April, 17 th , 2019
viii. Council Makes Final Decision	April, 24 th , 2019
ix. Contract Finalized	June 1 st , 2019
x. Selected LCP begins Operations	September 1 st , 2019

Reasonable accommodations for qualified individuals may be provided upon receipt of a request with 5 working days’ notice before the Pre-Proposal Meeting. Please contact the Summit County Procurement Office at (435) 336- 3994.

V.) SUMMIT COUNTY

Summit County is located in northeastern Utah, occupying 1,849 square miles of rugged and mountainous terrain, with the majority of the county occupied by the High Uinta Wilderness. Originally home to the indigenous Ute peoples and Northern Shoshone, Summit County maintains a legacy of stewardship and conservation for the land as evidenced by a history of ranching, farming, and silver mining. Built upon these traditions, Summit County has become a mecca for those seeking both summer and winter outdoor recreational opportunities such as skiing, mountain biking, snowmobiling, climbing, hiking, camping, and fly fishing. Divided by state highway 40, Summit County has two primary areas defined geographically and culturally. Known as the Snyderville Basin, inclusive of Park City, and Eastern Summit County, each area has distinct cultural identities and specific mental health and substance abuse needs.

Coalville, the county seat, resides in Eastern Summit County. Coalville, along with Henefer, Oakley, Kamas, and Francis, fall within a cultural agrarian distinction. Hosting a history of ranching, farming, dairy production and logging, Eastern Summit County was settled by pioneers in the late 1800's. As a result, many families still reside on the lands homesteaded by their pioneering ancestors. Miners, and immigrants who worked the mines and built the railroad, by contrast, settled Park City. Eastern Summit County has two school districts, North Summit School District (*Coalville, Henefer, Echo, Peoa, and Wanship*) and South Summit School District (*Oakley, Kamas, Francis, Woodland, and Promontory*).

Park City is the largest incorporated population center in Summit County at 8,299 fulltime residents.¹ Originally established as a mining town, it transitioned to a resort economy in 1963 and an Olympic venue in 2002. The Olympics helped popularize the area as a destination, and as a result, 70% of homes are vacation rentals and/or second homes, and the median home price is \$868,100. Adjacent to Park City is unincorporated Snyderville Basin (*Kimball Junction, Jeremy Ranch, Silver Summit, etc.*) with a population of 18,552.² Both areas fall within the boundaries of the Park City School District. While a formerly young community, Park City is transitioning into an older community with a median age of 40.3, 9.7 years older than the state median of 30.6.³ 94% of Summit County residents have a high school degree with 54% having completed a bachelor's degree or higher.⁴ Key economic indicators for Summit County include an educated and affluent population, exceptional school districts, a strong faith community in Eastern Summit County, a diversified tech industry, recreational opportunities, a growing tourism industry, and business-friendly policies. Key events include the Sundance Film Festival, world championships for aerials and bobsled, Kimball Arts Festival, Tour of Utah, High School World Cup-Lacrosse, Triple Crown World Series-Softball, and additional winter Olympic events. Over 180 nonprofits are based in Summit County, with the majority housed in Park City.

¹United States Census Bureau. "QuickFacts, Park City, Utah." www.census.gov.
<https://www.census.gov/quickfacts/fact/table/parkcitycityutah/PST045216#viewtop>

² United States Census Bureau. "QuickFacts, Snyderville Basing, Utah." www.census.gov.
https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml?src=bkmk

³ DataUSA. "Park City, Utah." [Datausa.io](http://datausa.io)
<https://datausa.io/profile/geo/utah/>

⁴ TownCharts. "Summit County Education Data." www.towncharts.com.
<http://www.towncharts.com/Utah/Education/Summit-County-UT-Education-data.html>

VI.) BEHAVIORAL HEALTH IN SUMMIT COUNTY



Behavioral Health in Summit County has experienced a consistent growth in utilization. Current numbers show a 53% increase in the number of unique clients seen by the current LCP from July 2016 to July 2018. As a result, there has been a corresponding increase in the time it takes to see a clinician. According to data collected in the annual Summit County Provider Survey, wait-times average 2 weeks for initial intake, and up to 90 days for treatment sessions. Individuals in need of medication management can experience wait-times of over 120 days (*The Annual Provider Survey is administered to all known behavioral health practitioners in Summit County*).

Current clinician-to-client ratio for full-time Summit County residents is approximately 1 to 790. During high seasons such as winter and summer, this number jumps to approximately 1 to 2,300 (*Numbers include LCP and all other behavioral health providers*).

The client and services counts set forth in *Figure 1* below have been submitted to the County by the current LCP.

July 2017-July 2018 Client County												
	Unique Clients					TOTAL	Services Provided					TOTAL
	Mental Health		SUD		Mental Health		SUD					
	Adult	Youth	Adult	Youth	Adult		Youth	Adult	Youth			
Inpatient Care	7	5	0	0	12	49	61	0	0	110		
Residential Care & Services	1	2	4	0	7	1	2	4	0	7		
Outpatient Care & Services	654	368	310	0	1332	4305	1936	8577	0	14818		
24 Hour Crisis Care	75	41	95	0	211	243	64	198	0	505		
Psychotropic Medication Management	215	48	0	0	263	819	128	0	0	947		
Psychoeducational Services & Psychosocial Rehabilitation	167	38	0	0	205			0	0	0		
Case Management	389	104	0	0	493	2001	153	0	0	2154		
Community Support Services: Housing	2	0	0	0	2	2	0	0	0	2		
Community Support Services: Respite	0	24	0	0	24	0	24	0	0	24		
Consultation & Education Services	Currently Not Provided					Currently Not Provided						
Services to Incarcerated Persons	0	0	242	0	242	1915	0	2155	0	4070		
Peer Support Services	223	15	20	0	258	223	15	20	0	258		
	1731	646	671	0	3049	9558	2383	10954	0	22895		

Figure 1

Currently, Summit County has a 27.89% Medicaid penetration rate which ranks 9th in the State and above the 18.75% State average.

VII.) SUMMIT COUNTY MENTAL WELLNESS STRATEGIC PLAN

The Summit County Mental Wellness Strategic Plan (“**Strategic Plan**”), serves as the guiding document for improving mental health and substance abuse in Summit County. The Summit County Mental Wellness Strategic Plan is a community-based effort and would not have been possible without the dedication of countless individuals and organizations in the Summit County community.

With the passing of two Treasure Mountain Junior High School students in 2016 to the synthetic opioid Pink (U-47700), three community initiatives arose as a direct result of the incidents. Ushered together by the Park City Community Foundation, the Park City School District, CONNECT Summit County, and the Department, a unified response to mental health & substance abuse was developed. Expanding to include additional stakeholders such as law enforcement, mental health practitioners, non-profits, religious leaders, local governments, students, parents, concerned citizens, school boards and superintendents representing all three districts, the Summit County Mental Wellness Alliance (the “**Alliance**”) was established.

Building off of the Department's 2016 "*Summit County Mental Health Assessment*" (the “**Assessment**”; found here: <https://www.summitcountyhealth.org/wp-content/uploads/2016/11/Report-of-Mental-Health-Survey.pdf>), the Alliance crafted the Strategic Plan with five strategic goals (the “**Goals**”) and corresponding workgroups to address community needs identified in the Assessment. It was recognized that responsibility for improving mental health and substance abuse programs and services required a shared approach by both public and private interests, as no single entity possesses the resources for sustainable solutions. Central to these Goals was the need for a plan focused on the overall state of behavioral health within Summit County. In order to truly be effective, a detailed implementation plan with clear timelines and objectives is needed, which align to the Goals (the “**Implementation Plan**”). It is vital for success that all stakeholders play a role in the creation and execution of the Implementation Plan.

Affirmed through legislative action by the Council and the Park City Council, the Strategic Plan represents the collaborative work of over 250 committee members committed to improving the well-being of Summit County residents as they work towards addressing issues of mental health and substance abuse within our community. It is expected that the LCP will be a critical partner in the continued execution of the Strategic Plan through the Implementation Plan. This will include participation in committees focused on the Strategic Plan and community-based events.

Goals of the Strategic Plan are:

Goal I: *Expand community **access** to mental health & substance abuse programs and services in Summit County.*

Goal II: *Increase **prevention and education** around mental health & substance abuse in Summit County.*

Goal III: *Ensure **success and sustainability** of mental health & substance abuse programs and services in Summit County.*

Goal IV: *Establish systems to support life during **recovery and reintegration** into the community.*

Goal V: *Ensure **equity** of mental health & substance abuse programs and services for Latino Community members.*

For more information, the Strategic Plan can be found here:

<https://summitcountyhealth.org/wp-content/uploads/2017/12/Strategic-Plan.pdf>

VIII.) STATEMENT OF SERVICES TO BE CONTRACTED

Through this RFP, Summit County will award approximately \$2.3 million for the first year, prorated to 10 months. The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. **Final numbers will be known by July, 2019.**

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

- All Financial Numbers are Based on Best Projections for FY20 -

In addition to this funding, the LCP may be asked to provide services funded from “special revenues” that the County or Department receives from a variety of sources such as grants, awards, and cultivated donations. The “special revenues” will be used by the Department to provide additional treatment services on a need basis without any further RFPs or competitive bidding beyond this RFP. **The County expects that if a client is enrolled in a commercial insurance plan the County will be the payer of last resort.**

The County will provide office space to the selected LCP in the Kamas (2 offices, group therapy space, and a private waiting area) and Coalville (1 office space and shared waiting area) Health Department offices with rent waived. Office space in the Park City area may be available at a rate below current market value. Complete terms to be set during contracting.

A) Preferred Practice Guidelines

- 1) Given the State’s commitment to evidence-based practices, the County mandates that the LCP adhere to the DSAMH Preferred Practice Guidelines (PPG). The Guidelines state that, “Family, group, social, and self- management skills development interventions are highly recommended treatment modalities.” (Utah Public Mental Health System Preferred Practice Guidelines can be found here: http://dsamh.utah.gov/pdf/mh_practice_guidelines/MH%20Preferred%20Practice%20Guidelines.pdf)
- 2) Services in this RFP are based on current research in the field which include the following sources: the National Institute of Drug Abuse’s *Principals of Drug Addiction Treatment a Research Based Guide*; *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, American Society of Addiction Medicine – Third Edition 2013; Utah State Division of Substance Abuse and Mental Health *Preferred Practice Treatment Guidelines* (link given above); Utah State Department of Licensing *Core and Categorical Rules for Treatment*; Utah Code Annotated (“UCA”), Title 58, Chapter 60, *Mental Health Professional Practice Act*; Utah Administrative Rule R156-60, *Mental Health Professional Practice Act Rule*, and public input.
- 3) Services in this RFP are focused on the utilization of a community-based system of care designed to supplement and decrease the need for more costly inpatient behavioral health services delivered in a hospital setting. Community behavioral health is focused on accessibility and responsiveness to the local community’s needs in a variety of community settings rather than aggregating and isolating patients and patient care in central hospitals.

B) Mandated and Directed Services

The Utah Legislature has mandated in UCA Title 17, Chapter 43, *Local Human Services Act*, that all Local Authorities provide directly or through an LCP local substance abuse services (UCA §17-43-201) and local mental health services (UCA §17-43-301) to adults, youth, and children within its boundaries. These services should be identified in responses to questions in FORM A and FORM B to this RFP. The selected LCP will be expected to meet all of the services as mandated by statute and/or DSAMH directives (the “**Mandated Services**”). These Mandated Services include:

1) UCA §17-43-201 (Substance Abuse Services)

- (a) For persons convicted of driving under the influence in violation of UCA §41-6a-502 or §41-6a-517, conduct the following as defined in UCA §41-6a-501:
 - (i) A screening;
 - (ii) An assessment;
 - (iii) An educational series; and
 - (iv) Substance abuse treatment.

2) UCA §17-43-301 (Mental Health Services)

- (i) Inpatient care and services;
- (ii) Residential care and services;
- (iii) Outpatient care and services;
- (iv) 24-hour crisis care and services (Pending MCOT & Crisis-Line Change);
- (v) Psychotropic medication management;
- (vi) Psychosocial rehabilitation, including vocational training and skills development;
- (vii) Case management;
- (viii) Community supports, including in-home services, housing, family support services, and respite services;
- (ix) Consultation and education services, including case consultation, collaboration with other County service agencies, public education, and public information; and
- (x) Services to persons incarcerated in the County jail or County correctional facility.

- 3) In addition to the Mandated Services, DSAMH, through authority granted in UCA §17-43-201 and §17-43-301, provides additional directives each year in which the County and LCP must abide. Those directives for FY19 (July 1st, 2018 – June 30th, 2019) are listed in Sections D-S below. (*Full directives can be found here:* https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19%20Divison%20Directives%20v.2.pdf)

C) Priority Needs

- 1) Of the Mandated Services listed above, the County has identified five critical needs for improving behavioral health in Summit County. The LCP will be expected to focus on improving the quality of care for these priority needs while ensuring all Mandated Services are provided for. The selected LCP will work with the Department to develop community relationships to supplement the delivery of these selected services. The five priorities are, in descending order:

- 1. Outpatient Care**
- 2. Case Management**
- 3. Psychotropic Medication Management**
- 4. Incarcerated Services (Including Drug Court)**
- 5. Crisis Care**

D) DSAMH FY19 Directives: Combined Mental Health & Substance Abuse Directives

- 1) LCP shall perform a strength-based assessment on each client, which complies with the Medicaid Provider Manual and current Administrative Rule as described in R523. (*Rule can be found here: <https://rules.utah.gov/publicat/code/r523/r523.htm>*)
- 2) The LCP's Clinical Records shall be maintained using the approved protocol as defined by the DSAMH checklist and the Office of Licensing chart monitoring tools.
- 3) The LCP shall participate with key community partners. (Alliance, CONNECT Summit County, Summit County Clubhouse, school districts, local practitioners, local governmental agencies, local non-profits, etc.) Participation will be evidenced through stakeholder feedback and applicable records (minutes, written communication, such as letters or email, etc.).
- 4) The LCP shall establish and/or expand Adult, Youth, and Family Peer Support Services within Summit County. Certified Peer Specialists and Family Resource Facilitators who are employed by the LCP are to be integrated meaningfully into all levels of agency process and service, effectively utilizing peer and family voice. The LCP shall seek ways to maximize effective on-going training for peers and peer supervisors specific to the unique make-up, resources and structure of each local area or demographic group. The LCP shall develop appropriate policies and procedures consistent with DSAMH standards to provide guidance and support for Certified Peer Support Specialists and Family Resource Facilitators.
- 5) The LCP shall promote integrated programs that address an individual's substance use disorder, mental health, intellectual/developmental disabilities, physical health, and criminal risk factors as described in UCA §62A-15-103(2)(vi). The LCP shall use a Holistic Approach to Wellness by:
 - (i) Identifying tobacco use in the assessment,
 - (ii) Providing services in a nicotine free environment,
 - (iii) Providing appropriate smoking cessation services and resources (*including medication*),
 - (iv) Implementing a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB, and
 - (v) Training staff in recognizing health issues often seen in the behavioral health population, and provide information and referrals as appropriate.

E) DSAMH FY19 Directives: Suicide Prevention, Intervention and Postvention

- 1) During FY20, the Department and LCP shall continue to implement, monitor and report on the County's prevention, intervention, and postvention efforts. (*QPR, Hope Elevated, etc.*)
- 2) LCP records must contain a safety/crisis plan when clinically indicated which can be quickly and easily accessed and updated as needed.
- 3) The LCP shall develop a plan for coordination of follow-up care based on best practices with inpatient and emergency department services for clients being treated for a suicide related event.
- 4) LCP shall ensure that all individuals within the care of the Summit County jail or a correctional institution (together, the "**County Jail**") will have the appropriate safety plan in place before being turned over to the County Jail.

F) DSAMH FY19 Directives: Drug Testing Program Requirements

- 1) All drug testing conducted by the LCP shall comply with the requirements outlined in Administrative Rule R523-15.
- 2) The LCP will be required to perform, either directly or through a subcontract, all Regular Urinalysis ("**UAs**"), related to the Summit County Drug Court (the "**Drug Court**").
- 3) All UA testing shall be completed within 72 hours. Unless extraordinary circumstances are at play, as determined by the Summit County Attorney, failure to meet this deadline may be considered grounds for termination of the LCP contract.

- 4) LCP shall ensure that all Drug Court related UA test results are transmitted to the appropriate Drug Court or Probation staff member.

G) DSAMH FY19 Directives: Justice Reinvestment Initiative

- 1) The LCP shall participate, with the Department, in all State and Local justice reform efforts.
- 2) The LCP shall adhere to Evidence-Based Practice in Community Treatment.
- 3) The LCP shall provide ongoing training to Drug Court staff on criminogenic risk, need, and responsivity.

H) DSAMH FY19 Directives: Juvenile Justice Reform

- 1) In accordance with the Juvenile Justice Amendments (2017-HB 239) changes to the Juvenile Justice System, the LCP will participate in all State and Local Juvenile Justice Reform efforts.

I) DSAMH FY19 Directives: Recovery Support Services

- 1) The LCP shall provide Recovery Support Services (“RSS”), which include culturally and linguistically appropriate services that assist individuals and families working toward recovery from behavioral health problems. The LCP shall incorporate a full range of social, legal, and other services that facilitate recovery, wellness, and linkage to and coordination among service providers, and other supports shown to improve quality of life for people in and seeking recovery, as well as for their families.
 - (a) RSS includes access to evidence-based practices such as:
 - (i) Supported Employment,
 - (ii) Education,
 - (iii) Housing,
 - (iv) Assertive Community Treatment,
 - (v) Illness Management, and
 - (vi) Peer-Operated Services.
 - (b) RSS may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment, but seek support services. If the LCP needs to supplement its RSS with community partners, it will do so in coordination with the Department.
- 2) All RSS services provided by the LCP shall be documented and reported in the Substance Abuse Mental Health Information System (“SAMHIS”), recovery support data specifications file as indicated in the data specifications and as approved and directed by DSAMH.

J) DSAMH FY19 Directives: Billing Requirements

- 1) Services rendered by the LCP shall be reimbursed based on the approved service rates listed in the most current RSS manual located on the DSAMH website at <https://dsamh.utah.gov/provider-information/patr-org-program-manual/>
- 2) Services that are provided outside of the approved list of services will not be reimbursable. Services that are submitted under “billing contracts” through SAMHIS will be billed automatically through the DSAMH KiSSFLOW system. All other invoices submitted for billing must be submitted monthly through the DSAMH KiSSFLOW system. Each RSS funding program must be submitted separately and in accordance to the appropriate funding program code.
- 3) Pass-through State and Federal funds run through the Department are to be invoiced on a date to be determined by the LCP to the Department.

K) DSAMH FY19 Directives: Mental Health Services Directives

- 1) The LCP shall use the “unfunded” State General Funds when no funding is available.

- 2) The LCP will utilize the Outcomes Questionnaire (“**OQ**”), or the Youth Outcomes Questionnaire (“**YOQ**”), and will share the results of the OQ/YOQ with the client and incorporate such into the clinical process, as evidenced in the chart (*excluding children age five and under*).
- 3) The LCP shall collaboratively work with other agencies and local non-profits to provide Supported Employment services that assist an eligible recipient in obtaining and retaining competitive, integrated, and meaningful permanent employment.
- 4) The LCP shall utilize Wraparound Facilitation (*as defined by the Utah Family Coalition and/or nationally accepted evidence based Wraparound Facilitation Definition*) and Multi-Agency Collaboration in the provision of services for Children, Youth and Families. The LCP shall participate in USH Adult and Children Continuity of Care meetings.
- 5) The LCP shall provide Adult Outplacement services which provide wrap-around supports and recovery enhancement to the patient. The LCP shall document such within the plan of care.
- 6) The LCP shall oversee all written requests for Children’s Outplacement Funds and shall ensure that such are submitted to DSAMH for each individual client.
- 7) The LCP shall provide Mental Health Early Intervention services (“**MHEI**”), for children and youth who may or may not have a Serious Emotional Disturbance (“**SED**”) designation, but are at risk to become so without early intervention services. Service provision is limited to Family Resource Facilitation, MCOTs, and School-Based Behavioral Health. Temporary Assistance for Needy Families (“**TANF**”) funds focused on School-Based Behavioral Health for counties with the highest rates of intergenerational poverty shall be allocated according to the previous schedule and tracked by the LCP and submitted to DSAMH.

L) DSAMH FY19 Directives: Substance Use Disorder Treatment Services Directives

- 1) The LCP, with the Department and Park City Hospital, shall provide Naloxone education, training and assistance to individuals with opioid use disorders (“**OD**”), and when possible to their families, friends, and significant others.
- 2) The LCP and Department shall ensure clients are allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program (“**OT**”), and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual’s OUD.
- 3) The LCP and Department shall ensure medications available by prescription or office-based implantation shall be permitted for treatment if it is appropriately authorized through prescription by a licensed prescriber or provider.
- 4) In all cases, the LCP shall allow medications to continue for as long as the prescriber or treatment provider determines that the medication is clinically beneficial.
- 5) The LCP and Department shall ensure that clients will not be compelled to taper or abstain from medications as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber’s recommendation or valid prescription.

M) DSAMH FY19 Directives: Drug Court Program

- 1) The LCP will serve as the primary therapist for the Summit County Drug Court Program (the “**Drug Court Program**”).
- 2) The LCP, along with support from the County, shall be certified by the Administrative Office of the Courts in accordance with Utah Judicial Council Rule 4-409, and retain certification throughout the contracted period. This rule is available online at: <http://www.utcourts.gov/resources/rules/ucja/ch04/4-409.htm>
- 3) The LCP shall serve Drug Court participants identified as High Risk/High Need by using a validated criminogenic risk tool.

- 4) The LCP shall oversee documentation of High Risk/ High Need and shall ensure that said documentation is placed/ maintained in each participant's clinical record.
- 5) The LCP shall submit annually to DSAMH all Drug Court Service Reports or any alternative data collection system adopted by DSAMH and as requested to the DSAMH Justice Program Manager.
- 6) The LCP shall disclose any and all participant fees related to Drug Court participation (*Treatment, case management, drug testing, court fees etc.*) to individuals prior to their admission.
- 7) The LCP and County shall have no prohibitions against Medication Assisted Treatment ("MAT"), or a requirement to be abstinent from medications used in addiction treatment in order to enter the Drug Court Program, or to progress or complete the Drug Court Program.
- 8) The LCP and County shall ensure each Drug Court Program team member, who interacts or has decision-making authority regarding the participants of the Drug Court Program attend a minimum of eight hours of continuing education per year. The continuing education shall have a focus on substance use disorders.
- 9) The LCP shall use Drug Court funds for treatment, case management, recovery support and drug testing expenses only.
- 10) The LCP's case managers shall ensure that Drug Court participants meet with the Department of Workforce Services and/or to determine eligibility for Medicaid, other public insurance or commercial insurance.
- 11) The LCP shall ensure that Drug Court participants receive assistance throughout their episode of care with Medicaid enrollment.
- 12) The LCP shall ensure that public funds are the payor of last resort for Drug Court participants.
- 13) The LCP acknowledges that Drug Court funding shall be determined in accordance with statute by the Director of the Department of Human Services, the Director of the Department of Corrections and the State Courts Administrator.
- 14) The LCP shall notify the Department of Corrections and the State Courts Administrator of any court changes including court closures, changes in judges, drug court staff, or court coordinators.

