CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
UNITED HEALTHCARE OF ILLINOIS, INC.

I. PREAMBLE

United Healthcare of Illinois, Inc., including its subsidiaries, if any, ("UHCI") hereby enters into this Corporate Integrity Agreement ("CIA") with the Office of Inspector General ("OIG"), of the United States Department of Health and Human Services ("HHS"), to seek to ensure compliance by its employees (as well as all third parties with whom UHCI may engage as consultants or subcontractors) with the requirements of the Federal health care programs, including but not limited to the Medicare+Choice program (as currently defined at 42 U.S.C. § 1395w-21 *et. seq.*, and 42 C.F.R. Parts 400, 403, 410, 411, 417 and 422). UHCI's compliance with the terms and conditions in this CIA shall constitute an element of UHCI's present responsibility with regard to participation in the Federal health care programs.

This CIA is being executed in connection with an investigation and audit by the OIG relating to UHCI's classification of certain Medicare beneficiaries as institutionalized, which is a basis for enhanced capitation payments under the Medicare+Choice program. Contemporaneous with this CIA, UHCI is entering into a

Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

II. TERM OF THE CIA

The term of this CIA shall be five (5) years from the effective date of this CIA. The effective date of this CIA shall be the date on which the final signatory of this CIA executes this CIA. The compliance obligations assumed by UHCI under this CIA shall be suspended on the date upon which all of UHCI's contracts with Federal health care programs expire or terminate. If all of UHCI's contracts with Federal health care programs expire or terminate during the term of this CIA and UHCI proposes to enter into any new contract with a Federal health care program during the term of this CIA, UHCI agrees to enter into a new CIA with OIG that is acceptable to OIG for the new contract, prior to entering into any such contract. The period of compliance obligations assumed by UHCI under any new CIA shall be coextensive with the term of this CIA.

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III. CORPORATE INTEGRITY OBLIGATIONS

Beginning January 1, 2000, Medicare+Choice organizations, such as UHCI, are required by regulation to have a compliance program that meets the standards adopted by the Health Care Financing Administration ("HCFA") of HHS. In accordance with that requirement, UHCI has in place a compliance program based in part upon the compliance program of its parent corporation, UnitedHealth Group, Incorporated ("UnitedHealth") and UnitedHealthcare, Inc. ("UnitedHealthcare"), an indirect subsidiary of UnitedHealth. UHCI's compliance program is described in UnitedHealth's *Integrity and Compliance Program Description* and UnitedHealthcare's *Medicare+Choice Program Integrity and Compliance Program Supplement*, both of which were adopted by UHCI and provided to the OIG for its review on March 14, 2000 ("the UHCI Compliance Documents").

UHCI's compliance program seeks to meet the regulatory standards required by HCFA for its Medicare+Choice contractors. UHCI's compliance program already addresses many of the responsibilities included in this CIA. For at least the term of this CIA, UHCI's compliance program shall be revised where necessary to meet the following elements of this CIA.

The term "Pre-Existing Contractors" shall refer to Covered Persons (defined below) who are independent contractors with whom UHCI has an existing contract on the effective date of this CIA that has not been renewed or modified after the effective date of this CIA. Once UHCI renegotiates, modifies, or renews a contract with a Pre-Existing

Contractor, such Contractor ceases to be a Pre-Existing Contractor as that term is used for purposes of this CIA, and UHCI shall have full responsibility for the Code of Conduct distribution, training and certification compliance obligations as pertain to such Contractor as contemplated for Covered Person by Sections III.B. and III.C. of this CIA. Notwithstanding any other provision of this CIA, the following are UHCI's only obligations hereunder with respect to Code of Conduct distribution, training and certification for Pre-Existing Contractors: (i) UHCI shall attempt to renegotiate contracts with Pre-Existing Contractors to require such contractors to meet all of the Code of Conduct distribution, training and certification requirements of Sections III.B. and III.C. of this CIA; and (ii) UHCI shall make the Code of Conduct available to all Pre-Existing Contractors and shall make the general training, and specific training, where appropriate, available to all Pre-Existing Contractors, and shall use its best efforts to encourage their attendance and participation. The Compliance Officer shall keep a record of all Pre-Existing Contractors who attend such training. If UHCI meets its obligations above, the failure of a Pre-Existing Contractor to meet obligations set forth in its contract with UHCI shall not constitute a breach of this CIA by UHCI.

A. Compliance Program Positions

1. Compliance Officer UHCI has appointed and shall retain for at least the term of this CIA, an individual to serve as its Compliance Officer, who is responsible for developing and implementing

policies, procedures, and practices designed to promote compliance with the requirements set forth in this CIA and with the requirements of the Federal health care programs. The Compliance Officer is and shall remain a member of senior management of UHCI and shall not hold the position of Chief Financial Officer or General Counsel or hold a position within the Office of General Counsel of UHCI while serving as Compliance Officer. Under UHCI's compliance program, the Compliance Officer is and shall remain responsible for making regular (at least quarterly) reports regarding compliance matters directly to the CEO and/or to the Board of Directors of UHCI and is and shall remain authorized to report to the UHCI Board of Directors at any time. UHCI shall grant the Compliance Officer considerable independence to conduct his or her compliance activities. The Compliance Officer also is and shall remain responsible for monitoring the day-to-day activities engaged in by UHCI to further its compliance objectives as well as any reporting obligations created under this CIA. In performing his or her duties, the Compliance Officer shall utilize HCFA's December 1999 Medicare+Choice Monitoring Guide, as it may be amended from time to time, as a primary assessment tool to assess the adherence of UHCI to certain

HCFA requirements for managed care contractors. Further, with regard to data submission by UHCI to HCFA, the Compliance Officer shall be authorized to stop the submission of data that he or she believes contains material errors until such time as the issue in question has been resolved. In the event a new Compliance Officer is appointed during the term of this CIA, UHCI shall notify the OIG, in writing, within fifteen (15) days prior to such a change.