N) DSAMH FY19 Directives: Women's SAPTBG set aside

- 1) The LCP shall provide services to pregnant women, and women with dependent children in need of substance use disorder treatment through SAPTBG funds.
- 2) SAPTBG funds shall be used by the LCP used to provide treatment services at the I.0, II.1, II.5, III.1, III.3, and III.5 American Society of Addiction Medicine Levels of Care, as defined in the American Society of Addiction Medicine's Criteria 3rd Edition;
- 3) SAPTBG funds shall be used by the LCP to provide any of the following services:
 - (a) Gender-specific substance use disorder treatment and other therapeutic interventions for women that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting,
 - (b) Child-care while the women are receiving services,
 - (c) Therapeutic interventions for the children which may address their developmental needs, potential for substance use disorders, and issues of sexual and physical abuse and neglect,
 - (d) Sufficient case management to ensure the women and their children have access to the services listed above,
 - (e) Regular Urinalysis testing, and
 - (f) Ongoing assessment of the children who are in the mothers and children's programs that will include, but not be limited to: developmental adjustment; motor skills; cognitive skills; health, including immunization history; interaction with mother and other adults; language and general affect.

O) General Funds for children living with parents receiving residential substance use disorder treatment services

- 1) The LCP shall provide the following services to children living with parents receiving residential substance use disorder treatment services:
 - (a) Room and board.
 - (b) Therapeutic day care to address developmental needs, the potential for substance use disorders, and issues of sexual and physical abuse and neglect.
 - (c) Case Management and transportation for behavioral and physical health care services.
 - (d) Ongoing assessment that will include, but not be limited to:
 - (i) developmental adjustment,
 - (ii) motor skills,
 - (iii) cognitive skills,
 - (iv) health, including immunizations history,
 - (v) interaction with mother and other adults, and
 - (vi) language and general affect.

P) DSAMH FY19 Directives: Women's Funds

- 1) The LCP shall provide evidence-based treatment and/or recovery support services for women. Priority shall be given to women referred or involved with the Utah Division of Child and Family Services.

Q) DSAMH FY19 Directives: Opioid Treatment and Recovery Support Funds

- 1) The LCP shall provide evidence-based treatment and recovery supports services for individuals with OUD.
- 2) The LCP shall submit, with the Area Plan, a local needs assessment, detailed description of planned OUD services and a budget.
- 3) The LCP shall be able to provide OUD using MAT.
- 4) The LCP shall support innovative telehealth in rural and underserved areas to increase the capacity of communities to support OUD prevention and treatment.
- 5) The LCP shall implement or expand access to clinically appropriate evidence-based practices for OUD treatment, particularly, the use of MAT, i.e., the use of FDA-approved medications (*e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monopropduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine*) in combination with psychosocial interventions.
- 6) The LCP shall provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings.
- 7) The LCP shall enhance or support the provision of Peer Support and other RSS designed to improve treatment access and retention, and support long-term recovery to include relapse and suicide prevention efforts.

R) DSAMH FY19 Directives: Substance Use Disorder Prevention Services Directives

Affective September 1, 2019, the Department will incorporate these services into Local Authority operations and as such, are not a part of this RFP.

S) DSAMH FY19 Directives: School-Based Programs

- 1) The LCP shall provide School-Based Behavioral Health services within the North Summit School District, South Summit School District, Park City School District and the Weilenmann School of Discovery at a capacity to meet the current demand for service. The LCP will be free to contract with any private school located in Summit County on its own terms so long as no funds associated with this RFP are utilized.

- 2) The LCP shall provide school-based behavioral health programs and services for youth 18 years of age and younger who are currently enrolled in the public-school system. The goal of these coordinated services will be to prevent youth who may be at-risk for developing a mental illness from disrupting his or her school placement. The programs and services shall be focused on maintaining the youth/child in their regular school setting, providing services in the school (described below), and collaborating with school staff. The LCP is expected to work with all three Summit County school districts and the Weilenmann School of Discovery to provide services in as many schools as possible.
- 3) As services are provided at school locations, many of the outcome measures will come from the district's or school's metrics (i.e.; attendance rates, office referrals, academic measures, on track for graduation, and teacher reports). The LCP shall be required to utilize the YOQ to demonstrate client progress with the goal of decreasing symptomology that in turn will support the student having increased access to academics.
- 4) The LCP shall work to penetrate into the community and reach families who do not have or have limited access to behavioral health services. Additional services can be leveraged through the LCP's system of care which could include:
 - (i) off/on-site medication management,
 - (ii) psychological assessment, and/or
 - (iii) access to a continuum of behavioral health services including,
 1. in- home services,
 2. partial day-treatment,
 3. day-treatment, and/or
 4. respite services.

T) County Specific Services

- 1) The LCP shall provide a minimum of 1 clinician (Ph.D. or Psy.D) to provide school-based psychoeducational consultation, and education services, including assessments of school aged youth.
- 2) The LCP shall provide mental health and substance abuse services in Spanish through a minimum of two clinicians with a preference of four.
- 3) The LCP shall have a minimum of two days a week in which office hours conclude at 8:00pm. Starting times for these days will be at the discretion of the LCP.
- 4) The LCP shall provide access to a psychiatrist or psychiatric APRN to consult on treatment, medications, and diagnosis within the County Jail.
- 5) LCP shall have a commitment to the Strategic Plan and its success. This will be demonstrated by participation and membership on the following Strategic Plan committees (*Committee Descriptions can be found beginning on page 18 of the Strategic Plan*):
 - (a) Local Director
 - (i) Mental Wellness Executive Committee
 - (b) Staff
 - (i) Alliance Steering Committee
 - (ii) Alliance Access & Capacity Committee
 - (iii) Communities That Care Committee
 - (iv) Latino Mental Health Committee
- 6) The LCP shall provide, as part of its crisis care, in partnership with the Department, a plan to participate in the Summit County Stabilization Team. This team is used to supplement the services of the state MCOT program.

Section 2 – Application & Administrative Requirements

I) AVAILABILITY OF FUNDING

Through this RFP, the County will award approximately \$2.3 million for the first year, prorated to 10 months for the first year, and 12 months after. The County will provide the LCP funding through an agreed capitation dispersal contract. Fee for service may be considered with justification. Please note that this amount is an estimate. True amounts will not be known until July, 2019. Any positive or negative change in the funding from state or federal sources will be addressed in partnership with the LCP and the Department.

II) LCP MINIMUM QUALIFICATIONS

Proposals will not be considered unless the LCP meets the following criteria on or before the proposal due date and continues to meet the criteria through the selection and funding process. LCPs shall continue to meet application criteria after services begin or be subject to sanctions, such as contract suspension or cancellation. To be eligible to participate in this RFP, potential LCPs (“**Bidders**”) must successfully demonstrate in their proposal how they meet the following minimum qualifications:

- 1) Have at least ten years of experience providing substance abuse services.
- 2) Have at least ten years of experience providing mental health services.
- 3) Have at least five years of experience providing case management to children, youth, adults and families.
- 4) Be established as a legal community behavioral health agency, 501c3 non-profit, or managed care organization under state or federal statutes and regulations.
- 5) Be licensed by the State of Utah, Department of Human Services, and Office of Licensing to provide the requested services.
- 6) Be registered to do business in Summit County or be able to show intent to do so if selected as the LCP.
- 7) Be eligible per federal regulations to handle Medicaid funds. (*Non-Profit or governmental agency*)

III) SUBMISSION OF PROPOSALS

B) SciQuest Procurement System

- 1) All responses to this RFP must be submitted through the state procurement system SciQuest. Only bids received via SciQuest will be considered.
(<https://solutions.sciquest.com/apps/Router/SupplierLogin?CustOrg=StateOfUtah>) All inquiries or questions relating to this RFP must be addressed to Clay Coleman in the Summit County Procurement Office. All communications regarding this RFP will be conducted through the query system in SciQuest. Phone calls or in person visits are prohibited. **Do not directly contact the County, Department or other County officers or employees.**

C) Formatting

- 1) All submissions will be in a single PDF document.
- 2) Text must be legible. Pages must be typed in black, single-spaced, using a font of Arial (Body CS) 10, with all margins (left, right, top, bottom) at least one inch each. You may use Arial 8 only for charts or tables.
- 3) You must submit your application and all attached documents in Adobe PDF format or your application will not be reviewed.
- 4) To ensure equity among applications, page limits cannot be exceeded.
- 5) Any files uploaded or attached to SciQuest must be PDF file format and must contain a valid file format extension in the filename. In addition, the use of compressed file formats such as ZIP, RAR or Adobe Portfolio will not be accepted.

D) RFP Submission Packet

- 1) Applications must include all required application components. These components must be submitted in the order detailed below.

Component	Instruction	Page Maximum
Cover Letter	<ul style="list-style-type: none"> Must be on official letterhead. Conveys intent to provide services as outlined in this RFP if selected. Confirms ability to meet minimum qualifications. 	1 Page
Attachment A: Agency Confirmation Sheet	<ul style="list-style-type: none"> Complete Attachment A and attach to PDF packet. 	1 Page
Executive Summary	<ul style="list-style-type: none"> Must follow formatting requirements as stated above 	3 Pages
FORM A: Governance & Oversight Narrative	<ul style="list-style-type: none"> Complete FORM A and attach to PDF packet. 	40 Pages
Attachment B: Staffing / Budget	<ul style="list-style-type: none"> Complete Attachment B and attach to PDF packet. 	3 Pages
FORM B: Mental Health Narrative	<ul style="list-style-type: none"> Complete FORM B and attach to PDF packet. 	40 Pages
FORM C: Substance Use Disorder Treatment Narrative	<ul style="list-style-type: none"> Complete FORM C and attach to PDF packet. 	40 Pages
Attachment C: Request for Business Confidentiality	<ul style="list-style-type: none"> Optional, not required in RFP submission if not requesting. Complete Attachment C and attach to PDF packet. 	1 Page
Attachment D: Proposed Org Chart	<ul style="list-style-type: none"> Must be on official letterhead. 	2 Pages
Attachment E: List of Network Providers	<ul style="list-style-type: none"> Complete Attachment E and attach to PDF packet. 	5 Pages
Attachment F: Copy of FY18 Annual Report	<ul style="list-style-type: none"> Provide a copy of the LCP's Annual Report. 	NA
Attachment G: Copy of FY18 DSAMH	<ul style="list-style-type: none"> Required if a current LCP. If more than 1 audit is conducted, such as serving as the LCP for two or more 	NA

Audit (Area Plan Audit)	<p>areas, copies of each LCP audit is required.</p> <ul style="list-style-type: none"> For organizations currently not serving as an LCP, indicate so on official letterhead in replacement. 	
Attachment H: Audited Financial Statement	<ul style="list-style-type: none"> Provide a copy of the LCP's most recent Audited Financial Statement. 	NA

2) Cover Letter

- (a) The proposal will have a cover letter indicating the Bidder's willingness to enter into an agreement with the County and agree to conform with all County assurances. An officer of the company who has the authority to commit to the Bidder's proposal must sign this letter. The proposal will include the full name, legal status (corporation, state of incorporation, partnership, proprietorship, etc.), business address of the Bidder and telephone number.
- (b) The cover letter will be signed, in ink, by a principal of the Bidder who is authorized to execute the service contract. The name of the principal and his/her business title will be included in the signature element in either type or print.

3) Agency Confirmation Sheet

- (a) The Bidder will complete the Agency Confirmation Sheet and submit as part of the bid.

4) Executive Summary

- (a) Provide a brief summary of the RPF submission.
- (b) The Executive Summary will not exceed 3 pages.

5) FORM A: Governance & Oversight Narrative

- (a) Complete question as instructed on the first page of the form.
- (b) If you are unable to answer a question, or the question does not apply to you, respond by indicating such.

6) Attachment A: Staffing and Budget Worksheet

- (a) The Bidder will complete the Staffing & Budget Worksheet and submit as part of the bid.

7) FORM B: Mental Health Narrative

- (a) Complete question as instructed on the first page of the form.
- (b) If you are unable to answer a question, or the question does not apply to you, respond by indicating such.

8) FORM C: Substance Use Disorder Treatment Narrative

- (a) Complete question as instructed on the first page of the form.
- (b) If you are unable to answer a question, or the question does not apply to you, respond by indicating such.

9) Attachment C: Request for Business Confidentiality (Optional)

- (a) Form not required.
- (b) Bidders wishing to claim exemption under Utah's Government Records Access and Management Act, Utah Code Ann. §§ 63G-2-101 to 901 must complete the Request for Business Confidentiality form and submit as part of the bid.

10) Attachment D: Proposed Organizational Chart

- (a) The Bidder will provide a copy of their organizational chart showing the reporting structure of the organization along with the reporting structure for proposed operations in Summit County.

11) Attachment E: List of Network Providers

- (a) Bidders operating as a Managed Care Organization, Accountable Care Organization, or plan on contracting with additional agencies in order to meet the mandates services outlined in this RFP are required to complete Attachment E.
- (b) If no formal agreement currently exists, a letter of intent to partner will need to be attached.

12) Attachment F: Copy of FY18 Annual Report

- (a) Bidder will provide a copy of its latest Annual Report.
- (b) If the report is available online, the Bidder may submit, on official letterhead, instructions on accessing the report. It is up to the Bidder to ensure that the instructions are accurate and that the report will be accessible to all RFP reviewers.

13) Attachment G: Copy of FY18 DSAMH Audit

- (a) Required if a current LCP.
- (b) For organizations currently not serving as an LCP, indicate so on official letterhead.
- (c) If more than 1 audit is conducted, such as serving as the LCP for two or more areas, copies of each LCP audit is required.

14) Attachment H: Copy of FY18 Annual Report

- (a) Bidder will attach a copy of its latest Annual Report Audited Financial Statement.

IV) GENERAL PROVISIONS FOR THE RFP

E) Costs

- 1) All costs associated with the preparation of the proposal will be borne by the Bidder. All proposals become the property of the County. The County will not be responsible for said costs in any event, including, but not limited to, termination of the project in whole or in part, or rejection of the proposal as non-responsive.
- 2) Bidders bear all costs and expenses related to this RFP including, but not limited to, preparation and delivery of the proposal, attending the pre-proposal meeting(s), and attending the interview.

F) Firm Pricing, Quotes, and Proposals

- 1) All prices, quotes, or proposals are to remain firm for one hundred and eighty (180) days after the closing date. Any proposal, which does not offer to remain firm for the period, may be considered to be non-responsive.

G) Receiving Proposals

- 1) Summit County Procurement will administer the receipt and opening of all proposals. After the closing date, only the identity of each Bidder will be made public. If only one proposal is received in response to County request, Summit County Procurement, in coordination with the Department, may recommend an award of a contract to the single Bidder, if the conditions cited above are met. Alternatively, Summit County Procurement may re-solicit for the purpose of obtaining additional proposals.

H) Modifying or Withdrawing Proposals

- 1) Bidders may modify or withdraw their proposals at any time prior to the closing date through the SciQuest portal. Requests to modify a proposal before the closing date shall be made in writing to Summit County Procurement.

I) Rejection of Proposals

- 1) Any proposal containing significant deviations from the specifications of this RFP shall be considered non-responsive and may be rejected in whole or in part.

J) RFP Cancellation

- 1) This RFP may be cancelled at any time prior to the execution of a written service contract if deemed in the best interests of the County. This includes cancellation of the RFP after an award has been made, but prior to the execution of a written service contract. A Bidder is not entitled to recover any costs related to the preparation of the proposal due to cancellation of the RFP or withdrawal of an award prior to the execution of a written service contract.

K) Request for Protected Information

- 1) All documents submitted in response to this RFP will be treated as public records in accordance with GRAMA unless a claim of business confidentiality is submitted per the Request for a Protected Status. If claiming confidentiality, the Bidder shall state its reasons using Attachment C. All such requests will be reviewed by the Summit County Attorney's Office.

L) Written Service Contract Required

- 1) The selected Bidder must agree to all requirements in the RFP scope of work unless an exemption is stated in the proposal. The selected Bidder must also be willing to enter into a written service contract with the County and agree to all the terms set forth in the attached Standard Form RFP Agreement. **IF YOU WISH TO ALTER THE RFP, FORMS, OR ATTACHMENTS, THE EXCEPTION MUST BE SPECIFICALLY IDENTIFIED WITH REASONABLE ALTERNATIVES PRESENTED. BIDDER UNDERSTANDS THAT DEVIATIONS FROM THE STANDARD FORM AGREEMENTS ARE MADE AT THE COUNTY'S DISCRETION.** Bidders are advised that County is not bound by the terms of the RFP until a written service contract is fully executed. Any activity taken by a Bidder prior to a written service contract being fully executed is done at the Bidder's sole risk. If requesting exceptions, submit the documentation in your Pricing Proposal.

V) QUESTION SUBMISSION

Questions must be submitted through SciQuest. The deadline for questions submission is February 27th, 2019 at **11:59 pm**. All questions with responses will be e-mailed on an ongoing basis to all potential Bidders that have expressed an interest in the RFP. Expressed interest is exhibited through registration in SciQuest. **Do not contact County officers or employees, or selection committee members.**

VI) ASSURANCES

All proposals must contain a written assurance that, should the County offer a service contract, the selected Bidder will agree to the following items:

A) Licensing

- 1) All applicable federal, state, and local licenses must be acquired before the contract is entered into. Licenses must be maintained throughout the contract period. Persons doing business as an Individual, Association, Partnership, Corporation or otherwise shall be registered with the Utah State Department of Corporations. NOTE: Forms and information

on registration may be obtained by calling (801) 530-4849 or toll free at (877) 526-3994, or by accessing www.commerce.utah.gov.

B) Reimbursement Provisions

- 1) The selected LCP will establish a reimbursement model with the County during contract negotiations. It is the County's preference to utilize a capitation system of payment.
- 2) The LCP will bill Medicaid whenever the client is Medicaid eligible or is eligible for other third-party insurance. Every effort should be made to identify Medicaid eligible clients and to assist clients who are not currently Medicaid eligible in becoming eligible.

C) Co-pay

- 1) All clients should be assessed this co-pay and programs are responsible to collect the co-pay. Co-pays which are deemed uncollectible are the responsibility of the LCP and the uncollected balance cannot be billed to the County. Alternative co-pay schedules may be permitted but must first be approved by the Department. Some State and Federal contracts may have stipulations which supersede this co-pay regulation. It should be noted that the co-pay schedule is subject to modification after review and discussion with the Department.

D) Billing Reporting

- 1) LCPs will be required to provide to the County and Department all service billing activity information for County funded and non-County funded clients served. Services will be billed and reported through the Utah Web-Based Information System for Treatment Services (UWITS) or other approved method and will be due at least monthly or on a timeframe specified by the Department. The current UWITS software allows for billing to Medicaid and other third-party insurance companies. LCPs will be responsible for keeping their billing data current.

E) UWITS Reporting

- 1) LCPs will be required to enter admission, discharge, demographic, treatment and outcome information for clients served into UWITS. Data elements for State, County and other external sources will be extracted out of the UWITS system every month on dates to be specified by the County, and therefore LCPs will be responsible for keeping their data accurate and updated. LCPs who wish to use their local information systems will be allowed to do so only after a successful test of an interface to the UWITS system. LCPs must be able to demonstrate a successful interface within six months of execution of the contract. Costs of producing and testing an interface to the UWITS system will be the responsibility of each individual LCP.

F) Indemnification

- 1) LCPs will indemnify, hold harmless and defend Summit County, its officers, agents and employees from and against any and all losses, damages, injuries, liabilities, and claims, including claims for personal injury, death, or other damage to personal property or profits and liens of workmen and material men (suppliers), however allegedly caused, resulting directly or indirectly from, or arising out of, negligent acts or omissions by LCP, its agents, representatives, officers, employees or subcontractors in the performance of the contract if awarded to LCP.

G) Insurance

- 1) If awarded the contract, LCP will, at their sole cost and expense, secure and maintain, during the term of the contract, including all renewal or additional terms, the following minimum insurance coverage:
 - (a) General Insurance Requirements for all Policies

- (i) Any insurance coverage required herein that is written on a “claims made” form rather than on an “occurrence” form and shall:
 - 1. provide full prior acts coverage or have a retroactive date effective before the date of the service contract,
 - 2. be maintained for a period of at least three (3) years following the end of the term of the service contract or contain a comparable “extended discovery” clause, and
 - 3. contain evidence of current extended discovery coverage and the purchase options available to the County upon policy termination.
- (ii) All policies of insurance shall be issued by insurance companies licensed to do business in the state of Utah and either:
 - 1. Currently rated A- or better by A.M. Best Company; and
 - 2. (1A) for construction contracts only, the insurer must also have an A.M. Best Company financial size category rating of not less than VII.

—OR—

- 3. Listed in the United States Treasury Department’s current Listing of Approved Sureties (Department Circular 570), as amended.
- (iii) The LCP shall furnish certificates of insurance, acceptable to the County, verifying compliance with the insurance requirements herein prior to the execution of this agreement. LCP shall also provide updated certificates of insurance on or before the anniversary date of any of the evidenced policies throughout the life of this agreement.
 - (iv) In the event any work is subcontracted, the LCP shall require its subcontractor, at no cost to the County, to secure and maintain all minimum insurance coverages required of the LCP hereunder.
 - (v) The LCP's insurance policies shall be primary and non-contributory to any other coverage available to the County. The workers' compensation, general liability and auto liability policies shall be endorsed with a waiver of subrogation in favor of the County.
 - (vi) In the event that governmental immunity limits are subsequently altered by legislation or judicial opinion, the LCP shall provide a new certificate of insurance within thirty (30) days after being notified thereof in writing by the County, certifying coverage in compliance with the modified limits or, if no new limits are specified, in an amount acceptable to the County.
 - (vii) All required policies shall provide that coverage thereunder shall not be canceled or modified without providing (30) days prior written notice to the County in a manner approved by the County Attorney.
 - (viii) In the event LCP fails to maintain and keep in force any insurance policies as required herein County shall have the right at its sole discretion to obtain such coverage and reduce payments to the LCP for the costs of said insurance.