2. Compliance Committee UHCI has appointed and shall retain a Compliance Committee. The Compliance Committee includes and shall continue to include the Compliance Officer and senior managers from each of UHCI's major departments. The composition of the Compliance Committee may change from time to time, but shall continue to have representative senior managers from each of UHCI's major departments.

B. Written Standards.

1. *Code of Conduct.* UHCI has adopted and shall retain a Code of Conduct. Within one-hundred and twenty (120) days of the effective date of this CIA, UHCI shall review the Code of Conduct and, if necessary to satisfy the obligations in this CIA, shall amend it ("Code of Conduct"). Within one-hundred and twenty (120) days of the effective date of this CIA, UHCI shall distribute the Code of Conduct required by this

CIA to (a) any officer, director, or employee of UHCI or (b) any other person who (i) furnishes health care items or services at a facility owned or operated by UHCI (i.e., in the event that UHCI offers a staff model managed care product) for which UHCI claims reimbursement from any Federal health care program, or (ii) directly participates in the preparation or submission of data or reimbursement requests from any Federal health care program on behalf of UHCI (hereinafter, "Covered Person"), as well as any individual or entity with whom UHCI contracts to provide services and supplies to beneficiaries of Federal health care programs (hereinafter, "Contracted Provider").

UHCI shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of managers, supervisors, and all Covered Persons. The Code of Conduct shall, at a minimum, continue to set forth:

a. UHCI's commitment to full compliance with all statutes, regulations, and guidelines applicable to Federal health care programs, including its commitment to provide quality health care consistent with Federal and applicable State health care program regulations and procedures or instructions otherwise communicated by the Health Care Financing Administration ("HCFA") (or other appropriate regulatory agencies) and/or its agents;

b. UHCI's requirement that all of its Covered Persons shall be expected to comply with all statutes, regulations, and guidelines

applicable to Federal health care programs and with UHCI's own policies and procedures (including the requirements of this CIA);

c. UHCI's requirement that all of its Contracted Providers shall be expected to comply with all statutes, regulations, and guidelines applicable to Federal health care programs and with UHCI's own policies and procedures (including the requirements of this CIA) related to the contract with UHCI;

d. the requirement that all of UHCI's Covered Persons shall be expected to report suspected violations of any statute, regulation, or guideline applicable to Federal health care programs or of UHCI's own policies and procedures;

e. the possible consequences to both UHCI and to any Covered Person of failure to comply with all statutes, regulations, and guidelines applicable to Federal health care programs, and with UHCI's own policies and procedures or of failure to report such non-compliance;

f. the right of all Covered Persons to use the confidential disclosure program, as well as UHCI's commitment to confidentiality and non-retaliation with respect to disclosures; and

g. access to the confidential disclosure program for all Contracted Providers, as well as UHCI's commitment to confidentiality and non-retaliation with respect to disclosures.

Within one-hundred and fifty (150) days of the effective date of the CIA, each Covered Person shall certify, in writing, that he or she has received, read, understood, and agreed to abide by UHCI's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within two (2) weeks after the commencement of their employment or contract or within one-hundred and fifty (150) days of the effective date of the CIA, whichever is later. These certifications shall be maintained in a reasonable manner for, at a minimum, the term of this CIA. Contracted Providers that enter into contracts with UHCI after the effective date of this CIA shall receive the Code of Conduct within two (2) weeks after the commencement of the contract(s) or within one-hundred and fifty (150) days of the effective date of the CIA, whichever is later.

UHCI will annually review the Code of Conduct and will make any necessary revisions. These revisions shall be distributed to Covered Persons and Contracted Providers within thirty (30) days of initiating such a change. Covered Persons shall certify on an annual basis that they have received, read, understood and agreed to abide by the Code of Conduct.

2. *Policies and Procedures.* Pursuant to the UHCI Compliance Documents, UHCI is required to develop, implement, and maintain its own compliance policies and procedures. Within one-hundred and twenty (120) days of the effective date of this CIA, UHCI shall review existing written and unwritten policies and procedures, and, as appropriate, shall develop and initiate the implementation of revised written policies and procedures regarding the operation of UHCI's compliance program and its compliance with all federal and state health care statutes, regulations, and guidelines, including the requirements of the Federal health care programs (hereinafter, "Policies and Procedures"). At a minimum, the written Policies and Procedures shall specifically address the requirements set forth by HCFA, including applicable operational policy letters, regulations or additional guidance that is provided to Medicare+Choice organizations offering coordinated care plans. In addition, the Policies and Procedures shall include disciplinary guidelines and methods for Covered Persons to make disclosures or otherwise report on compliance issues to UHCI management through the Confidential Disclosure Program required by Section III.E., below. UHCI shall assess and update as necessary the Policies and Procedures at least annually and more frequently, as appropriate. A summary of the written Policies and Procedures will be provided to OIG in the Implementation Report. The Policies and Procedures will be available to OIG upon request.

Within one-hundred and fifty (150) days of the effective date of the CIA, the relevant portions of the Policies and Procedures shall be distributed or made available to all appropriate Covered Persons. Compliance staff or supervisors should be available to explain the Policies and Procedures within their respective areas.

C. Training and Education.

1. *General Training.* UHCI conveys its compliance principles to all new employees, including those of UHCI, through its New Employee Orientation. Within one-hundred and twenty (120) days of the effective date of this CIA, UHCI shall provide at least two (2) hours of general training to each Covered Person. This general training shall explain UHCI's:

a. Corporate Integrity Agreement requirements;

b. Compliance Program (including the Policies and Procedures as they pertain to general compliance issues); and

c. Code of Conduct.

These training materials shall be made available to the OIG, upon request.

New Covered Persons shall receive the general training described above as part of UHCI's new employee orientation within thirty (30) days of commencing their employment or within one-hundred and twenty (120) days after the effective date of this CIA, whichever is later. Every Covered Person shall receive such general training on an annual basis while the CIA is in effect.