(b) Required Insurance Policies

(i) The LCP, at its own cost, shall secure and maintain during the term of this Agreement, including all renewal terms, the following minimum insurance coverage:

- a. Workers' compensation with limits as required by the State of Utah, and employer's liability coverage in the amount of \$1,000,000 per loss. Proof of workers' compensation coverage is required unless a waiver of coverage is allowed and acquired pursuant to Utah law. This requirement includes a LCP who is doing business as an individual and/or as a sole proprietor as well as corporations and partnerships. In the event any work is subcontracted, the LCP shall require its subcontractor(s) similarly to provide workers' compensation insurance for all of the latter's employees, unless a waiver of coverage is allowed and acquired pursuant to Utah law.
- b. Commercial general liability insurance, on an occurrence form, with both Summit County and The State of Utah listed as additional insured, in the minimum amount of \$1,000,000 per occurrence with a \$2,000,000 general policy aggregate and \$2,000,000 products completed operations policy aggregate. The policy shall protect the County, the LCP, and any subcontractor from claims for damages for personal injury, including accidental death, and from claims for property damage that may arise from the LCP's operations under the service contract, whether performed by the LCP itself, any subcontractor, or anyone directly or indirectly employed or engaged by either of them. Such insurance shall provide coverage for premises operations, acts of independent LCPs, and completed operations. The policy shall be primary and not contributing to any other policy or coverage available to the County whether such coverage be primary, contributing or excess.
- c. Professional liability insurance with a minimum policy limit of \$1,000,000 per occurrence.
- d. Commercial automobile liability insurance that provides coverage for owned, hired, and non-owned automobiles, in the minimum amount of \$500,000 per person, \$1,000,000 per accident, \$250,000 per occurrence for property damage, or a single combined limit of \$2,000,000.

—OR IF THERE WILL NOT BE ANY VEHICLE OPERATIONS—

- e. The LCP shall not operate a vehicle in connection with any services rendered under this service contract. Inasmuch as the LCP agrees not to operate a vehicle in connection with services rendered under this service contract, the County shall not require the LCP to provide commercial automobile liability insurance.

H) Records Retention

- 1) All records must be retained by the LCP for a period of six (6) years or until the client reaches the age of 22 (which ever period is longer) after the date of last reimbursement by the County.

I) Government Records Access and Management Act (GRAMA)

- 1) County is a governmental entity subject to the Utah Government Records Access and Management Act (“GRAMA”), Utah Code Ann. (“UCA”) §§ 63G-2-101 to -901. As a result, County is required to disclose certain information and materials to the public, upon request. Generally, any document submitted to County is considered a “public record” under GRAMA. Any person who provides to County a record that the person believes to be protected under UCA §63G-2-305(1) or (2) shall provide both:
 - (i) a written claim of business confidentiality; and
 - (ii) a concise statement of reasons supporting the claim of business confidentiality. Generally, GRAMA only protects against the disclosure of trade secrets or commercial information that could reasonably be expected to result in unfair competitive injury.
- 2) For your convenience, County has provided a Business Confidentiality Request Form which is attached to this RFP as an Attachment. All documents submitted in response to this RFP will be treated as public records in accordance with GRAMA, unless a claim of Business Confidentiality has been properly made and approved by the County Attorney’s Office. All proposed costs/pricing/fees submitted to the County shall be considered public record.

J) Compliance with Fiscal Audit Requirements

- 1) The LCP must fully comply with all Summit County fiscal requirements. The LCP must comply with the Single Audit Act of 1984, and the Office of Management and Budget (OMB) Circular A-133. Those LCPs who do not reach the threshold for a Single Audit (\$500,000 or more expended in federal funds) must have an annual financial audit performed in accordance with Generally Accepted Government Auditing Standards, if its total revenues (including Medicaid) received from Summit County are greater than or equal to \$350,000. If its revenues are greater than or equal to \$200,000 but less than \$350,000, it is required that such LCP have an annual CPA review performed. If its revenues are greater than or equal to \$100,000 but less than \$200,000, such LCP is required to have an annual unaudited CPA compilation performed. If its revenues are less than \$100,000, a basic annual financial report with balance sheet and income/expense statement shall be prepared. LCPs receiving less than \$25,000 from Summit County have no annual financial reporting requirement.
- 2) All required reports must be submitted to the Department within 90 days after the end of the LCP’s fiscal year.

K) Compliance with Monitoring Activities

- 1) The LCP must fully participate with the County’s fiscal, administrative and program monitoring, including quality assurance and utilization review visits. LCPs will implement findings as a result of these monitoring activities.

L) Meetings

- 1) LCP’s leadership shall meet quarterly with the Summit County Mental Wellness Executive Committee. This committee is comprised of members of the Summit County Council, Park City Council, Department of Health, Summit County Attorney’s Office, CONNECT Summit County, and the Park City Community Foundation.
 - (i) The LCP will actively participate in the committees and workgroups related to the implementation of the Summit County Mental Wellness Strategic Plan.

M) Future Direction

- 1) The LCP shall assure that it will participate with the County on the development of new initiatives, programs, services and amendments to the Strategic Plan.

N) Compliance with Federal and State Requirements

- 1) The LCP shall meet government mandates including, but not limited to, those of Americans qualifying with Disabilities Act (ADA), Equal Employment Opportunity (EEO), Government Records Access Management Act (GRAMA), Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 (confidentiality).

O) Changes or Modifications

- 1) Any changes or modification made by the County to the RFP will be made by written addendum. Potential LCP's submitting a proposal based on any information other than that contained in County's RFP and any addenda do so at their own risk.

P) Financial Solvency

- 1) The LCP shall establish and maintain an operating fund to cover the cost of all services provided. The amount of the operating fund must be at least equal to the LCP's expected average expenses for all services for a 60- day period or the minimum established by the LCP's Board, whichever is greater.

Q) Independent Contractor

- 1) LCP agrees that if it enters into a service contract with the County, it will be treated as an independent contractor and have no authority, express or implied, to bind the County to any agreements, settlements, liability, or understanding whatsoever with any third party which is outside the scope of the service contract in connection with the services or goods sought to be obtained.

R) Free and Competitive Selection

- 1) Any agreement or collusion among prospective or potential LCPs to fix a price or limit competition shall render the proposal void. Such conduct is unlawful and subject to criminal sanction. Each LCP shall certify that no one in its firm or company has either directly or indirectly restrained free and competitive selection, participated in any collusion of the bidding process, or otherwise taken any action unauthorized by the County's policies and applicable law.

S) Laws of the State of Utah

- 1) All service contracts pursuant to acceptance of the LCP's proposal will be interpreted, construed, and given effect according to the laws of the State of Utah and the Summit County Code. No service contract will be assigned, in whole or in part, without the express written consent of the Summit County Council in its capacity as the Local Substance Abuse Authority and Local Mental Health Authority through statutory mandate of UCA §§17-43-201 & 301.

T) Termination

- 1) The County may terminate the service contract at any time it deems such termination to be in the public interest or for public convenience or necessity by giving written notice to the LCP at least ninety (90) calendar days prior to the desired termination date.

U) Utah Department of Human Services

- 1) The LCP understands and agrees that it will be obligated to the terms and conditions imposed on the County by the Utah Department of Human Services and/or DSAMH. The LCP agrees that the service contract between the County and the Utah Department of Human Services will be incorporated into the resulting service contract derived from this RFP. A complete copy of the contract between the County and the Utah Department of Human Services is available upon request.

V) Ethical Standards

- 1) LCP represents that it has not:
 - (a) provided an illegal gift to any County officer or employee, or former County officer or employee, or to any relative or business entity of a County officer or employee, or relative or business entity of a former County officer or employee;
 - (b) retained any person to solicit or secure this service contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, other than bona fide employees of bona fide commercial agencies established for the purpose of securing business;
 - (c) breached any of the ethical standards set forth in Utah code; or
 - (d) knowingly influenced, and hereby promises that it will not knowingly influence, any County officer or employee or former County officer or employee to breach any of the ethical standards set forth in Utah code or Summit County ordinance.

W) Infringement

- 1) The LCP shall not infringe on patents, copyrights, trademarks, or intellectual property rights. The consequences from violation, including costs of defending a claim and indemnification from an action of claim by a third party, shall be borne solely by the LCP.

X) Protests

- 1) Protests in regard to the RFP shall be submitted in writing prior to the RFP closing date. All other protests shall be submitted in writing within seven (7) calendar days after notification of the award is posted on Bid Sync. A protestor may file only one protest after the RFP closing date. Protest letters shall specifically and completely state the facts that the protestor believes constitute error in the RFP document or the award.

Y) Emergency Management/Business Continuity Plan

- 1) As mandated by the Substance Abuse and Mental Health Services Administration and prescribed by DSAMH, an emergency management and business continuity plan will be maintained for the length of the service contract by the LCP. The plan will address the critical functions or processes of the LCP's business operations essential for providing the required services.

Z) Employee Status Verification System

- 1) LCP shall register and participate in the Status Verification System before entering into a service contract with the County, as required by UCA § 63G-12-302. The Status Verification System is an electronic system operated by the federal government, through which an authorized official of a state agency or a political sub-department of the state may inquire by exercise of authority delegated pursuant to 8 U.S.C. § 1373 to verify the citizenship or immigration status of an individual within the jurisdiction of the agency or political sub-department.
- 2) LCP is individually responsible for verifying the employment status of only new employees who work under LCP's supervision or direction and not those who work for another LCP or subcontractor, except each LCP or subcontractor who works under or for another LCP shall certify to the main LCP by affidavit that the LCP or subcontractor has verified, through the Status Verification System, the employment status of each new employee of the respective LCP or subcontractor. The LCP shall comply in all respects with the provisions of UCA § 63G-12-302. LCP's failure to so comply may result in the immediate termination of its service contract with the County.

VII) POINT OF CONTACT

All inquiries or questions relating to this RFP must be addressed to Clay Coleman in the Summit County Procurement Office. All communications regarding this bid will be conducted through the query system in SciQuest. Phone calls or in person visits are prohibited. **Do not contact the agency, Department, other County officers or employees.**

VIII) SELECTION PROCESS

A) Screening

- 1) Proposals are screened for eligibility and completeness using the minimum requirements stated in the RFP. These preliminary requirements will be strictly enforced. Proposals that do not meet minimum requirements outlined in the RFP will not be considered.

B) Review by RFP Selection Committee

- 1) The RFP Selection Committee shall review each program proposal to ensure that the behavioral health service continuum in Summit County is adequately sustained through the provision of quality services by the Bidder using state-of-the-art, evidence-based strategies in a cost-effective and clinically effective manner.
- 2) The RFP Selection Committee is a volunteer group with membership representing several key service areas of this RFP. The RFP Selection Committee will be managed by the Department and Summit County Procurement.

C) Scoring Criteria

- 1) Each proposal will receive a Program Proposal score and a Cost Proposal score. The Program Proposal score will comprise 80% of the total proposal score as rated in FORM A, FORM B, and FORM C. The Cost Proposal score will comprise 20%.

D) Program Proposal Review

- 1) The RFP Selection Committee will evaluate the Program Proposal of each Bidder and assign an appropriate score to each using the criteria, in **FORM A, FORM B, and FORM C.**
- 2) Each Program Proposal will be reviewed separately by the RFP Selection Committee. The RFP Selection Committee shall conduct interviews with the Bidders to discuss concerns and address questions pertaining to the Program Proposal. Upon completion of the interview process the RFP Selection Committee will provide the final score for the Program Proposal to Summit County Procurement.
- 3) Scores will be assigned using a scale of 0 to 80.

E) Cost Proposal

- 1) Summit County Procurement will review the Cost Proposal. Scores will be assigned using a scale of 0 to 20.

F) Presentations

- 1) The two Bidders with the highest combined scores will be invited by Summit County Procurement to make formal presentations to the County Council. The RFP Selection Commission shall also be in attendance. Formal presentations will be conducted in an open work session of the County Council in April.
- 2) Upon announcement of the two finalists, a series of questions will be sent to each Bidder to answer during their presentation, along with the format and items to cover.

G) Finale Decision

- 1) Serving in its capacity as the Local Substance Abuse Authority and Local Mental Health

Authority through statutory mandate of UCA §17-43-201 & 301 et. seq., the County Council, with recommendation from the RFP Selection Committee, will make the final decision to award the county service contract to the responsible Bidder whose proposal is determined to be the most advantageous to the County, taking into consideration price and the evaluation factors set forth in this RFP (the “**Award**”). The Council may hold a public hearing before making an Award. The Council, RFP Selection Committee, staff of the Department, Summit County Attorney’s Office, and Summit County Procurement reserve the right to discuss proposals with those submitting them, for purposes of clarification. Once an Award has been made, the winning Bidder shall have sixty (60) calendar days to enter into a binding service contract with the County (the “**Negotiation Period**”).

- 2) The County reserves the right to reject any or all proposals or waive minor irregularities when to do so would be in the best interest of Summit County. Minor irregularities are those which will not have a significant adverse effect on overall competition, cost or performance.
- 3) Where the County waives minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the successful Bidder from full compliance with the RFP specifications and other contract requirements if the Bidder is awarded a service contract.
- 4) The County reserves the right to not make an Award and to instead solicit additional proposals at a later time.
- 5) The County reserves the right to make more than one Award and to enter into more than one service contract from this RFP.
- 6) The County reserves the right to make an alternative Award to another Bidder should the Negotiation Period end without consummating a binding service contract. The County may, in its sole discretion, waive the Negotiation Period.
- 7) Debrief meetings with RFP Selection Committee members is prohibited. However, a Bidder may discuss the RFP process with the chair/facilitator of the RFP Selection Committee at any time. A Bidder may request any public documents from the process, including the winning proposal and the RFP Selection Committee score sheets after an award has been made.

Section 3 – Forms & Attachments

- I. **Attachment A:** *Agency Confirmation* 30
- II. **FORM A:** *Governance & Oversight Narrative* 31
- III. **Attachment B:** *Staffing / Budget* 36
- IV. **FORM B:** *Mental Health Narrative* 37
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- VI. **Attachment C:** *Request for Business Confidentiality* 71
- VII. **Attachment D:** *Organization Chart* 72
- VIII. **Attachment E:** *List of Network Providers* 73

Attachment A
Agency Confirmation
Mental Health & SUD Contract 2019

Legal Name of Agency:			
Doing Business As (if applicable):			
Address:	City	State	Zip Code
RFP Contact Person		Telephone Number	
E-Mail:			

I certify that to the best of my knowledge the information contained in this proposal is accurate and complete and that I have the legal authority to commit this organization to a contractual agreement. I realize the final funding for any service is based upon funding levels and the approval of the Summit County Council.

Agency's Authorized Representative	Date
	Title or Position with Agency
Signature of Authorized Representative	

Additional Individual to keep informed of the RFP Status.	
RFP Contact Person	Telephone Number
E-Mail:	

RFP # SUCO20197552

FORM A - GOVERNANCE & OVERSIGHT NARRATIVE

Submitting Agency (LCP): _____

Instructions:

The following form is modeled off of the annual Area Plan the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County and the RFP process. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form A is limited to a maximum of 40 pages.** Refer to Section VII of the RFP to ensure all required services and metrics are provided in your provided responses. FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here:

https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for the fiscal year. Funding contracts are for July 1st to June 30th.

1) LCP Qualifications

Is the LCP a licensed non-profit or governmental agency (Special Service District) eligible to receive Medicaid funding?
Does the LCP have at least ten years of experience providing mental health services?
Does the LCP have at least ten years of experience providing substance abuse services?
Does the LCP have at least five years of experience providing case management to children, youth, adults and families
LCP will provide evidence of being licensed in the State of Utah, Department of Human Services and Office of Licensing to provide the requested services.
Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

2) Experience and Capability

Provide your mission statement and describe how it supports the community behavioral health model of service.

Describe, in detail, your experience with providing the services outlined in this RFP.

If you currently serve as an LCP in a Mental Health or Subsistence Abuse District contiguous to Summit County, this lend to improving services in Summit County?

Currently, the Department will provide space for clinicians in the Kamas (*2 offices and a private waiting area*) and Coalville (*1 office space and shared waiting area*) Health Department Offices. Space in Park City will be available, located at a central transit hub, the Summer for 2020. During the interim, temporary space has been secured for 12 months. Will you require this Park City space, or will you plan on finding your own Park City / Kimball Junction offices?

Describe LCP's experience and capability to deliver, track, and bill Medicaid services and manage operations.

Describe LCP's experience with Quality Management, including a plan capable of adhering to DSAMH documentation standard and requirements.

- Staffing, supervision, training, retention, and leadership,
- Systems of quality assurance as it relates to clinical chart documentation and compliance,
- Capacity and plan to perform quality improvement activities, data entry, data and outcome tracking and program evaluation

Describe LCP's experience with Quality Management, including staffing, supervision, training and leadership.

Describe LCP's experience with Quality Management, including systems of quality assurance as it relates to clinical chart documentation and compliance.

Describe LCP's experience with Quality Management, including capacity and plan to perform quality improvement activities, data entry, data and outcome tracking and program evaluation.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

3) Staffing and Administration

Describe, in detail, LCP's Organizational Structure, including:

1. Staffing capacity to perform all functions in this RFP,
2. Mental Health Treatment Staffing Plan showing proposed treatment FTEs by profession and where reporting structure, clinical supervisor to staff ratios, staff to client ratios, professional credentialing and staff specialization.
3. SUD Treatment Staffing Plan showing proposed treatment FTEs by profession and where reporting structure, clinical supervisor to staff ratios, staff to client ratios, professional credentialing and staff specialization.
4. QM Staffing Plan including staff for QI activities, data entry, data and outcomes tracking, and program evaluation functions.
5. Staff Supervision Model that includes a description of the role of the clinical supervisor(s) in staff coaching, client care, and QI and service utilization activities.
6. Treatment Services Staff Training Schedule and Technical Assistance Plan

Describe, in detail, LCP's communication plan and ability to inform and communicate with the public and beneficiaries regarding services.

Describe, in detail, LCP's plan and ability to recruit and retain quality staff members, including those able to provide competent, culturally aware, and linguistically accurate care in Spanish.

Describe, in detail, LCP's support programs located outside of the District

Describe, in detail, LCP's ability to ensure that all services outlined in this RFP are provided by staff with required credentials and licenses.

LCP meets the minimum General Insurance requirements of this RFP as outlined in Section 2-IV-G: Yes/No

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

4) LCP's Audited Financial Statement

Describe, in detail, LCP's overall organizational structure, including:

- LCP's audited financial statements as Attachment H and provide written explanation of any of the following findings:
 - Auditor presents a qualified audit opinion,
 - Balance sheet liability exceed assets,
 - There are overdue payments due to a State or Federal agency,
 - There is a Federal or State account currently in collections,

- There is current pending litigation for fraud, misrepresentation, errors or omissions involving one or more current or former employees of the organization,
- Auditor notes or footnotes that indicate:
 - Organizational instability or uncertainty as to its ability to continue in its current business,
 - Overdue State/Federal amounts,
 - Pending litigation involving organizations' employees, management, director or Board of Directors.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

5) Access & Eligibility for Mental Health and/or Substance Abuse Clients

How will you inform the public on what services are available?

What are your projected days and hours of operations, including holidays?

Describe LCP's format or scheduling appointments, including any triage measures used to reduce wait-times.

What are the criteria used to determine who is eligible for a public subsidy?

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Subcontractor Monitoring

Describe how subcontractors are selected and what criteria is utilized.

Describe how monitoring will be conducted, what items will be monitored, and how required documentation will be kept up-to-date for subcontractors.

What services outlined in this RFP will you require subcontractors for?

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

7) Transition and Implementation Plan (Unless current LCP)

Describe your plan for hiring and on-boarding staff to serve Summit County. Include details on any plans to retain current clinicians and case managers to maintain continuity of care.
Describe your plan for transferring of all files related to the care of clients, including IT Infrastructure development.
Describe your plan for mitigating client attrition due to LCP change.
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

- END OF FORM A -

Attachment B

For this attachment, each LCP is required to create a spreadsheet with the following information pertaining to estimated staffing in Summit County:

- Position Classification
 - Administration
 - Staff
 - Clinicians
 - Spanish Service Clinicians
 - Case Management
 - Peer Support
 - Lab
- Position Title
- Position Licensure and/or Certification
- FTE
- Benefit Percentage
- Average Pay for the Position
- Salary Funds Support from the Summit County Contract
- Percentage of Total Salary and Benefits Supported by the Summit County Contract
- Salary Funds Support From the LCP
- Percentage of Total Salary and Benefits Supported by the LCP
- Totals for the Above

See Example Below

LCP: Example Behavioral Health

Classification	Title	License / Certification	FTE	Benefit Percentage	Funded from Contract	Percentage	Funding from LCP	Percentage	Position Total
Administration	Director	LCSW	1	20%	\$ 50,000	50%	\$ 50,000	50%	\$ 120,000
Staff	Reception	-	0.5	0%	\$ -	0%	\$ 12,000	100%	\$ 12,000
Clinician	Spanish Services	LCSW	0.75	15%	\$ 70,000	100%	\$ -	0%	\$ 80,500
Case Management	Case Manager - Drug Court	Adult - MHCM	1	20%	\$ 45,000	100%	\$ -	0%	\$ 54,000
Peer Support	Peer Councilor	CPSS	0.25	0%	\$ 500	100%	\$ -	0%	\$ 500
TOTAL			4		\$ 165,500		\$ 62,000		\$ 267,000

RFP # SUCO20197552

FORM B - MENTAL HEALTH BUDGET NARRATIVE

Submitting Agency (LCP): _____

Instructions:

The following form is modeled off of the annual **Mental Health Area Plan** the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

If you are unable to provide a service, please indicate the reasons why. If you feel you need to amend your ability to meet the service, provide detailed rational along with the proposed amended delivery.

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form B is limited to a maximum of 40 pages.** Refer to Section 1-VII of the RFP to ensure **all required services and metrics are provided in your provided responses.** FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for FY20. Funding contracts are for July 1st to June 30th.

The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. Final numbers will be known by July, 2019.

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

Projected FY20 Mental Health Funding from Contracted Sources: \$1,300,000

Inpatient Services: *Inpatient services refer to inpatient hospital services overseen by a psychiatrist for includes treatment for serious mental disorder. Inpatient psychiatric services vary from short-term or outpatient therapy for low-risk patients to long term care or permanent care such as routine assistance treatment, or a specialized and controlled environment.*

1) Adult Inpatient:

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$84,500	Form A1 - Projected Clients Served in FY19 Area Plan	7
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$90,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	7
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

2) Children/Youth Inpatient

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - FY19 Amount Budgeted:	\$85,250	Form A1 - FY19 Projected clients Served:	5
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$86,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	5
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

Residential Care: Residential Care is a structured service setting or program that provides short-or long-term overnight care delivered in a specialty facility/hospital/center/clinic, specifically for the treatment of behavioral health clients. It is an intensive treatment setting or program distinct from a hospital inpatient setting or program, and provides supervised living coupled with supportive mental health services. Residential Habilitation is a bundled service which includes personal care, homemaker services, nutritional meals and snacks, medication oversight (to the extent permitted under state law), social and recreational activities and 24-hour onsite response to ensure the care, well-being, health and safety needs of the residents are met at all times.

3) Adult Residential Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,000	Form A1 - Projected Clients Served in FY19 Area Plan	1
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$10,000	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	1
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

4) Children/Youth Residential Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$20,000	Form A1 - Projected Clients Served in FY19 Area Plan	2
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	0	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	0
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Outpatient Care: *Outpatient Care is a structured service setting or program that provides ambulatory (not overnight) care specifically for the treatment of behavioral health clients. Care is generally provided for visits of 3 hours or less in duration and 1 or 2 days per week or as needed.*

5) Adult Outpatient Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$365,241	Form A1 - Projected Clients Served in FY19 Area Plan	460
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$386,031	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	468
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Describe programmatic approach for serving individuals in the least restrictive level of care who are civilly committed. (Civil Commitment is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment in a hospital (inpatient), or in the community (outpatient). All citizens have civil liberties that need to be protected under both federal and state laws, so following "due process" is of paramount importance. Treatment is not punishment! The state may need to deprive someone of their civil liberties because they pose a danger to self or others due to mental illness.)

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

6) Children/Youth Outpatient Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$262,725	Form A1 - Projected Clients Served in FY19 Area Plan	319
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$268,053	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	344

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

24-Hour Crisis Care: Crisis Care is defined as a 24-hour, 365-day service available during a personal or social situation where mental distress is a significant contributing factor. Crisis is a behavioral change that brings the user to the attention of crisis services and this for example might result from relapse of an existing mental illness. The crisis is the impact of the change on the user and the disruption it causes to their life and social networks.

For this RFP, the LCP is required to have full and timely coverage, 24/7, for crisis incidents in the Summit County Jail. For all other incidents, the LCP is required to respond during business hours. Incidents outside of these hours will be handled through the State Crisis-Line, Mobile Crisis Outreach Teams (MCOTs), and the Summit County Stabilization Team. Please note, once the LCP is selected, they will work with the Department to greater define their role with Crisis Care. The current expectation is a 60/40 split between the County and LCP for FY20. Per Crisis-Line and MCOT legislation passed in 2018, a local crisis-line is not required, but a plan for warm handoff is. The local director of the LCP will play a critical role in the oversight of this service and will serve on the Crisis Care Committee comprised of first responders, law enforcement, the Department, and the Park City Hospital.

7) Adult 24-Hour Crisis Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$11,392	Form A1 - Projected Clients Served in FY19 Area Plan	47
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$21,501	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	75
Describe access to crisis services during daytime work hours, after hours, weekends, and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify proposed activities and where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Provide specifics, including timeline, of crisis services for incarcerated individuals.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

8) Children/Youth 24-Hour Crisis Care

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,620	Form A1 - Projected Clients Served in FY19 Area Plan	39
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$14,308	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	41
Describe access to crisis services during daytime work hours, after hours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify proposed activities and where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Provide specifics, including timeline, of crisis services for youth during school hours school.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Psychotropic Medication Management: *Psychotropic Medication Management is the level of outpatient treatment where the sole service rendered is by a qualified psychiatrist or psychiatric APRN (Advanced Practice Registered Nurse), who is the initial evaluator of the patient's need for psychotropic medications, the provision of a prescription and as-needed, ongoing, medical monitoring/evaluation related to the patient's use of the psychotropic medication. Interactive psychotherapy is not being rendered at this time by the physician/prescriber, but may be provided by another clinician. The LCP is expected to provide a minimum of 40 hours of access a week to a psychiatrist and/or psychiatric APRN for Psychotropic Medication Management.*

9) Adult Psychotropic Medication Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$122,815	Form A1 - Projected Clients Served in FY19 Area Plan	213
Form A1 - Actual FY18	\$147,260	Form A1 - Actual FY18	215

Expenditures Reported by Current LCP (VBH)		Clients Served as Reported by Current LCP (VBH)	
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. Address how the LCP plans to expedite wait-times for appointments.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

10) Children/Youth Psychotropic Medication Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$30,583	Form A1 - Projected Clients Served in FY19 Area Plan	47
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$46,503	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	48
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. Address how the LCP plans to expedite wait times for appointments.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Psychoeducational Services & Psychosocial Rehabilitation: *Psychoeducational Services & Psychosocial Rehabilitation focuses on a patient's current life and relationships within the family, social, and work environments through one-on-one conversations with a therapist. The goal is to identify and resolve problems with insight, as well as build on strengths.*

11) Adult Psychoeducation Services & Psychosocial Rehabilitation

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$20,071	Form A1 - Projected Clients Served in FY19 Area Plan	165
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$25,357	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	167
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

12) Children/Youth Psychoeducation Services & Psychosocial Rehabilitation

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$5,080	Form A1 - Projected Clients Served in FY19 Area Plan	21
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$7,724	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	38
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

Case Management: *Case Management is an intensive service that is a key part of the continuum of mental health care and supports for persons with serious mental illness. Case management involves building a caring, trusting relationship with the client, promoting independence through the coordination of appropriate services, and providing on-going, long-term support as needed to function in the least restrictive, most natural environment and achieve an improved quality of life. Case management emphasizes frequent contact, small caseloads (<100 cases) and high intensity of care designed to improve planning for and responsiveness to the consumer's multiple service needs. The case manager coordinates required services from across the mental health system as well as other service systems (e.g., criminal justice, social services) as the consumer's service needs change. Intensive case managers fulfill a vital function for clients by working with them to realize personal recovery goals and providing the support and resources that the consumer needs to achieve goals, stabilize his/her life and improve his/her quality of life.*

13) Adult Case Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$70,525	Form A1 - Projected Clients Served in FY19 Area Plan	375
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$84,048	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	389
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change). Provide the expected number of case managers to be provided.			
Has the LCP met the services and metrics of this required service?			

- COMMITTEE USE ONLY -

14) Children/Youth Case Management

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$54,408	Form A1 - Projected Clients Served in FY19 Area Plan	104
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$61,979	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	104
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change). Provide the expected number of case managers to be provided			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Adult Community Supports: *Adult Community Supports is independent, normal housing with flexible, individualized supportive services that allow individuals to maintain as much independence as possible.*

15) Adult Community Supports

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$509	Form A1 - Projected Clients Served in FY19 Area Plan	2
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$509	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	2
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services			

directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

Respite Services: *Respite Services are services are designed to prevent unnecessary hospitalizations or out of home placements for those receiving mental health services. These services are provided by highly trained staff and licensed foster care providers.*

16) Respite Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$9,916	Form A1 - Projected Clients Served in FY19 Area Plan	25
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$9,421	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	24
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Peer Support Services: *Peer Support Services are provided by mental health clients and include mental health treatment and/or support services, such as social clubs, peer-support groups, and other peer-organized or consumer-run activities.*

17) Adult Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$11,054	Form A1 - Projected Clients Served in FY19 Area Plan	223
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$12,643	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	223
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
How is adult peer support supervision provided? Who provides the supervision? What training do supervisors receive?			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

18) Children/Youth Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$18,965	Form A1 - Projected Clients Served in FY19 Area Plan	23
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$6,322	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	15
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).
How are Family Resource Facilitator (FRF) peer support supervision provided? Who provides the supervision? What training do supervisors receive?
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

Consultation & Education Services: *Consultation and Education Services address specific behaviors by assessing and address the client's needs by developing an individualized plan with providers and additional support team members (Parents, teachers, employers, friends, etc.). A plan includes specific strategies for addressing the concerning behaviors.*

19) Adult Consultation & Education Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	No Data – Mandated Service Currently Not Provided	Form A1 - Projected Clients Served in FY19 Area Plan	No Data – Mandated Service Currently Not Provided
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	No Data – Mandated Service Currently Not Provided	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	No Data – Mandated Service Currently Not Provided
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

20) Children/Youth Consultation & Education Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	No Data – Mandated Service Not Provided	Form A1 - Projected Clients Served in FY19 Area Plan	No Data – Mandated Service Not Provided
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	No Data – Mandated Service Not Provided	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	No Data – Mandated Service Not Provided
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Services to Incarcerated Persons: *Services to Incarcerated Persons include access to a psychiatrist or psychiatric APRN to consult on treatment, medications, and diagnosis within the Summit County Jail along with general mental health services.*

21) Services to Incarcerated Persons

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$10,187	Form A1 - Projected Clients Served in FY19 Area Plan	237
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$12,150	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	242
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

Outplacement Services: *Outplacement Services include assisting individuals with finding work; assessing individuals' skills, attitudes, behaviors, and interest relevant to work; providing vocational rehabilitation and/or other training; and providing work opportunities.*

22) Outplacement Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$18,591	Form A1 - Projected Clients Served in FY19 Area Plan	4
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$18,617	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4
Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Describe how you will collaborate with the Division of Workforce Services and the Summit County Clubhouse to meet this Mandated Service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

Unfunded Clients: *Unfunded Clients are those individuals covered under the State’s General Fund which do not qualify for Medicaid, have insurance, or are able to self-pay.*

23) Unfunded Clients

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	\$41,569	Form A1 - Projected Clients Served in FY19 Area Plan	36
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$43,053	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	59
Describe the activities and means you will undertake to ensure full access to the Mandated Services listed in this RFP are made available to Unfunded Clients.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

School-Based Services: *School-based mental health services are those delivered by the LCP in the three school districts. (North Summit School District, South Summit School District, and Park City School District). School-based mental health programs will provide services for youth 18 years of age and younger who are currently enrolled in the public-school system. For purposes of these monies, state regulated charter schools are considered to be part of the public-school system. The goal of these coordinated services will be to prevent youth who may be at-risk for developing a mental illness from disrupting his or her school placement. The services will be focused on maintaining the youth/child in their regular school setting, providing services in the school and collaborating with school staff.*

24) School Based Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form A1 - Amount budgeted in FY19 Area Plan	Service Provided but Data Not Available	Form A1 - Projected Clients Served in FY19 Area Plan	Service Provided but Data Not Available
Form A1 - Actual FY18 Expenditures Reported by Current LCP (VBH)	Service Provided but Data Not Available	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	Service Provided but Data Not Available

Describe the activities and means you will undertake to meet this Mandated Service and identify where services will be provided. For each service and mean, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).
Describe how you will coordinate care with local school district personnel and guardians.
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

25) Other Services (Refer to section 1-VII-N)

Describe how you will insure that services are delivered in Spanish by means of a qualified and culturally competent clinician. How will you recruit and retain a minimum of 2 Spanish speaking clinicians and additional support staff?
Describe how you will insure collaborative efforts with other community partners. (<i>Summit County Health Department, CONNECT Summit County, Summit County Mental Wellness Alliance, Summit County Sheriff's Department, Summit County Jail, Summit County Attorney's Office, Park City Police Department, IHC, UNI, School Districts, Non-Profits, and local government</i>)
Describe how you will insure clinician and case manager retention to maintain continuity of care.
How will LCP will provide Peer Specialists/Family Resource Facilitators for Peer Support Services.
Describe how you will insure that any transition in LCPs will minimize the effects on the continuity of care of current LCP clients. Have you a plan to incorporate current LCP clinicians /staff into your organization.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

26) Quality & Access

Describe how LCP will provide open and timely access to services while maintaining the highest quality of care. Include specifics for services provided in Park City, Kamas, and Coalville. (Current levels in Kamas are 1 fulltime and 2 part-time clinicians, and 1 part-time clinician in Coalville. Space for both locations provided by the Department.)

Identify process activities focused on Implementation of this document for Summit County.

Identify process activities focused on Training of Evidence Based Practices in accordance with DSAMH guidelines and directives.

Identify marketing and public relations activities focused on educating and developing a community based behavioral health service organization.

Identify activities focused on increased service capacity.

Identify process improvement activities focused on Increased Access for Medicaid & Non-Medicaid Funded Individuals.

Identify process improvement activities focused on efforts to respond to community input/need

Identify process improvement activities focused on Coalition Development

Describe how mental health needs for people in Nursing Facilities will be met. (Summit County has one Nursing Facility located in Oakley.)

Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

27) Integrated Care

Describe how you will develop partnerships with the Department, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.
Describe plans to integrate care and ensure that clients have their physical, mental and substance use disorder needs met, including screening and treatment and recovery support.
Describe plans to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).
Recovery Plus: Describe your plan to reduce tobacco and nicotine use and how the LCP will maintain a <i>tobacco free environment</i> . SUD Target= reduce tobacco and nicotine use by 5%.
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

28) Children/Youth Mental Health Early Intervention

Describe the <i>Family Resource Facilitation with Wraparound</i> activities you propose to undertake and identify where services are provided. <i>Describe how you intend to partner with other Department of Human Services child serving agencies.</i> For each service, identify whether you will provide services directly or through a contracted provider.
Do you agree to abide by the <i>Mental Health Early Intervention Family Resource Facilitation and Wraparound Agreement</i> ? YES/NO
Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

29) Children/Youth Mental Health Early Intervention

Describe the Early Intervention activities you propose to undertake and how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider.

Describe outcomes that you will gather and report on.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

30) Suicide Prevention, Intervention & Postvention

Describe the proposed role the LCP will play in working with the community for suicide prevention. *(Summit County utilizes the ChooseLife program developed by the National Health Service – Scotland.)*

Describe the proposed role the LCP will play in working with the community for suicide intervention and postvention. *(Summit County utilizes the ChooseLife program developed by the National Health Service – Scotland.)*

Describe how you will collaborate with emergency services *(Park City Hospital, UNI, MCOT, Stabilization Team, etc.)* to coordinate follow-up care after emergency room visits for suicide related events; both general collaboration efforts as well as specific efforts for your clients.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

31) Justice Reinvestment Initiative

Identify key staff members who will be part of the JRI Implementation Team and their qualifications.

Describe the evidence-based mental health screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.

Identify your outcome measures.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

- END OF FORM B -

RFP # SUCO20197552

FORM C - SUBSTANCE USE DISORDER TREATMENT BUDGET NARRATIVE

Submitting Agency (LCP): _____

Instructions:

The following form is modeled off of the annual **Substance Use Disorder (SUD) Area Plan** the selected LCP is required to develop with the Department each Spring as required under Utah law. Some questions have been amended to reflect the greater needs of Summit County. The selected LCP will work with the Department to implement this document in accordance with DSAMH guidelines and directives for the remainder of FY20 (September – July).

If you are unable to provide a service, please indicate the reasons why. If you feel you need to amend your ability to meet the service, provide detailed rationale along with the proposed amended delivery.

In the cells below, provide an answer/description for each question. Please note, the cells will expand to meet the text length. **Form A is limited to a maximum of 40 pages.** Refer to Section 1-VII of the RFP to ensure **all required services and metrics are provided in your provided responses.** FY19 & FY18 budgets and accompanying client counts are provided by DSAMH and the current LCP (Valley Behavioral Health) as presented in the FY19 Area Plan. A copy of the FY19 Area Plan can be found on the DSAMH website located here: https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19_Area_Plans/Summit.pdf

Proposed Budgets and Clients Served are to be based on a twelve-month period. If selected, the LCP will work with the Department and DSAMH to adjust the amounts to meet the remaining ten months of the Medicaid and State Contracts for FY20. Funding contracts are for July 1st to June 30th.

The following amounts are projections for FY20, and are expected to increase. This amount does not include funds brought about as a result of Proposition 3 and its corresponding Medicaid expansion. Final numbers will be known by July, 2019.

Projected Total Federal Contracted Medicaid:	\$990,000
Projected Total State Contracted Grants:	\$1,200,000
Projected Total Contracted County Match:	\$200,500
Approximate Ancillary County Support*:	\$650,000

** Ancillary County Support includes office space in Coalville, Kamas, and Park City/Kimball Junction, UA testing support, prevention services, and crisis response services (Stabilization Team).*

Projected FY19 Mental Health Funding from Contracted Sources: \$700,000

1) SUD Screening and Assessment Services (S2BI, BSTAD, NMASSIST, AUDI Test-C, TAPS, NIAA, SKINNER, etc.)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$3,000	Form B - Projected Clients Served in FY19 Area Plan	15
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$30,000	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	175
Describe activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

2) SUD Detoxification Services (ASAM IV-D, III.7-D, III.2-D, I-D or II-D)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$7,841	Form B - Projected Clients Served in FY19 Area Plan	3
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$7,841	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	2
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide detox services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			

If this service is not provided by the LCP in Summit County, where are individuals accessing detox services?
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

3) Residential SUD Treatment Services (ASAM III.7, III.5, III.3, III.1)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	19,842	Form B - Projected Clients Served in FY19 Area Plan	2
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$39,683	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4
Describe the activities you propose and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

4) Outpatient (Non-methadone – ASAM I)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$440,957	Form B - Projected Clients Served in FY19 Area Plan	314
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$431,003	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	279

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

5) Outpatient (Methadone - ASAM I)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$2,000	Form B - Projected Clients Served in FY19 Area Plan	1
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$2,000	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	1
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. If you will not be providing or subcontracting for this service, describe future plans.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

6) Office-based Opioid Treatment - (Vivitrol, Naltrexone, Buprenorphine)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$33,917	Form B - Projected Clients Served in FY19 Area Plan	49

Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$0	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	0
Describe activities you propose to ensure access to Buprenorphine, Vivitrol and Naltrexone and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service. If you will not be providing or subcontracting for this service, describe future plans.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

7) Intensive Outpatient (ASAM II.5 or II.1)

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$175,797	Form B - Projected Clients Served in FY19 Area Plan	118
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$140,064	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	95
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

8) Recovery Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$5,543	Form B - Projected Clients Served in FY19 Area Plan	6
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$3,342	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	4
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

9) Peer Support Services

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$12,799	Form B - Projected Clients Served in FY19 Area Plan	35
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$8,775	Form B - Actual FY18 Clients Served as Reported by Current LCP (VBH)	20
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.			
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).			

How is peer support supervision provided? Who provides the supervision? What training do supervisors receive?
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

10) Opioid Treatment Funds (STR & SOR)

<p>The allowable uses for this funding are described in the SFY 18 Division Directives:</p> <ol style="list-style-type: none"> 1. Contract with Opioid Treatment Programs (OTP); 2. Contracts for Office Based Treatment (OBT) providers to treat Opioid Use Disorder (OUD) using Medication Assisted Treatment (MAT); 3. Provision of evidence based-behavioral therapies for individuals with OUD; 4. Support innovative telehealth in rural and underserved areas; 5. Implement or expand access to clinically appropriate evidence-based practices (EBPs) for OUD; 6. Provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings; 7. Enhance or support the provision of peer and other recovery supports.
Describe the activities you propose and identify where services will be provided.
How will you identify, engage and retain individuals in your area with opioid use disorders?
Describe how your plan will improve access and outcomes for individuals with OUD in your community.
For each service, identify whether you will provide services directly or through a contracted provider. List all contracted providers that will provide these services.
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

11) Quality & Access Improvements

Describe how you will increase access to treatment?
Describe your plan to improve the quality of care.
Describe Implementation and Training of Evidence Based Practices to Ensure Fidelity.
Describe Clinical Supervision Protocol or Plan.
How do you evaluate client outcomes?
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

12) Services to Persons Incarcerated in the Summit County Jail

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. If contracted, provide information on contractor exhibiting their qualifications to provide this service.
Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).
Describe your proposed crisis coverage plan for 24/7, 365-day coverage within the Summit County Jail. If you plan to subcontract, please describe your oversight plan to ensure full coverage in the Summit County Jail.

Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

13) Integrated Care

Describe how you plan to partner with the Department, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers to integrate client care between behavioral health and physical health.
Describe your efforts to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy, Nicotine).
Recovery Plus: Describe your plan to reduce tobacco and nicotine use and how you will maintain a <i>tobacco free environment</i> . SUD Target= reduce tobacco and nicotine use by 5% as set by DSAMH.
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

14) Women's Treatment

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$198,995	Form A1 - Projected Clients Served in FY19 Area Plan	113
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$212,761	Form A1 - Actual FY18 Clients Served as Reported by Current LCP (VBH)	113
Describe the evidence-based services provided for women including gender-specific substance use disorder treatment and other therapeutic interventions that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting.			

Describe the therapeutic interventions for children of clients in treatment that addresses their developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect.

Describe case management, childcare, and transportation services for women the LCP is able to provide to ensure they have access to the services you provide.

Has the LCP met the services and metrics of this required service?

- COMMITTEE USE ONLY -

15) Adolescent (Youth) Treatment

LCP Amount Budgeted:		LCP Projected Clients Served:	
Form B - FY19 Amount Budgeted:	\$65,207	Form A1 - FY19 Projected clients Served:	23
Form B - Actual FY18 Expenditures Reported by Current LCP (VBH)	\$66,610	Form A1 - Actual FY18 Clients Serviced as Reported by Current LCP (VBH)	31

Describe the evidence-based services provided for adolescents and families. Identify your plan for incorporating the 10 Key Elements of Quality Adolescent SUD Treatment: (1)

1. Screening / Assessment,
2. Attention to Mental Health,
3. Comprehensive Treatment,
4. Developmentally Informed Programming,
5. Family Involvement,
6. Engage and Retain Clients,
7. Staff Qualifications / Training,
8. Continuing Care / Recovery Support,
9. Person-First Treatment,
10. Program Evaluation.

Justify any increase or decrease in funding and/or any expected increase or decrease in the number of individuals the LCP proposes to serve either directly or through contract. (10% or greater change).

Describe collaborative efforts with other state child serving agencies (DCFS, DJJS, SOC, DSPD, Juvenile

Describe any significant programmatic changes from the previous year.
Describe the Recovery Support Services you will provide with Drug Court RSS funding. (These services must be services that are approved on the DC RSS service list)
Has the LCP met the services and metrics of this required service?
- COMMITTEE USE ONLY -

17) Justice Reinvestment Initiative (JRI)

Form B - FY19 Amount Budgeted:	\$18,000	LCP Amount Budgeted:	
Describe your experience with JRI.			
Describe the evidence-based substance abuse screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.			
Identify training and/or technical assistance needs.			
Has the LCP met the services and metrics of this required service?			
- COMMITTEE USE ONLY -			

- END OF FORM C -

Attachment C

REQUEST FOR PROTECTED STATUS

(Business Confidentiality Claims under Utah's Government Records Access and Management Act ("GRAMA"), Utah Code Ann. §§ 63G-2-101 to -901)

I request that the described portion of the record provided to Summit County be considered confidential and given protected status as defined in GRAMA.