2. *Specific Training.* Within one-hundred and fifty (150) days of the effective date of this CIA, each Covered Person who is directly involved in one or more of the following subject areas shall receive at least three (3) hours of specific training devoted to the applicable subject matter (hereafter "Specific Training"), in addition to the general training required above: data collection and submission for enrollment/disenrollment, encounter data, and adjusted community rates; claims processing; marketing; utilization review; quality assurance; and appeals and grievance procedures. This Specific Training shall include a discussion of:

a. the particular subject matter in which the individual is involved and the specific risk areas associated with that subject matter (*i.e.*, an individual involved in marketing should receive at least three hours of specific training on the risk areas associated with managed care marketing);

b. the policies, procedures and other requirements applicable to the specific subject matter in which the individual is involved;

c. the personal obligation of each individual involved in the provision of services for Federal health care programs, to ensure that reasonable and appropriate care is provided to beneficiaries of Federal health care programs;

d. applicable statutes, regulations and operational policy letters;

e. the legal sanctions for improper conduct; and

f. examples of proper and improper conduct.

These training materials shall be made available to OIG, upon request. Persons providing the training must be knowledgeable about the applicable subject area(s) and shall coordinate such training with the Compliance Officer.

New Covered Persons for whom Specific Training under this provision is required, shall receive this training within thirty (30) days of the beginning of their employment or within one-hundred and fifty (150) days after the effective date of this CIA, whichever is later. If a new Covered Person has any responsibility for any of the Specific Training subject areas identified above, another Covered Person who already has completed the Specific Training and has supervisory experience shall oversee all of the new Covered Person's work pertaining to the applicable subject matter of the Specific Training, until such time as the new Covered Person receives the applicable Specific Training.

Each Covered Person shall receive such Specific Training on an annual basis.

3. *Certification.* Each Covered Person shall certify, in writing, that he or she has attended the required training. The certification shall specify the type of training received and the date received. The Compliance Officer shall retain the certifications, along with specific course materials. These shall be made available to OIG upon request.

D. Engagements to Perform Annual Assessments. UHCI shall retain an outside entity, such as an accounting, auditing or consulting firm (hereinafter, "Independent Review Organization"), to perform consulting engagements to assess UHCI's enrollment

data submission, encounter data submission, adjusted community rate data submission, claims processing, and selective marketing/disenrollment practices with respect to UHCI's participation in the Medicare+Choice program. An additional engagement will determine whether UHCI is in compliance with this CIA ("compliance engagement"). Accordingly, the Independent Review Organization(s) will conduct six separate consulting engagements. The Independent Review Organization shall provide a final report or other final rendering of conclusions to UHCI. A complete copy of the Independent Review Organization's final reports or other final rendering of conclusions pursuant to these engagements shall be included in each of UHCI's Annual Reports to the OIG.

These independent analyses shall be an annual requirement and shall cover a twelve (12) month period. With its first, second, third and fourth Annual Reports (described below), UHCI may submit a request that OIG waive for the next reporting year the CIA's independent analysis requirement for *either* the claims processing or selective marketing/disenrollment engagement. The OIG shall retain full discretion to grant or deny this request with respect to either engagement and denial of the request shall not constitute an appealable decision. The Independent Review Organization(s) must be retained to conduct the engagements of the first year within one-hundred and twenty (120) days of the effective date of this CIA. The Independent Review Organization(s)

must have expertise in the procedures being assessed, as well as the reporting and other requirements of the Medicare+Choice program.

Where the engagement requires an analysis of a *statistically valid* sample of items, as specified below, the analysis shall be a variable appraisal, unless otherwise specified, and the following parameters shall apply: the sample size shall be determined through the use of a probe sample; at a minimum, the full sample must be within a ninety (90) percent confidence level and a precision of twenty-five (25) percent; the probe sample must contain at least thirty (30) sample units and cannot be used as part of the full sample; both the probe sample and the full sample must be selected through random numbers. To make a selection through random numbers, UHCI and/or the Independent Review Organization shall use OIG's Office of Audit Services Statistical Sampling Software, also known as *RAT-STATS*, which is available through the Internet at *www.hhs.gov/progorg/oas/ratstat.html*.

1. *Medicare+Choice Program Enrollment Data Engagement.* The purpose of the enrollment data engagement is to determine the accuracy and reliability of UHCI's submission of Medicare+Choice Program enrollment data to HCFA, including data for dual eligibility, institutionalization status, hospice, ESRD and out-of-area status. The enrollment data engagement shall consist of an analysis of a statistically valid sample of items that can be projected to the population of enrollment transactions for the relevant

one-year time period. Each annual enrollment data assessment shall include the following components in its methodology:

a. Enrollment Data Engagement Objective: A clear statement of the objective of the enrollment data engagement and the procedure(s) that will be applied to achieve the objective.

b. Enrollment Data Engagement Population: Identify the population, which is the group about whom data must be gathered and analyzed. Explain the methodology used to develop the population and provide the basis for this determination.

c. Sources of Data: Provide a full description of the source of data upon which the enrollment data engagement's conclusion(s) will be based, including the legal or other standards applied, documents relied upon, and/or any contractual obligations.

d. Sampling Unit: Define the sampling unit, which is any of the designated elements that comprise the population of interest.

e. Sampling Frame: Identify the sampling frame, which is the totality of the sampling units from which the sample will be selected.

The enrollment data engagement shall provide:

a. findings regarding UHCI's Medicare+Choice Program enrollment data submission operation (including, but not limited to, the operation of the

enrollment data certification process, the weaknesses of the process that provides the basis for the certification, the internal controls of the process by which certification is obtained, and the overall effectiveness of the system);

b. findings regarding whether UHCI is utilizing adequate and appropriate methods in its enrollment data submission;

c. findings regarding UHCI's procedures to identify and report data discrepancies and to correct enrollment data that is incorrect;

d. findings regarding whether UHCI's receipt of enhanced capitation payments in cases of Medicare/Medicaid dual-eligibility, institutionalization, hospice status, ESRD status and out-of-area status, is accurate and appropriate, including, but not limited to, whether UHCI's requests for dual eligible capitation, institutionalization capitation, hospice capitation, ESRD capitation or out-of-area capitation, if any, can be supported by documentation *(i.e.*, copies of Medicaid cards and/or the HI Mini-Master database for dual eligibility verification);

e. findings regarding the steps UHCI is taking to bring its operations into compliance or to correct problems identified by the engagement.