Name: _____

Address: _____

Description of the portion of the record provided to Summit County that you believe qualifies for protected status under GRAMA (identify these portions with as much specificity as possible) (attach additional sheets if necessary):

The following reasons support this claim of business confidentiality (please check the box/boxes that apply):

- The described portion of the record is a trade secret as defined in Utah Code Ann. § 13-24-2.
- The described portion of the record is commercial or non-individual financial information the disclosure of which could reasonably be expected to result in unfair competitive injury to the provider of the information or would impair the ability of the governmental entity to obtain the necessary information in the future and the interest of the claimant in prohibiting access to the information is greater than the interest of the public in obtaining access.
- The described portion of the record would cause commercial injury to, or confer a competitive advantage upon a potential or actual competitor of, a commercial project entity as defined in Utah Code Ann. § 11-13-103(4).

REQUIRED: Written statement of reasons supporting a business confidentiality claim as required by Utah Code Ann. § 63G-2-305(1)-(2) (attach additional sheets if necessary):

NOTE: Claimant shall be notified if the portion of the record claimed to be protected is classified as public or if the determination is made that the portion of the record should be disclosed because the interests favoring access outweigh the interests favoring restriction of access. Records claimed to be protected under this business confidentiality claim may not be disclosed until the period in which to bring the appeal expires or the end of the appeals process, including judicial appeal, **unless the claimant, after notice, has waived the claim by not appealing the classification within thirty (30) calendar days.** Utah Code Ann. § 63G-2-309(2).

Signature of Claimant: _____

Date: _____

Attachment D

Organization Chart

The Bidder will provide a copy of their organizational chart showing the reporting structure of the organization along with the reporting structure for proposed operations in Summit County.

Summit County Council

SUD Treatment & Mental Health Services RFP # SUCO20197552

Summit County Courthouse | Coalville, Utah

April 10, 2019



Executive Summary



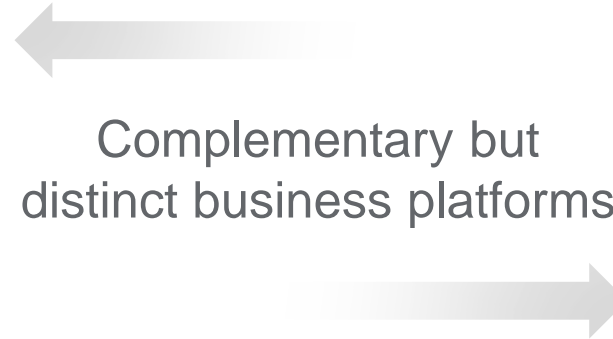
UNITEDHEALTH GROUP

A DISTINCTIVELY DIVERSIFIED ENTERPRISE



HEALTH BENEFITS

Helping people live healthier lives



Complementary but distinct business platforms



HEALTH SERVICES

Making the health care system work better for everyone

FOUNDATIONAL COMPETENCIES

Clinical care insight

Technology

Data and information

OUR UNITED CULTURE

Integrity

Compassion

Relationships

Innovation

Performance

Corporate Experience

- Since July 2011, Optum has partnered with Salt Lake County to manage the Medicaid Plan for Behavioral Health Services; we currently manage behavioral health services for more than 100,000 clients in Salt Lake County.
- Optum is a national leader with more than 30 years of experience delivering substance use disorder (SUD) and mental health services to more than 5.8 million public sector clients in 31 states:
 - 28 of the states where we provide services have integrated physical and behavioral health services
 - We have three “carve-out” behavioral health programs: Salt Lake County, Utah; Idaho, and San Diego County, California
- This depth and breadth of experience serving in both large metropolitan areas, as well as rural and frontier communities, provides a foundation of knowledge that allows us to build efficient and effective systems of care for each community.



Experienced Local Leadership

- **Tracy Luoma** has served as the Executive Director for Optum for the last three years and has a total of 17 years of Utah-specific health care experience including six years with the Utah Division of Substance Abuse and Mental Health where she served as the Administrative Services Director, five years with the Utah Department of Health-Division of Medicaid and Health Financing where she served for two years as the Finance Director and three years as the Deputy Director. Ms. Luoma also worked for a year with the Molina Utah Medicaid ACO.
- **Satish Annadata, MD, MPH, MBA** has served as the Optum Senior Medical Director for the last year and previously worked in public service for the U.S. Department of Veterans Affairs. Dr. Annadata is board-certified in Psychiatry and Brain Injury Medicine by the American Board of Psychiatry and Neurology. He has over 18 years of field experience in healthcare operations and strategy focused on achieving the best patient outcomes at the lowest cost.
- **Connie Mendez, LCSW, MBA** has served as the Optum Deputy Director of Utilization Management and Care Coordination for the last eight years and has a total of 17 years of clinical experience in quality assurance, compliance and operations of programs that offered residential and day treatment services for youth and families covered by Medicaid programs.
- **Randy Dow, LCSW** has served as the Optum Medicaid Network and Contracts Director for the last year and has 31 years of community mental health experience serving both as a provider and as Children's Services Director and in various other roles in Salt Lake, Tooele and Uintah counties.
- **Suzann S. Nowels, LCSW** has served as the Optum Clinical Director for the last eight years and has 29 years of Utah community mental health experience serving as both a direct care provider and as a Manager/Director of a variety of public sector behavioral health programs.
- **Jason Norwood** has served as the Optum Finance Manager for the past eight years and has more than 10 years of healthcare industry experience.
- **Gina Attallah, LCSW** has been with Optum for the last seven years and was recently promoted to the position of Director of Compliance and Quality Assurance/Performance Improvement. Prior roles at Optum were as the Clinical Supervisor and Clinical Quality Manager. Prior to joining Optum, Ms. Attallah worked as a clinician serving Medicaid covered youth and families for 12 years.



Collaboration and Commitment

- Helping people live healthier lives requires understanding the capabilities, needs and goals of each individual, family and community, then working collaboratively to develop local systems of care that are effective, efficient and sustainable.
- We are committed to transparency and accountability. Our determination to work with local stakeholders and implement an individualized program for every contract is the foundation for our successful public/private partnerships across the country.
- We recognize the commitment and significant progress Summit County has made in addressing the behavioral health needs of its residents.
- We look forward to adding our experience and resources to support the County in its stated goal of fostering an “accessible, efficient, client centered, and integrated system of care for individuals residing in Summit County.”

Highlights of our Approach

Optum will ensure that the right services are available when clients need them. We will monitor and oversee the progress of individual clients, and be accountable for the overall quality and effectiveness of Summit County's behavioral healthcare delivery system.

The Optum model will:

- Allow all qualified Summit County behavioral health providers to serve the County's clients and bring experienced providers from nearby communities to expand services and improve access
- Offer Summit County clients a choice of treatment providers
- Improve the County's ability to hold its LCP accountable for system improvements and ensure transparency in system oversight of the LCP's operations
- Eliminate constraints and potential conflicts by separating clinical treatment and financial management, laying the foundation for reinvesting savings and expanding the array of services
- Increase collaboration with Summit County clients and stakeholders to ensure that they have a voice, choice and involvement in the design and evolution of their mental health and SUD services delivery system



Delivering State Mandated Services

- Optum Summit County will develop and maintain a network of providers to ensure that all of the State Mandated Services for Substance Use and Mental Health Services are provided.
- We have specific experience managing the delivery of Utah Mandated Services as the LCP for Salt Lake County. In addition, we have designated teams -- including our Quality, Clinical and Network teams -- to ensure our network is comprehensive, providing the right services to clients and following federal, state and county guidelines and requirements.
- Quality Assurance Performance Improvement (QAPI) process: Quality management and continuous quality improvement, are at the core of our approach to managing behavioral healthcare in relation to the ten mandated services.
- During our seven years of experience in Salt Lake County, we have managed and organized all DSAMH and CMS Medicaid audits in partnership with the County; as a result, we are familiar with DSAMH mandates and Medicaid regulations.
- We audit our providers on an ongoing basis to verify that they fulfill these requirements and, based on outcomes from audits, we design our trainings to address areas for provider improvement and development.

Transition and Implementation Plan



Community Collaboration, Planning and Communication

- Optum is committed to a collaborative effort to facilitate a smooth transition for clients, providers and the community at large.
- Key stakeholders who should participate in this process include: Summit County Council, Department of Health, Summit County Mental Wellness Alliance, Summit County Connect, Valley Behavioral Health, school districts, law enforcement and jail staff, behavioral health providers, Park City Hospital, the People's Clinic, Coalville and Kamas Health Centers, Medicaid ACOs and other community organizations as appropriate.
- Their feedback is incorporated into our Implementation Project Plan to ensure we understand the unique needs of each community, identify organizations that can help inform clients, their families and the community at large regarding changes, that all key stakeholders have the knowledge and resources necessary to keep clients connected to needed services and supports and know how and who to contact at Optum to resolve problems.

Transition Approach

- The Optum leadership team and other members of the Optum Salt Lake County team have been involved in evaluating the system of care in Summit County, meeting with providers to discuss opportunities in Summit County, reviewing the RFP and preparing our response, and developing implementation and transition plans to ensure a smooth transition, should we be selected as the LCP.
- We have already developed comprehensive internal transition plans to ensure that all staff -- including leadership, clinical support, client services, call center and administrative support staff -- will be trained and ready to support Summit County and that our IT, related technology and operational infrastructure will meet the needs of Summit County, its residents, and our network of providers.
- Optum and VBH have had a relationship since July of 2011, initially transitioning Salt Lake County's behavioral health system from VBH to Optum and in the years since 2011, with Optum serving as the LCP and VBH as a major contracted provider. This familiarity and experience should facilitate a smooth transition for Summit County.

Transition Priorities

- Transition from a staff model managed care program (i.e., the model Valley Behavioral Health uses, in which the LCP directly **employs** clinical professionals) to a network model managed care program (in which the LCP **contracts** with independent clinical professionals) requires the LCP to:
 - Establish a network of qualified and experienced providers
 - Organize and host Summit County community conversations to get stakeholder input regarding what Optum can do to help facilitate a smooth transition
 - Communicate and engage clients and their families/caregivers to make them aware of the change. Optum would provide a welcome letter, phone outreach, and client care coordination to help them select and connect with a provider
 - Work with VBH staff to acquire required information regarding clients served, utilization history, programs, key partners/relationships and processes required to ensure a smooth transition for clients and their families/caregivers
 - Ensure key stakeholders are aware of the change, engaged in the development and deployment of the transition plan, have the resources to help communicate and support the community in the transition process and know how to connect with the LCP to report problems

Implementation Management

- On contract award we assign an Implementation Project Manager (IPM) who assembles an Implementation Team, many of whom are already engaged in evaluating Summit County requirements.
- All aspects of the initial implementation will be completed under the guidance of the Implementation Project Manager (IPM). Working with Summit County and the implementation team, the IPM will define processes, identify accountabilities, resolve issues, and ensure Summit County's service priorities are achieved.
- The IPM will:
 - Develop a detailed Implementation Project Plan
 - Serve as the liaison with Summit County for all implementation activities
 - Cultivate positive relationships between Summit County representatives and our operations personnel
 - Oversee the research and resolution of all issues that arise
 - Monitor and report on progress
 - Disseminate critical information among Summit County, key stakeholders and Optum

Testimonials

- “We have worked as a Medicaid Provider for Salt Lake County since Summit opened our doors in May of 2012. We initially were contracted with Valley Mental Health. All providers were nervous about the change when Optum came in to take over the contract. We quickly found Optum to be great to work with. They are responsive to any issues and we get quick resolution to our questions and concerns. They provide great trainings for our clinical and our billing teams. They have been open to providing a wide range of services and we have been able to expand our outreach to the patients with the most need. We have access to resources through the clinical team and we have worked together on cases, bringing in many community resources.” -- **Karen Malm PhD (Owner) Summit Community Counseling**
- “At the time Optum first began serving Salt Lake County, it was evident that the Optum Implementation team was very familiar with the County and had done substantial work to understand the demographics of members, provider alignment, community agencies and organizations. We had excellent training in the systems, hardware and software needed to provide the best customer and Member experience. For me personally, I was hired at the end of my trial work period on the SSA ticket to work program. I was returning to work after several years on disability. This team exhibited confidence in me and my abilities. I received an enormous amount of support in creating the first year road map for recovery and resiliency in Salt Lake County. The map was based on innovative programs in other communities that were a good fit, identifying gaps in services and bridging them, and outreach to members and families. The recommendations, support and confidence of a whole team of passionate and caring individuals was helpful to me personally, but also to network providers, community agencies and the larger community.” – **Julie Hardle, former Case Manager from VBH, currently serving as Vice President of Consumer Affairs for Optum**



Vision for Integration of Physical and Mental Health



Vision for Integration of Physical and Mental Health

- The transition from VBH clinicians to a network of independent behavioral providers will require new linkages between physical and behavioral health providers to facilitate and support integrated care.
- We will work with each of the four Medicaid ACOs operating in Summit County (We currently work with all four of these entities in Salt Lake County), our contracted behavioral health providers, and other local community behavioral and physical health providers, including: the Park City Hospital and their affiliated clinicians, People's Clinic, Coalville and Kamas Health Centers, Counseling Center of Park City, Jewish Family Services, and other local providers, to determine each entity's willingness to participate in integrated/coordinated care activities and what Optum can do to facilitate integrated care.
- Our priority is to identify clients with complex, chronic or comorbid health conditions and to work with their Medicaid ACO to coordinate care. We engage the behavioral health provider in participation with the physical health providers to create a "holistic" model. Optum's clinical team will gather collateral information on the client and engage the client's medical team to ensure all parties are part of the recommendations toward treatment management. Our goal is to foster communication between systems, educate providers and improve the treatment outcomes for our clients. For clients not covered by Medicaid, we will work directly with their identified physical health providers or help them secure ongoing medical referrals.
- Initial areas of focus include: educating primary care providers on how to access behavioral health services, the services and programs that are available to Summit County clients, and how to refer to behavioral health providers. The clinical team will use communication through collaboration with case management, prescribers, and multi disciplinary treatment team meetings as the preferred mechanisms for this integration.
- We will establish regular meetings with the ACOs to discuss individual cases to integrate care. Our clinical team will consistently notify each ACO of any inpatient psychiatric admissions for their clients, as well as the discharge plans/appointments and medications prescribed for their clients when returning to the community.



Service Location and Space of Network Providers

Service Location and Space of Network Providers

- Please see grid on the next slide which lists providers who have given us a commitment to provide services for Summit County residents (both in Summit and Salt Lake Counties).
- Most of our providers committed to delivering services in Summit County are already looking for suitable office locations in Park City. Upon contract award, we will work with the County to identify locations in Park City that might be available, at less than market rates, for our providers.
- We also have commitments from providers to deliver services in Coalville and Kamas, utilizing the space offered by the County, to meet the behavioral health needs of residents of these communities.

Service Location and Space of Network Providers

Name of Entity	Service(s) Provided	Summit County	Salt Lake County
Alliance House	Outpatient (Clubhouse Model)		X
Ascendant Behavioral Health	Outpatient MH and SUD Treatment, Psychological Testing and Medication Management		X
Asian Association of Utah (Refugee Center)	Outpatient, Case Management, SUD Screening and Assessment Services		X
Clinical Consultants	Outpatient Substance Abuse and Mental Health Services, MAT, Domestic Violence Treatment Services		X
Dodi Wilson	Outpatient (Also Jail and Drug Court consideration)	X	
First Step House	Outpatient and Residential Substance Use Treatment for Adults		X
Hopeful Beginnings	Outpatient Services, Medication Management, School Based Services, Crisis Management, In-Home Treatment, Unskilled Respite, 24 Hour Crisis Care, Psychoeducation and Psychosocial Rehabilitation	X	
House of Hope	Outpatient, and Residential SUD Treatment for Women and Children		X
Lotus Center for Healing and Wellness	Outpatient		X
Multicultural Counseling Center	Outpatient Mental Health Services with Spanish speaking capability		X

Service Location and Space of Network Providers Cont.:

Name of Entity	Service(s) Provided	Summit County	Salt Lake County
New Beginnings Behavioral Treatment	Mental Health Residential Treatment for Youth ages 9 to 17		X
Odyssey House	Outpatient, IOP, and Residential Programming for SUD and Dual Diagnoses Treatment. They also have an onsite medical clinic for integration. Also provide school based services in Salt Lake City School District		X
Project Reality	Outpatient Substance Abuse Services, MAT		X
Psychiatric and Behavioral Solutions	Outpatient MH and SUD treatment, Relprev and Clozaril Clinics, Medication Assisted Treatment, Case Management, Peer Support	X	X
Salt Lake County Youth Services	Juvenile Receiving Center, FAST Program (Crisis Respite and Treatment to keep clients in home)		X
Sarah Rothstein	Outpatient Adult and Youth	X	
Silverado Counseling	Outpatient		X
Summit Community Counseling	Outpatient Services, Psychological Testing, In-Home Treatment, Unskilled Respite, 24 Hour Crisis Care, Psychoeducation and Psychosocial Rehabilitation	X	X
SunDance Behavioral	Outpatient Mental Health Treatment, Medication Management	X	X
Volunteers of America	Outpatient MH and SUD Treatment, Intensive Case Management		X

Provider Testimonials

- “When OPTUM took over the contract for Medicaid in Salt Lake County, we were able to get a foot in the door and serve many more individuals with Medicaid in Salt Lake County. We started out as a small provider, and with OPTUM’s support we increased our accessibility with clients. OPTUM also made it possible for us to collaborate with community partners and have equal footing with some of the larger providers by helping mediate increasing collaborative efforts. Working side by side with OPTUM over the years we have been able to expand our services throughout the county to grow our business. We now offer wrap around services in homes, community settings, schools, and in our office.” – **Nicole Nickles (Owner), Hopeful Beginnings**
- “Volunteers of America, Utah has grown and thrived due to the partnership with Optum. Optum has supported new programs, such as the Assertive Community Treatment Team. This evidence based practice had never been offered in Utah before and is the treatment of choice for seriously and persistently mentally ill clients who require wrap around services. Optum has also spearheaded the development of supportive employment services for clients with serious mental illness or substance use disorder who want to work. So many clients have benefited from these programs that take a holistic approach to care. In addition the Optum team is always available to help us. They meet with providers for training and troubleshooting and clearly want to help us succeed.” – **Audrey Rice (Vice President of Clinical Operations) Volunteers of America**



Community Stakeholder Testimonial

- “Utah Support Advocates for Recovery Awareness (USARA) values our partnership with Optum and their commitment to support community based, non-clinical, peer facilitated Recovery Support Services at our SLCo Recovery Community Center (RCC). Optum has invested in growth of peer workers by providing a comprehensive 40-hour training for Certified Peer Support Specialists, many who are now employed by USARA. Optum truly understands the unique needs of people who struggle with substance use and mental health disorders and has offered 2 weekly recovery support groups at the RCC. Optum has also been an annual sponsor for our SLCo community Recovery Day celebration during National Recovery Month! I can genuinely say USARA's collaboration with Optum staff and it's organization has contributed to the success of our mission to help the people we serve find hope, experience compassion, better manage their health and a in life in recovery!” **Mary Jo McMillen, USARA Executive Director**

In Conclusion...

- Every state, every county, every contract is different. At Optum, we take great pride in our ability to customize each of our programs so that they become an integral part of the local healthcare delivery systems. For instance, even though Summit County and Salt Lake County would be supported by the same infrastructure and many of the same staff, the programs would be different, reflecting Summit County priorities, services, network providers, community resources, and ethnic and cultural groups.
- Community collaboration is critical. We look forward to adapting our program to best serve Summit County. One key point is that *change will be incremental*. A true system of care evolves over time, reflecting the priorities of local stakeholders.
- Every program we offer is assessed to determine long-term sustainability and to ensure the programs and services can evolve with the needs of the individuals and communities they serve. It is also important that our programs and services reflect the cultural needs of the community including providing materials, resources, and support for clients of Hispanic cultures and other diverse populations.
- We have more than seven years of Utah-specific experience, engaging community stakeholders, building a provider network, working with Salt Lake County health staff, clients and their families, Medicaid ACOs, the Utah Division of Substance Abuse and Mental Health and recruiting, training and managing a team of experts to do almost the exact same work Summit County needs; we would be honored to be your partner in helping Summit County clients live healthier lives.



Thank you.

Tracy Luoma

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801-982-3018

Blaine Bergeson

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602-821-4631





OUR SUMMIT COUNTY BEHAVIORAL HEALTH SOLUTION:

Our proposal for the delivery of behavioral health services in Summit County is a community-driven solution, intended to be adaptable to the needs of Summit County. Our proposal envisions working with the County, its agencies, and community partners to support and strengthen the existing behavioral health resources in Summit County. We believe that a close partnership can result in a behavioral health delivery system that will be cost effective, deliver highest quality of care to individuals in Summit County, and will improve the overall health and quality of life of Summit County residents.

Our proposal has four overall components:

1. Community Partnership
2. Medicaid Managed Care and State Match Funding Assistance
3. Collaborative Provider Partnerships
4. Meeting Mandated and Division Directives using a Collaborative, Strategic, and Phased Approach

Community Partnership

- U of U Health Plans is committed to assisting Summit County in implementing its Strategic Plan.
- U of U Health Plans understands that Park City, Kamas, and Coalville each have unique behavioral health care needs and a one-size-fits all approach will not be effective.
- The first step in most of our proposal responses involve working with Summit County and its community partners to assess Summit County's behavioral health needs and available services to identify gaps in care so we can bring the right solution for Summit County residents.





Medicaid Managed Care and State Match Funding Assistance

- U of U Health Plans has over 20 years of experience as a Medicaid Managed Care Organization.
- We are currently contracted as a Medicaid ACO and deliver physical health services statewide to 49,000 Medicaid members.
- U of U Health Plans is in a unique position to offer an additional funding arrangement to enhance overall support for Summit County's behavioral health program while limiting the financial burden to Summit County.
 - An Intergovernmental Transfer (IGT), if approved by the Utah Department of Health and the Center for Medicaid and Medicare Services, could increase Summit County's Medicaid funding.

Collaborative Provider Partnerships

- In addition to existing local county providers, U of U Health Plans' close provider partnership with UNI will give extraordinary access to UNI's specialized services within Summit County.
- Despite nationwide shortages of behavioral health providers, UNI oversees a strong network of behavioral health providers and is well-connected to Utah's leading behavioral health experts.
- UNI also has the ability to coordinate with physician residents training and fellows at the University of Utah to deliver services in Summit County. Residents may be used to augment existing practices, thereby increasing access to support the community.
- In addition to a close provider partnership with UNI, U of U Health Plans works with other highly skilled providers such as Odyssey House, Sundance Behavioral Resources and local providers. The U of U Health Plans provider network includes many interested and engaged providers who would like to locate services to Summit County, enhancing access that has otherwise been unavailable.

Meeting Mandated and Division Directives using a Collaborative, Strategic, and Phased Approach

- U of U Health Plans' proposals to meet the State Mandated Service requirements and Division Directives involve a two-prong approach:
 - First, U of U Health Plans, UNI, and Summit County will work together to gather data to assess utilization needs, location of those needs, and determine the available budget.
 - Second, U of U Health Plans, UNI, and Summit County will work collaboratively to scale the proposed solution to address Summit County's needs within the county's budget.
- In collaboration with strong provider-partners such as UNI, Odyssey House, and Sundance Behavioral Resources,, we are confident that we have the resources to assist Summit County meet the State Mandated Services and Division Directives within 12 to 24 months of the proposed contract start date.



TRANSITION PLAN

U of U Health Plans has experience in transitioning individuals to U of U Health Plans' commercial insurance products and provider network. U of U Health Plans' experience in transitioning members will allow us to respond to and minimize the disruptions that can occur when individuals transition between providers.

- U of U Health Plans will work closely with Valley Behavioral Health to identify members currently receiving services. Steps for transitioning will include:
 - Obtaining a hand-off report from Valley detailing individuals currently in care management.
 - Identifying members who require medication management.
 - Identifying individuals who are currently in treatment and their treatment providers. From this report:
 - Work with Valley Behavioral Health to identify individuals who should not have their provider-patient relationship interrupted. Enter into single case agreements with these providers to ensure on-going member treatment.
 - Identify members who can be safely and appropriately transition to network providers.
- U of U Health Plans will develop Communication Plan with input from Summit County. The Communication plan will:
 - Start to develop a relationship with the member.
 - Assess member needs.
 - Help members explore their new in-network alternatives.
 - Follow up as needed to ensure member satisfaction with services.





PHYSICAL AND MENTAL HEALTH INTERGRATION

U of U Health Plans has a high-touch, “whole person” approach to care management. We believe that behavioral health impacts medical health and vice versa.

- Our behavioral health care managers complete a full assessment of members which includes medical, behavioral health, and substance use history.
- Depending on needs of the member, referrals are made to behavioral, substance use, and/or medical providers.
 - Summit County Medicaid residents not insured by Healthy U will be assisted to find medical providers within their plans network.
 - For those without insurance the care manager will work to find low cost resources.
- U of U Health Plans’ care managers facilitate communication between providers.
- U of U Health Plans’ care managers also take into consideration an individuals “social determinants of health” and can connect members to community resources.
- U of U Health Plans’ care managers work closely with the member, and together, the member and the care manager develop a plan of care to help the member achieve optimum health.
- U of U Health Plans’ provider partners, such as UNI and Odyssey House, are committed to creating integrated care programs in Summit County by providing behavioral therapy services alongside medical and coordinating with their medical peers as well as community resources.





NETWORK PROVIDERS

To ensure eligible Summit County residents have access to Behavioral Health providers, U of U Health Plans will take a multi-faceted approach in the on-going development and maintenance of its provider network. U of U Health Plans fully intends to provide as many services as possible within Summit County. Our unique partnership with the UNI and the University of Utah Department of Psychiatry provides multiple opportunities to relocate, recruit and develop behavioral therapy services in Summit County. Additionally, Odyssey House and Sundance Behavioral Resources are committed to supporting Summit County by offering care directly in the county. Together, we are fully committed to develop a model that supports and strengthens the community. By contracting and partnering with local community providers and these entities, U of U Health Plans strongly believes this model will provide access to services otherwise unavailable under an exclusive staff model.

1. Direct contracts with local providers in Summit County.
2. Direct contracts with providers in Wasatch and Salt Lake counties for services unavailable in Summit County.
3. Relocation and development of services in Summit County in collaboration with UNI, the University of Utah Department of Psychiatry, Odyssey House, Sundance Behavioral Resources and local agencies such as Jewish Family Services, the Christian Center, and the People's Health Clinic.
4. Use of telehealth and other virtual programs to fill network gaps during development, and to augment the provider network for after-hours, weekends, and holiday care.
5. Recruitment of Spanish-speaking providers and/or use of interpreting services.





Direct Contracts with Local Providers in Summit County

- U of U Health Plans has secured commitments from many local behavioral therapists within Summit County to participate in the Medicaid program.
- Network providers cover child, adolescent, and adult services.
- Network providers offer counseling, medication management, and substance use disorders therapy.
- Medication management services are available at U of U Health Redstone Clinic (adults) and Summit Pediatrics (child/adolescents).

Direct Contracts with Providers in Surrounding Counties

- U of U Health Plans has secured commitments from several local behavioral therapists within Wasatch County (such as Heber City) to participate in the Medicaid program.
- Day treatment, inpatient, residential treatment, and same-day access clinics are available within Salt Lake County.
- UNI will prioritize, to the best of its ability and as appropriate, inpatient access. Additionally, U of U Health Plans has the experience and ability to negotiate single-case agreements alongside its care management team to ensure covered access and continuity of care.

Relocation and Development of Services in Summit County

- Given the shortage of behavioral therapy services within Summit County, U of U Health Plans in collaboration with Sundance Behavioral Resources, Odyssey House, and UNI/University of Utah Department of Psychiatry, will relocate and develop additional provider access directly in Summit County.
- Sundance Behavioral Resources is committed to working with U of U Health Plans as a provider in the network and is actively seeking space in Summit County. Sundance Behavioral Resources requests access to the available county space as an interim solution.
- Odyssey House will consider developing RTC access in Summit County contingent upon volumes for efficiency purposes. Additionally, Odyssey House is equipped to provide peer support, community education, outpatient mental and substance use therapy, as well as services to incarcerated persons (include MAT). UNI is fully committed to providing access within Summit County to behavioral therapy services, based on assessment and need. UNI will work with U of U Health Plans and the county to establish necessary care in Summit County, such as:
 - Additional outpatient services (e.g., IOP)
 - Additional psychotropic medication management
 - Psychoeducational services and psychosocial rehab
 - Consultation and education services
 - Face-to-face counseling for incarcerated persons
 - Additional substance use disorders therapy
 - Peer support services as needed and in conjunction with local agencies
 - Residents and fellows within local clinics as needed





Use of Telehealth and Virtual Programs

- U of U Health Plans will provide face-to-face visits, as much as possible, for members. However, where immediate network shortages exist, services are being developed directly in Summit County, or crisis or after-hours care is needed, U of U Health Plans will utilize telehealth and virtual programs to augment and improve provider access.
- In addition to telehealth counseling, **GATE** (Giving Access to Everyone) allows Primary Care Physicians to electronically consult with psychiatric specialists; thereby allowing patients to stay within the PCP's practice for medication management, consultation, etc.
- The **UNI CrisisLine** provides 24-hour intervention and support for those in crisis regardless of location.
- The **UNI WarmLine** provides immediate peer support to those in need regardless of location.
- **SafeUT** provides immediate crisis and suicide intervention support through a text app, primarily geared towards adolescents. UNI will work directly with Summit County schools to integrate a SafeUT workflow with local school counselors for crisis and suicide prevention.

Recruitment of Spanish-Speaking Providers

- U of U Health Plans will work with local providers and agencies to recruit Spanish-speaking providers within Summit County. U of U Health Plans currently holds contracts with several interpreting agencies and, given the shortage of Spanish-speaking providers in Summit County, will extend those contracts to support Medicaid Behavioral Health services.

See Attachment E for listing of providers by mandated service





ABOUT US

University of Utah Health Plans was formed in 1998 as a strategic initiative of University of Utah Health. Our status as a not-for-profit, government agency allows us to be unapologetically member-oriented.

- We currently administer medical, behavioral health, and pharmacy benefits.
- Our health plan administration includes fully insured and self-funded employer groups, Marketplace plans, as well as government programs including Medicare and Medicaid.

We currently serve 201,000 members across Utah, Idaho, Wyoming, and Nevada. All of our operations, from member and provider customer service to case management, are Utah-based.

Our Mission

To serve the people of Utah by improving health and quality of life, providing access to the highest quality of care, and delivering exceptional value to our members, clients, and the community. To enhance value and ensure excellence in patient care, education, and research, we are integrated with the University of Utah and University Health.

Our Vision

University of Utah Health Plans is committed to be a health care partner distinguished by collaboration, excellence, leadership and respect.

We are the right partner for Summit County

University of Utah Health Plans is uniquely positioned to provide access to world-class behavioral health care to Summit County residents. Through our collaboration with UNI, we can ensure residents receive the appropriate care where and when they need it. We have the infrastructure in place to administer claims accurately and timely. And we have expert knowledge of the Medicaid program to ensure our programs are fully compliant with Medicaid requirements. We are a trusted resource in the community with a rich history of community partnerships.

University of Utah Health Plans is committed to be a health care partner distinguished by collaboration, excellence, leadership, and respect.

This is more than insurance—this is personal.



HEALTH PLANS
UNIVERSITY OF UTAH

Attachment E Reformatted – List of Network Providers & Services

Inpatient Care & Services
<i>Located in Summit County</i>
<i>Located Outside Summit County</i>
University Neuropsychiatric Institute (Salt Lake County)
NOTE: U of U Health Plans will negotiate single case agreements when necessary.
Residential Care & Services
<i>Located in Summit County</i>
NOTE: U of U Health Plans will negotiate single case agreements when necessary.
<i>Located Outside Summit County</i>
UNI Girls Transition Center (Salt Lake County)
NOTE: U of U Health Plans working with additional agencies in Salt Lake County
NOTE: U of U Health Plans will negotiate single case agreements when necessary.
Outpatient Care
<i>Located in Summit County</i>
CG Mental Health
Elizabeth Doshier, LCSW
Expansive Horizons Counseling
Four Seasons Therapy
Gale and Associates
Innerwell Psychotherapy
Insight Psychotherapy
Jewish Family Services
John R. Taylor, PhD
Nelson Roxi, Mountain Strength Wellness Center
Pamela C. Wilkison, PhD
Park City Therapy
Pathways of Healing
Patricia Lindsay, PhD
Red Willow Counseling & Recovery
Sarah Rothstein, LCSW
Sundance Behavioral Resources (Contingent upon space – requesting County space)
Summit Counseling
Summit Neuropsychology
Summit Pediatrics
NOTE: UNI Recovery Works – (Currently located in Salt Lake County. Similar program could be offered in Summit County. Includes IOP.)
<i>Located Outside Summit County</i>
Corinna A. Porter, PhD (Wasatch County)
Harmony Family Therapy (Wasatch County)
Life Changes Counseling (Wasatch County)
Solstice Counseling and Wellness (Wasatch County)
Summit Community Counseling (Wasatch County)
Synergism Counseling (Wasatch County)
UNI Day Treatment – Kidstar (Salt Lake County)
UNI Day Treatment – Teenscope (Salt Lake County)

UNI Downtown Behavioral Health (Salt Lake County)
UNI Recovery Works (Salt Lake County)
Virtual
UNI GATE Program
UNI Telehealth
24 Hour Crisis Care
Located in Summit County
NOTE: UNI will work with Summit County to provide back-up for MCOT services when needed.
Located Outside Summit County
UNI Consult Clinic (Salt Lake County) (Not 24 hour)
UNI Day Treatment Center (Salt Lake County) (Not 24 hour)
UNI Receiving Center (Salt Lake County) (Not 24 hour)
UNI Same Day Psychiatric Clinic (Salt Lake County) (Not 24 hour)
Virtual
UNI CrisisLine
UNI SafeUT
UNI Telehealth
UNI WarmLine
Psychotropic Medication Management
Located in Summit County
Summit Pediatrics
Sundance Behavioral Resources (Contingent upon space – requesting County space)
U of U Health Redstone Clinic
NOTE: UNI will expand its service offerings in Summit County
Located Outside Summit County
UNI Consult Clinic (Salt Lake County)
UNI Receiving Center (Salt Lake County)
UNI Same Day Psychiatric Clinic (Salt Lake County)
Virtual
UNI GATE Program
Psychoeducational Services & Psychosocial Rehab
Located in Summit County
Sundance Behavioral Resources (Contingent upon space – requesting County space)
U of U Health Redstone Clinic
NOTE: UNI will expand its service offerings in Summit County
Located Outside Summit County
Life Changes Counseling (Wasatch County)
Case Management
Located in Summit County
NOTE: U of U Health Plans will provide in-home visits and work face-to-face with local Summit County agencies and providers to coordinate case management. U of U Health Plans will explore providing on-site case management at U of U Health Redstone Clinic or in conjunction with Sundance Behavioral Resources.

Located Outside Summit County
U of U Health Plans Care Management Services (Salt Lake County)
Community Support Services
Located in Summit County
NOTE: U of U Health Plans would like to collaborate with Summit County on these services.
Located Outside Summit County
Consultation & Education Services
Located in Summit County
NOTE: UNI will provide these services in Summit County in conjunction with the County's needs and recommendations.
Located Outside Summit County
Services to Incarcerated Persons
Located in Summit County
NOTE: UNI will explore providing these services in Summit County.
Located Outside Summit County
Virtual
UNI Telehealth
SUD
Located in Summit County
Park City Therapy
Red Willow Counseling and Recovery
Sundance Behavioral Resources (Will consider adding SUD services. Contingent upon space – requesting County space)
U of U Health Redstone Clinic (Will develop these services at Redstone Clinic)
Located Outside Summit County
UNI Recovery Clinic (Salt Lake County)
Peer Support Services
Located in Summit County
NOTE: UNI will explore developing these services within Summit County.
Located Outside Summit County
Virtual
UNI WarmLine



Proclamation No. 2019-7

PROCLAMATION RECOGNIZING
Dana Lynn Shaw
FOR 25 YEARS OF PUBLIC SERVICE TO THE CITIZENS OF
SUMMIT COUNTY, UTAH

Whereas, Dana was born in Heber, Utah and shortly thereafter her parents moved to Kamas; and

Whereas, Dana attended South Summit Elementary School, South Summit Middle School, South Summit High School, Southern Utah University, and Weber State University. She was hired in by Summit County, September of 1994; and

Whereas, Dana comes from a family of public servants, her father was a local EMT, Firefighter, and Search & Rescue Team Member – while her mother was an EMT and ran the South Summit Ambulance Service; and

Whereas, Dana has held the positions of Bailiff, Reserve Deputy, EMT, Dispatcher, Lead Dispatcher, Dispatch Supervisor during her 25 years of service to the citizens of Summit County; and

Whereas, Dana has diligently attended to the collateral assignments of Tactical (SWAT) Dispatcher, Search and Rescue Dispatcher, Terminal Agency Coordinator, 911 Call Evaluator, and NENA Certified Call Center Manager during her tenure with the Summit County Sheriff's Office; and

Whereas, Dana has been vital to saving lives and promoting officer safety while attending to her post in the Public Safety Answering Point and Dispatch Center at the Summit County Sheriff's Office on nights, holiday's and weekends; and

Whereas, Dana served diligently during 2002 Winter Olympics contributing to the safety and successful completion of an international event. Was a founding member of the SWAT Tactical Dispatch Team (2005), received the Sheriff's Star – (Employee of the Year) in 2009, and earned a Good Samaritan and five Unit Citations over her career; and

Whereas, As a result of her profound experience, years of training, and calm presence during stressful situations: Dana was directly responsible for saving the life of Matt Sullins of Kamas, Utah in 2017. Dana provided immediate and vital CPR instructions to his wife to stabilize his vital signs while simultaneously coordinating a unified medical, fire, and law enforcement response, and launched a air ambulance. While Matt's case was the most memorable, Dana has saved numerous men, women, and children throughout her career in Dispatch; and

Whereas, Dana has been vital professional asset to the Summit County Sheriff's Office as supervisor, mentor, colleague, TAC coordinator, unofficial SWAT Mother, supreme coordinator, ultimate multi-tasker, and unconditional friend; and

Whereas, Dana will now channel a lifetime of professional skills and talents into reaping the benefits of a well deserved pension while continuing to provide profound love and support to family and many friends; and

Whereas, Dana must prepare for a very, very long retirement while attending numerous NASCAR races, preparing first-class gift baskets, and attending glamorous social events.

Now, therefore, be it resolved that the Summit County Council does hereby recognize the retirement of Dana Lynn Shaw and thanks her for her contributions to the County, for her continued support of employees and her commitment to making Summit County an all-around better place for those who live in and visit here.

APPROVED AND ADOPTED this 10th day of April 2019.
SUMMIT COUNTY COUNCIL

Roger Armstrong, Chair

Doug Clyde, Vice Chair

Kent Jones, Clerk

**MARGARET H. OLSON
COUNTY ATTORNEY**

Criminal Division

PATRICIA S. CASSELL
Chief Prosecutor

BLAKE HILLS
Prosecuting Attorney

RYAN P. C. STACK
Prosecuting Attorney

IVY TELLES
Prosecuting Attorney



Summit County Courthouse \$ 60 N. Main \$ P.O. Box 128 \$ Coalville, Utah 84017
Telephone (435) 336-3206 Facsimile (435) 336-3287
email: (first initial)(last name)@summitcounty.org

Civil Division

DAVID L. THOMAS
Chief Deputy

JAMI R. BRACKIN
Deputy County Attorney

HELEN E. STRACHAN
Deputy County Attorney

To: Summit County Council

From: Helen Strachan

Date: April 10, 2019

RE: Proposed amendments to Title 2, Chapter 34, "Eastern Summit County Agricultural Preservation and Open Space Advisory Committee"

On March 27, 2019, the County Council had a work session to discuss proposed amendments to Title 2, Chapter 34 of the Summit County Code related to the "Eastern Summit County Agricultural Preservation and Open Space Advisory Committee." (*see attached*). The County Council asked whether all extraneous policies previously adopted by the Committee and attached to their last staff report are being repealed. The Committee will continue to have grant applicants fill out the "Notification of Interest" ("NOI") form and once complete, the application will be presented to the Committee who will score the application using the Committee's scoring and ranking sheet. Both the NOI form and the current scoring and ranking sheet are attached. I have also included the staff report from the March 27, 2019 meeting. Staff asks that Council adopt the amendments to Title 2, Chapter 34.

ORDINANCE NO. ____

AN ORDINANCE AMENDING TITLE 2, CHAPTER 34 OF THE SUMMIT COUNTY CODE

**EASTERN SUMMIT COUNTY AGRICULTURE PRESERVATION AND OPEN SPACE
ADVISORY COMMITTEE**

WHEREAS, the Eastern Summit County Agricultural Preservation and Open Space Advisory Committee (hereinafter “ESAP”) met at a regularly held public meeting on October 11, 2018 and forwarded recommendations to the Summit County Council with respect to amendments to Title 2, Chapter 34 of the Summit County Code ; and

WHEREAS, the purpose of ESAP’s recommendations are to consolidate existing and extraneous ESAP policies into the existing Title 2, Chapter 34 of the Summit County Code and provide clarifying language to both ESAP, the Summit County Council, and members of the public with respect to the process of applying for grants for agricultural and/or open land purposes

NOW THEREFORE, the County Legislative Body of the County of Summit, State of Utah, hereby ordains as follows:

Section 1. Title 2, Chapter 34: Title 2, Chapter 34 of the Summit County Code is amended as depicted in Exhibit A.

Section 2: Effective Date: This Ordinance shall take effect fifteen (15) days after the date of its publication.

APPROVED, ADOPTED, AND PASSED and ordered published by the Summit County Council, this ____ day of _____, 2019.

SUMMIT COUNTY COUNCIL
SUMMIT COUNTY, UTAH

Approved as to form:

By Council Chair

County Attorney’s Office

ATTEST:

SUMMIT COUNTY CLERK

_____ Date of Publication _____, 2019.

EXHIBIT A

Chapter 34
EASTERN SUMMIT COUNTY AGRICULTURE PRESERVATION AND OPEN SPACE LANDS
ADVISORY COMMITTEE

2-34-1: PURPOSE:**2-34-2: AUTHORITY:****2-34-3: MEMBERSHIP:****2-34-4: ~~POWERS AND DUTIES~~PROCEDURE FOR GRANT ISSUANCE AND OTHER DUTIES:****2-34-5: CONDUCT OF COMMITTEE MEMBERS:****2-34-6: MEETINGS AND ORGANIZATION:****2-34-1: PURPOSE:**

The eastern Summit County agriculture preservation and open space lands advisory committee (hereinafter referred to as either "ESAP" or (the "committeeCommittee"), is created for the purpose of advising and providing input to the county manager ("manager") and the county council regarding the creation, identification and preservation of agricultural le lands and open space lands within eastern Summit County, ~~and working with local mayors to preserve agricultural corridors into their cities.~~

2-34-2: AUTHORITY:

This committee is created as an advisory board-body to the county manager and county council for the purpose stated above. There shall be no actual or apparent authority vested in this board-committee except the authority granted in this chapter. Neither this committee nor any member thereof is empowered to bind the county as to the purchase of any agricultural lands or open lands, including the acquisition of conservation easements.

2-34-3: MEMBERSHIP:

- A. Members: Members shall be appointed and approved on a nonpartisan basis by the county manager with the advice and consent of the county council, and shall commence service at the first regular meeting in March of each calendar year, or at such other time thereafter as soon as practical. As indicated below, other organizations may have the right to nominate members, which will only serve if and when approved by the county manager.
- B. Terms: Members may serve three (3) year terms until a replacement is made. A member is term limited to three (3) consecutive terms. Members shall serve on a voluntary basis, without compensation, except that mileage or other travel expenses associated with service may be reimbursed by the county.

C. Representation: The committee shall be comprised of no less than seven (7) and no more than eleven (11) voting members. Preference for membership of the committee, which may include members from any of the following groups:

1. Eastern Summit County planning commission (the "ESCPC"). There shall be no more than two (2) members representing the ESCPC on the committee at any time.
2. A professional real estate agent located in eastern Summit County.
3. A land use attorney located in eastern Summit County.
4. An agriculture services representative (NRCS or similar organization).
5. A Summit County ~~farm-Farm bureau~~ Bureau representative (nominated by the ~~farm-Farm bureau~~ Bureau).
6. An at large community representative living in north Summit.
7. An at large community representative living in south Summit.
8. A local builder and/or developer.
9. An open ~~space-lands~~ or wildlife organization representative.

D. Ex Officio Members: In addition to the voting members identified above, the county manager may appoint nonvoting ex officio members to the committee in an effort to fulfill the purposes set forth herein. ~~Ex officio members may include:~~

- ~~1. Representative(s) from the Summit County community development department.~~
- ~~2.1. Staff representative(s) from other county departments and/or incorporated cities and towns.~~

E. Reporting: The committee shall make an annual presentation to the county council and county manager as to its goals, budget and activities. report in its advisory capacity to the manager at least once each year.

F. Chair/Vice Chair: The committee shall appoint from among the voting members, a chair and a vice chair, who shall be charged with conducting the meetings and ensuring that the reporting required under this chapter is completed in the manner required. The chair shall serve a term of one (1) year. No member shall serve as chair for more than two (2) consecutive one (1) year terms. The vice chair shall serve a term of one (1) year. No member shall serve as vice chair for more than two (2) consecutive one (1) year terms. If the chair leaves the committee during an appointed term, the vice chair shall succeed to the office of chair for the remainder of the term. If the vice chair leaves the committee or succeeds to the office of chair, the committee, at its next regularly scheduled meeting, shall hold an election to fill the vacancy of vice chair.