2. *Encounter Data Engagement.* The purpose of the encounter data engagement is to determine the accuracy and reliability of UHCI's submission of

Medicare+Choice encounter data to HCFA. The encounter data engagement shall consist of an analysis of a statistically valid sample of items that can be projected to the population of claims for the relevant one-year time period. Each annual encounter data assessment shall include the following components in its methodology:

a. Encounter Data Engagement Objective: A clear statement of the objective of the encounter data engagement and the procedure(s) that will be applied to achieve the objective.

b. Encounter Data Engagement Population: Identify the population, which is the group about whom data must be gathered and analyzed. Explain the methodology used to develop the population and provide the basis for this determination.

c. Sources of Data: Provide a full description of the source of data upon which the encounter data engagement's conclusion(s) will be based, including the legal or other standards applied, documents relied upon, and/or any contractual obligations.

d. Sampling Unit: Define the sampling unit, which is any of the designated elements that comprise the population of interest.

e. Sampling Frame: Identify the sampling frame, which is the totality of the sampling units from which the sample will be selected.

The encounter data engagement shall provide:

a. findings regarding UHCI's encounter data submission operation (including, but not limited to, the operation of the encounter data certification process, the weaknesses of the process that provides the basis for the certification, the internal controls of the process by which certification is obtained, and the overall effectiveness of the system);

b. findings regarding whether UHCI is utilizing adequate and appropriate methods in its encounter data submission;

c. findings regarding UHCI's procedures to correct encounter data that is incorrect;

d. findings regarding the steps UHCI is taking to bring its operations into compliance or to correct problems identified by the audit.

3. *Adjusted Community Rate Data Engagement*. The purpose of the adjusted community rate data engagement is to determine the accuracy and reliability of UHCI's submission of Medicare+Choice adjusted community rate data to HCFA. The annual adjusted community rate proposal should be analyzed. Each annual adjusted community rate analysis shall include the following components in its methodology:

a. Adjusted Community Rate Data Engagement Objective: A clear statement of the objective of the adjusted community rate data engagement and the procedure(s) that will be applied to achieve the objective.

b. Base Year Amounts: Identify the base year amounts (usually two years prior) and evaluate whether there is adequate documentation (e.g., general ledger) to support those amounts.

c. Rate Proposal: Identify the estimates that were used to develop the adjusted community rate proposal and evaluate whether those estimates are reasonable and supported by adequate documentation.

d. Evaluate any and all figures relied upon in the adjusted community rate proposal for accuracy and support by adequate documentation by analyzing a statistically valid sample of items that can be projected to the population of figures.

The adjusted community rate data engagement shall provide:

a. findings regarding UHCI's adjusted community rate data submission operation (including, but not limited to, the operation of the adjusted community rate data certification process, the weaknesses of the process that provides the basis for the certification, the internal controls of the process by which certification is obtained, and the overall effectiveness of the system);

b. findings regarding whether UHCI is utilizing adequate and appropriate methods in its adjusted community rate data submission;

c. findings regarding UHCI's procedures to correct adjusted community rate data that is incorrect;

d. findings regarding the steps UHCI is taking to bring its operations into compliance or to correct problems identified by the audit.

4. *Claims Processing Engagement.* The purpose of the claims processing engagement is to determine whether UHCI's Medicare+Choice operation is in compliance with the prompt payment provisions at 42 C.F.R. §§ 422.502(c) and 422.520. The claims processing engagement shall consist of an attribute appraisal of a statistically valid sample of claims that can be projected to the population of claims for the relevant time period. Each annual claims processing engagement shall include the following components in its methodology:

a. Claims Processing Engagement Objective: A clear statement of the objective of the claims processing engagement and the attribute appraisal procedure(s) that will be applied to achieve the objective.

b. Claims Processing Engagement Population: Identify the population, which is the group about whom data must be gathered and analyzed. Explain the methodology used to develop the population and provide the basis for this determination.

c. Sources of Data: Provide a full description of the source of the data upon which the claims processing engagement's conclusion(s)

will be based, including the legal or other standards applied, documents relied upon, payment data, and/or any contractual obligations.

The claims processing engagement shall provide:

a. findings regarding UHCI's claims processing operation (including, but not limited to, the operation of the claims processing system, weaknesses of this system, internal controls, effectiveness of the system);

b. findings regarding whether UHCI is processing claims for services billed to UHCI on behalf of Medicare beneficiaries in an adequate and timely manner;

c. findings regarding UHCI's procedures to correct inaccurate or untimely claims processing; and

d. findings regarding the steps UHCI is taking to bring its operations into compliance or to correct problems identified by the audit.

5. *Selective Marketing/Disenrollment Engagement.* The purpose of the selective marketing/disenrollment engagement is to determine whether UHCI is discriminating on the basis of the health status of individuals when enrolling or disenrolling beneficiaries of the Medicare+Choice program. These risk areas are described in greater detail at Sections II.A.2.(b) and (c) of the OIG's Compliance

Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plans, 64 Fed.Reg. 61893, November 1999. The Independent Review Organization shall use a combination of methods to perform an attribute appraisal, including, but not necessarily limited to the following: the use of "secret shoppers" to test UHCI's marketing efforts and sales agents; surveys or exit interviews of a statistically valid sample of current and former enrollees (particularly those who disenroll just prior to undergoing costly care) regarding their experiences with UHCI's marketing and disenrollment process.

Each annual selective marketing/disenrollment engagement shall include the following components in its methodology:

a. Selective Marketing/Disenrollment Engagement Objective: A clear statement of the marketing/disenrollment engagement's objective and the attribute appraisal procedure(s) that will be applied to achieve the objective.

b. Selective Marketing/Disenrollment Engagement Population: Identify the population, which is the group about whom data must be gathered and analyzed. Explain the methodology used to develop the population and provide the basis for this determination.

c. Sources of Data: Provide a full description of the source of the information upon which the selective marketing/disenrollment engagement's conclusions will be based, including the legal or other

standards applied, documents relied upon, and/or any contractual obligations.