2-34-4: POWERS AND DUTIES PROCEDURE FOR GRANT ISSUANCE AND OTHER DUTIES:

- A. Recommendations Scoring System: The committee shall create a scoring system whereby agricultural lands and/or open lands can be evaluated in relation to their potential importance to eastern Summit County. Such scoring system shall include the setting of a minimum score upon which real properties can become eligible for funding under this chapter. advise the manager on acquiring and permanently preserving agriculture lands and open spaces in eastern Summit County. This may include creating criteria and a scoring system whereby agriculture land and open space can be evaluated in relation to its potential importance to eastern Summit County. The scoring system shall be recommended to the County Manager for final approval.
- B. Proposals: The chair of the committee, or his/her designee, shall have responsibility of presenting all proposals from the committee to the manager. Notification of Interest:
1. Application Submittal and Presentation: Landowners who desire to nominate real property for agricultural lands and/or open lands preservation, whether in exchange for compensation or otherwise, may do so by filing a Notification of Interest (the "NOI") with the committee on forms provided for that purpose (the "NOI"). Upon receipt of an NOI application, County staff will review the application and verify completeness of required information. The application will then be scheduled on the ESAP agenda for an initial presentation by the landowner and/or representative.
 2. Site Visit and Evaluation: Following the initial presentation, the committee may conduct a site visit to review and verify the evaluation criteria related to the real property.
 3. The committee shall score all NOI's as eligible or ineligible for grant funding based upon the Scoring System established under Section 2-34-4(A) above and shall make a recommendation to the county manager with respect to proposed grants of Summit County as follows:
 - a. Conservation Easements: In the case of the purchase of conservation easements, the recommended grant by Summit County shall be limited up to the lesser of \$250,000 or up to 10% of the appraised value of the conservation easement, including all phases, if the purchase is in phases.
 - b. Land Acquisitions: In the case of the purchase of fee title to land for conservation purposes, the recommended grant by Summit County shall be limited up to the lesser of \$250,000 or up to 10% of the fair market value of the land.
 - c. The recommended grants proposed in Section 3(a) and (b) above are guidelines and are not intended to fix the amount of County participation in any given instance. The committee may waive the provisions of

Section 3(a) and (b) above on a case-by-case basis upon the finding of extenuating circumstances. However, in no case shall the recommended grant be greater than the lesser of \$250,000 or 15% of the appraised value of the conservation easement, including all phases, if the purchase is in phases (conservation easements) or 15% of the fair market value of the land (land acquisitions).

4. The committee's recommendation to the county manager is valid for twenty-four (24) months from the date of issuance.

C. Final Authority: Notwithstanding anything in the foregoing to the contrary, the manager retains all final authority regarding such transactions and if deemed necessary for the health, safety, or welfare of citizens of the county, the manager may take direct action on any issues discussed.

D. Grant Award: Grant awards issued by the county manager are valid for six (6) months from the date of award. Upon a showing of due diligence, the applicant may request and the committee may extend the award for up to three (3) additional six (6) month periods. In no event shall an award be valid for any period exceeding twenty-four (24) months. Failure to satisfy the conditions of the award within the allotted time period will result in its expiration without further action by the county.

E. Final Authority: Neither the determination of eligibility nor the recommendations on grants are binding on the county manager. The county manager retains all final authority regarding such transactions and if deemed necessary for the health, safety, or welfare of citizens of the county, the county manager may take direct action on any acquisition or grant without obtaining a recommendation or ranking from the committee. In such cases, the county manager may notify and meet with the committee prior to taking such direct action on any acquisition or grant.

F. The committee shall also develop recommendations for the county manager on different methods that may be used to preserve and acquire agricultural lands and open lands including, but not limited to, transfer of development rights, donated or purchased conservation easements, and public (including federal, state, and local) and private funding sources and mechanisms.

2-34-5: CONDUCT OF COMMITTEE MEMBERS:

A. Ethical Principles: The following ethical principles shall guide the actions of the committee and its members in carrying out the powers and duties described above:

1. Serve The Public Interest: The primary obligation of the committee and each member is to serve the public interest.

2. Support Citizen Participation: The committee shall ensure a forum for meaningful citizen participation and expression in the process of promoting agriculture land and open ~~space-land~~ preservation, and assist in the clarification of community goals, objectives, and policies.
3. Recognize The Comprehensive And Long Range Nature Of Their Decisions: The committee and its members shall continuously gather and consider all relevant facts, alternatives and means of accomplishing them, and explicitly evaluate all consequences before making a recommendation or decision.
4. Facilitate Coordination: The committee shall ensure that individuals and public and private agencies possibly affected by a prospective decision regarding agriculture land or open ~~space-land~~ receive adequate information far enough in advance of the decision.
5. Avoid Conflict Of Interest: Committee members shall avoid conflicts of interest and even the appearance of impropriety. At the commencement of any matter before the committee, members shall divulge in public, any past, present, or expected relationship with any party affiliated with such matter. A member with a potential conflict of interest shall abstain from voting on the matter, not participate in any deliberations on the matter, and leave the committee table, but may remain in the chamber. The member shall also not discuss the matter privately with any other official voting on the matter.
6. Render Thorough And Diligent Service: If a committee member has not sufficiently reviewed relevant facts and advice affecting a public decision, that member should not participate in that decision.
7. Not Seek Or Offer Favors: A committee member must not directly or indirectly solicit any gift or accept or receive any gift (whether in money, services, loans, travel, entertainment, hospitality, promises, or in some other form) under circumstances in which it could be reasonably inferred that the gift was intended or could reasonably be expected to influence them in the performance of their duties or was intended as a reward for any recommendation or decision on their part.
8. Not Disclose Or Improperly Use Confidential Information For Financial Gain: A committee member shall not disclose or improperly use confidential information for financial gain, and must not disclose to others confidential information acquired in the course of their duties or use it to further a personal interest.
9. Ensure Full Disclosure At Public Meetings: The committee shall ensure that the presentation of information occurs only at the scheduled public meeting, not in private, unofficially, or with other interested parties absent, and must make partisan information received in the mail or by telephone or other communication part of the public record.
10. Maintain Public Confidence: A committee member must conduct himself/herself publicly so as to maintain public confidence in the committee.

11. Respect For And Courtesy To Other Committee Members, Public And Staff: Each committee member has the same rights and privileges as any other member. Any member has the right to be heard and to hear what others have to say about items being considered by the committee.

- B. Representation Of Applicants Or Petitioners: No member of the committee shall represent for consideration applicants or petitioners before the committee on matters on which the committee is to make determinations or recommendations.
- C. Ex Parte Communication: Prearranged private **communications and/or** meetings between a committee member and an individual(s) and, their agents, or other interested parties with a matter pending before the committee are prohibited, unless authorized by the committee in advance. When such communication does occur it must be made part of the public record by the committee member.
- D. Attendance: Each committee member shall be responsible for attending all scheduled meetings of the committee. Should circumstances arise where a member is unable to attend a scheduled meeting, the member shall be responsible for notifying the chair, the director of community development, or his/her designee, as soon as possible. Committee members who fail to attend three (3) regular meetings of the committee within any consecutive three (3) month period may, at the discretion of the manager, be removed from the committee. (Ord. 749-A, 12-15-2010)

2-34-6: MEETINGS AND ORGANIZATION:

- A. Regular Meetings: Regular meetings of the committee shall be scheduled as needed.
- B. Special Meetings: Special meetings, work sessions and field trips, for any purpose, may be held at the call of the chair of the committee, ~~the manager or the director of community development~~. Work session and field trip meetings shall be for discussion and informational purposes only; no action shall be taken on any item.
- C. Public Notice: All regular, special, work session and field trip meetings of the committee are open to the public and will be noticed in accordance with the requirements of the development code and the Utah ~~o~~Open ~~M~~meetings ~~A~~act.
- D. Action: All recommendations shall be made at a public meeting by motion, made and seconded and by a voice vote. The motion shall be in the form of findings of fact and shall state the reason for the findings by the committee and a statement of any conditions to be attached to the action.

E. Executive Session: Closed or executive sessions may be held for any purposes allowed under the Utah Open Meetings Act, including, but not limited to, property acquisition.

F. ~~Bylaws:~~ The committee shall conduct its business according to this chapter and the Committee may make recommendations to the County Council for amendments. ~~bylaws, which shall be approved by the county council, with the committee meeting as needed to act on the business of the committee.~~

G. Quorum: A majority of the committee members shall constitute a quorum and the action of the majority of the members present shall be the action of the committee.

Eastern Summit County Agricultural Preservation and Open Space Advisory Committee (ESAP)

Notification of Interest (NOI) For Agricultural or Open Space Land Preservation

- 1) Address/Location of Property:

- 2) Assessor's Parcel Number (s) (Tax ID#s):

- 3) Total Acreage of Parcel(s):

- 4) Development potential of property (#of lots) under current zoning at base density as determined by the Summit County Development Code in affect at the time of application. (may require lot of record determination application and applicable fees.)

- 5) Property Owner(s) Name and Contact Information:

- 6) Authorized Representative and Contact Information:

- 7) Agricultural or Open Space Land Values: (Explain the reasons you are interested in preserving this property as agricultural or open space land)

Owner(s) signature: _____

Date: _____

Date Received: _____

Eastern Summit County
Agriculture Preservation and Open Space Advisory Committee (ESAP)
ELIGIBILITY AND EVALUATION GUIDELINES

July 2017

Project Name: _____

Date: _____

: **Check each box that applies:**
***In order for an application to qualify, an applicant must meet 8 of the 10 criteria.**

1. Has the applicant followed the review procedures required for the Notice of Interest (NOI) application?
2. Is the property within the AP-40, HC Zone or a Municipal Agricultural Zone?
3. Is the entire property area qualified for a “greenbelt” designation?
4. Are farming or ranching operations present on the land?
5. Does the preservation of the parcel or agricultural operation help prevent or minimize sprawling of residential development?
6. Does the property include or protect critical watersheds, view sheds, water quality, wildlife habitat, stream corridors, woodlands, or historic structures?
7. Will the property contribute to and promote the agricultural viability and open land character of Eastern Summit County?
8. Will all existing water rights attached to the property at the time of application remain with the property to maintain the agricultural use?
9. Is the property at least five (5) acres in size or located contiguous to already preserved agricultural lands or open space or other county open space and will it contribute to or enhance the existing preserved agricultural lands and open space?
10. Does the property serve as a buffer or screening between producing farms and ranches and non-agricultural uses or development?

**MARGARET H. OLSON
COUNTY ATTORNEY**



Criminal Division

PATRICIA S. CASSELL
Chief Prosecutor

BLAKE HILLS
Prosecuting Attorney

RYAN P. C. STACK
Prosecuting Attorney

IVY TELLES
Prosecuting Attorney

Summit County Courthouse \$ 60 N. Main \$ P.O. Box 128 \$ Coalville, Utah 84017
Telephone (435) 336-3206 Facsimile (435) 336-3287
email: (first initial)(last name)@summitcounty.org

Civil Division

DAVID L. THOMAS
Chief Deputy

JAMI R. BRACKIN
Deputy County Attorney

HELEN E. STRACHAN
Deputy County Attorney

**To: Summit County Council
From: Helen Strachan
Date: March 27, 2019
RE: Proposed amendments to Title 2, Chapter 34, "Eastern Summit County Agricultural Preservation and Open Space Advisory Committee"**

The purpose of this meeting is to discuss the recommendations of the Eastern Summit County Agricultural Open Space Advisory Committee (hereinafter "ESAP") to amend Title 2, Chapter 34 of the Summit County Code (see Exhibit A).

ESAP Background: The Promontory Specially Planned Area or "SPA" was created in 2001. The Development Agreement implementing that Promontory SPA included a provision as part of the community benefits associated with the project that states as follows:

4.7.1 Agricultural Preservation Contributions. \$3,000, subject to Price Level Adjustment, for each Residential Unit will be payable by the purchasers of Lots at the time of Lot sale. The County may withhold the issuance of building permits pending payment of this Agricultural Preservation Contribution. The Agricultural Preservation Contribution shall be retained by the County in trust and used to acquire title to or conservation easements on agricultural properties in Summit County or otherwise to preserve or enhance agricultural operations in Summit County.

Thereafter, in 2005, the County Commission created ESAP for the express purpose of advising the then-County Commission (now the County Manager) on the identification and preservation of agricultural lands and open space in Eastern Summit County. The funding source for ESAP and the County Manager comes from Agricultural Preservation Contributions required under the Promontory SPA.

ESAP's purpose, powers and duties have been codified in the Summit County Code, Title 2, Chapter 34. ESAP is advisory to both the County Manager and County Council and its stated purpose is to "advise and provide input to the county manager regarding the identification and preservation of agriculture land and open space within eastern Summit County, and working with local mayors to preserve agricultural corridors into their cities." ESAP's powers include the

ability to create criteria and a scoring system to evaluate agricultural and open space lands “in relation to its potential importance to eastern Summit County.” ESAP revised its criteria last year and the new criteria were given the blessing of County Manager, Tom Fisher.

However, in addition to the powers and duties outlined in Title 2, Chapter 34, ESAP has, over the years, adopted extraneous policies separate from Title 2, Chapter 34. I have attached those policies as Exhibit B. It is ESAP’s desire to consolidate some of these extraneous policies with the existing Title 2, Chapter 34 and abandon a few of them altogether. For example, ESAP feels that the existing “Media Communications Policy,” is unnecessary as it is rarely used and echoes much of what is already covered by the State’s Open Meetings Act.

The proposed changes to Title 2, Chapter 34 are summarized below:

- First, ESAP wishes to change the committee’s name from the “Eastern Summit County Agricultural Preservation and Open *Space* Advisory Committee” to the “Eastern Summit County Agricultural Preservation and Open *Lands* Advisory Committee.” While the change is rather small, ESAP feels that “open space” is often a loaded term in Eastern Summit County and prefers the concept of “open lands.”
- ESAP is suggesting some clean-up language with respect to the “Membership” Section 2-34-3. It removed the requirements that the Community Development Department serve “ex officio” on ESAP, which is consistent with ESAP’s practice over the last two years since the creation of the Rural Affairs Liaison position. ESAP also added clarifying language regarding the terms/appointments of its Chair and Vice Chair.
- ESAP is recommending a new section, 2-34-4 “Procedure for Grant Issuance and Other Duties.” This new section is consistent with a previously established policy of ESAP. Title 2, Chapter 34 has never had clear language on how the grant process works and this section attempts to add clarity to the process. The process begins with a property owner filling out a Notification of Interest form and nominating real property for agricultural land and/or open land preservation. County staff then reviews the form for completeness and schedules the application before ESAP.

The property owner makes an initial presentation to ESAP, who may choose to conduct a site visit of the property. Thereafter, ESAP scores the property based upon its established scoring system criteria and makes a recommendation to the County Manager. ESAP is recommending language, consistent with the extraneous policy they have been using, that grant awards are limited to the lesser of \$250,000 or up to 10% of the appraised value (if the grant is for a conservation easement) or, in the case of fee title purchase of property, the grant award is limited to the lesser of \$250,000 or up to 10% of the fair market value of the land. ESAP established these limitations based upon the finite funding in the ESAP budget. However, ESAP has built in discretion to waive that provision on a case-by-case basis upon a finding of extenuating circumstances. They have limited said discretion, stating that in no case shall the recommended grant be

greater than the lesser of \$250,000 or 15% of the appraised value of the conservation easement or 15% of the fair market value of the land, if a land acquisition.

- ESAP is recommending deadlines on the validity of the grant recommendations, adding language that ESAP's recommendation to the County Manager is valid for twenty-four (24) months from the date of issuance. Once the grant is issued by the County Manager, it is then valid for six months, with a possibility of three, six-month extensions.
- ESAP added clarifying language regarding the fact that the County Manager is the final authority. It would like to add language that says, while the County Manager is the final authority, he also has discretion to notify and meet with ESAP prior to taking direct action on any grant awards.
- ESAP also is suggesting language that allows them to make recommendations to the County Manager regarding different methods that land may be conserved for agricultural and open land purposes, such as public/private partnerships, transfers of development rights, and donations.

Staff and ESAP request that you review the proposed amendments and recommend approval of the same. Thank you.

Public Works Director



Derrick A. Radke, P.E.

MEMORANDUM

April 2, 2019

To: Summit County Council

From: Derrick Radke, PE - Summit County Public Works Director

Re: Agenda Item for April 10, 2019
UTOPIA FIBER - Franchise Agreement Proposal

UTOPIA FIBER has requested that Summit County enter into a Franchise Agreement which is enclosed for your consideration. The proposed agreement allows UTOPIA FIBER to install "fiber optic-related" lines and equipment within the County right-of-way. The Agreement is non-exclusive and requires UTOPIA FIBER to still follow the required Permitting process as any other utility or person wanting to work in our right-of-way.

Because of the nature of the business that UTOPIA FIBER engages, they will not be required to pay the County a franchise fee. UTOPIA FIBER is a telecommunications service provider. They do not provide any video, broadcast, or television programming services over their network. They strictly provide high speed bandwidth either to the Internet or to other locations/end points as specified by our clients. The immediate requirement for presence in Summit County is to serve a number of business customers in the Kimball Junction area and also in the area near the interchange of I-80 and UT 189. Expansion could be possible in either area as businesses may request connections to the network in the future. The term of this agreement is for 10 years and would expire in January of 2026.

David Thomas, Chief Civil Deputy County Attorney drafted the Agreement. The terms of the Agreement are consistent with State and Federal Law.

I would recommend that the Franchise Agreement with UTOPIA FIBER be executed. If you concur, please sign the Agreements and return one the two copies to my office. The original Agreements have been delivered to Annette Singleton, Office Manager. If you have any questions or if I can be of further assistance, please let me know.

Enclosure (2 copies - Franchise Agreement Documents)

CC: Joshua Chandler, UTOPIA FIBER General Counsel, sent to: jchandler@utopiafiber.com
file: (C:\Users\DRadke\Documents\MyDocs\communications\Franchise Agreements\UTOPIA\cc-utopia franchise agreement 4-2-19.doc)

P.O. Box 128 · Coalville, UT 84017
Coalville: (435) 336-3970 · Kamas: (435) 783-4351 ext. 3970 · Park City (435) 615-3970
Fax: (435) 336-0823 · Park City Fax (435) 615-0823

**FRANCHISE AGREEMENT BETWEEN
SUMMIT COUNTY, UTAH AND
UTOPIA FIBER**

This Franchise Agreement ("Franchise") is between Summit County, Utah, hereinafter referred to as the "County" and Utah Telecommunication Open Infrastructure Agency ("UTOPIA Fiber"), an interlocal entity and political subdivision of the State of Utah, hereinafter referred to as "the Grantee." The County and the Grantee are referred to together as "the Parties."

The County hereby acknowledges that the Grantee has the financial, legal, and technical ability to provide services, facilities, and equipment necessary to meet the fiber optic-related needs of the community, and having afforded the public adequate notice and opportunity for comment, desires to enter into this Franchise with the Grantee for the construction and operation of a Fiber Optic System on the terms set forth herein.

SECTION 1

Definition of Terms

1.1 Terms. For the purpose of this Franchise, the following terms, phrases, words, and abbreviations shall have the meanings ascribed to them below. When not inconsistent with the context, words used in the present tense include the future tense, words in the plural number include the singular number, and words in the singular number include the plural number:

- A. "Affiliate" when used in relation to any person, means another person who owns or controls, is owned or controlled by, or is under common ownership or control with, such person.
- B. "County" means Summit County, Utah, or the lawful successor, transferee, or assignee thereof.
- C. "FCC" means Federal Communications Commission or successor governmental entity thereto.
- D. "Fiber Optic System" means the Grantee's facility, consisting of a set of closed transmission paths and associated signal generation, reception, and control equipment that is designed to provide Fiber Optic Service to multiple customers within the Service Area.
- E. "Grantee" means UTOPIA Fiber or the lawful successor, transferee, or assignee thereof.

F. "Person" means an individual, partnership, association, joint stock company, trust, corporation, or governmental entity but not the County.

H. "Public Way" shall mean the surface of, and the space above and below, any public street, highway, freeway, bridge, land path, alley, court, boulevard, sidewalk, parkway, way, lane, public way, drive, circle, or other public right-of-way, including, but not limited to, public utility easements, dedicated utility strips, or rights-of-way dedicated for compatible uses and any temporary or permanent fixtures or improvements located thereon now or hereafter held by the County in the Service Area which shall entitle the County and the Grantee to the use thereof for the purpose of installing, operating, repairing, and maintaining the Fiber Optic System. Public Way shall also mean any easement now or hereafter held by the County within the Service Area for the purpose of public travel, or for utility or public service use dedicated for compatible uses, and shall include other easements or rights-of-way as shall within their proper use and meaning entitle the County and the Grantee to the use thereof for the purposes of installing and operating the Grantee's Fiber Optic System over poles, wires, cables, conductors, ducts, conduits, vaults, manholes, amplifiers, appliances, attachments, and other property as may be ordinarily necessary and pertinent to the Fiber Optic System. Public Way shall not include bike paths or trails not dedicated for utility services or compatible uses.

I. "Service Area" means the present boundaries of the County, and shall include any additions thereto by annexation or other legal means, subject to the exceptions in subsection 3.9.

SECTION 2

Grant of Franchise

2.1 Grant. The County hereby grants to the Grantee a nonexclusive Franchise which authorizes the Grantee to construct and operate a Fiber Optic System in, along, among, upon, across, above, over, under, or in any manner connected with Public Ways within the Service Area, and for that purpose to erect, install, construct, repair, replace, reconstruct, maintain, or retain in, on, over, under, upon, across, or along any Public Way such facilities and equipment as may be necessary or appurtenant to the Fiber Optic System.

2.2 Competitive Equity. The Grantee acknowledges and agrees that the County reserves the right to grant one (1) or more additional franchises or other similar lawful authorization to provide Fiber Optic Services within the County; provided, the County agrees that, within ninety (90) days of

the Grantee's request, it shall amend this Franchise to include any material terms or conditions that it makes available to the new entrant, or provide relief from existing material terms or conditions, so as to insure that the regulatory and financial burdens on each entity are materially equivalent. "Material terms and conditions" include, but are not limited to: insurance; System build-out requirements; security instruments; and notice and opportunity to cure breaches. The parties agree that this provision shall not require a word for word identical franchise or authorization for a competitive entity so long as the regulatory and financial burdens on each entity are materially equivalent.

2.3 Term. The Franchise granted hereunder shall be for an initial term of ten (10) years commencing on the Effective Date of the Franchise as set forth in subsection 7.7, unless otherwise lawfully terminated in accordance with the terms of this Franchise.