The selective marketing/disenrollment engagement shall provide:

a. findings regarding whether UHCI discriminates on the basis of health status when enrolling and disenrolling beneficiaries of Federal health care programs;

b. findings regarding whether UHCI is utilizing adequate and appropriate methods to avoid such discrimination in marketing and disenrollment;

c. findings regarding UHCI's procedures to correct marketing or disenrollment practices that are improper or inappropriate; and

d. findings regarding the steps UHCI is taking to bring its operations into compliance or to correct problems identified by the engagement.

6. *Compliance Engagement.* The purpose of the compliance engagement is to provide findings regarding whether UHCI's compliance program, policies, procedures, and operations comply with the terms of this CIA. This engagement shall include section by section findings regarding the requirements of this CIA.

7. *Verification/Validation.* In the event that the OIG determines that it is necessary to conduct an independent analysis to determine whether or the extent to which UHCI is complying with its obligations under this CIA, UHCI agrees to pay for the

reasonable cost of any such analysis or engagement by the OIG or any of its designated agents.

E. Confidential Disclosure Program. Within ninety (90) days of the effective date of this CIA, UHCI shall establish a Confidential Disclosure Program that enables Covered Persons to disclose to an individual who is not in the reporting individual's chain of command, any identified compliance issues or questions associated with UHCI's policies, practices or procedures with respect to Federal health care programs.

UHCI shall maintain as a feature of its Confidential Disclosure Program, a 24-hour toll-free telephone line known as the *Compliance Line* (actually administered by UnitedHealth), through which incidents of suspected non-compliance or other misconduct can be reported. UnitedHealth supplies wallet cards to remind employees of the Compliance Line and employees' obligation to report suspected violations of law, policies, procedures, and contractual obligations. UHCI shall additionally publicize the existence of the *Compliance Line* to Covered Persons through means such as e-mails, its employee Intranet news, on wallet cards, on pay stubs, in its employee magazine (*Perspective*), in the employee newsletter, and in postings in prominent common areas.

The Confidential Disclosure Program emphasizes a non-retribution, non-retaliation policy, and includes a reporting mechanism for anonymous, confidential communication. To the extent that an issue solely related to a human resources issue is reported, it will be referred to UHCI's human resources department for handling. Upon receipt of a

complaint not involving a human resources issue, the Compliance Officer (or designee) shall gather the information in such a way as to elicit all relevant information from the individual reporting the alleged misconduct. The Compliance Officer (or designee) shall make a preliminary good faith inquiry into the allegations set forth in every disclosure to obtain information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice, and (2) provides an opportunity for taking corrective action, UHCI shall conduct an internal review of the allegations set forth in such a disclosure and conduct proper follow-up.

The Compliance Officer shall maintain a confidential disclosure log, which shall include a record and summary of each allegation received, the status of the respective investigations, and any corrective action taken in response to the investigation.

F. Ineligible Persons.

1. *Definition*. For purposes of this CIA, an "Ineligible Person" shall be any individual or entity who: (i) is currently excluded, suspended, debarred or otherwise ineligible to participate in the Federal health care programs; or (ii) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment, or ineligibility. To the extent that UnitedHealthcare's Medicare+Choice Program Integrity and Compliance Program Supplement contains a

broader definition of ineligible persons, the above definition is not intended to supplant it. Rather, the definition set forth in this CIA represents the minimum required by OIG.

2. *Screening Requirements*. UHCI shall not knowingly or negligently hire or engage as a Covered Person or Contracted Provider any person who is an Ineligible Person. UHCI shall screen or shall arrange for the screening of all prospective Covered Persons and Contracted Providers prior to engaging their services by (i) requiring applicants to disclose whether they are Ineligible Persons, and (ii) reviewing the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://www.arnet.gov/epls) and the HHS/OIG list of excluded individuals and entities (available through the Internet at http://www.dhhs.gov/progorg/oig) (these lists and reports will hereinafter be referred to as the "Exclusion Lists"). With regard to the screening of Contracted Provider applicants and Covered Person applicants who are health care practitioners, UHCI shall review relevant information available from the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.

3. *Review and Removal Requirement.* Within ninety (90) days of the effective date of this CIA, UHCI will review its list of current Covered Persons and Contracted Providers against the Exclusion Lists. Thereafter, UHCI will review the list of Covered Persons and Contracted Providers semi-annually. If UHCI has notice that a Covered Person or Contracted Provider has become an Ineligible Person, UHCI will

remove such person from responsibility for, or involvement with, UHCI's business operations related to the Federal health care programs and shall remove such person from any position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds, at least until such time as the person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions*. If UHCI has notice that a Covered Person or Contracted Provider has been charged with a criminal offense related to any Federal health care program, or is suspended or proposed for exclusion during his or her employment or contract with UHCI, within ten (10) days of receiving such notice UHCI will remove such individual from responsibility for, or involvement with, UHCI's business operations related to the Federal health care programs until the resolution of such criminal action, suspension, or proposed exclusion, provided that if labor or other contractual agreements make such removal legally impermissible, UHCI shall closely supervise the individual in all aspects of his or her duties related to UHCI's business operations related to Federal health care programs.

G. Notification of Proceedings. Within thirty (30) days of discovery, UHCI shall notify OIG, in writing, of any ongoing investigation or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that UHCI has committed a crime or has engaged in fraudulent activities or any other knowing

misconduct. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. UHCI shall also provide written notice to OIG within thirty (30) days of the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the proceedings, if any. To the extent that materials submitted by UHCI under this Section III.G. are protected from disclosure to third parties under applicable provisions of 5 U.S.C. §552 and 45 C.F.R. Part 5, the OIG shall treat all such materials accordingly.

H. Reporting.

1. *Reporting of Overpayments.* If UHCI identifies or learns of an overpayment that can be adjusted through the payor's established reconciliation process, then UHCI shall notify the payor (e.g., HCFA or the Medicaid state agency) within 45 days (or such lesser or greater time as may be prescribed by the payor) and make any repayments or identify appropriate adjustments to be made by the payor in the time frame required by, and in accordance with, the payor's policies and instructions. For all other overpayments, UHCI shall within 30 days of UHCI's discovery of the overpayment notify and repay (repayment shall not be required if the payor explicitly instructs UHCI not to repay the overpayment) the overpayment in accordance with the payor's policies and instructions. In the event of an overpayment, UHCI shall take remedial steps within 60 days of its discovery of the overpayment (or such additional time as may be agreed to

by the payor) to correct the problem, including preventing the underlying problem and the overpayments from recurring.

2. *Reporting of Material Deficiencies*. If UHCI determines that there is a material deficiency, UHCI shall notify the OIG within thirty (30) days of discovering the material deficiency. If the material deficiency results in an overpayment, the report to the OIG shall be made at the same time as the report to the payor and shall include all of the information required by Section III.H.1 plus: (i) the payor's name, address, and contact person where the overpayment was sent; and (ii) the date of the check and identification number (or electronic transaction number) on which the overpayment was repaid. Regardless of whether the material deficiency resulted in an overpayment, the report to the OIG shall include:

a. a complete description of the material deficiency, including the relevant facts, persons involved, and legal and program authorities;

b. UHCI's actions to correct the material deficiency; and

c. any further steps UHCI plans to take to address such material deficiency and prevent it from recurring.

3. *Definition of "Overpayment."* For purposes of this CIA, an "overpayment" shall mean the amount of money the provider or health plan has received in excess of the amount due and payable under the Federal health care programs' statutes, regulations or program directives, including carrier and intermediary instructions.

4. *Definition of "Material Deficiency."* For purposes of this CIA, a "material deficiency" means anything that involves: (i) a substantial overpayment or improper payment relating to any Federal health care program, which would not include insubstantial routine adjustments or reconciliations made by UHCI, HCFA or the Medicaid state agency in the course of administering UHCI's Medicare+Choice and Medicaid contracts; (ii) a matter that a reasonable person would consider a potential violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized; or (iii) in the event that UHCI provides health care, i.e., through a staff model managed care product, the provision of items or services of a quality that fails to meet professionally recognized standards of health care. A material deficiency may be the result of an isolated event or a series of occurrences.

IV. NEW LOCATIONS

In the event that UHCI purchases or establishes new business units after the effective date of this CIA, UHCI shall notify OIG of this fact thirty (30) days of the date of purchase or establishment. This notification shall include the location of the new operation(s), phone number, fax number, Federal health care program provider number(s) (if any) and contract number. All Covered Persons and Contracted Providers at such locations shall be subject to the requirements in this CIA that apply to new Covered

Persons and Contracted Providers (e.g., completing certifications and undergoing training).

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within one-hundred and eighty (180) days after the effective date of this CIA, UHCI shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA. This Implementation Report shall include:

1. the name, address, phone number and position description of the Compliance Officer required by Section III.A;
2. the names and positions of the members of the Compliance Committee required by Section III.A;
3. a copy of UHCI's revised Code of Conduct required by Section III.B.1;
4. the summary of the Policies and Procedures required by Section III.B.2;
5. a description of the training programs required by Section III.C., including a description of the targeted audiences and a schedule of when the training sessions were held;
6. a certification by the Compliance Officer addressing whether:
    a. the Policies and Procedures required by Section III.B have been developed, are being implemented, and have been distributed or

made available to all pertinent Covered Persons and Contracted Providers;

b. all Covered Persons have completed the Code of Conduct certification required by Section III.B.1; and

c. all Covered Persons have completed the training and executed the certification required by Section III.C.

7. a copy of the proposed audit work plan as identified in Section III.D.5;

8. a description of the Confidential Disclosure Program required by Section III.E;

9. the identity of the Independent Review Organization(s) and the proposed start and completion date of the first audit; and

10. a summary of personnel actions taken pursuant to Section III.F.

B. Annual Reports. UHCI shall submit to OIG (with copies provided to the HCFA contact identified in this CIA) Annual Reports with respect to the status and findings of UHCI's compliance activities for each of the one-year periods covered by this CIA. The Annual Reports shall include:

1. any change in the identity or position description of the Compliance Officer and/or members of the Compliance Committee described in Section III.A during the period covered by the Annual Report;

2. a certification by the Compliance Officer that:

a. all Covered Persons have completed the annual Code of Conduct certification required by Section III.B.1; and

b. all Covered Persons have completed the training and executed the certification required by Section III.C.

3. notification of any changes or amendments to the Policies and Procedures required by Section III.B during the period covered by the Annual Report, and the reasons for such changes (e.g., change in HCFA policy);

4. a complete copy of the report(s) prepared pursuant to the Independent Review Organization's engagements under this CIA for the period covered by the Annual Report, including a description of the methodology used;

5. UHCI's response/corrective action plan to any issues raised by the Independent Review Organization in the course of its engagements under this CIA for the period covered by the Annual Report;

6. a summary of Overpayments and Material Deficiencies reported pursuant to Section III.H., during the period covered by the Annual Report;

7. a report of the aggregate overpayments that have been returned to the Federal health care programs, during the period covered by the Annual Report;

8. a copy of the confidential disclosure log required by Section III.E for the period covered by the Annual Report;

9. a description of any personnel action (other than hiring) taken by UHCI during the period covered by the Annual Report, as a result of the obligations in Section III.F;

10. a summary and/or update describing any ongoing investigation or legal proceeding conducted or brought by a governmental entity, involving an allegation that UHCI has committed a crime or has engaged in fraudulent activities or other knowing misconduct, which must be reported pursuant to Section III.G. The statement shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation, legal proceeding or inquiry;

11. a corrective action plan to address the probable violations of law identified in Section III.H with respect to the period covered by the Annual Report;

12. a copy of UHCI's Medicare+Choice program certifications of enrollment data (including dual-eligibility status, institutionalization, hospice status, ESRD status and out-of-area status), encounter data and ACR data, provided to HCFA during the period covered by the Annual Report;

13. a listing of all of UHCI's locations (including both street and mailing addresses), the name under which UHCI is doing business at each location,

the phone and fax numbers for each location, and the contract number associated with the health plan in each location.