SECTION 3

Standards of Service

3.1 Conditions of Occupancy. The Fiber Optic System installed by the Grantee pursuant to the terms hereof shall be located so as to cause a minimum of interference with the proper use of Public Ways and with the rights and reasonable convenience of property owners who own property that adjoins any of such Public Ways.

3.2 Other Ordinances. The Grantee agrees to comply with the terms of any lawfully adopted generally applicable local ordinance and regulations, to the extent the provisions of the ordinance or regulations do not have the effect of limiting the benefits or expanding the obligations of the Grantee that are granted by this Franchise. Neither party may unilaterally alter the material rights and obligations set forth in this Franchise. In the event of a conflict between any ordinance and this Franchise, the Franchise shall control, provided however, that the Grantee agrees that it is subject to the lawful exercise of the police power of the County.

3.3 Restoration of Public Ways. If during the course of the Grantee's construction, operation, or maintenance of the Fiber Optic System there occurs a disturbance of any Public Way by the Grantee, Grantee shall replace and restore such Public Way at Grantee's expense to a condition reasonably comparable to the condition of the Public Way existing immediately prior to such disturbance and in a manner reasonably approved by the County Engineer.

3.4 Relocation for the County. Upon its receipt of reasonable advance written notice, to be not less than five (5) business days in the event of a temporary relocation and no less than ten (10) business days for a permanent relocation, the Grantee shall, at its own expense except as provided by law or entitlement, protect, support, raise, lower, temporarily disconnect, relocate in or remove from the Public Way, any property of the Grantee when lawfully required by the County by reason of traffic conditions, public safety, street abandonment, freeway and street construction, change or establishment of street grade, installation of sewers, drains, gas or water pipes, power lines or other municipal utility infrastructure, or any other type of public structures or improvements which are not used to compete with the Grantee's services.

3.5 Relocation for a Third Party. The Grantee shall, on the request of any Person holding a lawful permit issued by the County, protect, support, raise, lower, temporarily disconnect, relocate in or remove from the Public Way as necessary any property of the Grantee, provided: (A) the expense of such is paid by said Person benefiting from the relocation, including, if required by the Grantee, making such payment in advance; and (B) the Grantee is given reasonable advance written notice to prepare for such changes. For purposes of this subsection, "reasonable advance written notice" shall be no less than ten (10) business days in the event of a temporary relocation, and no less than sixty (60) days for a permanent relocation.

3.6 Trimming of Trees and Shrubbery. After obtaining the prior written consent of the County, the Grantee shall have the authority to trim trees or other natural growth overhanging any of its Fiber Optic System within Public Ways in the Service Area so as to prevent branches from coming in contact with the Grantee's wires, cables, or other equipment. The Grantee shall reasonably compensate the County for any damage caused by such trimming, or shall, in its sole discretion and at its own cost and expense, with the prior written consent of the County, reasonably replace all trees or shrubs damaged as a result of any construction of the Fiber Optic System undertaken by the Grantee. Such replacement shall satisfy any and all obligations the Grantee may have to the County pursuant to the terms of this Section. Nothing herein shall give the Grantee the right to trim trees not within Public Ways without the permission of the landowner or without the permission of the County upon showing of public need.

3.7 Safety Requirements. Construction, operation, and maintenance of the Fiber Optic System shall be performed in an orderly and workmanlike manner. All such work shall be performed in accordance with generally applicable federal, state, and local regulations and the National Electric Safety Code. The Fiber Optic System shall not endanger or unreasonably interfere with the safety of Persons or property in the Service Area.

3.8 Aerial and Underground Construction. Prior to construction, in each case, all applicable permits shall be applied for and granted and all fees shall be paid. All other codes and ordinances of the County that pertain to such construction shall be complied with.

A. In those areas of the Service Area where all of the transmission or distribution facilities of the respective public utilities providing telephone communications and electronic services are underground, the Grantee likewise shall construct, operate, and maintain all of its transmission and distribution facilities underground. In those areas of the Service Area where the transmission or distribution facilities of the respective public utilities providing telephone communications, and electric services are both aerial and underground, the Grantee shall consult with the County Engineer to determine whether the construction will be aerial or underground, and wherever possible depending on the season and the location construct, operate and maintain all of its transmission and distribution facilities, or any part thereof, underground. If the reason for not putting the facilities underground is seasonal, subject to County waiver as weather and other conditions may require the Grantee shall make reasonable efforts to move such facilities underground as weather permits, but no later than June 30 of the next summer.

B. For the purposes of this Franchise, with the exception of service drops, facilities to be placed "underground" shall be at least twenty four (24) inches below the surface grade.

C. Nothing contained in this Section shall require the Grantee to construct, operate, and maintain underground any ground-mounted appurtenances such as subscriber taps, line extenders, system passive devices (splitters, directional couplers), amplifiers, power supplies, pedestals, or other related equipment.

3.9 **Extensions of the Fiber Optic System.** The Grantee shall have the right, but not the obligation, to extend the Fiber Optic System into any portion of the Service Area where another operator is providing Fiber Optic Service, into any annexed area which is not contiguous to the present Service Area of the Grantee, or into any area which is financially or technically infeasible due to extraordinary circumstances, such as a runway or freeway crossing.

3.10 **New Construction.** In cases of new subdivision construction, the developer shall give Grantee reasonable notice of such construction or development and the particular date of which open trenching will be available for the Grantee's installation of conduit. Costs of trenching shall be borne by the developer unless agreed to otherwise between Grantee and developer.

3.11 **Technical Standards.** The Grantee is responsible for insuring that the Fiber Optic System is designed, installed and operated in a manner that fully complies with FCC rules as revised or amended from time to time. As provided in these rules, the County shall have, upon request, the right to obtain a copy of tests and records required in accordance with appropriate rules but has no authority, pursuant to federal law, to enforce compliance with such standards.

SECTION 4

Regulation by the County

4.1 Renewal of Franchise.

A. The County and the Grantee agree that any proceedings undertaken by the County that relate to the renewal of the Grantee's Franchise shall be governed by and comply with the provisions of federal law and FCC regulations.

B. The Grantee and the County agree that at any time during the term of the then current Franchise, while affording the public appropriate notice and opportunity to comment, the County and the Grantee may agree to undertake and finalize informal negotiations regarding renewal of the then current Franchise and the County may grant a renewal thereof.

4.2 **Conditions of Sale.** If a renewal of the Grantee's Franchise is denied or the Grantee's Franchise is lawfully terminated pursuant to Section 6 of this Franchise, and the County either lawfully acquires ownership of the Fiber Optic System or by its actions lawfully effects a transfer of ownership of the Fiber Optic System to another party, any such acquisition or transfer

shall be in accordance with federal law.

The Grantee and the County agree that in the case of a final determination of a lawful revocation of the Franchise, the Grantee shall be given a reasonable opportunity to effectuate a transfer of its Fiber Optic System to a qualified third party. Furthermore, the Grantee shall be authorized to continue to operate pursuant to the terms of its prior Franchise during such a period of time; however, under no event shall such authorization exceed a period of time greater than twelve (12) months from the effective date of such revocation. If, at the end of that time, the Grantee is unsuccessful in procuring a qualified transferee or assignee of its Fiber Optic System which is reasonably acceptable to the County, the Grantee and the County may avail themselves of any rights they may have pursuant to federal or state law. It is further agreed that the Grantee's continued operation of the Fiber Optic System during the twelve (12) month period shall not be deemed to be a waiver, nor an extinguishment of, any rights of either the County or the Grantee.

4.3 Transfer of Franchise. The Grantee's right, title, or interest in the Franchise shall not be sold, transferred or assigned, other than to an entity controlling, controlled by, or under common control with the Grantee, without the prior consent of the County, such consent not to be unreasonably withheld. No such consent shall be required, however, for a transfer in trust, by mortgage, by other hypothecation, or by assignment of any rights, title, or interest of the Grantee in the Franchise or Fiber Optic System in order to secure indebtedness. Within thirty (30) days of receiving a request for transfer, the County shall notify the Grantee in writing of any additional information it reasonably requires to determine the legal, financial and technical qualifications of the transferee. If the County has not taken action on the Grantee's request for transfer within one hundred twenty (120) days after receiving such request, consent by the County shall be deemed given.

SECTION 5

Insurance and Indemnification

5.1 Insurance Requirements. The Grantee shall maintain in full force and effect, at its own cost and expense, during the term of the Franchise, Comprehensive Commercial General Liability Insurance in the amount of Two Million Dollars (\$2,000,000) combined single limit per occurrence and Three Million Dollars (\$3,000,000) aggregate for bodily injury and property damage. The Grantee shall provide a Certificate of Insurance designating the County as an additional insured to the County. Additionally, the Grantee shall maintain in full force and effect, Automobile Liability insurance with limits of no less than \$500,000 combined single limit per accident for bodily injury and property damage. Such insurance shall be noncancellable except upon thirty (30) days prior written notice to the County. Upon written notice from the County, the Grantee shall increase the limits of such insurance to at least the amount of the Limitation of Judgments described in Section 63-30d-604 of the Governmental Immunity Act of Utah, as calculated by the state risk manager every two years and stated in Utah Admin. Code R37-4-3.

5.2 Indemnification. The Grantee agrees to indemnify, save and hold harmless, and defend the County, its officers, boards and employees, from and against any and all claims, demands, liens, and all liability for damages of whatsoever kind, including but not limited to any liability or claims resulting from property damage or bodily injury (including accidental death), which arise out of the Grantee's acts or omissions pursuant to or related to this Franchise, and to pay any

and all costs, including reasonable attorney's fees, incurred by the County in defense of such claims, provided that the County shall give the Grantee written notice of its obligation to indemnify the County within ten (10) days of receipt of a claim or action pursuant to this subsection. Notwithstanding the foregoing, the Grantee shall not indemnify the County for any damages, liability or claims resulting from the willful misconduct or negligence of the County.

SECTION 6

Enforcement and Termination of Franchise

6.1 Grounds for Termination. The County may terminate or revoke this Franchise and all rights and privileges herein provided for any of the following reasons:

A. The Grantee, by act or omission, materially violates a material duty herein set forth in any particular within the Grantee's control, and with respect to which redress is not otherwise herein provided. In such event, the County, acting by or through its County Manager, may determine, after hearing, that such failure is of a material nature, and thereupon, after written notice giving the Grantee notice of such determination, the Grantee, within sixty (60) calendar days of such notice, shall commence efforts to remedy the conditions identified in the notice and shall have ninety (90) calendar days from the date it receives notice to remedy the conditions. After the expiration of such 90-day period and failure to correct such conditions, the County may declare the franchise forfeited and this Franchise terminated, and thereupon, the Grantee shall have no further rights or authority hereunder; provided, however, that any such declaration of forfeiture and termination shall be subject to judicial review as provided by law, and provided further, that in the event such failure is of such nature that it cannot be reasonably corrected within the 90-day time period provided above, the County shall provide additional time for the reasonable correction of such alleged failure if the reason for the noncompliance was not the intentional or negligent act or omission of the Grantee.

6.2 Remedies at Law. In the event the Grantee or the County fails to fulfill any of their respective obligations under this Franchise, the County or the Grantee, whichever the case may be, shall have a breach of contract claim and remedy against the other, in addition to any other remedy provided herein or by law; provided, however, that no remedy that would have the effect of amending the specific provisions of this Franchise shall become effective without such action that would be necessary to formally amend the Franchise.

6.3 Third Party Beneficiaries. The benefits and protection provided by this Franchise shall inure solely to the benefit of the County and the Grantee. This Franchise shall not be deemed to create any right in any person who is not a party and shall not be construed in any respect to be a contract in whole or in part for the benefit of any third party (other than the permitted successors and assigns of the Parties hereto).

6.4 Uncontrollable Events. The Grantee shall not be held in default under, or in noncompliance with, the provisions of the Franchise, nor suffer any enforcement or penalty relating to noncompliance or default, where such noncompliance or alleged defaults occurred or were caused by strikes, acts of God, power outages, or other events reasonably beyond its ability to control including any delays caused by the County.

6.5 Bonds and Surety

- A. Except as expressly provided herein, the Grantee shall not be required to obtain or maintain bonds or other surety as a condition of being awarded the Franchise or continuing its existence.
- B. Notwithstanding the above provisions, the Grantee shall be responsible for standard performance bonds and insurance required for encroachment permits for work done within Public Ways.

6.6 Termination by Grantee. Notwithstanding any other provision of this Franchise to the contrary, Grantee may terminate this Franchise with or without cause six months after giving the County notice of Grantee's intent to terminate.

SECTION 7

Miscellaneous Provisions

7.1 Actions of Parties. In any action by the County or the Grantee that is mandated or permitted under the terms hereof, such party shall act in a reasonable, expeditious, and timely manner. Furthermore, in any instance where approval or consent is required under the terms hereof, such approval or consent shall not be unreasonably withheld.

7.2 Entire Agreement. This Franchise constitutes the entire agreement between the Grantee and the County on the subject of Fiber Optic Service. Amendments to this Franchise for any purpose, including but not limited to any changes in state or federal law, shall be mutually agreed to in writing by the Parties.

7.3 Notice. Unless expressly otherwise agreed between the Parties, every notice or response required by this Franchise to be served upon the County or the Grantee shall be in writing, and shall be deemed to have been duly given to the required party when placed in a properly sealed and correctly addressed envelope: a) upon receipt when hand delivered with receipt/acknowledgment, or b) upon receipt when sent certified or registered mail.

The notices or responses to the County shall be addressed as follows:

Summit County Manager
60 North Main
Street PO Box 128
Coalville UT 84017

With Copy to:

Summit County Attorney
60 North Main Street

P.O. Box 128
Coalville, UT 84017

The notices or responses to the Grantee shall be addressed as follows:

UTOPIA Fiber
Attn: Executive Director
5858 S. 900 E.
Murray, UT 84121

The County and the Grantee may designate such other address or addresses from time to time by giving notice to the other in the manner provided for in this subsection.

7.4 Descriptive Headings. The captions to Sections and subsections contained herein are intended solely to facilitate the reading thereof. Such captions shall not affect the meaning or interpretation of the text herein.

7.5 Severability. If any Section, subsection, sentence, paragraph, term, or provision hereof is determined to be illegal, invalid, or unconstitutional, by any court of competent jurisdiction or by any state or federal regulatory authority having jurisdiction thereof, such determination shall have no effect on the validity of any other Section, subsection, sentence, paragraph, term or provision hereof, all of which will remain in full force and effect for the term of the Franchise.

7.6 Applicable Law. The terms and conditions contained herein shall be interpreted according to the laws of the State of Utah, except where expressly preempted by federal law.

7.7 Effective Date. The Effective Date of this Franchise is the ____ day of _____, 2019 pursuant to the provisions of applicable law. This Franchise shall expire on the 31st day of _____, 2029, unless extended by the mutual agreement of the Parties.

Considered and approved this ____ day of _____ 2019.

SUMMIT COUNTY

Roger Armstrong, Chair
Summit County Council

Utah Telecommunication Open Infrastructure
Agency

Roger Timmerman, Executive Director

MINUTES

SUMMIT COUNTY
BOARD OF COUNTY COUNCIL
WEDNESDAY, MARCH 27, 2019
SUMMIT COUNTY COURTHOUSE
COALVILLE, UTAH

PRESENT:

Roger Armstrong, Council Chair
Doug Clyde, Council Vice-Chair
Chris Robinson, Council Member
Glenn Wright, Council Member

Tom Fisher, Manager
Janna Young, Deputy Manager
Dave Thomas, Chief Civil Deputy
Margaret Olson, Attorney
Kent Jones, Clerk

Council Member Carson was excused for the day.

Work Session – Interview applicants for vacancy on the North Summit Recreation Special Service District Board

The Council interviewed Jordan Wilson, Beau Morrill, Michael Grant, and Derrick Peterson for a vacancy on the Recreation Board.

Closed Session – Personnel and Property Acquisition

Council Member Robinson made a motion to convene in closed session to discuss personnel. The motion was seconded by Council Member Clyde and passed unanimously, 4 to 0.

The Summit County Council met in closed session from 2:00 p.m. to 2:34 p.m. to discuss personnel. Those in attendance were:

Roger Armstrong, Council Chair
Doug Clyde, Council Vice-Chair
Chris Robinson, Council Member
Glenn Wright, Council Member

Tom Fisher, Manager
Janna Young, Deputy Manager
Dave Thomas, Chief Civil Deputy
Margaret Olson, Attorney
Annette Singleton, Executive Assistant

Council Member Wright made a motion to leave session to discuss personnel and convene in closed session to discuss property acquisition. Council Member Clyde seconded and all voted in favor, 4-0.

The Summit County Council met in closed session from 2:34 p.m. to 3:34 p.m. to discuss property acquisition. Those in attendance were:

Roger Armstrong, Council Chair
Doug Clyde, Council Vice-Chair
Chris Robinson, Council Member
Glenn Wright, Council Member

Tom Fisher, Manager
Janna Young, Deputy Manager
Dave Thomas, Chief Civil Deputy
Margaret Olson, Attorney
Annette Singleton, Executive Assistant

Council Member Clyde made a motion to dismiss from closed session to discuss property acquisition and convene in open session. Council Member Robinson seconded with all voting in favor, 4-0.

Work Session continued

Pledge of Allegiance

Review Francis City Public Notice of Certification of Annexation Petition for parcels CD-2039, CD-2039-A, CD-2039-B and CD-2038; Kent Jones

Kent Jones, Clerk, reviewed the following information regarding Certification of a Petition notice from Francis City to consider annexation of parcels CD-2039, CD-2039-A, CD 2039-B, and CD-2038. The Community Development Director has reviewed the petition and has no concerns. No action is required of the Council unless they are inclined to protest.

Convene as the Governing Board of the Mountain Regional Water Special Service District

Council Member Clyde made a motion to convene as the Governing Board of the Mountain Regional Water Special Service District. Council Member Robinson seconded the motion and all voted in favor, 4-0.

Consideration and possible approval of Resolution MRW 2019-02, a Resolution Annexing Certain Real Property to the Mountain Regional Water Special Service District (SL-I-2-40); Marti Gee

Marti Gee, Assistant General Manager of the Mountain Regional Water Special Service District, submitted the following Annexation Petition from Justin Wright and Holly Wright regarding Parcel SL-I-2-40. She recommended approval by Resolution.

Council Member Clyde made a motion to approve Resolution MRW 2019-02, a Resolution Annexing Certain Real Property to the Mountain Regional Water Special Service District (SL-I-2-40), as recommended. Council Member Wright seconded and all voted in favor, 4-0.

Dismiss as the Governing Board of the Mountain Regional Water Special Service District

Council Member Clyde made a motion to leave session as the Governing Board of the Mountain Regional Water Special Service District and reconvene as the Board of County Council. Council Member Robinson seconded with all voting in favor, 4-0.

Consideration of Approval

Discussion and possible approval of Resolution 2019-03, A Resolution Approving an Interlocal Agreement Between Summit County, Utah and Uinta County, Wyoming for Mutual Aid and Assistance in Law Enforcement; Margaret Olson and Alan Siddoway

Alan Siddoway, Deputy, and County Attorney Margaret Olson, presented the following Interstate Mutual Aid Agreement between Summit County and Uinta County, Wyoming for Mutual Aid and Assistance in Law Enforcement with a recommendation of approval by Resolution.

Council Member Clyde made a motion to approve Resolution 2019-03, A Resolution Approving an Interlocal Agreement Between Summit County, Utah and Uinta County, Wyoming for Mutual Aid and Assistance in Law Enforcement as recommended. Council Member Wright seconded and all voted in favor, 4-0.

Discussion and approval of Proclamation No. 2019-5, a Proclamation Declaring the Month of April “County Government Month”; Krachel Murdock

Council Member Clyde made a motion to approve Proclamation 2019-5, a Proclamation Declaring the Month of April “County Government Month” with Council Member Wright seconding the motion and all voting in favor, 4-0.

Discussion and approval of Proclamation 2019-6, a Proclamation Recognizing Lynn Little for 18 ½ Years of Public Service to the Citizens of Summit County, Utah; Carolyn Rose

Council Member Clyde made a motion to approve Proclamation 2019-6, a Proclamation Recognizing Lynn Little for 18 ½ Years of Public Service to the Citizens of Summit County, Utah. Council Member Robinson seconded the motion and all voted in favor, 4-0.

Advice and consent of County Manager’s recommendation to appoint members to the Snyderville Basin Open Space Advisory Committee (BOSAC)

Council Member Wright made a motion to consent to the County Manager’s recommendation to appoint Nell Larson, and Kim Frauenberg to the Snyderville Basin Open Space Advisory Committee with terms of service to expire March 3, 2022. Council Member Clyde seconded and all voted in favor, 4-0.

Council Comments

- Chair Armstrong discussed the need for properties that support health transition issues
- Attended the Pink Park City Ski Event

- Council Member Wright will attend the MAOG meeting in April
- Attended a County wildland fire preparedness meeting
- UAC Board Meeting scheduled in April in conjunction with Spring Conference
- Noted the Citizens Climate Lobby asked for support of legislation proposed
- Attended a meeting with National Fire Service, South Summit Fire, Mountain Regional, and Weber Basin regarding watershed protection issues in Weber Canyon
- Park City School District should include discussion on transportation and traffic

Manager Comments

- Manager Fisher noted SSSD is considering a bond question for the November ballot
- He has started Employee Town Hall meetings. Discussions include the Work Plan and Contract with the Council, cyber security, and Q & A

Council Minutes dated March 13, 2019

Council Member Robinson made a motion to approve the minutes of March 13, 2019 with corrections noted. Council Member Clyde seconded. All voted in favor, 4-0.

Work Session continued

Discussion regarding proposed amendments to Title 2, Chapter 34, “Eastern Summit County Agricultural Preservation and Open Space Advisory Committee” and general update regarding the 2019 goals of the ESAP Committee; Helen Strachan and Don Sargent

Don Sargent, ESAP Committee Member, reviewed the following information regarding proposed amendments to Title 2, Chapter 34, of the Eastern Summit County Agricultural Preservation and Open Space Advisory Committee. Several changes are being submitted and staff asks that the Council gives consent to move forward with formal approval.

Council Members reviewed language changes and corrections suggested for implementation of a final document. Anita Lewis, Rural Affairs, reviewed the following presentation regarding the Mission, Process, and Guidelines of the committee.

Discussion regarding monument preservation; Devron Andersen and Rhonda Francis

Rhonda Francis, County Recorder/Surveyor, and Devron Andersen met with the Council to discuss the importance of Survey Monuments and what the State mandates for Counties’ responsibilities are for these monuments. Mr. Andersen reviewed the following presentation.

Public Input

There was no public input.

The Council meeting adjourned at 6:10 p.m.

Roger Armstrong, *Chair*

Kent Jones, *Clerk*