The first Annual Report shall be received by OIG no later than one (1) year and ninety (90) days after the effective date of this CIA. Subsequent Annual Reports shall be submitted no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and Annual Reports shall include a certification by the Compliance Officer, under penalty of perjury, that: (1) subject to any exceptions noted in the applicable report, UHCI is in compliance with all of the requirements of this CIA, to the best of his or her knowledge; and (2) the Compliance Officer has reviewed the Report and has made reasonable inquiry regarding its content and believes that, upon such inquiry, the information is accurate and truthful.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing subsequent to the effective date of this CIA, all notifications and reports required under this CIA shall be submitted to the entities listed below:

OIG:

Civil Recoveries Branch - Compliance Unit
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Phone 202.619.2078; Fax 202.205.0604

HCFA:

Scott Nelson
Health Plan Administration Group
Center for Health Plans & Providers
Health Care Financing Administration
Mail Stop: C4-23-07
7500 Security Blvd.
Baltimore, MD 21244-1850

UHCI:

Compliance Officer
United Healthcare of Illinois, Inc.
233 N. Michigan Avenue
Chicago, IL 60601

VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s), may examine UHCI's books, records, and other documents and supporting materials for the purpose of verifying and evaluating: (a) UHCI's compliance with the terms of this CIA; and (b) UHCI's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by UHCI to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of UHCI's Covered Persons who consent to be interviewed at his or her place of business during normal business hours or at such other place and time as may

be mutually agreed upon between the Covered Person and OIG. UHCI agrees to assist OIG in contacting and arranging interviews with such Covered Persons at OIG's request. Employees may elect to be interviewed with or without a representative of UHCI present.

VIII. DOCUMENT AND RECORD RETENTION

UHCI shall maintain for inspection all documents and records relating to capitated payments from the Medicare program or other Federal health care programs or relating to compliance with this CIA, for six (6) years (or longer if otherwise legally required).

IX. DISCLOSURES

Subject to HHS' Freedom of Information Act ("FOIA") procedures, set forth in 45 C.F.R. Part 5, the OIG shall make a reasonable effort to notify UHCI prior to any release by OIG of information submitted by UHCI pursuant to its obligations under this CIA, and identified upon submission by UHCI as trade secrets, commercial or financial information and privileged and confidential under the FOIA rules. With respect to disclosure of such information, UHCI shall have the rights set forth in 45 C.F.R. §5.65(d). UHCI shall make a good faith effort to refrain from identifying any information as trade secrets, commercial or financial information and privileged and confidential that does not meet the criteria for exemption from disclosure under FOIA.

X. BREACH AND DEFAULT PROVISIONS

UHCI is expected to fully and timely comply with all of the obligations herein throughout the term of this CIA, including the submission of the final Annual Report.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, UHCI and OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day, beginning ninety (90) days after the effective date of this CIA and concluding at the end of the term of this CIA, UHCI fails to have in place any of the following:

a. a Compliance Officer;

b. a Compliance Committee;

c. written Code of Conduct;

d. written Policies and Procedures;

e. a training program; and

f. a Confidential Disclosure Program.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due, after any extension is taken into account) for each day UHCI fails to meet any of the deadlines to submit the Implementation Report or the Annual Reports to the OIG.

3. A Stipulated Penalty of $2,000 (which shall begin to accrue on the date the failure to comply began) for each day UHCI:

a. knowingly or negligently hires or enters into a contract with an Ineligible Person after that person has been listed by a federal agency as excluded, debarred, suspended or otherwise ineligible for participation in the Medicare, Medicaid or any other Federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)) (this Stipulated Penalty shall not be demanded for any time period during which UHCI can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.F) as to the status of the person);

b. knowingly or negligently employs or contracts with an Ineligible Person and that person: (i) has responsibility for, or involvement with, UHCI's business operations related to the Federal health care programs or (ii) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or in part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (this Stipulated Penalty shall not be demanded for any time period during which UHCI can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.F) as to the status of the person); or

c. knowingly or negligently employs or contracts with a person who: (i) has been charged with a criminal offense related to any Federal health care program, or

(ii) is suspended or proposed for exclusion, and that person has responsibility for, or involvement with, UHCI's business operations related to the Federal health care programs (this Stipulated Penalty shall not be demanded for any time period before 10 days after UHCI received notice of the relevant matter or after the resolution of the matter).

4. A Stipulated Penalty of $1,500 (which shall begin to accrue on the date that UHCI fails to grant access) for each day UHCI fails to grant access to the information or documentation as required in Section VII of this CIA.

5. A Stipulated Penalty of $1,000 (which shall begin to accrue ten (10) days after the date that OIG provides notice to UHCI of the failure to comply) for each day UHCI fails to comply fully and adequately with any obligation of this CIA, where the failure to comply does not form the basis for stipulated penalties under Section X.A.1 through X.A.4 of this CIA. In its notice to UHCI, the OIG shall state the specific grounds for its determination that UHCI has failed to comply fully and adequately with the CIA obligation(s) at issue.

B. Payment of Stipulated Penalties.

1. *Demand Letter.* Upon a finding that UHCI has failed to comply with any of the obligations described in Section X.A and that Stipulated Penalties are appropriate, OIG shall notify UHCI by personal service or certified mail of (a) UHCI's failure to comply; and (b) the OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand Letter").

Within fifteen (15) days of the date of the Demand Letter, UHCI shall either (a) cure the breach to the OIG's satisfaction and pay the applicable stipulated penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute the OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.D. In the event UHCI elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until UHCI cures, to the OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.C.

2. *Timely Written Requests for Extensions*. UHCI may submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after UHCI fails to meet the revised deadline as agreed to by the OIG-approved extension. Notwithstanding any other provision in this section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until two (2) business days after UHCI receives OIG's written denial of such request. A "timely written request" is defined as a request in writing received by OIG at least five (5) business days prior to the

date by which any act is due to be performed or any notification or report is due to be filed.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by wire transfer or by certified or cashier's check, payable to "Secretary of the Department of Health and Human Services," and submitted to OIG at the address set forth in Section VI.

4. *Independence from Material Breach Determination.* Except as otherwise noted, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for the OIG's determination that UHCI has materially breached this CIA, which decision shall be made at the OIG's discretion and governed by the provisions in Section X.C., below.

C. Exclusion for Material Breach of this CIA

1. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by UHCI constitutes an independent basis for UHCI's exclusion from participation in the Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)). Upon a determination by OIG that UHCI has materially breached this CIA and that exclusion should be imposed, the OIG shall notify UHCI by certified mail of (a) UHCI's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude").

2. *Opportunity to cure.* UHCI shall have thirty-five (35) days from the date of the Notice of Material Breach and Intent to Exclude Letter to demonstrate to the OIG's satisfaction that:

a. UHCI is in full compliance with this CIA;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 35-day period, but that: (i) UHCI has begun to take action to cure the material breach, (ii) UHCI is pursuing such action with due diligence, and (iii) UHCI has provided to OIG a reasonable timetable for curing the material breach.

3. *Exclusion Letter.* If at the conclusion of the thirty-five (35) day period, UHCI fails to satisfy the requirements of section X.C.2, OIG may exclude UHCI from participation in the Federal health care programs under the terms set forth herein. OIG will notify UHCI in writing of its determination to exclude UHCI (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in section X.D, below, the exclusion shall go into effect thirty (30) days after the date of the Exclusion Letter. The exclusion shall have national effect and will also apply to all other federal procurement and non-procurement programs. If UHCI is excluded under the provisions of this CIA, UHCI may seek reinstatement pursuant to the provisions at 42 C.F.R. §§ 1001.3001-.3004.

4. *Material Breach.* A material breach of this CIA means:

a. a failure by UHCI to report a known material deficiency, take corrective action and pay the appropriate refunds, as provided in section III.D;

b. repeated or flagrant violations of the obligations under this CIA, including, but not limited to, the obligations addressed in section X.A of this CIA;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with section X.B above; or

d. a failure to retain and use an Independent Review Organization for analysis purposes in accordance with section III.D.

e.. any conduct that constitutes a serious threat to the quality of care received by a Medicare beneficiary, in the event that UHCI provides health care, i.e., through a staff model managed care product.

D. Dispute Resolution

1. *Review Rights.* Upon the OIG's delivery to UHCI of its Demand Letter or of its Exclusion Letter, and as an agreed upon contractual remedy for the resolution of disputes arising under the obligation of this CIA, UHCI shall be afforded certain review rights comparable to the ones that are provided at 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005, as if they applied to the Stipulated Penalties or exclusion sought pursuant to

this CIA. Specifically, the OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an ALJ and, in the event of an appeal, the Departmental Appeals Board ("DAB"), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within fifteen (15) days of the date of the Demand Letter, and the request for a hearing involving exclusion shall be made within thirty (30) days of the date of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for stipulated penalties under this CIA shall be (a) whether UHCI was in full and timely compliance with the obligations of this CIA for which the OIG demands payment; and (b) the period of noncompliance. UHCI shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. If the ALJ finds for the OIG with regard to a finding of a breach of this CIA and orders UHCI to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable twenty (20) days after the ALJ issues such a decision, notwithstanding that UHCI may request review of the ALJ decision by the DAB.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion under this CIA shall be (a) whether UHCI was in material

breach of this CIA; (b) whether such breach was continuing on the date of the Exclusion Letter; and (c) whether the alleged material breach could not have been cured within the 35 day period, and if not, whether (i) UHCI had begun to take action to cure the material breach within that time period, (ii) UHCI has pursued and is pursuing such action with due diligence, and (iii) UHCI provided to OIG within that time period a reasonable timetable for curing the material breach. For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision that is favorable to the OIG. UHCI's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude UHCI upon the issuance of the ALJ's decision. If the ALJ sustains the determination of the OIG and determines that exclusion is authorized, such exclusion shall take effect twenty (20) days after the ALJ issues such a decision, notwithstanding that UHCI may request review of the ALJ decision by the DAB.

XI. EFFECTIVE AND BINDING AGREEMENT

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, UHCI and OIG agree as follows:

A. this CIA shall be binding on the successors, assigns and transferees of UHCI; however, OIG shall waive this successor liability provision upon receipt of verified proof to the OIG's reasonable satisfaction that UHCI has wholly divested itself of any interest or involvement, direct or indirect, in the transferred or assigned entity or contract, that the successor is an independent entity unrelated in any manner to UHCI, that the successor

has acquired its interest at fair market value in an arms' length transaction, and that the successor has policies, procedures and practices in effect to promote its compliance with the requirements of Medicare, Medicaid and all other Federal health care programs, as applicable;

B. this CIA shall become final and binding on the date the final signature is obtained on the CIA;

C. any modifications to this CIA shall be made with the prior written consent of the parties to this CIA; and

D. the undersigned UHCI signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

ON BEHALF OF UNITED HEALTHCARE OF ILLINOIS, INC.

William P. Whitely

William P. Whitely
President and CEO
United HealthCare of Illinois, Inc.

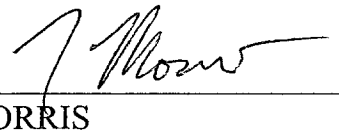
11/22/00
DATE

Joel L. Michaels

Joel L. Michaels
Ankur Goel
McDermott, Will & Emery
Counsel to United HealthCare of Illinois, Inc.

11/6/2000
DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES



LEWIS MORRIS
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

11/9/00
DATE